HEALTHWATCH & PUBLIC INVOLVEMENT ASSOCIATION

Quality Accounts and the Scrutiny Role of Local Healthwatch

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HAPIA BRIEFING NOTE

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Healthwatch and Public Involvement Association

CONTENTS

HEALTHWATCH AND PUBLIC INVOLVEMENT ASSOCIATION

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AIMS AND OBJECTIVES OF HAPIA

1) Supporting the development of Local Healthwatch and Healthwatch England [HWE] as powerful and effective bodies that enable the public to monitor, influence and improve health, social care and public health services.

2) Promoting democratic and accountable public involvement organisations across England, which genuinely empower patients, care receivers, carers, and all individuals and communities to influence planners, commissioners and providers of health, social care and public health services, in order to achieve safe and effective services.

3) Investigating, challenging and influencing health, social care and public health bodies which fail to provide or commission safe, effective, compassionate and accessible services.

4) Collaborating with other community and voluntary sector bodies, patients and service users to achieve the HAPIA'S objectives.

5) Holding the government to account for its legislative and policy commitments to public influence in health, social care and public health services.

Steering Group 2013-4

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Quality accounts and the scrutiny role of Healthwatch

Background

Among the many priorities for Local Healthwatch Groups (HW), commenting on Trust's draft Quality Accounts (QA) is one not to be missed. By providing knowledgeable, meaningful commentary on QA's, HW can influence improvements in local health services. The current focus on integrated services, also give LHW an opportunity to use QAs to influence the effectiveness of social care services.

The Department of Health (DH) introduced QAs in 2010 as part of the national commitment to improve quality and transparency in the NHS. A toolkit was produced to give guidance to service providers in the production of their annual QAs (DH 2010). Subsequently, amendments were made such as aligning of information on quality indicators from the Health and Social Care Information Centre (HSCIC). An example is the number and rate of patient safety incidents and the proportion which resulted in severe patient harm (DH February 2012; NHS England, 9 January 2014).

Purpose of Quality Accounts

There is clear information for the public, available on the NHS Choices website, about the purpose and format of a QA :

"*A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.*

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided".

Scrutiny role of Healthwatch

From the outset it was clear that external assurance was a vital part of QA's being effective. In a letter to Chief Executives of NHS Trusts, Local Involvement Networks (LINks), Council Overview & Scrutiny Committees (OSCs), and Commissioners of NHS Services, Professor Sir Bruce Keogh, NHS Medical Director at the DH in 2010, pointed out that:

"….providers should share their proposed content and the data that they plan to use at an early, separate, stage with commissioners, LINks and OSCs and ideally this should be part of year-round ongoing discussions".

(DH 14 January 2010).

At that time Local Involvement Networks (LINks) were the main representative voice of patients and the public, before being superseded by Local Healthwatch in April 2013. In the DH Toolkit, providers are informed that they must offer the opportunity to local scrutiny groups to comment on draft QA's in a timely manner, and to publish scrutiny comments in the final QA.

How has Healthwatch performed its scrutiny role?

In the first year, evidence pointed to a lack of opportunity for HW and other external scrutiny groups to engage with their trusts. An Audit Commission report suggested that this was partly due to a delay of 4 months in the DH Toolkit being communicated to Trusts, leaving little time from April 2011 for meaningful engagement with scrutiny groups (Audit Commission, January 2012).

A King's Fund report on the first year of QA's similarly found that many trusts did not engage early enough in a meaningful way with external scrutiny groups in preparing their QA's (King's Fund, 2011). Although there were a small number of good examples of early engagement, most LINks and OSC's commented in QAs about the short timescale for reviewing draft QAs.

Since then, anecdotal reports from LHW indicate that some do have an ongoing year-round dialogue with local Trusts. However, the extent to which this is 'the norm' is not known. It is hoped that the current evaluation of Healthwatch, commissioned by DH, will give a clearer picture of progress of HW involvement in the QA process.

