Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

**TRUST BOARD**
**26th September 2013**

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| **TITLE** | **Clinical Quality Assurance in the New World (Francis, Keogh, Berwick, Cavendish and the CQC New Inspection Regime)** |
| **EXECUTIVE SUMMARY** | This paper seeks to update the Trust Board on national developments, what they mean for Ashford & St Peter's NHS Foundation Trust and key recommendations moving forward.<br><br>A significant shift in organisational understanding, approach to regulatory compliance and culture is required if the Trust is to be fully able to respond to the new external environment in the most effective way. The work already underway within the organisation to refresh the culture is a necessary, positive step in the journey.<br><br>Ashford & St Peter's Hospitals NHS FT **was not** named as one of first 18 acute hospitals to be reviewed (September – December) as part of the pilot of the new CQC inspection regime. |
| **ASSURANCE (Risk) / IMPLICATIONS** | Board assurance is provided that the organisation is preparing for the new regulatory environment |
| **LINK TO STRATEGY OBJECTIVE** | **SO1:** To achieve the highest possible quality of care and treatment for our patients in terms of outcome, safety and experience. |
| **STAKEHOLDER / PATIENT IMPACT AND VIEWS** | The impact of stakeholders, staff and patients is considered within the Francis Report, the Government response and the assurance provided to the Board within this paper concerning the current position of ASPH. |
| **EQUALITY AND DIVERSITY ISSUES** | All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients. |
| **LEGAL ISSUES** | The trust has a legal obligation to ensure quality is at the heart of service provision and that patient safety is the organisations highest priority. |
| **The Trust Board are asked to:** | Discuss the paper, consider other actions that may be necessary to progress the organisational approach. |
| **Submitted by:** | Suzanne Rankin, Chief Nurse |
| **Date:** | 19th September 2013 |
| **Decision:** | For Assurance |

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

# Clinical Quality Assurance in the New World (Francis, Keogh, Berwick, Cavendish and the CQC New Inspection Regime)

## 1. Introduction

This paper seeks to update the Trust Board on national developments, what they mean for Ashford & St Peter's NHS Foundation Trust and key recommendations moving forward.

## 2. National Developments

There have been a number of seminal national papers reviews and reports focusing on clinical quality.

### 2.1 The Francis Report – Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – full report can be reviewed from http://www.midstaffspublicinquiry.com/

On 9 June 2010 the Secretary of State for Health, Andrew Lansley MP, announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. This report was published on 6th February 2013.

The report included 290 recommendations and a host of learning for health care providers, commissioners, regulators and wider. The recommendations focussed on the following themes:

- readily accessible fundamental standards and means of compliance
- no tolerance of non-compliance and the rigorous policing of fundamental standards
- emphasis on and commitment to common values throughout the system by all within it
- openness, transparency and candour in all the system's business
- strong leadership in nursing and other professional values
- strong support for leadership roles
- a level playing field for accountability
- information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.

### 2.2 The Keogh Mortality Review – full report can be reviewed from http://www.nhs.uk/nhsengland/bruce-keogh-review/Pages/Overview.aspx

In response to the Francis Report, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review.

The intelligence was built by creating a *"data pack"* on each trust around the performance of the hospitals across six key areas:

- mortality
- patient experience
- safety

- workforce
- clinical and operational effectiveness
- leadership and governance

The review showed excellent practice in all 14 of the trusts reviewed. However, also found significant scope for improvement, with each needing to address an urgent set of actions in order to raise standards of care. 11 of the 14 trusts were placed in special measures, and their progress will be overseen by the NHS Trust Development Authority or Monitor. Each trust received their report.

As a response to the Keogh review the Government announced its plans to:

- Legislate to make sure failed managers can no longer get new jobs elsewhere in the NHS.
- It would also develop a programme to identify, support and train outstanding leaders.
- It will use the new role of Chief Inspector of Hospitals (created in response to the Francis Inquiry findings with Professor Sir Mike Richards appointed) to ensure that a failing hospital will be put into special measures with a limited time period to sort out problems.

