Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 18th July, 2013
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Chaloner (Vice-Chair)
Councillor Claisse
Councillor Cunio
Councillor Lewzey
Councillor Parnell
Councillor Spicer
Labour Vacancy

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)
The Health Overview and Scrutiny Panel will have 6 scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the halth Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.
- To consider Councillor Calls for Action for health and social care matters.
- To respond to proposals and consultations from NHS bodies in respect of substantial

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2013/14

2013	2014
23 May 2013	31 January 2014
18 July	20 March
19 September	
21 November	

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for the disabled. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

variations in service provision and any other major health consultation exercises.

- Liaise with the Southampton LINk and its successor body “Healthwatch” and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body “Healthwatch”.
- Provide a vehicle for the City Council’s Overview & Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City’s health, care and well-being to Southampton’s LINk and its successor body “Healthwatch” for further monitoring.

Southampton City Council’s Seven Priorities

- More jobs for local people
- More local people who are well educated and skilled
- A better and safer place in which to live and invest
- Better protection for children and young people
- Support for the most vulnerable people and families
- Reducing health inequalities
- Reshaping the Council for the future

CONDUCT OF MEETING

Terms of Reference
Details above
The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed
Only those items listed on the attached agenda may be considered at this meeting.

Quorum
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Rules of Procedure
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

DISCLOSURE OF INTEREST

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Personal Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PERSONAL INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:
(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value for the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital

of that class.

Other Interests

A Member must regard himself or herself as having a, ‘Other Interest’ in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the “rationality” or “taking leave of your senses” principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, ‘live now, pay later’ and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 ELECTION OF CHAIR

To appoint a Chair to the Health Overview and Scrutiny Panel.

2 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

4 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

5 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

6 STATEMENT FROM THE CHAIR

7 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 23rd May 2013 and to deal with any matters arising, attached.

8 CARE QUALITY COMMISSION - A NEW START: CONSULTATION ON THE WAY CQC REGULATES, INSPECTS AND MONITORS CARE

Report of Head of Communities, Improvement and Partnerships seeking comments and detailing principles for inspection of all care services and monitoring of acute NHS Trusts, attached.

9 PATIENTS FIRST AND FOREMOST: THE INITIAL GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Report of the Chair, Southampton City Clinical Commissioning Group, detailing the Government's response to the report by the Mid Staffordshire NHS Foundation Trust Public Inquiry and the Francis Report, attached.