What is obvious is that there needs to be ongoing and vigilant scrutiny of health and social care services so that high standards are maintained. This was stated in the recent Annual Statement of Quality Watch (Health Foundation and Nuffield Trust, October 2014). Quality Watch aims to provide an independent picture of the quality of health and social care services. The report highlights many good things in healthcare, compared with 10 years ago, but also points out that the quality of health and social care can change, concluding that the need for scrutiny of the quality of care is more vital than ever.

Future Local Healthwatch involvement in QA's

From the sample of expert evidence above it is clear that LHW has a key part to play in making an impact on quality improvement of local health and social care services. By gathering independent experiences and views from patients and the public, HW will have a wealth of local data which can be drawn on to inform their commentary in QA's. A list of 'tips' below has been drawn from the various documents in this briefing, together with experience from LHW regarding their participation in the QA process with local trusts. LHW can make recommendations to Trusts in their area to go into the QA, and these recommendations must be published in the QA without editing by the Trust.

Tips for Healthwatch involvement in QAs

- Start early – ideally the process of working with Trusts on QAs should be all year round, but as a minimum start preparing in January, long before the draft QAs start arriving in April.

- Look at previous years' QA comments from HW and other scrutiny groups and look for evidence to see if their comments were addressed by the Trust

- Submit your QA statement with recommendations for the Trust. Ensure that it is published in full and not edited by the Trust in any way. The QA with your statement and recommendations must go to the Trust Board.

- Follow up regularly with the Trust to make sure your recommendations are either implemented or that the Trust can explain why they have not implemented them.

- Appraise whether the QA is easy to read for lay members of the public – if not, ask for explanation of any aspects which are not clear, including graphs and tables.

- Remember that the QA is specifically about quality and safety across the whole Trust. It is important not to be misled by 'Awards' or 'Innovations' being highlighted instead of indicators across all settings in which care is delivered by the trust.

- Look for trends of safety indicators, for example, are there more pressure ulcers than last year? If there is year-on-year improvement this is likely to be a good sign that the organisation is learning from errors.

- Put positive comments on evidenced improvements, as well as negative.

- Read the King's Fund Report on QA's (2011) and other documents in this Briefing.

- Get a clear picture of levels of patient harm – for example, patient falls are common in hospital and are a cause of considerable suffering. Ask questions about what is being done to prevent falls then monitor whether preventive measures have been successful. Check progress with the NHS Safety Thermometer

REFERENCES

Audit Commission (January 2012). *NHS Quality Accounts 2010-11 Providing external assurance: Findings from auditors' work at NHS trusts and foundation trusts*. (21pp).

Department of Health (December 2010). *Quality Accounts toolkit, 2010/11 - Advisory guidance for providers of NHS services producing Quality Accounts for the year 2010/11* (98pp).

Department of Health (14 January 2010). *QUALITY ACCOUNTS: Roles of Commissioning PCTs, Local Involvement Networks (LINks) and local authority Overview and Scrutiny Committees (OSCs).* (8pp). Gateway No: 13393.

Department of Health (February 2012). *QUALITY ACCOUNTS: REPORTING REQUIREMENTS FOR 2011/12 AND PLANNED CHANGES FOR 2012/13*, (15pp). Gateway reference number: 17240

Health Foundation and Nuffield Trust (October 2014). *Cause for concern: Quality Watch annual statement 2014,* (36pp).

King's Fund (January 2011). *How do quality accounts measure up? Findings from the first year*. Authors Catherine Foot, Veena Raleigh, Shilpa Ross, Tom Lyscom; (36pp).

NHS England (9 January 2014). *QUALITY ACCOUNTS – REPORTING ARRANGEMENTS FOR 2013/14.* Authors Sir Bruce Keogh, NHS Med Dir NHS England, David Bennett, Chair and CE Monitor, David Flory, CE NHS Trust Development Authority, (8pp). Gateway Ref 00931

QUALITY ACCOUNTS: Roles of Commissioning PCTs, Local Involvement Networks (LINks) and local authority Overview and Scrutiny Committees (OSCs) (8pp).

