Public Document Pack

Nottingham
City Council

NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY PANEL

Date: Wednesday, 29 January 2014

Time: 1.30 pm (pre-meeting for all Panel members at 1pm)

Place: LB 31, Loxley House

Councillors are requested to attend the above meeting to transact the following business

Deputy Chief Executive/Corporate Director for Resources
Constitutional Services Officer: Jane Garrard **Direct Dial:** 0115 8764315

AGENDA **Pages**

		Pages
1	**CHANGE IN COMMITTEE MEMBERSHIP** To note that Councillor Anne Peach has been appointed to fill a vacancy	
2	**APOLOGIES FOR ABSENCE**	
3	**DECLARATIONS OF INTERESTS**	
4	**MINUTES** To confirm the minutes of the last meeting held on 27 November 2013	3 - 6
5	**NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2013/14** Report of the Head of Democratic Services	7 - 14
6	**COMMISSIONING OF CARE AT HOME SERVICES** Report of the Head of Democratic Services	15 - 18
7	**IMPLICATIONS FOR HEALTH SCRUTINY OF THE MID-STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY (FRANCIS INQUIRY)** Report of the Head of Democratic Services	19 - 40
8	**WORK PROGRAMME 2013/14** Report of the Head of Democratic Services	41 - 46

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE CONSTITUTIONAL SERVICES OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST 15 MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES

NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at Loxley House on 27 NOVEMBER 2013 from 1.30 pm to 2.58 pm

✓	Councillor Ginny Klein	(Chair)
✓	Councillor Thulani Molife	(Vice-Chair)
✓	Councillor Mohammad Aslam	
	Councillor Merlita Bryan	
✓	Councillor Azad Choudhry	
	Councillor Eileen Morley	
✓	Councillor Brian Parbutt	
	Councillor Wendy Smith	
	Councillor Timothy Spencer	
	Vacancy	

✓ indicates present at meeting

<u>Colleagues, partners and others in attendance</u>

Lisa Burn	-	Public Health	)	
Jane Garrard	-	Overview and Scrutiny	)	
Paul Haigh	-	Residential and Day Services	)	Nottingham City Council
Jane Houston	-	Quality Assurance	)	
Mark Leavesley	-	Constitutional Services	)	
Helen Scott	-	Public Health	-	Nottinghamshire County Council

28 MEMBERSHIP

RESOLVED to note the resignation as a City Councillor of Steph Williams.

29 APOLOGIES FOR ABSENCE

Councillor Smith - personal

30 DECLARATION OF INTEREST

Councillor Choudhry – Item 5 (minute 32) ‘Quality of care in City Council care homes’ – personal interest as the partner of a care home owner.

31 MINUTES

The Panel confirmed the minutes of the meeting held on 25 September 2013 as a correct record and they were signed by the Chair.

32 NHS HEALTH CHECK

The Panel considered a report of the Head of Democratic Services on the Council’s responsibilities in relation to the NHS Health Check scheme, the commissioning of which transferred to local authorities on 1 April 2013.

Helen Scott and Lisa Burn, Public Health at Nottinghamshire County and Nottingham City respectively, presented the report and, in response to questions from the Panel, provided the following additional information:

(a) people that have received the invitation to attend but not yet done so are ‘chased’ via GPs and pharmacies;

(b) Diva Social Marketing have conducted 400 telephone interviews with invitees to find out why they have/have not attended a health check and also invite them to one of four focus groups for a more in-depth discussion about the service. One outcome from these discussions was that the ‘Health Check’ name could be misleading as the service is primarily aimed at ‘heart-health’;

(c) over 50% of attendees have been referred on to other groups that offer services such as help with stopping smoking, healthy eating and dieting;

(d) the scheme should be self-funding in the future due to NHS savings made from not having to treat so many due to early intervention/prevention;

(e) one current issue is that those not registered with a GP will not be identified and, therefore, work is underway to link into other agencies, such as those working with the homeless and immigrants;

(f) Health Checks can also be carried out in some pharmacies but they will be referred to their GP for follow up;

(g) there is variation between GPs on their engagement with the Health Check programme and the take-up rates that they achieve. Public Health is working with GPs who have been identified as under-performing;

(h) Health Checks are often carried out by nurses or healthcare assistants and training is provided to practice staff. It can be difficult to be fully assured about the quality of the Health Check carried out and lifestyle advice given. However, high risk cases are referred to medical experts in the relevant issue and there is greater quality assurance on this.

The Panel was concerned about access to the NHS Health Check programme for those individuals not registered with a GP and requested that work be undertaken to explore how this current gap can be addressed.

RESOLVED to

(1) recommend that work be undertaken to explore how to improve access to NHS Health Check for those individuals not registered with a GP;

(2) request that an update on the NHS Health Check programme, including take up rates and work to improve access for those individuals not registered with a GP, be provided in summer 2014.

33 QUALITY OF CARE IN NOTTINGHAM CITY COUNCIL CARE HOMES

The Panel considered a report of the Head of Democratic Services regarding the Council’s role, as a provider of residential care, in ensuring that citizens living in care homes receive safe, appropriate and high-quality care.

Paul Haigh, Residential and Day Care Services, and Jane Houston, Adult Provision, presented the Panel with the following information:

(a) the National and Local Framework includes;

(i) 16 Care Quality Commission (CQC) outcomes;
(ii) NHS Nottingham Clinical Commissioning Group (CCG) Inspections;
(iii) local authority contract compliance inspections;
(iv) Medicines Management Inspections, which include 28 criteria (carried out by the Nottingham CCG);
(v) monthly evidence-based self assessments, centred on the CQC outcomes, which are completed by residents, staff and carers;

(b) the City Council currently has three older peoples' care homes (Cherry Trees, Laura Chambers and The Oaks) and one care home for adults with learning disabilities (Oakdene);

(c) the care homes were inspected by the CQC during the first part of 2013, with all meeting the required levels (no 'concerns' raised by the inspectors) and being rated between 3* - 5 (5 being the highest score possible);

(d) the staffing structure and policies and procedures in place at care homes support quality provision, and all staff have a responsibility to provide good-quality care for residents and those using home care;

(e) there are literacy/numeracy courses available for staff to ensure paperwork is correctly completed and the 'Passport to Care' scheme, a staff development tool. The City is currently looking at marketing the scheme to other authorities;

(f) benefits for residents, carers and citizens, arising from the systems in place, are:

(i) a confidence in services;
(ii) clearly-defined standards, ensuring people know what to expect from the service;

(g) to ensure continued, consistent provision, observations of residents' care at different times, from different staff and from different perspectives, is undertaken;

(h) complaints/feedback is logged through the Council's 3c's system and the Social Care Complaints Team, with all complaints, however minor, being recorded;

(i) there is a significant turnover of staff at the lower levels and, although there are large numbers of applicants to fill those posts, there is a major skills gap.

During discussion, the following comments/observations were made:

(j) Martin Gawith, Healthwatch Nottingham, suggested that if a home is deemed to be failing/under-performing, the management in place should be removed/changed, not the home closed and the residents moved elsewhere, as the impact of moving for older people is significant; and that residents should be given some form of tenancy rights/ agreement. The quality of care in care homes is an area of concern and focus for Healthwatch Nottingham in the coming year;

(k) the Council should have a more' hands-on' approach with the homes it has responsibility for, rather than just reacting when something goes wrong;

(l) the Council's ambition is for all of its care homes to achieve quality banding 5.

(m) Care homes often have a low paid and low valued workforce, many of whom have low educational attainment levels. Even when the Council receives high numbers of applications for vacancies, the majority of applicants are unsuitable with some unable to even understand concepts of 'person centred care';

(n) It is difficult to compare staffing with the private sector because no statistics are available. The Commercialism Team is looking at this in terms of training and positioning the Council as a preferred employer.

RESOLVED to note the information provided.

34 WORK PROGRAMME

Jane Garrard, Overview and Scrutiny Review Co-ordinator, presented a report of the Head of Democratic Services, outlining the Panel's work programme.