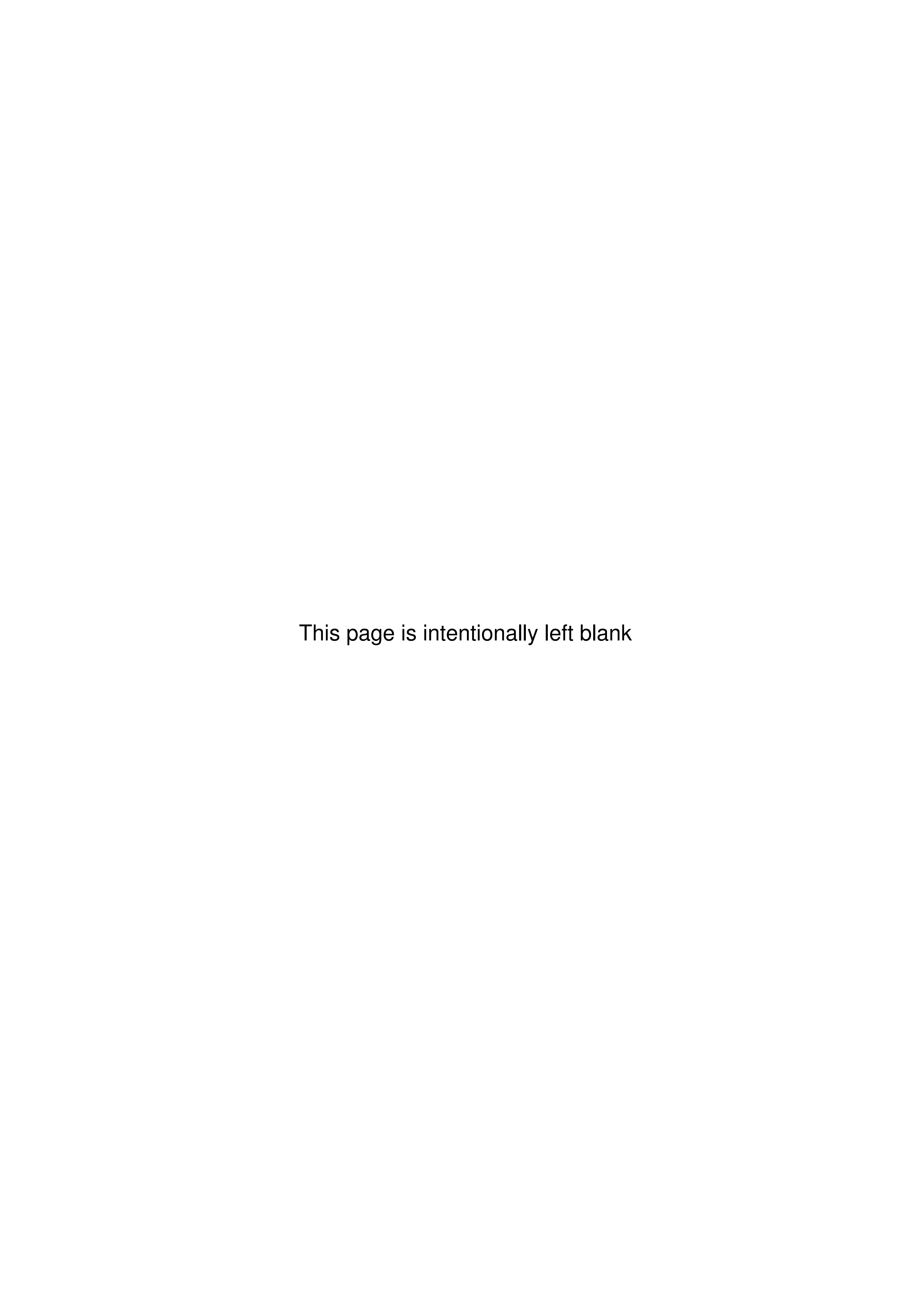
10 HEALTHWATCH SOUTHAMPTON

Report of the Commissioner for Supporting People and Adult Care Services, detailing the contract, functions and role of Healthwatch, Southampton, attached.

11 GP SERVICES, PORTSWOOD

Report of the Head of Primary Care Team, NHS, detailing GP Services in Portswood, attached.

Wednesday, 10 July 2013 HEAD OF LEGAL, HR AND DEMOCRATIC SERVICES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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL
MINUTES OF THE MEETING HELD ON 23 MAY 2013

Present: Councillors Claisse, Jeffery (Chair), Cunio, Spicer, Chaloner and McEwing

Apologies: Councillors Lewzey and Parnell

1. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The Panel noted apologies from Councillor Parnell and Councillor Lewzey and that Councillor McEwing was in attendance as a nominated substitute for Councillor Lewzey in accordance with Procedure Rule 4.3.

2. **ELECTION OF VICE-CHAIR**

RESOLVED that Councillor Chaloner be elected Vice-Chair for the 2013-14 municipal year.

3. **STATEMENT FROM THE CHAIR**

The Chair welcomed the new Panel Members and Councillor Shields as the new Cabinet Member for Health and Adult Services.

4. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the minutes of the meeting held on 21st March 2013 be approved and the following comments from Southampton Defend the NHS in relation to Page 33, Item 45 – The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 be noted:-

- bullet point 3, third line should read "the three Southampton MP's"; and
- to investigate whether it had been agreed that the previous Chair would write to the three Southampton MP's expressing the Council's concern with the revised regulations.

5. **SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY COMMITTEES: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION**

The Panel considered the report of the Head of Service, Communities, Change and Partnerships, seeking agreement of the revised Health Overview and Scrutiny Panel (HOSP) to the existing framework for assessing substantial change in NHS provision across Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) region. (Copy of the report circulated with the agenda and appended to the signed minutes).

The following comments were noted:-

- The purpose of the report was to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) areas.
- This was the third refresh of the framework, originally developed with advice from the Independent Reconfiguration Panel, placing greater emphasis on the importance of constructive working relationships, clarifying party roles, providing better coordination of engagement and consultation with service users and thereby improving confidence in the planning of service change.
- Appendix 1 – Framework for Assessing Change – Questionnaire - in relation to any changes and/or reductions in service it was critical that the financial implications be taken into account.
- In relation to any substantial changes, it was important that regard was given to the involvement of "hard to reach groups" and the need for any impact assessment for ethnic minority groups/vulnerable groups. It was noted that this would be dependant on the issues raised.