APPENDIX

Example of submission to the QA of the London Ambulance Service

To: Steve Lennox, Director Health Promotion & Quality, London Ambulance Service,

June 2ND 2014

QUALITY ACCOUNT FOR 2013-2014

We present below our contribution to the LAS's Quality Improvement Priorities for the Quality Account. We value the continuous engagement with the LAS in relation to discussions about all aspects of LAS performance and clinical care. This engagement takes places at the six internal LAS committees on which we are represented, at Trust Board meetings and at meetings with leaders of the LAS. We also value the contributions by the Chair, Chief Executive, Directors, the Head of Patient & Public Involvement and Public Education and other LAS leaders at our meetings.

1) PATIENT SAFETY SHOULD BE THE HIGHEST PRIORITY FOR THE LAS

Providing the safest and most effective care for patients should be the highest priority for the LAS. Reporting, investigating and learning from patients safety incidents must be fundamental to ensuring patient are safe. Patients must always be told when they have been harmed due to clinical errors. The LAS should ensure that all ambulances and equipment are clean and sterile, shortfalls in infection control are taken seriously and acted upon, all clinical equipment is available when needed, intact and up to date.

WE RECOMMEND that the LAS publishes in the public arena the outcome of all Serious Incidents investigated, with evidence demonstrating enduring improvements to service quality and safety, and evidence of staff and organisational learning.

2) PRE HOSPITAL DEMENTIA CARE WILL BE TRANSFORMED

The LAS should develop clear effective dementia pathways with the LAS commissioners (CCGs), acute hospitals and where possible community care professionals to ensure 'right care first time' for patients with dementia and cognitive impairment. LAS should continue the development of its Clinical Support Desk to ensure its capacity and expertise to advise clinical staff on meeting the needs of people with dementia, especially with regard to assessing cognitive impairment and pain.

WE RECOMMEND the LAS should produce evidence to demonstrate that front line staff have continuous education and training in this area. This should include access to Health Education England training resources. See also section on mental health (4) below. Access to appropriate care pathways for patient with cognitive impairment must become fundamental to providing right care, first time.

3. PATIENTS WHO FALL SHOULD ALWAYS RECEIVE INTEGRATED CARE

When patients fall and do not require access to hospital acute care, paramedics should have direct access to local Falls Teams, in order to ensure expert clinical advice and care for these patients and avoid inappropriate transfers to A&E.

WE RECOMMEND that the LAS ensures care for people who have fallen is provided within appropriate time-scales, and includes agreed care pathways and integrated care plans, with clear governance mechanisms to ensure care plans are fully implemented, enable appropriate access to services and demonstrate clear outcomes for the patient.

4. CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS MUST BE TRANSFORMED

Considerable progress has been made by the LAS in the prioritization of care for people with mental health problems. E-learning approaches have been adopted for training of staff, work is developing with mental health Trusts to develop mental health pathways and the Chief Executive is providing leadership by chairing the LAS Mental Health Committee.

WE RECOMMEND that the LAS develops a specialist team of paramedics and nurses who are expert in the care of patients with a mental health diagnosis. All paramedics and A&E support workers should be continuously and dynamically trained in the care of people with mental health problems, bearing in mind the special needs of people with learning difficulties and the need focus on cultural, language and age related issues. A significant proportion of this training should be live rather than via e-learning, as interpersonal skills and attitudes appropriate to this group of patients needs to be practiced, evaluated and demonstrated.

5. EXCELLENT END OF LIFE CARE MUST ALWAYS BE PROVIDED

The LAS should continue to develop its excellent work with Advance Care Plans (ACP), End of Life Care (EoLC) and CoOrdinate My Care (CmC). Protocols should be developed between the LAS and London's CCGs and GPs to ensure that CoOrdinate My Care (CmC) is fully developed to meet the needs of people who have an Advance Care Plan.

We RECOMMEND that the LAS enables far greater number of people to access appropriate care through CoOrdinate My Care (CmC). The LAS should publish

examples of good practice in 'end of life care' for front line staff, together with evidence of outcomes showing the effectiveness of appropriate and compassionate care for these patients.