RESOLVED, subject to the addition to summer 2014 of an update report on NHS Health Checks, to note the work programme.

HEALTH SCRUTINY PANEL
29 JANUARY 2014
NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2013/14
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider Nottingham CityCare Partnership's proposals for their Quality Account 2013/14, including plans for public engagement in developing the Quality Account.

2. Action required

2.1 The Panel is asked to consider and comment on the information provided in the report and at the meeting, focusing on how CityCare Partnership is to determine its priorities for its Quality Account 2013/14 and how it plans to involve stakeholders in doing so.

3. Background information

3.1 A Quality Account is an annual report to the public from providers of NHS healthcare services about the quality of their services. It aims to enhance accountability to the public and engage the organisation in its quality improvement agenda, reflecting the three domains of quality: patient safety, clinical effectiveness and patient experience.

3.2 A Quality Account should:
- improve organisational accountability to the public and engage boards (or their equivalents) in the quality improvement agenda for the organisation;
- enable the provider to review its services, show where it is doing well, but also where improvement is required;
- demonstrate what improvements are planned;
- provide information on the quality of services to patients and the public;
- demonstrate how the organisation involves, and responds to feedback from patients and the public, as well as other stakeholders.

3.3 Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining what is being done well and where improvement is needed. But, they also look forward, explaining what has been identified as priorities for improvement.

3.4 Guidance from the Department of Health requires that a Quality Account should include:

- priorities for improvement – clearly showing plans for quality improvement within the organisation and why those priorities for improvement have been chosen; and demonstrating how the organisation is developing quality improvement capacity and capability to deliver these priorities;
- a review of quality performance – reporting on the previous year's quality performance offering the reader the opportunity to understand the quality of services in areas specific to the organisation;
- an explanation of who has been involved and engaged with to determine the content and priorities contained in the Quality Account; and
- any statements provided from either NHS England or Clinical Commissioning Group as appropriate; Local Healthwatch; and Overview and Scrutiny Committees including an explanation of any changes made to the final version of the Quality Account after receiving these statements.

3.5 Quality Accounts are public documents, and while their audience is wide ranging (clinicians, staff, commissioners, patients and their carers, academics, regulators etc), Quality Accounts should present information in a way that is accessible for all. For example, data presentation should be simple and in a consistent format; information should provide a balance between positive information and acknowledgement of areas that need improvement. Use of both qualitative and quantitative data will help to present a rounded picture and the use of data, information or case studies relevant to the local community will help make the Quality Account meaningful to its reader.

3.6 As a first step towards ensuring that the information contained in Quality Accounts is accurate (the data used is of a high standard), fair (the interpretation of the information provided is reasonable) and gives a representative and balanced overview, providers have to share their Quality Accounts prior to publication. This includes sharing with:

- The appropriate NHS England Area Team where 50% or more of the provider's health services are provided under contract, agreement or arrangement with the Team or the clinical commissioning group which has the responsibility for the largest number of persons to whom the provider has provided relevant health services during the reporting period;
- The appropriate Local Healthwatch organisation; and
- The appropriate local authority overview and scrutiny committee

3.7 NHS England/ the clinical commissioning group has a legal obligation to review and comment on a provider's Quality Account, while Local Healthwatch and Overview and Scrutiny Committees are offered the opportunity to comment on a voluntary basis. Any statement provided

should indicate whether the Committee believes, based on the knowledge they have of the provider that the report is a fair reflection of the healthcare services provided. The organisation then has to include these comments in the published Quality Account.

3.8 A proposed outline of the Nottingham CityCare Partnership's Quality Account 2013/14 is attached to this report and Rosemary Galbraith, Assistant Director of Quality and Safety and Deputy Director of Nursing at Nottingham CityCare Partnership will be attending the meeting to inform the Panel of the Partnership's proposals for their Quality Account 2013/14 including their plans for public engagement in developing the Quality Account.

3.9 Following this, Nottingham CityCare Partnership will be invited to present their draft Quality Account to the Panel's May 2014 meeting, at which point the Panel can decide whether to put forward any comments for inclusion or not.

3.10 This Quality Account exercise mirrors that undertaken by the Joint City and County Health Scrutiny Committee for Trusts delivering services across Nottingham City, Nottingham County, and, in some instances, further afield. The CityCare Partnership operates exclusively within the City, hence its consideration by this Panel.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – Nottingham CityCare Partnership Annual Quality Account 2013/14 Outline

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

None

7. Wards affected

All

8. Contact information

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Nottingham CityCare Partnership CIC
Annual Quality Account 2013/14 Outline

Improving the health and wellbeing of people in Nottingham is our primary aim at CityCare. We're really listening to what members of the public, our patients and our staff say about the services we deliver, and their ideas for change to ensure the quality of our services.

A Quality Account is a formal document requested by the Department of Health, which will be published on 28 June 2014. This year's Quality Account will cover the period of April 2013-March 2014. Following Department of Health guidelines, it will include a review of key quality achievements over the last year and also provide a summary of the main priorities for improvements over the coming year, along with some mandated content.

We are dedicated to ensuring that quality remains a key focus for us, and make a commitment to providing the highest quality, cost effective care for the citizens we serve. We are therefore keen to ensure our Quality Account incorporates the views of our staff, the local population we serve and other local organisations. We are currently in the early stages of this engagement process, and are asking for comments on the proposed content (see appendix 1) and any additional suggestions for areas to cover.

We have reviewed last year's report for progress against the chosen priorities and will carry forward where necessary, themes into this year's report. This may be where a priority is still in development, or where the work undertaken has highlighted further areas for improvement.

We will also provide an update on any outstanding actions from the look back section in last year's report.

Following further engagement with stakeholders the report will be developed and a final draft will be presented to Nottingham City's Health Scrutiny Panel, NHS Nottingham City Clinical Commissioning Group and Healthwatch) by May 2013, in order that their comments and statements can be incorporated.

We would be most grateful if you would consider the proposed content (Appendix 1) and advise us on any additional content you would like to see included.

If you would like to read last year's Quality Account please visit our website – www.nottinghamcitycare.nhs.uk

Rosemary Galbraith
Assistant Director of Quality & Safety and Deputy Director of Nursing December 2013

Appendix 1

Proposed Content of Nottingham CityCare Partnership CIC Annual Quality Account 2013 / 14

Part 1 – Board Statement on Quality

This will include our Chief Executive's Statement on the organisation's commitment to Quality and Improvement.

Part 2 – Review of Quality Performance

This will include mandated statements of Quality Assurance from the Nottingham CityCare Partnership CIC Board.

This section will also provide information regarding the quality of services CityCare provides in the three areas of Patient Safety, Patient Experience and Clinical Effectiveness.

It will review the priorities identified in last year's report plus an update on any outstanding actions identified from the previous year.

This year's look back has a focus on leadership, professional support, education and training and how these drive quality improvements, alongside continued spotlights on some clinical areas.

PATIENT SAFETY

Medicines management has our attention with this report looking at progress with various schemes to improve safety of medicines in CityCare

- tailored training – provision of specialist training to specific teams
- development of a competency assessments for all nurses involved in insulin administration
- improving education and training/support for non-medical prescribers
- Safeguarding (adults/children)
- Incident reporting
- Infection control

CLINICAL EFFECTIVENESS

- increasing research capacity – produce and deliver a co-ordinated plan for research training, set up research web page, working in partnership with local universities and support research activity.
- clinical training, supervision on-going training - develop robust training programme for restorative model for clinical supervision and develop a plan for how supervision will be cascaded through identified services.
- leadership - review of the OD strategy
- leadership - explore new NHS leadership programme, via East midlands leadership academy support managers to access resources, continue to support managers on the liberating social enterprise leadership programme

DRAFT

- staff survey – action plan to be owned by staff working group, executive team to focus on elements of the results requiring improvements, decide how the 2013 survey will be delivered.
- Francis Report - review recommendations to identify areas which could benefit from making changes; demonstrate a shared culture in which the patient is the priority in everything CityCare does; review common set of core values and standards to be shared throughout the organisation; ensure leadership at all levels; review systems for risk management to include openness and transparency in everything we do; integrating PPI reporting into early warning systems; embedding learning from compliments and complaints.
- Pressure ulcer prevention
- Falls
- Nutrition

PATIENT EXPERIENCE

We are committed to improving the experience of people using our services. Capturing, listening and acting on people's views of our services is a continuous key priority to ensure our services are of high quality, relevant and accessible.

