

REPORT TO:	Health Policy and Performance Board
DATE:	7 January 2014
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Quality in Healthcare
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report provides the Board with :-

- an overview of health reports including Keogh Reviews, Cavendish Review, and the government response to the Francis Inquiry 'Hard Truths, The Journey to putting patient's first';
- an overview of the findings from 'Putting Patients Back in the Picture', the final report by Ann Clwyd PM and Professor Tricia Hart, the review of NHS Complaints systems;
- a further update on progress made in relation to Quality in Health care through the commissioning process in response to the findings of the Francis Inquiry and other reports; and
- aims to provide assurance to the Board on the quality of service provided to the population of Halton and the actions being taken to ensure improvements in quality.

2.0 RECOMMENDATION: That the Board:

- i) **Note the contents of the report; and**
- ii) **Notes the progress made in monitoring and improving the quality of health care delivered locally.**

3.0 SUPPORTING INFORMATION

The Cavendish Review

3.1 The Cavendish Review was published during July 2013 following an independent review into Healthcare assistants (HCA) and Support Workers in the NHS and Social Care settings, the review was led by Camilla Cavendish, health reporter for the Times. The report notes that 1.3 million of the front line care staff across health and social care are not registered with any professional body but they now deliver the bulk of care. The review was completed in just 14 weeks during which time the author spent the bulk of her time with front line staff.

The production of the report is based on two principals; to try to reduce the complexity and bureaucracy and to go with the grain of what the best employers are already doing. The report clearly outlines the silo working of the NHS and notes that 'social care is seen as a distant land occupied by a different tribe.'

The HCA workforce makes up about one third of the NHS workforce, which spends more time at the bedside than qualified nurses. These staff must therefore be seen as a critical resource for ensuring patient care, these staff report feeling undervalued and overlooked. There is no compulsory or consistent training and a profusion of titles, many of the staff are now delivering roles once the preserve of nurses and doctors. The other major issue for the NHS is that HCAs and the nurses who supervise them are viewed as separate workforces. The report clearly outlines recommendations for Trust Boards, Directors of Nursing and the NHS to ensure that HCAs are able to deliver safe and effective care.

The HCA workforce in social care dwarfs that of the NHS and had a high turnover rate up to 19% in care homes and 30% in domiciliary care. As in the NHS care workers in social care are increasingly taking on more complex and challenging tasks. The evidence is that in some places the training provided to these staff is minimal (in some areas staff reported being shown a DVD as their training and where then sent out to care for vulnerable people).

Another key finding of the review was the inescapable fact that people needed time to deliver care, it is impossible to build sustainable, caring, integrated health and social care system unless local authorities commission for outcomes rather than by the minute.

The simple approach taken by the review is to try to identify what is common, to then enable a reduction in complexity and duplication thereby giving the user a better service. The review therefore proposes a new common set of standards across health and social care (based on the processes currently used by the best employers) called a Certificate in Fundamental Care and asks the Care Quality Commission to require all workers to achieve this before working unsupervised. This certificate would link healthcare assistant training to nurse training for the first time. .

The review identifies recommendations in four key areas:

Recruitment, training and education

- Development of a certificate in fundamental care
- Higher certificate in fundamental care (more advanced skills)
- CQC should require staff to hold the base certificate
- NMC should advise how to draw the practical elements of nursing degree into the certificate.
- Develop rigorous system of quality assurance for training
- Employers should test values, attitudes and aptitude at recruitment stage

Making caring a career

- Developing bridging programmes into pre-registration nursing
- Clear plan to widen participation in recruitment to NHS funded courses
- Caring experience a prerequisite to entry into nursing degrees
- Development of robust career development framework for health and social care

Getting the best out of people : leadership, supervision and support

- HCAs to use Nursing Assistant as title on completion of certificate in fundamental care.
- Regulators, commissioners and employers define a single common dataset and commit to its use
- Directors of Nursing to take a greater Board level responsibility for recruitment, training

and management of HCAs.

- Improve processes through professional standards and other processes to enable the dismissal of unsatisfactory staff.
- Code of conduct for staff (Skills for Health) and progress the social care compact, or substitute a formal code of conduct for employers if not in place by June 2014.

Time to care

- DH to explore with social care how to move to commissioning for outcomes and eliminate commissioning based on activity by 2017
- NHSE include the perspectives of HCAs in its review of impact of 12 hour shifts
- Statutory guidance should include payment of travel time as contract conditions for home care providers.

The NHS Halton Clinical Commissioning Group (CCG) will be utilising the recommendations to ensure all health care providers in the contractual process for 2014/15 to ensure HCA training and competency is part of developmental and quality improvement programmes.

3.2 Keogh Reviews

During July 2013, NHS England published the Review into the Quality of Care and treatment provided in 14 hospital trusts in England: overview report.

Each of the 14 trusts were identified as having persistently higher than average mortality ratios, this measure was used for the review as it had been recognised that Mid Staffordshire NHS Trust has high mortality levels and these were associated with failures of all dimensions quality, clinical effectiveness, safety and patient experience.