**2.3 Patients First and Foremost – The Initial Government Response to the Report of Mid Staffordshire NHS Foundation Trust Public Inquiry** – full report can be reviewed from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

The Government made an initial response to the Francis Report Public Inquiry on the 26th March 2013 in a document entitled "Patients First and Foremost". This response set out a five point plan to revolutionise the care that people receive from the NHS, putting an end to failure and issuing a call for excellence:

1. **Preventing a problem** – this included Professor Don Berwick, former Health Advisor to President Obama, would be working with the NHS Commissioning Board (now NHS England) to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.
2. **Detecting a problem –** this included Chief Inspector of Hospitals Making Assessments Based on Judgement as Well as Data
3. **Taking action promptly -** this included the development of Fundamental Standards - The Care Quality Commission, working with NICE, commissioners, professionals, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall
4. **Ensure robust accountability** – this included the Health and Safety Executive to use Criminal Sanctions
5. **Ensuring staff are trained and motivated –** Code of conduct and minimum training for Healthcare Assistants

The report stated that all NHS hospitals should set out how they intend to respond to the Inquiry's conclusions before the end of 2013.

**2.4 Cavendish Review – An Independent Review into HealthCare Assistants and Support Workers in the NHS and Social Care Settings** – full report can be reviewed from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

As a result of the findings at Mid Staffordshire NHS Foundation Trust and failings also reported at Winterbourne View, the Secretary of State asked Camilla Cavendish to carry out

an independent review into Healthcare Assistants (HCAs) and support workers in the NHS and in social care. The review focused on what can be done to ensure that unregistered staff in the NHS and Social Care treat all patients and clients with care and compassion.

On 10th July 2013, the Cavendish report was published. This independent review made recommendations including:

- all healthcare assistants and social care support workers should undergo the same basic training, based on the best practice that already exists in the system,
- and must get a standard 'certificate of fundamental care' before they can care for people unsupervised.

**2.5 A promise to learn – a commitment to act: Improving the safety of patients in England (Don Berwick, National Advisory Group on the Safety of Patients in England)** – full report can be reviewed from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Professor Don Berwick, an international expert in patient safety and former Obama Health Adviser, undertook a review, at the request of the Government, into patient safety following the Francis Report. The report was published on 6th August 2013. The problems were identified through findings gathered from prior reports (those of Robert Francis and others), the statements of patients and other experts, the research evidence, and their own experience. The recommendations included:

- The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.
- All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.
- Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.
- All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
- Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

**2.6 The Care Quality Commission's (CQC). A new start – Consultation on Changes to the way the Care Quality Commission Regulates, Inspects and Monitors Care** – Full report can be reviewed from http://www.cqc.org.uk/public/sharing-your-experience/consultations/consultation-changes-way-we-inspect-regulate-and-monitor

In June 2013, the CQC released a consultation paper which sets out significant plans to change their inspection regime. The consultation ended on the 12th August, 2013. The trust submitted a response to the consultation document.

The paper set out plans whereby from October 2013, the CQC would begin a new inspection regime whereby all providers (all Acute Trust by June 2015) will be rigorously inspected and assessed by a team of experts, against new standards (5 domains) to assess quality and safety of services. At the end of the inspection, the inspected trust will receive a rating primarily based on the inspection judgement, a series of indicators and use of data already available: One of the following ratings will be given:

- **Excellent** meaning description of trust
  - No fundamentals of care breaches
  - No inadequate services with most services rated as “Good” or “Outstanding”
  - Any breaches in expected standards are acted on quickly and effectively by provider
  - No governance or finance issues from Monitor or the NHS TDA
- **Good** meaning description of trust
  - No fundamentals of care breaches or rare occurrence of breaches are acted on quickly and effectively by the provider
  - Care is generally judged as good and the majority of services are meeting expected standards and high-quality standards
  - No inadequate services
- **requires improvement meaning description of trust**
  - Fundamentals of care are breached and/or expected standards are not being met in one/or more domains.
  - Services across the provider may not be meeting expected standards in one or more domain
  - Significant action by the provider is required to address the problem
- **Inadequate meaning description of trust**
  - Serious and systematic failings in relation to quality and fundamentals of care are not met on an on-going basis across multiple domains
  - Urgent intervention is required

The CQC proposed four levels of ratings with a determination of frequency of inspection:
- Outstanding: Every 3-5 years
- Good: Every 2-3 years
- Requires Improvement: At least once per year
- Inadequate: As necessary

The Royal Surrey County Hospital NHS Trust and Frimley Park NHS Foundation Trust are part of the first wave (pilot) of acute trusts going forward for inspection, inspected during September – December 2013. It is likely that the January to March 2013 cohort of acute trusts, to be inspected, will be named in November 2013.

The inspections are announced with the CQC giving a trust a 2 month notice period prior to inspection, however part of the inspection will be unannounced. The CQC will produce Keogh style “Data packs” which will provide the intelligence, prior to inspection or triggers for inspection.