We will review progress made on the development and implementation of Customer Care training for CityCare staff, as well as outcomes for patients, lessons learnt and improvements made through patient surveys, PALS and Complaints reports, service changes and improvements made as a result of patient and public feedback in particular to focus on developments with customer care training and the 6 Cs including:-

- adding customer care training to the mandatory training matrix
- delivering train the trainer programmes
- offering opportunities for staff to develop higher level customer care skills through the delivery of customer care apprenticeship frameworks and accredited modules
- ensuring customer experience training includes 6 C's
- improving how we respond to service users after receiving their feedback

We will also showcase some particular developments that demonstrate our commitment to ensuring quality is at the heart of our continued drive and innovation.

This part will also include (mandated sections):

Participation in clinical audit
Clinical audit is a quality improvement process. It aims to improve patient care and outcomes through a review of care against clear criteria and making changes in light of this. This will include a mandatory statement and will report on national and local audits we have been involved with.

Participation in clinical research
Clinical research influences the safety and effectiveness of medications, devices/equipment, diagnostic products, treatments and interventions intended for patients. These may be used for prevention, treatment, diagnosis or for relief of symptoms in a disease.

This will include a mandatory statement and will report on research projects we have been involved with.

Quality goals agreed with our commissioners (CQUIN – Commissioning for Quality and Innovation)
CQUIN is a payment framework which enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.

This will include a mandatory statement and a report of our CQUIN goals and achievements.

Statement of data quality
This will include a mandatory statement and a report of our attainment level for the Information Governance Toolkit.

Statement on what others say about us - Care Quality Commission
The CQC is the independent regulator for health and social care providers, ensuring we meet essential standards in quality and safety.

This will include a mandatory statement detailing our registration status with CQC.

Part 4 – Priorities for Quality Improvement 2014/15

The emerging suggested priorities:-

PATIENT SAFETY
- Care delivery groups (would include Integration/Care co-ordination, mobile working, telecare and leadership)

PATIENT EXPERIENCE
- Complaints - training for managers, review of the complaints pathway/process (would include Increase awareness in services where there has been service change due to service user feedback)
- Patient stories for board/Patient experience group

CLINICAL EFFECTIVENESS
- Dementia - developing training, recruitment admiral nurses
- Falls/elderly /research
- Discharge project medicines management (in reach/out reach)

Part 5 – What other people think of our Quality Accounts

This will include mandated statements from:

- NHS Nottingham City Clinical Commissioning Group
- Local Involvement Network (LINk) / HealthWatch
- Nottingham City's Health Scrutiny Panel

Ends

DRAFT

HEALTH SCRUTINY PANEL
29 JANUARY 2014
COMMISSIONING OF CARE AT HOME SERVICES
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the Council's role, as a commissioner of care at home service delivered to adults over the age of 18 who receive social care and/or continuing healthcare funding.

2. Action required

2.1 The Committee is asked to use the information provided to inform questioning and discussion and to identify if there are any issues for further scrutiny.

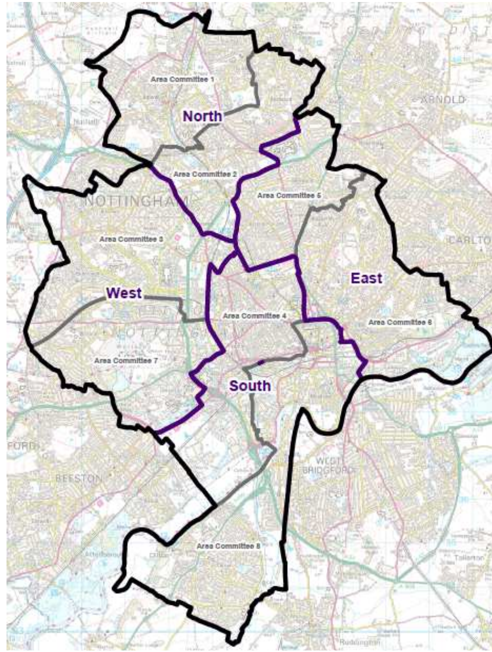
3. Background information

3.1 The previous contracts held by the Council for Homecare Services expired in December 2013 which provided the Council with an opportunity to review the service provision and the outcomes met through these services.

3.2 Following a comprehensive review of service provision, an approach has been developed which aims to ensure all citizens' needs, regardless of age, are met through a whole life model and are assisted to live independently in their communities. The new service provision will form part of a Framework of Providers of flexible services that in theory will respond to the changing needs of citizens based on a whole life model.

3.3 The Head of Quality and Efficiency will be attending the meeting to give a presentation about the new commissioning framework for homecare services. The Panel will have the opportunity to look closely at direct payments and the way payments are made "in lieu" of social care services which aims to put the citizen in control of deciding their own support and services, as an alternative to receiving direct social care.

3.4 The Panel might wish to scrutinise the Model of Service Delivery under the new framework which operates across the city as a zone based model. Extensive consultation took place in 2013 to establish to best approach to delivering care at home in Nottingham. The map below outlines the north, south, east and west zones which is based on Area Committee boundaries.



3.5 Care at home in the above zones will be delivered through a designated lead provider model, where each zone has one lead provider for that geographical area. The lead provider will then be required to deliver the majority of the care at home service in the zone. Members of the Panel may wish to scrutinise how services are selected and the quality of the service delivery in the zonal model.

3.6 In terms of service outcomes, the Panel might wish to scrutinise how hard to reach communities within the zones are identified and supported through the framework. Further clarity might be sought on how lead providers are monitored to ensure that the level of service meets the service specification.

3.7 In discussion with the Chair, it is proposed that the Panel may wish to consider following up on this issues as part of its 2013/14 work programme, exploring service user experience of homecare services.

4. List of attached information

None

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Care and Support White Paper published in July 2012

7. Wards affected

All

8. Contact information

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HEALTH SCRUTINY PANEL
29 JANUARY 2014
IMPLICATIONS FOR HEALTH SCRUTINY OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY (FRANCIS INQUIRY)
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the implications for health scrutiny of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

2. Action required

2.1 The Committee is asked to determine if, in light of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, any changes to the operation or approach of the Health Scrutiny Panel are required.

3. Background information

3.1 The Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Inquiry) examined the appalling care and serious failings at Stafford Hospital between 2005 and 2008. The number of excess deaths between 2005 and 2008 was estimated at 492 people. Examples of poor care included patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity. The report described the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'. The Inquiry looked at the hospital and the roles of the main organisations with an oversight role including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement and health scrutiny. It made 290 detailed recommendations.

3.2 The report, published in February 2013, attributed accountability to the Trust Board, but also pointed to a systemic failure by a range of national and local organisations to respond to concerns. This included the two local authorities who have both publicly acknowledged that they could have done more. The primary means for local authorities to do this is through the use of the health scrutiny powers available to them. There would be a reasonable expectation that if similar problems identified in Stafford were happening in Nottingham/ Nottinghamshire (and the report indicates that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS) the Councils would be aware and

take strong early action. Consequently, there is a need to ensure that health scrutiny operates as effectively as possible, and responds to recommendations for improvement.

3.3 In March 2013 the Panel considered the health scrutiny issues arising from the Francis Inquiry.

3.4 The Government published its full response to the Report on 19 November 2013, stating that it supports a ‘fundamental culture change’ across the health and social care system. The Executive Summary is attached at Appendix 1. The Government accepted the majority of recommendations, with 20 accepted in part, 57 accepted in principle only and 9 rejected.