SMRs or Standardised Mortality Ratios are measured by dividing the number of deaths in a time period by expected number of deaths. Expected deaths has a specific meaning in the context of SMR, the term provides an indication of how likely a patient is to die of the symptoms they had when they came into hospital. Currently three different methodologies are used:

- Summary Hospital Level Mortality Indicators (SHMI) published by NHS Information Centre;
- Hospital Standardised Mortality Ratio (HMSR) developed by Dr Foster Intelligence; or
- Risk Adjusted Mortality Index (RAMI) developed and published by CHKS.

The process for the reviews was labour intensive which commenced with a data gathering exercise and detailed analysis of the data, followed by a multi-disciplinary review with planned and unannounced site visits, the teams 15 to 20 strong consisted of patients, lay representatives, senior clinicians, junior doctors, student nurses and senior managers. During the visits the teams listened to staff and patients to gain insight into the services delivered as well as to CCGs, local politicians and those who represented local people. Common themes were identified across all 14 hospitals and the overview report provides eight ambitions for improvement and for each ambition areas of action are outlined.

The ambitions outlined are:

1. We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

2. The Boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They along with patients and the public will have rapid access to accurate, insightful and easy to use data about quality at service line level.
3. Patients, carers and members of the public will increasingly feel like they are being as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their care and the care of others.
4. Patients and clinicians will have the confidence in the quality assessments made by the Care Quality Commission, not least because they will be active participants on inspections.
5. No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.
6. Nurse staffing levels and skill mix will appropriately reflect the caseload and severity of illness of the patients they are caring for and be transparently reported by trust boards.
7. Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but the clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.
8. All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates and will be making this a key part of the quality improvement strategy.

For each of the 14 hospital reviewed individual reports were published via the Care Quality Commission's (CQC) website and where appropriate an improvement plan was developed. The CCG is using the Keogh ambitions to define quality markers for the 2014/15 contractual year. The CQC have now developed an inspection programme based on the Keogh reviews which will commence shortly with the next fourteen reviews to commence and will include follow ups of the initial reviews.

- 3.3 During November 2013 the Department of Health published '**Hard Truths, the journey to putting patients first**' which consists of two volumes plus a guide to nursing, midwifery and care staffing capacity and capability (How to ensure the right people, with the right skills, are in the right place at the right time), and a Concordat from the National Quality Board (Human Factors in Healthcare).

Hard Truths commences with a **statement of common purpose** which outlines the government commitment to the improvements to quality and safety in healthcare. The commitment outlines the values expected from the NHS (respect and dignity, commitment to quality, compassion, everyone counts, putting patient first, working together to do it better).

Areas of improvement and delivery are:

- Expert inspections of hospitals
- Independence for CQC
- Failure regime
- New system of ratings
- Involving patients and relatives

- Fundamental standards
- Publication of clinical outcomes
- New nursing and midwifery leadership programmes
- Senior leaders will spend time on front line
- Transparent reporting of staffing levels
- Clear processes to raise concerns or complain
- Will full neglect legislation
- Fit and proper person test
- Minimise burden of bureaucracy on trusts
- Criminal offence to supply or publicise false or misleading information
- Culture of making care safer through new patient safety collaborative
- Named consultant and nurse
- CQC, NHSE and monitor to safety data available
- Publication of safety thermometer data (Local trusts doing this as of November 13 WHHFT and STHKHT)
- Publication of never events data
- Re-launch safety alerts system
- Openness and candour – strengthened duty of candour, professional advice and conduct guidance, NHS litigation
- Listening to patients F&FTs, NHS Constitution. Support for patients to participate in decision regarding their care, CQC involving patients in inspections,
- Safe staffing guidance and publication (all local trusts now reporting to trust boards from April 14 will need to be published monthly, staffing levels will be reviewed by CQC, toolkit to engage and support staff and development of values based recruitment processes.
- Detecting problems early- expert inspection teams, inspector of hospitals, rating from outstanding to inadequate, by end of 2015 all hospitals will have been reviewed. CQC will develop fundamental standards, and ask five key questions is a service safe, effective, caring, responsive and well led?
- Guide for boards to ensure working effectively to improve patient care.
- Commissioners will focus on putting clinicians at the heart of commissioning with an explicit focus on improving health outcomes.
- Ensuring staff are trained and competent revalidation for nurses, older persons nurse post graduate qualification,
- Releasing staff from unnecessary work to enable more time for care

The recommendations will be used within the 2014/15 contractual round to drive clinical quality improvement for the population of Halton.

3.4 **Putting Patients Back in the Picture** is the final report of the review into the NHS complaints procedure; the review was completed by the Right Honourable Ann Clwyd MP and Professor Tricia Hart following the painful experience suffered by Ann Clwyd when her husband died in a hospital in Wales.