RESOLVED that the Panel accepted the Arrangements for Assessing Substantial Change in NHS provision as previously agreed by Health Overview and Scrutiny Panels and providers across the SHIP region, subject to minor typographical amendments.

6. **SOUTHAMPTON CITY COUNCIL SOCIAL CARE : ANNUAL PLANS AND PRIORITIES 2013/14**

The Panel received and noted the report of the Director of People detailing the key developments since the formation of the People Directorate, describing the emerging direction of travel for the services being transformed through this initiative and setting out the approach to initial cost savings. (Copy of the report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- Seven workstreams of activity had been developed which made it clear that the areas offering the greatest scope for improving or maintaining service levels were improving the way services were commissioned, which made how we interfaced with customers at the "front door" more effective, particularly in relation to the use of IT.
- Services that reduced the demand for chronic and ongoing dependence on intensive social care support would be key in delivering savings.
- The principle of the"Once and Done" culture was that customers were responded to immediately and received the service/information on a "once and done" basis and did not have to go to different teams/ departments for different issues.
- The transformation work would redesign Adult Social Care by placing a greater emphasis on prevention and demand management.
- Children's Safeguarding still had issues in relation to the quality and consistency of practice, hampered by the difficulty in recruiting and retaining experienced, high performing staff and at present approximately 30% of social workers were agency staff. Downsizing safeguarding would not only involve a restructure, but more significantly a cultural change in relation to the shared purpose of preventative work and early intervention to improve families' capacity to meet all

their needs with the aim of reducing vulnerable people requiring intensive levels of service.
- There were no permanent exclusions at any Southampton Primary Schools and exclusion information in relation to Secondary Schools would be supplied to the Panel.
- The development of an Integrated Commissioning Unit with the Clinical Commissioning Group (CCG) would create capacity to manage and monitor provider performance, leaving Adult Social Care to focus on individual cases.
- The Council had already made a decision not to review housing tenancies, however the Council had housing stock and the focus could be changed to use the stock more creatively.

7. SOUTHAMPTON CLINICAL COMMISSIONING GROUP (CCG) ; ANNUAL PLAN AND PRIORITIES 2013/14

The Panel received and noted the report of the Chair and Chief Officer Southampton City Clinical Commissioning Group detailing the 2012-2017 draft strategy and the 2013/14 priorities of the Clinical Commissioning Group (CCG). (Copy of report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- With effect from 1 April 2013, the CCG was now a legally constituted organisation.
- In the first year of operation the CCG would focus on gaining control and the delivery of the three strategic priorities of “Mental Health and Wellbeing”, “A Healthy Start in Life” and “Growing Older and Living with Long Term Conditions” which matched those of the Health and Wellbeing Strategy.
- Key objectives were to :-
    - take responsibility for the quality and cost of care;
    - deliver the annual plan including financial and performance standards;
    - drive service and system change;
    - provide local leadership for integration; and
    - establish the CCG as an effective organisation.
- The motion proposed at Annual Council on 15th May 2013 that services available though the NHS should be delivered by NHS providers in preference to private providers was supported, provided that the quality of patient safety was not compromised. However, the new regulations were open to interpretation and it was important that there was freedom to procure outside services, which would be open to scrutiny and challenge, when required;
- A Joint and Integrated Commissioning Board would be established to ensure effective collaboration and good governance across the agreed areas of council and health commissioning. The Board would be a sub-board of the Health and Wellbeing Board (HWBB), accountable to the Council’s Cabinet and the CCG Governing Body;
- Following an invitation to submit an expression of interest a bid was now being prepared to be designated as Intergrated Commissioning pioneers;
- Child obesity was a critical factor in reducing future obesity levels. A review of specification was underway and will be presented to a future meeting;

- A further report would be tabled at a future meeting, providing information on the outcome of the consultation on the draft strategy.

8. **SOUTHERN HEALTH NHS FOUNDATION TRUST (SHFT) : DRAFT QUALITY ACCOUNT 2012/13**

The Panel received the report of the Clinical Quality Manager, Southern Health NHS Foundation Trust (SHFT) detailing the Southern Health NHS Foundation Trust's draft 2012/13 Quality Account . (Copy of the report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- A quality account was an annual report to the public about the quality of services delivered by NHS service providers and was now a legal requirement.
- Southern Health was one of the largest providers of mental health, community, learning disability and social care services in the country, covering a large geographical area.
- Priorities to be delivered by April 2014 were improvements to patient safety, clinical outcomes and patient experience.
- The format of the Quality Account report would be modified and amended to make it more "user-friendly" in future.