3.5 The Government’s response makes very little direct reference to local government health scrutiny, except in its detailed response to each recommendation. Extracts detailing the Government’s response to the recommendations relating directly to health scrutiny are attached at Appendix 2. In its response to these recommendations the Government refers to Guidance being produced to help scrutiny committees understand and make use of the new powers and duties provided by the Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. It indicates that this Guidance will include information on developing co-ordination and co-operation between health scrutiny, Healthwatch and Health and Wellbeing Boards and support scrutiny committees in carrying out their role effectively. When the Guidance has been published, details will be provided to this Committee for its consideration.

3.6 In its response the Government stated that, in its view, the recommendation to give scrutiny committees powers of inspection would be duplicative, potentially burdensome and potentially create confusion about roles and responsibilities. The Government indicates that it intends to continue with the current arrangements whereby a health scrutiny committee can request that a provider allows it to visit premises, it can work with Local Healthwatch, which has ‘enter and view’ powers and/ or it can refer concerns to the Care Quality Commission who can carry out an inspection.

3.7 In terms of the recommendation relating to working with the Care Quality Commission (CQC), the Chair of the Health Scrutiny Panel recently met with the CQC’s Local Compliance Manager to get a better understanding of how the CQC works locally and to share information, including about current issues and concerns. The Joint Health Scrutiny Committee also submitted information to inform the CQC’s recent inspection of Nottingham University Hospitals NHS Trust.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – Mid Staffordshire NHS Foundation Trust Public Inquiry Government Response November 2013 Executive Summary

Appendix 2 - Mid Staffordshire NHS Foundation Trust Public Inquiry Extract of responses to recommendations relating directly to health scrutiny

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013

Report to and minutes of Health Scrutiny Panel meeting held on 28 March 2013

Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

'Hard Truths: The Journey to Putting Patients First' Mid Staffordshire NHS Foundation Trust Public Inquiry Government Response November 2013

7. Wards affected

All

8. Contact information

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Executive Summary

> *'The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed'*
>
> Robert Francis QC

1. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013, called for a 'fundamental culture change' across the health and social care system to put patients first at all times. Robert Francis QC, the Inquiry Chair, called for action across six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour.

2. The Government's initial response, *Patients First and Foremost*, set out a radical plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. This document and its accompanying volume build on this to provide a detailed response to the 290 recommendations the Inquiry made across every level of the system.

3. It also responds to six independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

- Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England.
- *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, by Camilla Cavendish.
- *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*, by Professor Don Berwick.
- *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart.
- *Challenging Bureaucracy*, led by the NHS Confederation.
- The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

4. Since the Inquiry reported, the Government has already instigated a number of significant changes which will improve inspection, increase transparency, put a clear emphasis on compassion, standards and safety, increase accountability for failure, and build capability.

- The Care Quality Commission has appointed three **Chief Inspectors** of hospitals, adult social care and primary care.
- The Chief Inspector of Hospitals has begun a first wave of inspections of 18 Trusts.
- **Expert inspections of hospitals with the highest mortality rates**, led by the NHS Medical Director, revealed unacceptable standards of care. Eleven hospitals were placed into 'special measures' **to put them back on a path to recovery and then to excellence**.
- The Care Quality Commission has consulted on a **new system of ratings** with patient care and safety at its heart.
- Legislation to introduce a responsive and effective **failure regime** which looks at quality as well as finance is progressing through Parliament.
- The Government is legislating to give **greater independence to the Care Quality Commission**
- The Care Quality Commission has conducted a major consultation on a new set of **fundamental standards:** the inviolable principles of safe, effective and compassionate care that must underpin all care in the future. The **fundamental standards will enable prosecutions of providers** to occur in serious cases where patients have been harmed because of unsafe or poor care, without the need for an advance warning notice.
- NHS England has published guidance to commissioners, *Transforming Participation in Health and Care*, on **involving patients and the public** in decisions about their care and their services.
- For the first time, NHS England has **published clinical outcomes by consultant** for ten medical specialties and has also begun to publish data on the friends and family test.
- **New nurse and midwifery leadership programmes** have been developed from which 10,000 nurses and midwives will have benefitted by April 2015. *Compassion in Practice* has an action area dedicated to building and strengthening leadership.
- A new fast-track **leadership** programme to recruit clinicians and external talent to the top jobs in the NHS in England has been launched, including time spent at a world-leading academic institution.
- By the end of the year, 96% of **senior leaders and all Ministers at the Department of Health will have gained frontline experience in health and care settings**.

5. This document sets out how the whole health and care system will prioritise and build on this, including **major new action on the following vital areas**:

- **Transparent monthly reporting of ward-by-ward staffing levels and other safety measures**.
- All hospitals will clearly set out how patients and their families **can raise concerns or complain, with independent support available from local Healthwatch or alternative organisations.**
- Trusts will report quarterly on complaints data and lessons learned, and the Ombudsman will significantly increase the number of cases she considers.
- A statutory duty of **candour** on providers, and a professional duty of candour on individuals through changes to professional guidance and codes.
- The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident.
- Legislate at the earliest available opportunity on **Wilful Neglect** – so that those responsible for the worst failures in care are held accountable.
- A new **fit and proper person's test** which will act as a barring scheme.
- All arm's length bodies and the Department of Health have signed a protocol in order to **minimise bureaucratic burdens on Trusts**.
- A new **Care Certificate** to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.
- The Care Bill will introduce a **new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading,** where that information is required to comply with a statutory or other legal obligation.

PREVENTING PROBLEMS

Culture

6. Patients and the public expect the NHS to do all it can to prevent any repetition of the terrible events at Mid Staffordshire NHS Foundation Trust. This requires a profound change in culture that means ensuring safe care for patients; treating people as partners; and supporting staff to care.

Patient Safety

7. This document sets out a range of new measures to take forward the findings of Professor Don Berwick's review and **make care safer for patients**, developing a culture that is dedicated to learning and improvement, and that continually strives to reduce avoidable harm in the NHS.

8. Following Don Berwick's recommendation, NHS England will establish a **new Patient Safety Collaborative Programme** across England to spread best practice, build skills and capabilities in patient safety and improvement science, and to focus on actions that can make the biggest difference to patients in every part of the country. The Safety Collaboratives will be supported systematically to tackle the leading causes of harm to patients. The programme will include establishing a **Patient Safety Improvement Fellowship** scheme to develop 5,000 Fellows within a national faculty within five years.

9. The Department of Health has agreed with the nursing and medical Royal Colleges and clinical leaders that **every hospital patient should have the name of the consultant and nurse responsible for their care above their beds.** The Government also intends to introduce a **named accountable clinician** for people receiving care outside hospitals, starting with vulnerable older people.

10. Patients and the public need easy access to reliable and accurate information about the safety of their hospital. **The Care Quality Commission and NHS England will work** with Monitor, Trust Development Authority, the Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean. This includes issuing a joint statement from the Care Quality Commission and NHS England on their commitment to complete alignment of patient safety measurement and **developing a dedicated hospital safety website for the public which will draw together up to date information on patient safety factors, for which robust data is available.** This will include information on staffing, pressure ulcers, healthcare associated infections and other key indicators, where appropriate at ward level. The website will aim to begin publication from June 2014. It will, over time, become a key source of public information, putting the truth about care at the fingertips of patients and updated monthly.

11. Trusts will continue to be encouraged to use **NHS Safety Thermometer data collection to help inform improvements in some key patient safety areas: pressure ulcers, falls resulting from harm, catheter-associated infections and venous thromboembolism.** NHS England will work with the Care Quality Commission, Monitor, Trust Development Authority, the Health and Social Care Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean.

12. NHS England will begin to **publish 'never events' data quarterly before the end of 2013, and then monthly from April 2014** to help Trusts, patients and the public drive improvement of services.

13. NHS England will **re-launch the patient safety alerts system by the end of 2013** in a clearer framework that will support organisations to understand and take rapid action in relation to patient safety risks. This new system will include greater clarity about how organisations can assess their compliance with alerts and other notifications and ensure they are appropriately implemented.