6. DELAYS IN PROVIDING URGENT AND EMERGENCY CARE ARE NOT ACCEPTABLE

Vulnerable patients who have requested emergency care should never be left waiting hours for LAS care. Expecting vulnerable patients, who are in pain, who have fallen, or taken an overdose, to make repeated calls to the LAS to get help suggests a significant breakdown in care provision. This particularly concerns patients categorised as needing care classified as C1 and C2. We understand the limitations caused by a shortage of staff and resources.

WE RECOMMEND that urgent action is taken to promote recruitment to the LAS front line from schools, universities, job centres and religious/cultural centres. The work-force must be enlarged to ensure that the Category C targets which follow are always met:

Category C1 – 90% within 20 minutes, 99% in 45 minutes (from Clock Start)
Category C2 – 90% within 30 minutes, 99% in 60 minutes (from Clock Start)

Achievement of targets in 2013 were as follows:
Category C1 – reached in 20 minutes – 72.88% (target 90%)
Category C2 – reached in 30 minutes – 66.88% (target 90%)

7. STAFF SHIFT PATTERNS SHOULD BE FULLY EVALUATED

There is considerable national and international research pointing to the deleterious effects of shift work, including shift work patterns on both short and long term physical and mental health. Some staff members are not suited to shift work and able to remain healthy as well, but are excellent front line clinicians.

WE RECOMMEND that the impact of long shifts on front line staff is fully evaluated by the LAS, especially in relation to the impact of 12 hour shifts, without adequate meal breaks and rest on: clinical care; the health of staff; training and complaints against staff, e.g. in relation to attitude and behaviour. Staff should be interviewed about the effects of shift work on their health and clinical practice during annual appraisals, and be involved in development of improved alternatives.

8. APPROPRIATE CARE PATHWAYS SHOULD BECOME FULLY OPERATIONAL

It is critical for the LAS to work with partners across health and social care to integrate services so that patients get better, more appropriate care and experience better clinical outcomes. 'Right Care First Time' should become the norm.

WE RECOMMEND that care pathways are developed by the LAS in conjunction with CCGs, acute trusts and providers of community care that are robust enough to give confidence to LAS crews and the public that they are available when required, clinically appropriate, fully-funded, subject to regular clinical audit and tests of reliable and continuous access.

9. LAS SHOULD ACTIVELY SEEK TO BE INFLUENCED BY PATIENTS AND THE PUBLIC IN ALL THAT IT DOES

The LAS should secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of the LAS.

WE RECOMMEND:

- **Engagement with FT members, Local Healthwatch, the Patients Forum, patient groups and the voluntary sector to ensure patient involvement in all aspects of the LAS's work.**
- **Holding wider public engagement around prioritisation and service re-design.**
- **Promoting the public education role of the LAS.**
- **Developing a wide range of methods to seek public views on LAS services and providing feedback.**
- **Acknowledging the value that the LAS places on the knowledge, insight and understanding of the contribution of patients and carers.**
- **Trust Board members enhance their public accountability by listening more to and meeting the public and acting on what they say.**

10. EQUALITY AND DIVERSITY

Excellent work has so far been done in relation to LGBT colleagues and the employment of women. Reflecting on the LAS workforce and comparing its diversity to the current diversity of London and its future growth demonstrates a substantial need for development. We have argued this point for several years but have seen little change in the diversity of the LAS workforce and no change in the ethnic and cultural diversity of the LAS Board. We would not be satisfied to be told this matter will be dealt with in the post 2020 period bearing in mind that the difficulties experienced by the LAS to recruit locally, despite the very fulfilling professional opportunities for front line staff, and the need to recruit from Denmark and New Zealand.

WE RECOMMEND that the LAS embed diversity into all aspects of public education, recruitment and training and ensure full inclusion and sensitivity toward patients and staff with any protected characteristics, not solely LGBT. Changes must be made at all levels in the LAS, including the Board, to embed these duties.