RESOLVED:-

i. that the draft Quality Account for 2012/13 be noted; and
ii. that officers would provide the panel with information on any "hot spots" in the Southampton area.

9. **SOLENT NHS TRUST : DRAFT QUALITY ACCOUNT 2012/13**

The Panel received the report of the Interim Chief Executive detailing the Solent NHS Trust Draft Quality Account for 2012/2013. (Copy of the report circulated with the agenda and appended to the signed minutes).

The following was noted:-

- Solent NHS Trust was in the final stages of being licensed as a Foundation Trust and once the Trust Development Authority had given final assurances on preparations they would be referred to Monitor for assessment and licensed as a Foundation Trust in autumn 2013.
- The 8 priorities identified for 2011/12 were on target and had been continuously monitored through each of the Clinical Divisions within the Trust.
- The Trust was currently the second most research active community/ care trust in England.
- The New Forest Parenting Programme which was an intervention programme for coping with attention deficit hyperactivity disorder in children would be continued.

- Teenage conception rates had been reduced by 6% in Southampton in 2012/13 which was one of the key targets for the Trust's Sexual Health Services. This is a key issues for Southampton
- 98% of the Right Care targets set under the Commissioning for Quality and Innovation Framework (CQUIN) during 2012/13 had been achieved. These were additional initiatives set up which were based around areas where commissioners wished to see specific progress.
- The Trust was in the process of creating a Single Point of Access (SPA) for services and over time this would be the primary method of contact.

RESOLVED that the Draft Quality Account for 2012/13 be noted.

10. **UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST (UHS): QUALITY ACCOUNT 2012/13**

The Panel received the report of the University Hospital Trust, Director of Nursing detailing the draft University Hospital Trust quality account for 2012/13. (Copy of report circulated with the agenda and appended to the signed minutes).

- The Panel noted the following 2013/14 Patient Improvement Framework (PIF) priorities:-
  - To improve the reporting of patient safety incidents and the mechanisms from learning from them.
  - To improve the Trust's performance in the measures that were included in the national safety thermometer which was part of the strategy for harm free care.
  - To improve the care of UHS patients with diabetes.
  - Prevention of premature deaths by effective management of deteriorating adults and improving cancer waits.
  - Improving the diagnosis rate for long term conditions for people with dementia.
  - Reducing episodes of ill health or injury by efficient emergency pathways, reducing readmissions and comparing benchmark information.
  - Improving positive patient experiences by patients, friends and family test and continuity of care.
  - Providing a safe environment with harm free care, improving diabetes care and reducing inappropriate admissions to full term babies to neonatal care unit.
- The Care Quality Commission undertook a responsive review of compliance at the Southampton General Hospital site in October 2012 and reported that patients and relatives were positive about staff and care they had received and in December 2012 the Princess Anne Hospital was inspected where mothers and partners were also positive about the care they had received.
- Due to the complexity and types of patients involved, a high level of data was required which resulted in a heavy administrative load for staff and various methods and strategies were being investigated to reduce this.
- The bed complement had been expanded to improve flexibility for patients and the discharge process had been improved which also freed up beds for emergencies.

- Work is underway to monitor patient flow through Emergency Department from the point of entry to their discharge. The outcomes of this would be reported to a future meeting.

RESOLVED that the draft quality account for 2012/13 incorporating the proposed top priorities be noted.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		CARE QUALITY COMMISSION: A NEW START: CONSULTATION ON THE WAY CQC REGULATES, INSPECTS AND MONITORS CARE		
DATE OF DECISION:		18 JULY 2013		
REPORT OF:		HEAD OF COMMUNTIES, IMPROVEMENT AND PARTNERSHIPS		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dorota Goble**	**Tel:**	**023 8083 3317**
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

Following the publication of the Care Quality Commission's Strategy for 2013 to 2016, 'Raising Standards, Putting People First' the commission are making significant changes to how they monitor, inspect and regulate care services. This report outlines the changes being made, highlighting the consultation that is currently underway. The deadline for comments and views is Monday 12th August 2013. This is the beginning of a series of consultations on detailed changes to how different types of services will be inspected, with changes being implemented over the next three years.