Openness and candour

14. The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not

been open about a safety incident. Subject to Parliamentary approval, from 2014 every organisation registered with the Care Quality Commission will be expected to meet a **new duty of candour. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients.** Trusts who were not open with their patients could be required to reimburse the NHS Litigation Authority for a proportion or all of the payment.

15. In addition to the statutory duty of candour on providers, there is also a **professional duty of candour on individuals that will be strengthened** through changes to professional guidance and codes. The professional values of individual clinicians are critical in ensuring an open culture in which mistakes are reported, whether or not they cause actual harm. The General Medical Council, the Nursing and Midwifery Council and the other professional regulators will be working to agree consistent approaches to candour and reporting of errors, including a **common responsibility across doctors and nurses, and other health professions to be candid with patients when mistakes occur whether serious or not, and clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities**. We will ask the Professional Standards Authority to advise and report on progress with this work. **The professional regulators will develop new guidance to make it clear professionals' responsibility to report 'near misses' for errors that could have led to death or serious injury, as well as actual harm, at the earliest available opportunity and will review their professional codes of conduct to bring them into line with this guidance. The professional regulators will also review their guidance to panels taking decisions on professional misconduct to ensure they take proper account of whether or not professionals have raised concerns promptly.**

Listening to patients

16. Listening to patients and the public and responding to what they say is at the heart of a compassionate healthcare system. Patients must be involved and given their say at every level of the system.

17. **The NHS Constitution** sets out in one place the rights that all patients should expect when they receive care, and which govern how NHS organisations must behave. NHS England, Clinical Commissioning Groups, Health Education England and the Department of Health are working together with others, including NHS staff and patients, to develop a joint strategy to embed the NHS Constitution in everything that the NHS does.

18. Following successful implementation in acute hospitals, **the use of the friends and family test will be extended to mental health settings by the end of December 2014.** This will allow patients and staff the chance to raise concerns about standards of care in their hospitals, quickly and effectively.

19. By December of this year 80% of clinical commissioning groups will be commissioning **support for patients' participation and decisions in relation to their own care.**

20. It is important that local Healthwatch, as the patient and public champion for health and care services, should be as strong and effective as possible so that it can speak up for patients and provide independent support on complaints. **Healthwatch England and the Local Government Association have recently launched a tool to help local areas identify what outcomes and impacts a good local Healthwatch could achieve.**

21. At a national level, **the Care Quality Commission is now involving patients in its inspections to inform its ratings of hospitals.** The three Chief Inspectors will use the insights of people who use services to guide, inform and influence the inspection process and the judgements that come out of it.

22. Improving that the way in which the NHS manages and responds to **complaints** will be critical in shaping a culture that listens to and learns from patients, and ending a culture of defensiveness, or at worst, denial about poor care and harm to patients. The Government welcomes the review of the NHS Hospitals Complaints System by Rt Hon Ann Clwyd MP and Professor Tricia Hart, and accepts the principles behind the recommendations.

23. The Government wants every hospital to promote a culture of openness and encourage feedback, **making it clear to patients, their families and carers – for example through a sign on every ward and clinical setting – how they can complain, how to get independent local support and informing them of their right to complain to the Ombudsman if they remain dissatisfied**. Trust Chief Executives and Boards will be expected to take personal responsibility for complaints, for example by signing off letters and through an update at each board meeting. **Detailed information on complaints and the lessons learned will be published quarterly.** This will include the number of complaints received as a percentage of patient interventions, the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman and the lessons learned and improvements made as a result of complaints. The Care Quality Commission will look closely at how well a Trust deals with complaints and the Government welcomes the commitment of the Ombudsman to significantly expand the number of cases she considers.

24. The Government will explore with NHS England and other key partners the introduction of a regular and standard way of asking people who have made a complaint about whether they were satisfied with the way it was handled- to enable comparison across hospitals.

Safe staffing

25. Building on the Compassion in Practice action area dedicated to ensuring the right staff, at the right time and with the right skills, **the National Quality Board and the Chief Nursing Officer are publishing a guidance document that sets out the current evidence on safe staffing**. **This clarifies** the expectations on all NHS bodies to ensure that every ward and every shift has the staff needed to ensure that patients receive safe care.

26. By Summer 2014, **the National Institute of Health and Care Excellence will produce independent and authoritative evidence based guidance on safe staffing, and will review and endorse associated tools for setting safe staffing levels in acute settings. The National Institute for Health and Care Excellence will then start work to develop similar guidance and endorsement for staffing in non-acute settings, including mental health, community and learning disability services.**

27. From April 2014, and by June 2014 at the latest, **NHS Trusts will publish ward level information on whether they are meeting their staffing requirements**. **Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools**. The first of these will take place by June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools. A review every six months will allow for the collection of several data points to inform appropriate staffing. Commissioners will use staffing data as a basis for further questions and discussions with providers.

28. The Care Quality Commission through its Chief Inspector of Hospitals will monitor this performance and take action where non-compliance puts patient at risk of harm and **appropriate staffing levels will be a core element of the Care Quality Commission's registration regime.**

29. Health Education England has been working with NHS trusts to develop the overall workforce plan for England for 2014-15, reflecting strategic commissioning intentions. **This work indicates that a number of trusts have already increased their nurse staffing levels during 2013-14 and others are planning to do so**. Initial plans indicate that Trusts intend to employ an increase of over 3,700 nurses in 2013-14.

30. The Department of Health has commissioned a programme of work from NHS Employers that will provide **tools and training for employers to support the engagement, health and well-being of their staff.**

31. A culture that prevents poor care before it occurs depends critically on the values of the people who work in the healthcare system. As set out in its mandate, **Health Education England is committed to introducing values-based recruitment for all students entering NHS-funded clinical education programmes.**

DETECTING PROBLEMS QUICKLY

32. The new Chief Inspector of Hospitals, Professor Sir Mike Richards has issued a 'call to action' to draw patients and doctors, nurses and other health professionals into **expert inspection teams**. In July 2013, 5,025 clinicians and 2,446 patients offered to take part in inspections. Inspectors will spend more time listening to patients, service users and the staff who care for them. Inspection will include a closer examination of records, and crucially, **inspections visits will also take place at night and at weekends, with more unannounced inspections**.

33. From January 2014, the Care Quality Commission will **rate hospitals' quality of care in bands ranging from outstanding to inadequate.** The three Chief Inspectors will use the insights of people who use services to guide, inform and influence the inspection process and the judgements that come out of it.

34. To give patients and the public confidence that problems are being sought out and dealt with, **by the end of 2015 the Care Quality Commission will have conducted inspections of all acute trusts**. Two waves of inspections have been announced. The first wave of 18

Trusts is under way and will be completed by Christmas 2013, with a second wave of 19 Trusts starting in January 2014. This will include **re-inspecting the 14 hospitals investigated by the Keogh Review of mortality outliers,** to assure itself that good progress is being made in improving the standard of care for patients.

35. In mental health, inspection will begin with wave one pilots in January to March 2014; followed by a second wave in April to June 2014. Ratings will be published from October 2014 for the NHS and January 2015 for the independent sector.

36. In adult social care, inspection will begin with wave one pilots in Spring 2014 followed by a second wave in Summer 2014. All social care services will have been rated by March 2016.

37. The Department of Health and the Care Quality Commission are developing for consultation the **fundamental standards** recommended by the Inquiry. They will be described in clear, unambiguous language, expressed in terms of what it means to patients and service users.

38. The Care Quality Commission has reviewed how it uses information to identify potential failures in the quality of care in hospitals. It will ask five key questions **– is a service safe, effective, caring, responsive and well led**? The fundamental standards, below which care should never fall, will be complemented by more stretching enhanced and developmental standards which commissioners will use to require providers to deliver services to patients and service users that are of a higher quality, and the Care Quality Commission will use to inform their ratings.