The inquiry was set up by the then Prime Minister to consider the handling of concerns and complaints. 20 individuals and 38 organisations were involved in the review. The reviewers asked to receive by post and email accounts of experiences on the complaints system with suggestions for improvements. Letters from patients, relatives and friends received before the review were also included in the process. More than 2500 letters and emails were received. The team also carried out seven public engagement events to take oral evidence from the public, alongside eight individual meetings with people considered to have particular expertise. Supported by patient representatives nine hospitals and one hospice were visited

were patients front line staff and board members were interviewed.

The report notes that complaints procedures had been reviewed by other inquiries, Dame Janet Smith as part of the Fifth Report of the Shipman Inquiry, the Health Select Committee and the Francis Report all outlined concerns of a similar nature regarding the management of complaints within the NHS. The Francis Inquiry in particular outlined his support for the Patient Association's standards for good complaints handling developed as part of the Health Foundation funded 'Speaking Up' project.

The report clearly outlines the **key points which lead to complaints:**

- Lack of information
- Failures of compassion
- Dignity and care
- Staff attitudes
- Resources

And the **key points raised about what it feels like to complain:**

- Information and accessibility
- Freedom from fear
- Sensitivity
- Responsiveness
- Prompt and clear processes
- Seamless service
- Support
- Effectiveness
- Independence

Organisations involved in managing complaints outlined key issues from their perspective:

- Complexity
- Advocacy
- Leadership and governance
- Skills and attitudes
- Toxic cocktail (people reluctant to complain and staff being defensive)
- Independence
- NHS reforms
- Whistle-blowing and Duty of Candour
- Lack of compliance

The report makes **recommendations in four areas:**

- Improving the quality of care 10 recommendations spread across staff and boards
- Improvements in the way complaints are handled- 19 recommendations across Regulators, Commissioners and providers.
- Greater perceived and actual independence in the complaints process five recommendations for trusts
- Whistle-blowing five recommendations for trusts, DH and CQC

The report also outlines **an approach to implementation and the pledges to act made by:**

- Nursing and Midwifery Council
- Royal College of Nursing
- NHS Trust Development Authority
- Health Education England
- Local Government Association
- NHS confederation
- NHS Employers
- General Medical Council
- Monitor
- Care Quality Commission
- NHS England
- The Parliamentary and Health Service Ombudsman

As part of the commissioning process for the 2014/15 contractual year the CCG will aim to include a requirement on all providers to improve complaints management and learning from complaints as a quality measure reported via the contractual performance processes.

3.5 **Delivery of quality improvement and assurance in line with the recommendations of the Francis Inquiry**

Following the last update to the Board it was agreed that this update would include an overview of some of the improvements areas delivered in the 2013/14 contract performance year as an outcome of implementation of Francis Inquiry recommendations.

All providers have in this year delivered:

- Development and implementation of quality and nursing strategies including action on safer staffing and HCA training, for acute providers all are publishing safety thermometer data through the open and honest care programme. Community and mental health providers are to follow.
- Development of clinical leadership programmes which include percentage of time by senior staff working with front line staff and development of leadership skills in clinical staff.
- Evidence of implementation of a culture of openness and transparency through duty of candour statements in complaint, incident and concerns reports and responses.
- All providers signed up to health economy wide working in relation to safer care and Health care acquired infection.
- All providers are now presenting at contracts quality meetings: incident reporting outcomes, full complaints reports, compliance with NICE guidance and alerts.

The CCG and LA as commissioners are working closely together to ensure quality is monitored and reported across all provision health and social care, this being delivered through the development of joint reporting processes and integrated working. .

As part of the commissioning process for 14/15 the CCG is aiming to commence the use of quality outcomes based commissioning processes to ensure quality measures deliver real patient outcomes and do not just count widgets.

4.0 **POLICY IMPLICATIONS**

4.1 The LA and CCG need to ensure that policies for local service delivery and development ensure a focus on care provision with the patient or user at the centre and deliver outcomes

for patients and their families.

4.2 The CCG must now develop its five year strategy for commissioning the strategy must be developed in an integrated way with the local authority and must focus on delivery of care that is high quality and safe. All areas within the strategy must focus on outcomes for patients and delivery of the health improvements as defined with the Joint Strategic Needs Assessment.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The CCG needs to ensure the continuous improvement of quality in all services, the financial challenge for the NHS remains

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

The delivery of high quality health care is essential to support the achievement of the potential of children and young people.

6.2 **Employment, Learning & Skills in Halton**

Good health is essential to enabling local people to achieve their potential through education and into employment.

6.3 **A Healthy Halton**

Quality of health care is essential in supporting the delivery of improved health to the population of Halton.

6.4 **A Safer Halton**

Health care services support the delivery of safety in Halton through support to local people.

6.5 **Halton's Urban Renewal**

The CCG is aiming to ensure Halton pound is spent within Halton and through this supporting the urban development and renewal for Halton.

7.0 **RISK ANALYSIS**

7.1 Key strategic objectives and key functions for the CCG are to commissioning health care to improve the Health of the local population and to drive continuous quality improvement in the service it commissions

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 All health service provision is delivered in line with the requirements of equality and diversity law.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act.