RECOMMENDATIONS:

(i) That the Panel notes the principles underlying how the CQC proposes to inspect services and regulate all care services, and specifically how it intends to monitor and judge acute NHS trusts.

(ii) That the Panel discuss the proposed changes to inspect all services and specifically acute NHS Trusts and consider if they wish to submit any comments to the CQC or to respond to the specific questions highlighted in Appendix x and x. It should be noted that the deadline for feedback in 12 August 2013.

REASONS FOR REPORT RECOMMENDATIONS

1. To highlight to the Panel key changes to how the CQC will monitor, inspect and regulate care services.
2. To give the Panel an opportunity to consider if they wish to respond to the consultation on how all services.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None.

DETAIL (Including consultation carried out)

4. In April this year the Care Quality Commission (CQC) published their new strategy, 'raising standards, putting people first'. This set out a clear purpose for the CQC – to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. A copy of this strategy will available in the Members' Room.

5. To deliver their purpose, the CQC are making significant changes to how they work and this consultation is the next step to making those changes. The consultation sets out the principles underlying how CQC will inspect all services and some more detailed proposals for how they will inspect NHS trusts and foundation trusts and independent acute hospitals. It also includes joint proposals between CQC and the Department of Health on changes to regulations that underpin their work, including some important new responsibilities for CQC set out in the Care Bill. The consultation, attached at Appendix 1, is the beginning of a series of consultations on detailed changes to how different types of services will be inspected, with changes being implemented at different times during the next three years. A timetable outlining when these changes will be introduced is included on page 5 of this document.

6. The CQC have developed these plans based on:
   - Recommendations from a report into the abuse of people with learning disabilities at Winterbourne View.
   - Robert Francis' report into failings at the Mid Staffordshire NHS Foundation Trust.
   - Independent reviews of the CCG's work – including Professor Keiran Walshe's evaluation and Deloitte's report on they we carry out investigations.
   - Consultation feedback on their new strategy for 2013 – 2016, 'raising standards, putting people first'.

7. The consultation is divided into the following sections:
   - Section 2: An overview of how they will inspect and regulate all care services
   - Section 3: How they will inspect and regulate NHS and independent acute hospitals
   - Section 4: Changes to CQC's regulations
   - Draft equality impact assessments
   - Proposed model for intelligent monitoring and expert judgement in acute NHS trusts

   A summary of the consultation questions are provided in Appendix 2, pages 35-36.

8. The consultation is accompanied by two equality impact assessments, attached at Appendix 2:

- A draft Equality and Human Rights Duties Impact Analysis – which gives more detail about the impact of the proposed changes on equality and human rights and how they will promote equality and human rights for people who use health and social care services.
- A draft Regulatory Impact Assessment – which outlines the costs and benefits to providers and people who use services.

Both of these impact assessments will be updated and published as final versions when they publish their response to this consultation.

9. The CQC also sets out a proposed model for intelligent monitoring and expert judgement in acute NHS trusts, attached at Appendix 3. This document focuses on the changes we are making to how we will monitor NHS acute services. It sets out our initial proposals for key indicators – which we call 'tier one' indicators – for NHS acute hospitals. We will monitor these indicators as part of our surveillance process to help us decide where and what to inspect. We want to test and develop these indicators with as wide a range of stakeholders as possible.

10. The Panel is invited to have an open discussion on the proposals within the CQC Strategy for 2013 to 2016 (Appendix 1) and the consultation documents (Appendices 2-x) and consider if they wish to submit any general comments to the CQC or respond to any of the specific questions in the consultation within the deadline of Monday 12 August 2013.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. None.