39. **The Government is legislating to enhance the independence of the Care Quality Commission to ensure there can be no political interference in its vital work to protect patients.**

40. The Secretary of State has made clear that so-called 'gagging orders' are unacceptable. NHS staff will be able to raise concerns about patient care in the knowledge that they will be listened to and their views will be welcomed. The new Chief Inspector of Hospitals will be judging **whether the culture of the organisation actively promotes the benefits of openness and transparency**; and staff **can now blow the whistle to their health and care professional regulatory bodies**. All healthcare professionals will be protected by the provisions of the Public Interest Disclosure Act 1998. **Compromise agreements must include an explicit clause making clear that nothing within the agreement prevents disclosure under the Act. NHS England will develop a friends and family test for staff** and the 'Cultural Barometer' is being piloted and evaluated prior to a potential further roll out.

41. Robert Francis found that there was a lack of communication and understanding between the different organisations that held responsibility for providing oversight, support and challenge to Mid Staffordshire NHS Foundation Trust. New arrangements for regulators and commissioners will ensure that the distinct roles and responsibilities, as well as the issues and areas they need to co-operate on, are clear and unambiguous. This includes structures for sharing information and joint decision-making where they are needed. The Care Quality Commission will focus on assessing quality and publishing its findings rather than intervening to drive improvement – which falls to the NHS Trust Development Authority and Monitor.

42. **Quality Surveillance Groups** have been in place since April 2013. Their role is to bring together all key organisations at a local level to share information to make judgements based on soft information and intelligence about the quality of care at hospitals where there are concerns about care standards. Once concerns are identified, action can be taken swiftly by the relevant organisation.

TAKING ACTION PROMPTLY

43. For more significant concerns where providers are unable to improve without further support, regulatory oversight will be required. **Clear, meaningful ratings will be accompanied by clear, risk-based intervention. For the first time, the NHS will have an effective failure regime that addresses quality as well as financial distress and failure.** This will give patients and the public confidence that action can be taken quickly when services are not performing well enough.

44. Expert inspection against standards, informed by hard data and soft intelligence, will enable the Care Quality Commission through its Chief Inspectors to make judgements about whether providers are:

- **Outstanding:** sustained high quality care over time across most services, together with good evidence of innovation and shared learning.
- **Good:** the majority of services meet high quality standards and deliver care which is person centred and meet the needs of vulnerable users.
- **Requires Improvement:** significant action is required by the provider to address concerns.
- **Inadequate:** serious and/or systematic failings in relation to quality.

45. **Trusts aspiring to Foundation Trust status will have to achieve 'good' or 'outstanding' under the Care Quality Commission's new inspection regime to be authorised.** Monitor and the Care Quality Commission will also implement a joint registration and licensing system in April 2014.

46. The regulatory regime will be based around a **'single version of the truth' grounded in standards and ratings through inspection**. Under the single failure regime, clinical unsustainability will be grounds for failure procedures, including placing organisations in special measures, just as financial unsustainability is at present. Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority will publish further guidance on how they will work together to address quality issues after April 2014. **Where a Foundation Trust is placed in special measures, it will have its freedom to operate as an autonomous body suspended.** This will provide a basis for tailored and proportionate intervention that puts patients first and puts things right promptly.

47. In October 2013, Monitor introduced a **Risk Assessment Framework for NHS Foundation Trusts** which will allow Monitor to track risk and trigger enforcement action. In April 2013, the NHS Trust Development Authority published *Delivering high quality care for patients: The accountability framework for NHS Trust Boards* which sets out its approach to the oversight of and intervention in NHS Trusts.

48. Monitor published **enforcement guidance** in March 2013 on how it plans to obtain compliance in Foundation Trusts where there are breaches of health care standards specified by the Care Quality Commission, NHS England and statutory regulators of health care professions.

49. Where an NHS Trust or Foundation Trust has been placed into special measures by the NHS Trust Development Authority or by Monitor, **the Board of the Trust will need to demonstrate to the relevant body that it is credibly and effectively addressing the issues that have been raised.**

50. Where cases of failure cannot be resolved at local level, either by the Trust Board or local commissioners supported by NHS England, the use of **special administration provides a mechanism for ensuring that issues are addressed as a last resort.** Under special administration, the Secretary of State (in the case of an NHS Trust) or Monitor (in the case of a Foundation Trust) replaces the Trust's Board with a special administrator. Proposals in the Care Bill are designed to ensure that this action can be taken in cases of clinical as well as financial unsustainability.

ENSURING ROBUST ACCOUNTABILITY

51. Putting in place a clear and well-functioning system of accountability in the NHS is a critical condition for creating a culture of safe, compassionate care. In addition to the ratings and inspections led by the Care Quality Commission through its Chief Inspector of Hospitals, the Boards of Trusts are responsible for both holding their own organisation to account and accounting to the public about its performance. **NHS organisations and all parts of the health and care system will be more accountable than ever before.**

52. **NHS England will hold clinical commissioning groups to account for quality and outcomes and for their financial performance, and will have the power to intervene where there is evidence that they are failing, or are likely to fail, in their functions.** Local commissioners of health, care, and other services have a new opportunity, through health and wellbeing boards, to work in partnership together to improve outcomes for the whole population.

53. There will be a new stronger **fit and proper persons test** for Board level appointments which will enable the Care Quality Commission to bar directors who are unfit from individual posts at the point of registration. This will apply to providers from the public, private and voluntary sectors. The Government believes that the barring mechanism will be a robust method of ensuring that directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact.

54. There must also, on occasion, be **direct consequences for senior managers for failures in their organisations**. NHS Employers will therefore be commissioned to work with the Care Quality Commission, the NHS Trust Development Authority and Monitor to develop guidance to support the effective performance management of very senior managers in

hospitals through appraisal and other means, including linking the Chief Inspector's ratings to individual contracts.

55. The Government agrees with Professor Don Berwick's recommendation that there should be a new criminal offence 'in the very rare cases where individuals or organisations are unequivocally guilty of **wilful or reckless neglect** or mistreatment of patients'. This will help to ensure that there is ultimate accountability for those guilty of the most extreme types of poor care. The Government will seek to legislate on this, will work with stakeholders beforehand to determine the details of this measure, and will consult on proposals for legislation as soon as possible.

56. Subject to Parliament, the Care Bill proposes a new criminal offence applicable to care providers who supply, publish or otherwise make available certain types of **information that is false or misleading**, where that information is required to comply with a statutory or other legal obligation. The Bill also proposes that this offence will apply to the 'controlling minds' of the organisation, where they have consented or connived in an offence committed by a care provider.

57. **In April 2013, Monitor published a guide for Boards on how to ensure organisations are working effectively to improve patient care.** Monitor will also be publishing an updated Code of Governance for Foundation Trusts in early 2014 which will make recommendations to strengthen corporate governance in light of the Inquiry report. There are also plans for regular governance reviews of foundation trusts which will include quality governance

58. The professional regulatory bodies are currently hampered by a cumbersome and complex inheritance of legislation. The **Government will seek an early opportunity to legislate, enabling all the professional regulators to move rapidly to a maximum 12 month period for concerns raised about professionals to be resolved or brought to a hearing, in all but a small minority of cases.**

59. As the **medical revalidation** programme is making good progress and is working effectively in practice, we are now at the right point for **transferring the programme to NHS England** to take forward and lead the continued implementation across England.

60. **Commissioners** have a vital role to play in securing safe, compassionate care for the populations they serve. Clinically-led commissioning groups, by **putting doctors, nurses and other health professionals at the heart of commissioning with an explicit focus on improving health outcomes for the whole population,** will provide a robust basis for effective commissioning. They will be supported by **strategic clinical networks and clinical senates.**

61. Ultimate responsibility for the NHS rests with the **Government**, and the Department of Health is committed to implementing the specific recommendations that Robert Francis directed at Government. Through the **'connecting'** programme, departmental civil servants and Ministers are gaining direct experience of the realities of care services at the point of care.

ENSURING STAFF ARE TRAINED AND MOTIVATED

62. Well-treated staff treat patients well. A wealth of academic evidence demonstrates that effective **staff engagement** is absolutely essential for creating positive cultures of safe, compassionate care. The Department of Health has asked the **Social Partnership Forum**, which brings together representatives of staff and employers in the NHS, to produce guidance on good staff engagement.