**The five questions**
The 16 outcomes of Essential Standards of Quality and Safety eventually will be replaced with 5 key questions/domains about are services. Below are the five key questions and what that means for ASPH.

**Are they safe?**
ASPH would be required to demonstrate that patients are protected from physical, psychological or emotional harm. For example, are patients getting infections because of poor hygiene and infection control? The Trust is already promoting real time reporting of incidents, reviewing its processes and ensuring our commissioners and regulators are informed of concerns and plans to address them. We know that we need to do more to spread the learning that come out of the root cause analyses and build the resilience in teams where issues have been raised owing to high levels of serious incidents or never events taking place.

**Are they effective?**
ASPH would need to demonstrate that people's needs are met, and their care is in-line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used which give them the best chance of getting better or living independently. Mortality reviews are happening on every death in the hospital and this is now being performance managed very closely. As a result we are getting very rich data on areas where we can improve the effectiveness of treatment given. Our mortality rates are improving as a result and this and other work to focus on improvement in effectiveness.

**Are they caring?**
ASPH would need to demonstrate that people are treated with compassion, respect and dignity and that care is tailored to their needs. Our process and data capture around the experience people are having of our services is very good, evidence by our Friends and Family response rates and scores. The score from our A and E patients is significantly lower than our inpatient scores. There is still improvement needed in supporting clinicians in the complaints process.

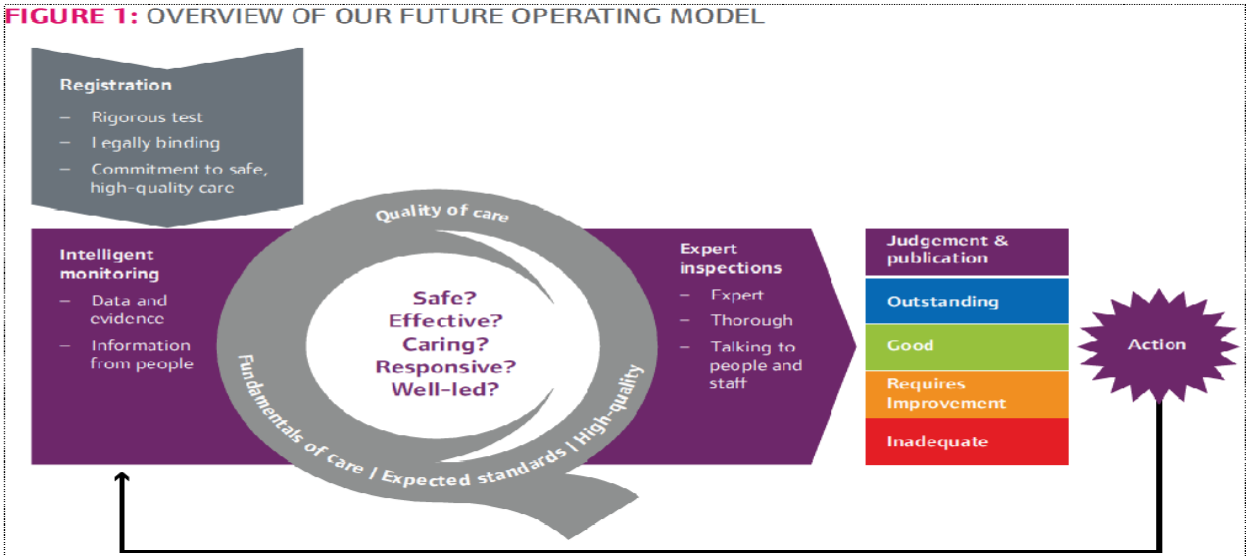
**Are they responsive?**
ASPH would need to demonstrate that people get treatment and care at the right time, without excessive delay, and that they are listened to in a way that responds to their needs and concerns.

**Are they well led?**
ASPH would need to demonstrate that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from people's views and experiences to make improvements.

In response to "Patient's First and Foremost" the CQC will develop standards for:

- **Fundamentals of care** – setting a bar below which standards of care should not fall below
- **Expected standards** – set out what anyone using a service can expect as a matter of course
- **High quality care** – The definitions will be led by organisations such as the National Institute for Health & Clinical Excellence (NICE).

**Figure 1 below demonstrates the future operating model**



## 3 How will the CQC answer these 5 Questions?

The CQC will utilise intelligence monitoring and expert inspections which would lead to a judgement.