Other Legal Implications:

14. None.

POLICY FRAMEWORK IMPLICATIONS

15. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	A new start: Consultation to the way CQC regulates, inspects and monitors care
2.	Proposed model for intelligent monitoring and expert judgement in acute NHS trusts
3.	Consultation impact assessments

Documents In Members' Rooms

1.	CQC strategy for 2013 to 2016, Raising standards, putting people first See link:- http://www.cqc.org.uk/sites/default/files/media/documents/20130503_cqc_strategy_2013_final_cm_tagged.pdf

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

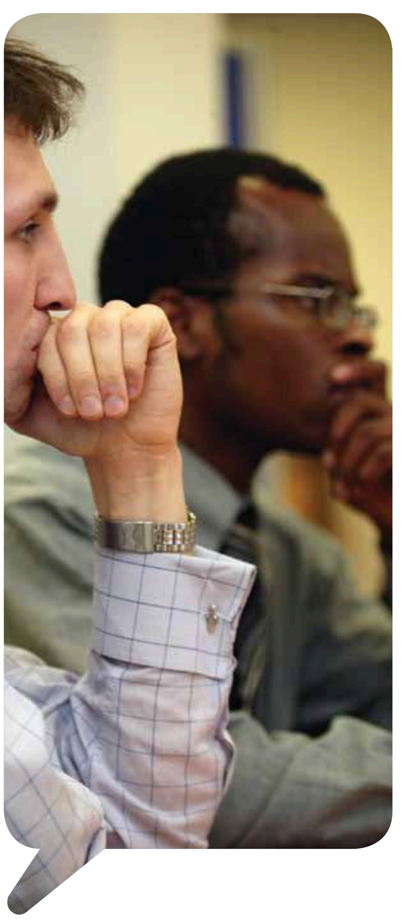
Agenda Item 8

Appendix 1

A new start

Consultation on changes to the way CQC regulates, inspects and monitors care

June 2013



The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.

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Foreword

▶ In April this year our new strategy, *Raising standards, putting people first*, set out a clear purpose for CQC – to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

▶ To deliver our purpose, we are making significant changes to how we work.
Most importantly, we are acting on the recommendations of the report into the abuse of people with learning disabilities at Winterbourne View, of Robert Francis' report into the failings at Mid Staffordshire NHS Foundation Trust and the government's response to those catastrophic failures of care in *Patients First and Foremost*.

▶ We have listened to independent reviews such as Professor Kieran Walshe's evaluation of our work, Deloitte's report on how we carry out investigations and Grant Thornton's review of our regulatory activity at University Hospitals of Morecambe Bay NHS Foundation Trust. The way the health and social care system is organised now makes it even more important that we work better with others.

▶ This consultation is an important next step towards making the changes needed to deliver our purpose. It sets out the principles underlying how CQC will inspect all services and some more detailed proposals for how we will inspect NHS trusts and foundation trusts and independent acute hospitals. It also includes some joint proposals between CQC and the Department of Health on changes to regulations that underpin our work, including some important new responsibilities for CQC set out in the Care Bill. This is the beginning of a series of consultations on detailed changes to how different types of services will be inspected, with changes being implemented at different times during the next three years.

▶ We approach this work with humility, recognising that the main responsibility for delivering quality care lies with care professionals, clinical staff, providers, and those who arrange and fund local services. However, we are clear that we will expose services providing mediocre and inadequate care and we will have zero tolerance for services where people are failed on the most fundamental aspects of care. At the other end of the spectrum we will acknowledge and highlight the many hospitals, care homes and other services in England where people are receiving good or outstanding care.

▶ The intention is to develop CQC into a strong, independent, expert inspectorate whose evidence-based, professional judgements are welcomed and instructive. How Ofsted approach their work is valued and we will learn from that. We will expect services to be open and honest about any problems they have. If there is a willingness to take responsibility for putting them right, we will take this into account in our response.

▶ Above all, we will always be on the side of people who use services, making sure that they are treated with respect and that their views and experiences of care are listened to and acted on. We will be independent of, but not distant from, our partners in the health and social care system. We will work closely with Healthwatch England to ensure we develop our new approach with people who use services.

▶ We will inspect and regulate different services in different ways based on what has the most impact on the quality of people's care. However, there are some principles that will guide our work:

- When we inspect we will ask the following questions about care services:
  - Are they safe?
  - Are they effective?
  - Are they caring?
  - Are they responsive to people's needs?
  - Are they well-led?
- We will agree clear standards of care that help us judge the quality and safety of services. They will include, but are not limited to, the

fundamentals of care recommended by Robert Francis below which no provider must fall without facing serious consequences. We will work with the National Institute for Health and Care Excellence (NICE) to ensure these align with their quality standards and so provide a comprehensive spectrum of standards, as recommended by Robert Francis.