63. Education and training are critical to securing the culture change necessary for the best patient care now and in the future. Action led by Health Education England and other organisations will focus on ensuring improvements in **continuous professional development and appraisal**. This will support NHS staff to prioritise the quality of care, work effectively in **multi-disciplinary teams**, to be compassionate, safety-conscious, and to genuinely listen to their patients and service users.

64. Improving the quality of **nursing** and the support available to nurses in the difficult and challenging work that they do to look after patients is at the heart of the response to the Francis report. We will continue to implement **Compassion in Practice and the 6 Cs,** fostering **nurse leadership** and supporting the implementation of **nurse revalidation.**

65. A key test of whether we have got safe, compassionate care right is the care we provide for older people, who can often be the most vulnerable patients, and those most in need of care that is properly joined up and well managed. Health Education England, working with the Chief Nursing Officer, the Director of Nursing at the Department of Health and Public Health England and the nursing profession, will develop a bespoke **older persons' nurse post-graduate qualification training programme.**

66. Health Education England has established the first set of pilots of up to one year of **pre-degree care experience for aspiring student nurses**. On completion the pilot will be evaluated to see how pre-degree care experience could be rolled out in an affordable and cost-neutral way, so that everybody who wants to train to be a nurse is able to gain caring experience before they start their studies.

67. The Nursing and Midwifery Council has committed to introduce an affordable, appropriate and effective model of **revalidation** for the nursing and midwifery professions to enhance public protection and continue to improve the quality of nursing for patients.

68. The review undertaken by Camilla Cavendish raised the need to improve recruitment, training, development and supervision of health and social care support workers, building on the work of Health Education England around the work on Agenda for Change Bands 1-4 and the publication by Skills for Care and Skills for Health of the National Minimum Training Standards in March 2013 to develop minimum standards for health care assistants and support workers. The Government has asked Health Education England to lead the work with the Skills Councils, and other delivery partners to develop a new **Care Certificate** to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.

69. One of the most powerful ways we can support staff to improve outcomes for patients and to enjoy more fulfilling work is to find ways of cutting back on **burdensome bureaucracy**

in order to release 'time to care'. The bureaucracy review led by the NHS Confederation, recommends three main ways to reduce unnecessary burden by understanding, reducing and actively policing the volume of requests from national bodies; by reducing the amount of effort it takes providers to respond to information requests; and by increasing the value derived from information that is collected.

70. NHS England has introduced a **Clinical Bureaucracy Index and Audit of Digital Maturity in Health and Care** to support trusts in tracking how well they are using digital technology to reduce the burden of information collection on front line staff compared to their peers. Additionally, the Department of Health and every arm's length body signed a **Concordat for reducing the administrative burden arising from national requests for information**. The concordat aims at ensuring that national requests for information are undertaken using a single transparent process and that there are significant year on year reductions in the cost and burden caused by requests for information to the front line.

71. Excellent **leadership** is critical to the delivery of quality care. Patients need the NHS to have appropriately skilled leaders, with the right values, behaviours and competencies, at every level of the system. The development programmes of the NHS Leadership Academy will support a range of NHS staff (including clinical staff) to lead their teams and organisations to achieve more compassionate care for patients. **A new fast-track leadership programme** will attract senior clinicians as well as fresh talent from outside the NHS to manage NHS hospitals following an intensive programme of direct experience and time spent in a leading academic institution.

CONCLUSION

72. **Improving care is the responsibility of all organisations and all individuals in the NHS**. When we published *Patients First and Foremost*, we asked Trusts to hold listening events and set out for their local communities what they are doing to improve services for patients. It is encouraging that many Trusts have considered the Inquiry report in public Board meetings, and have held listening events. We have asked for feedback on these events by the end of 2013 but would urge organisations to continue such conversations to understand the concerns of their patients and staff and identify areas for improvement.

73. Across the health and care system, staff want to deliver safe, effective and compassionate care, to feel safe to raise any concerns, and to have confidence that these will be tackled. This response is of necessity detailed in order to do justice to the insightful findings of a major public inquiry. Within this complexity, however, it is important never to lose sight of the simple messages at the core of changing culture: **hear the patient, speak the truth, and act with compassion**.

'Hard Truths: The Journey to Putting Patients First'

Mid Staffordshire NHS Foundation Trust Public Inquiry: Government Response

November 2013

Extract of responses to recommendations relating directly to health scrutiny

Recommendation 47

The Care Quality Commission should expand its work with overview and scrutiny committees and Foundation Trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.

Accepted.

The Care Quality Commission has taken steps to engage Overview and Scrutiny Committees and Foundation Trust Governors, to increase their input to its new approach to inspection and monitoring.

All Overview and Scrutiny Committees now receive a two-monthly bulletin from the Care Quality Commission to update them on work and encourage feedback from their scrutiny reviews and activity. Each Overview and Scrutiny Committees has received a welcome letter from Professor Sir Mike Richards, the Chief Inspector of Hospitals. Local Trusts being inspected under the Care Quality Commission's first wave of new in depth inspections have received a second letter inviting them to the public listening events and encouraging specific feedback about the Trusts.

The Care Quality Commission has put in place a contract with the Centre for Public Scrutiny to further develop information sharing and relationships with Overview and Scrutiny Committees across the regions. A sounding board of Overview and Scrutiny Committees was held in August 2013, which included encouraging Overview and Scrutiny Committees to access the Care Quality Commission's local data to inform their scrutiny work programmes.

The Care Quality Commission and Monitor have worked together so that Monitor's new statutory guidance for Governors provides briefing on the Care Quality Commission's role and new approach to inspection. It sets out ways in which Governors can have an effective role in the Care Quality Commission's monitoring and inspection, and how information should be shared.

Recommendation 119

Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.

Accepted.

Complaints data, along with other sources of feedback, have the potential to provide important information to local Healthwatch Organisations and Overview and Scrutiny Committees. It is important that Trusts respect patient confidentiality when releasing information on complaints to outside organisations but, subject to this caveat, we

consider that Trusts should seek to provide to these organisations with the complaints data that are requested.

The Department of Health will ensure that each quarter every hospital publishes information on the complaints it has received. This will include:

- the number of complaints received, as a percentage of patient interventions in that period;
- the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman; and
- lessons learned and improvements made as a result of complaints.

The Department of Health will work with NHS England and other key partners to determine the most effective mechanism through which to achieve these outcomes. Rt Hon Ann Clwyd MP and Professor Tricia Hart's *Review of the Handling of Complaints in NHS Hospitals* recommends that:

- There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals.
- Patients, patient representatives and local communities and local Healthwatch organisations should be fully involved in the development and monitoring of complaints' systems in all hospitals.

Local Healthwatch has an important role to play as patient champion, and it is right that individual local Healthwatch organisations have access to detailed information about complaints, subject to respect for patient confidentiality. Local Healthwatch have an important role to play in scrutinising complaints data locally.

The Department of Health will work with the Health and Social Care Information Centre to put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals.

Recommendation 147

Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

Accepted.

The Department of Health has worked with partners to develop guidance that will support effective scrutiny by local government of the commissioning and delivery of local services, helping to ensure they are effective and safe.

The guidance is aimed at local authorities, Health and Wellbeing Boards, NHS commissioners and providers, and local Healthwatch. The guidance underlines the importance of all partners in the system understanding their own and each other's roles and responsibilities, and working together to improve the quality of services.

The guidance also describes the new powers provided to local Healthwatch by the *Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny)*

Regulations 2013, and describes how Health and Wellbeing Boards and local Healthwatch can work collaboratively with local government scrutiny committees to ensure that the views and concerns of patients and public are heard throughout the scrutiny process.

The guidance is due to be published in November 2013.

Recommendation 149

Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

Accepted.

The Department of Health has worked with partners to develop guidance that will support local authorities to carry out effective scrutiny of the commissioning and delivery of local services, helping to ensure they are effective and safe.