**3.1 Qualitative intelligence**

- complaints and whistleblowing,
- safeguarding,
- negative comments on social media,
- output from inspections,
- media,
- disruption to management,

**3.2 Quantitative intelligence** - data and evidence aligned to the five questions compiled in a 'Surveillance' or 'Data' pack:

- Safety – mortality rates, never events, under-reporting of safety incidents, avoidable infections
- Effectiveness – mortality, complications, sub-optimal outcomes and avoidable morbidity,
- Experience – patients' view of treatment – PROMS, PREMS
- Responsiveness – access measures, discharge and integration
  Leadership – staff surveys, staffing, utilisation, monitor rating

**3.3 Inspections** will be:

- Robust – comprising of teams with specialist clinical knowledge
- Thorough – can last a month and cover weekends and night times
- Inclusive of views of staff and patients – will also conduct focus groups and listening events with patients, user representatives, staff members, patient organisations such as Healthwatch, strategic partners such as CCG, Monitor/NHS TDA/NHS England, Quality surveillance groups

## 4 New Focus to Clinical Quality Assurance: How will ASPH answer these questions?

In order to respond effectively to the new regulatory framework within the context of the post-Francis et al environment, a significant shift in the organisational engagement is necessary. Historically, meeting and achieving compliance has often been led by the nursing profession but clearly a multidisciplinary approach is essential. Two areas of focus in relation to engagement are key:

- Medical – Consultant leadership and ownership in conjunction with junior doctor understanding and experience.
- Stakeholders – patients, Healthwatch, CCG, Monitor, NHS England, local government.

The Trust is doing the following:

**4.1** A comprehensive Cultural Programme focusing on:

- **Health, Wellbeing and Resilience**. Analysing engagement through the pulse survey and the Wall, prioritising activities around health and wellbeing and resilience and supporting clinical staff to have their breaks.
- **Consultant engagement**. The Medical Director is hosting a Consultants' Conference in October, with external keynote speakers, focusing on the new NHS architecture, new inspection regime and Consultant responsibilities in relation to this.
- **Response to the Wall**. Optimising the very powerful impact of "peer challenge" to start an engagement piece around developing values based behaviours. Development into

face-to-face staff experience events in advance of the launch of the National Staff Survey, and "listening lunches" with Staff Governors and EPF are currently being explored.

- **Empowering Teams**. Cascading the F&F results and narrative feedback to individual wards and areas, to encourage areas to discuss results with staff, publish results & feedback locally, using it to inform improvement plans.
- **Celebration and Award events**. Over Q3 complete the annual awards process and following the success of the Pride in Nursing & Midwifery Day with a Therapies Showcase event.
- **Hot Spot Areas**. The CEO continuing to meet with 'hot spot' areas to understand issues and hold to account in relation to their improvement plans.
- **Better Leaders Better Care Programme**. The Hay Group's Development programme for Consultants and Clinical Specialty Leads.

**4.2** Establishing a Medical Director / Chief Nurse "Sounding Board" for junior doctors and other staff using Appreciative Enquiry to prepare us as an organisation.

**4.3** External communications and engagement using good news stories so that the local community hears about the good we are doing.

**4.4** Responding in a timely and effective way to complaints, concerns and other patient feedback

## 5 What does this mean for us at Ashford and St. Peter's NHS Foundation Trust?

**5.1** Clarity of the Trust's failure and risk regime: continue the work that has to look at our risk management processes and build clarity around remedy, consequences and escalation to where standards are not met.

**5.2** A cultural shift regarding engagement: outline and communicate the delivery plan of the aforementioned cultural programme.

**5.3** Building resilience: ensuring that staff members have a place where they can externalise the pressures of the work load and learn from mistakes. Triangulate staff's evaluation of programmes such as: the Schwartz Round, the CEO Sounding Board and the 'Let's Keep Talking' Wall to test its impact on health, wellbeing and resilience.

**5.4** Effective stakeholder engagement: continue our approach to involvement and continuous challenge, e.g. 24 hour hospital watch and quarterly review of Quality Account.

**5.5** Strengthening internal surveillance of clinical quality performance by:

- commissioning a Keogh/CQC style "*Data / surveillance pack*",
- building in another layer of assessment of compliance against standards "Service level" and
- thorough patient involvement in safety and quality activities

The risk to the organisation is difficult to judge, particularly after the 24th October following the launch of the new Care Bill putting into effect the new regulatory system. In the first instance therefore the commissioning of the data/surveillance packs needs endorsing by the Board.