- We will use **surveillance of information and evidence** to decide when, where and what to inspect, including listening better to people's experiences of care and using the best intelligence from across the system.
- Our inspectors will no longer be generalists who inspect all types of care services. We are now appointing powerful and respected **Chief Inspectors of Hospitals, Social Care and General Practice** to lead national teams of **expert inspectors**. The teams will include **clinical and other experts,** including **people with experience of receiving care**. We will spend longer inspecting NHS hospitals, including in the evenings and weekends when we know people can experience poorer care.
- Our expert inspectors will no longer make statements simply about compliance with standards. They will use professional **judgement,** supported by objective measures and clinical evidence, to assess the quality of services against our five key questions. This will include a **rating** to help people compare services and to highlight where care is good or outstanding and expose where care is inadequate or requires improvement.
- Our Chief Inspectors will use the expert judgements of their teams of inspectors, together with information and evidence held by CQC and our partners in the system, to provide **a single, authoritative assessment of the quality and safety of care services**.
- We will make sure that directors or leaders of organisations make a legal commitment to provide safe, high-quality care and are **personally held to account for it**.
- In NHS hospitals, we will introduce a **clear programme for hospitals** that are failing to provide quality care that makes sure that immediate action is taken to protect people and to hold those responsible to account.

▶ Some of the changes will take up to three years to make. We are grateful for the support of our partners and colleagues across the system in recognising our need to prioritise these, so that the changes to the way we inspect NHS and independent acute hospitals will be introduced first. We welcome the continued support as we begin our dialogue with colleagues in the other sectors. We will hold formal consultations with these sectors, starting with adult social care in autumn 2013.

▶ We will take account of the emerging thinking from other reviews and initiatives, including Don Berwick's task force looking at safety in the NHS, Camilla Cavendish's investigation into the non-professional care workforce in health and social care, and the review of complaints by Professor Tricia Hart and Ann Clwyd MP.

▶ Following the government's response to the failings at Winterbourne View, we are also making some immediate changes for those services caring for people with learning disabilities. We know that there are continuing problems with the quality of care for people with learning disabilities, including lengthy stays in hospital for people away from their families and communities. We will also work with experts in the field to develop a way of inspecting those services that includes looking at whether the right services are being commissioned.

▶ Over the past year we have developed these changes in conversation with the public, our staff, providers, organisations with an interest in our work, clinical and other experts and our partners in the health and social care system. This consultation is a continuation of those valuable discussions. We hope as many people as possible will give us their views and comments. We want to make sure these changes are the right ones and that they help us to deliver our purpose – to make sure health and social care services provide people with safe, effective, compassionate, high-quality care.

David Prior
Chair

David Behan
Chief Executive

Section 1: Introduction

This document asks what you think of our proposals to make significant changes to the way we inspect and regulate health and social care. It is the first of a series of consultations we will hold between now and 2016 as we develop and introduce different changes for different types of services.

We are committed to developing them in partnership with the public, people who use services, our staff, our partners in the system, experts, providers, and organisations with an interest in our work and we have an extensive programme of engagement planned to do this.

▶ Our proposed timescales for introducing the changes are set out below.

▶ **Section 2** of this document sets out the principles for our inspection and regulation of all care services. **It applies to everyone we regulate.** It includes:

- A better registration system for those applying to offer new care services, including holding senior managers, boards and directors of services to account for poor-quality care.
- Intelligent monitoring of information and evidence to decide when, where and what to inspect, including listening better to people's experiences of care.
- Improvements to how we will inspect services, including the introduction of Chief Inspectors to lead expert teams.
- Clear standards of care including, but not limited to, the fundamentals of care below which no provider must fall.
- A ratings system to help people choose between services and to encourage improvement.
- The action we will take in response to poor care.

▶ **Section 3** sets out more details on a new way of **inspecting and regulating NHS and independent acute hospitals**, including:

- The indicators that we will use to trigger action in our monitoring of information and evidence about acute hospitals.
- Longer, more thorough hospital inspections where required.
- A clear programme for failing hospitals that makes sure immediate action is taken to protect people and to hold those responsible to account.
- How we will issue and review ratings for acute hospitals.

▶ **Section 4** sets out proposals for changes to regulations made by the Department of Health and CQC which underpin our current proposals. This section of the consultation **applies to all providers registered with us**.

▶ **Section 5** repeats the consultation questions that we are asking throughout this document.