The guidance will help Local Authorities (along with local partners including NHS commissioners and providers, Health and Wellbeing Boards and Healthwatch) to understand the new powers and duties provided by the *Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.*

The Department is also delivering a range of programmes to increase the availability and transparency of data for local authorities, to support local democratic accountability including scrutiny processes.

The guidance is due to be published in November 2013.

Recommendation 150

Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.

Accepted in principle.

Under current provisions, bodies carrying out local authority scrutiny functions have legal powers to require providers of NHS services to provide information and to attend scrutiny meetings to answer questions. This could include making a request to visit providers' premises. Where a body carrying out local authority scrutiny function had concerns about a specific provider, they could refer the matter to the Care Quality Commission, who have powers of inspection.

Meanwhile, local Healthwatch has the power to enter and view certain premises, as well as powers to provide information and refer concerns to local authority scrutiny bodies.

Giving further powers to local authorities would therefore be duplicative and potentially burdensome. It might also create confusion over roles and responsibilities.

The work of Local Authority health scrutiny is already integral to ensuring an appropriate inspection regime is in place locally. By working collaboratively with both providers and local Healthwatch, local authority scrutiny bodies can ensure that concerns from patients and the public trigger further investigation where necessary.

The Department of Health has worked with partners to develop guidance that will support local authorities to carry out effective scrutiny. The guidance describes the new powers and duties provided by the *Local Authorities (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013,* and underlines the importance of all partners in the local system working together to improve the quality of services.

The guidance is due to be published in November 2013.

Recommendation 246

Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.

Accepted.

While Quality Accounts provide information about local providers' performance, and should be flexible enough to support reporting at that level, they should also contain key information, in a common form, that allows direct comparisons to be made. This includes information on compliance with basic requirements and performance on key metrics including a set of outcome statistics.

The *National Health Service (Quality Accounts Regulations) 2010,* the *National Health Service (Quality Accounts) Amendment Regulations 2011* and the *National Health Service (Quality Accounts) Amendment Regulations 2012* set out prescribed information that must be included within Part 2 of the Quality Accounts.

This includes the following information:

- where the provider is subject to periodic review by the Care Quality Commission including:the date of the most recent review;
- the assessment made by the Care Quality Commission following the review;
- the action the provider intends to take to address the points made in that assessment by the Care Quality Commission; and
- any progress the provider has made in taking the action identified in the point above prior to the end of the reporting period.
- the value and banding of the summary hospital level mortality indicator; and
- other outcome measures including C. difficile per 100,000 bed days and the percentage of patients admitted to hospital who were risk assessed for venous thromboembolism. In addition, NHS England will issue guidance in October 2013 to include the patient component of the friends and family test as part of these measures.

In addition, the *National Health Service (Quality Accounts) Amendment Regulations 2012* require all Quality Accounts to include an annex that contains the statements of the:

- Overview and Scrutiny Committee or joint Overview and Scrutiny Committee carrying out the functions of that Overview and Scrutiny Committee;
- relevant clinical commissioning group or NHS England where 50% or more of the relevant health services that the provider directly provides or sub-contracts during the reporting period are under contracts or arrangements with NHS England; and
- local Healthwatch organisation.

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HEALTH SCRUTINY PANEL
29 JANUARY 2014
WORK PROGRAMME 2013/14
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the Panel's work programme for 2013/14, based on areas of work identified by the Panel at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Panel is asked to note the work that is currently planned for municipal year 2013/14 and make amendments to this programme if considered appropriate.

3. Background information

3.1 The Health Scrutiny Panel is responsible for carrying out the overview and scrutiny role in relation to health and social care matters and for exercising the Council's statutory role in scrutinising health services for the City.

3.2 The Panel is responsible for determining its own work programme to fulfil its terms of reference. The work programme is attached at Appendix 1.

3.3 The work programme is intended to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service providers about substantial variations and developments in health services that the Panel has statutory responsibilities in relation to.

3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.5 Councillors are reminded of their statutory responsibilities as follows:

While a 'substantial variation or development' of health services is not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small

geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area.

This Panel has statutory responsibilities in relation to substantial variations and developments in health services set out in legislation and associated regulations and guidance. These are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

(a) Whether, as a statutory body, the relevant Overview and Scrutiny Committee has been properly consulted within the consultation process;
(b) Whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;
(c) Whether a proposal for changes is in the interests of the local health service.

Councillors should bear these matters in mind when considering proposals.

3.6 Nottingham City and Nottinghamshire County Councils have established a Joint Health Scrutiny Committee which is responsible for scrutinising decisions made by NHS organisations, together with reviewing other health issues that impact on services accessed by both City and County residents.

4. List of attached information

4.1 The following information can be found in the appendix to this report:

Appendix 1 – Health Scrutiny Panel 2013/14 Work Programme

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Reports to and minutes of Health Scrutiny Panel meetings held on 29 May, 24 July, 25 September and 27 November 2013

7. Wards affected

All

8. Contact information

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APPENDIX 1

Health Scrutiny Panel 2013/14 Work Programme

29 May 2013	• **CityCare Partnership Quality Account 2012/13** To consider CityCare Partnership's Quality Account 2012/13 and whether to make a statement for inclusion • **Adult integrated care** To consider the adult integrated care programme • **'Community case finders' hospital discharge** To consider work to facilitate timely hospital discharge and prevent unnecessary hospital admissions through the 'community case finders' model
24 July 2013	• **Healthwatch Nottingham** To meet with Healthwatch Nottingham and agree a protocol for the working relationship between health scrutiny and Healthwatch Nottingham • **Public health** To take an overview of the Council's public health responsibilities and key priorities and challenges • **Portfolio Holder for Adults and Health/ Chair of Health and Wellbeing Board** To consider the Portfolio Holder for Adults and Health's priorities for the Portfolio and Health and Wellbeing Board, including implementation of the Joint Health and Wellbeing Strategy • **Standards of care in Nottingham care homes** To scrutinise action taken to ensure high standards of care at care homes in Nottingham
25 September 2013	• **Changemakers scheme** To hear about the role of the Nottingham Changemakers and to consider how the benefits of this scheme can be maximised

	• **Draft Adult Mental Health Strategy** To consider the draft Adult Mental Health Strategy as part of the public and stakeholder consultation process
27 November 2013	• **Quality of care in Nottingham City Council care homes** To review work to ensure quality of care in Council-owned residential care homes • **NHS Health Check** To consider the Council's responsibilities in relation to NHS Health Check and to scrutinise the discharge of those responsibilities
29 January 2014	• **CityCare Partnership Quality Account 2013/14** Preliminary consideration of priorities for CityCare Partnership's Quality Account 2013/14 • **Commissioning of Care at Home Services** To consider the new arrangements for commissioning of care at home services for adults • **Government response to the Francis Report on the Mid Staffordshire NHS Foundation Trust Public Inquiry** To consider the implications of the Government's response for the Joint Health Scrutiny Committee
26 March 2014	• **Adult Integrated Care** To review progress in the Adult Integrated Care Programme, since commencement of the new model of working in January 2014 • **CityCare Partnership complaints** To review how CityCare Partnership responds to patient comments and complaints • **Strategic Review of the Care Home Sector**

	To consider the findings of the Strategic Review of the Care Home Sector • **Health Scrutiny Guidance (tbc)** To consider the implications of recent statutory health scrutiny guidance for the Health Scrutiny Panel

To schedule:

- Integration of children's health and care services
- GP waiting times
- How do individuals and their families/ carers make informed decisions and choices about care homes?
- Review of a public health commissioned service (focus to be determined)

2014/15

- Impact of introduction of new residential care home contracts on quality
- Discussion with Portfolio Holder for Adults and Health/ Chair of the Health and Wellbeing Board
- Access to NHS Health Check for people not registered with a GP
- Healthwatch Nottingham Annual Report
- Health and Wellbeing Board and Joint Health and Wellbeing Strategy
- Health scrutiny, Health and Wellbeing Board and Healthwatch protocol

Written reports requested:

- How can public health support work at a neighbourhood/ ward level?
- The extent to which the needs of the care home market are taken into account when planning applications are considered