Finally, this document is accompanied by:

- A draft **Equality and Human Rights Duties Impact Analysis** – which gives more detail about the impact of the proposed changes on equality and human rights and how they will promote equality and human rights for people who use health and social care services.
- A draft **Regulatory Impact Assessment** – which outlines the costs and benefits to providers and people who use services.

Both of these impact assessments will be updated and published as final versions when we publish our response to this consultation.

When we will introduce the changes

▶ In **June 2013** the Department of Health will consult on plans to strengthen corporate accountability in the wake of events at Winterbourne View hospital.

▶ From **July 2013** we will build on the commitments we made in the government's response to the failures at Winterbourne View and make sure that named directors, managers and leaders of services for people with learning disabilities commit to meeting our standards and are held to account for it.

▶ From **October 2013**, we will begin to change the way we inspect NHS and independent acute hospitals, because we recognise there is an urgent need to improve how we do this. The new Chief Inspector will spearhead a more specialist, expert and risk-based approach to inspection.

▶ We will award a rating for a hospital once we have inspected it under the new approach. As we do not yet have the legal powers to award ratings, our initial ratings will be in shadow form, and they will be confirmed subject to the passage of legislation through Parliament.

▶ We will also begin to develop changes to the way we inspect other services, prioritising those where people are in the most vulnerable circumstances and where there are higher risks to people.

- In **2014/15** we will introduce changes to the way we inspect all services for people with learning disabilities and mental health issues provided by NHS trusts and independent healthcare providers.
- Also in **2014/15** we will begin to change the way we inspect adult social care services, including introducing ratings. We will run the first of our consultations for adult social care in **autumn 2013** which will set out our initial thinking on how we will change our regulatory approach for this sector.

▶ Over the next two years we will review and develop changes to the way we inspect other services, including those who provide GP, out-of-hours and dental services. Our Chief Inspector of General Practice will lead this work, including the development of ratings for providers of GP services. This year we will run the first of our consultations for general practice which will set out our initial thinking on our new regulatory approach. We have not yet decided whether we will rate services such as dental practices and those that provide cosmetic surgery.

▶ **In 2015/16** we will make changes to our inspection of community healthcare and ambulance trusts, including introducing ratings.

At a glance: What's changing in the way we regulate and inspect

From	To
• Focus on Yes/No 'compliance' • A low and unclear bar	• Professional, intelligence-based judgements • Ratings – clear reports that talk about safe, effective, caring, responsive and well-led care
• 28 regulations, 16 outcomes	• Five key questions
• CQC as part of the system with responsibility for improvement	• On the side of people who use services • Providers and commissioners clearly responsible for improvement
• Generalist inspectors	• Specialists, with teams of experts • Longer, thorough and people-focused inspections
• Corporate body and registered manager held to account for the quality of care	• Individuals at Board level also held to account for the quality of care

Section 2: An overview of how we will inspect and regulate all care services

We will inspect and regulate different services in different ways based on what has the most impact on the quality of people's care.

However, there are some general principles that will guide our future 'operating model'. They apply to: the way we register those that apply to CQC to provide care services; the standards that those services have to meet; how we use data, evidence and information to monitor services; the expert inspections we carry out; the information we provide to the public on our judgements about care quality, including a rating to help people compare services; the action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

FIGURE 1: OVERVIEW OF OUR FUTURE OPERATING MODEL

Asking the right questions about the quality and safety of care

To get to the heart of people's experience of care, we need to make sure we ask the right questions about the quality of services, based on the things that matter to people. We will ask the following five questions of every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We developed these five questions with reference to the areas that Lord Darzi defined as central to quality in healthcare: safety, clinical effectiveness and the experience of people who use services. The first two of these link directly to our key questions: whether a service is safe and effective. However, because we regulate social care as well as health services, our approach to assessing effectiveness will be broader than clinical effectiveness.

We have separated the experience of people who use services into two parts: how caring a service is and how responsive it is to meeting people's needs. And although leadership, governance and culture has not been a formal element of our existing approach, our experience has shown that these factors make the difference between success and failure.

We will develop guidance on what we will focus on when we carry out an inspection to provide a judgement in relation to all of the five key areas, working with our strategic partners and drawing on developments and emerging thinking from the field. We will consult publicly on the guidance we develop, including how we will focus the new approach to providing a judgement on the five questions for different sectors to make sure it is relevant and tailored appropriately.

What do we mean by these five questions?

▶ By **safe**, we mean that people are protected from physical, psychological or emotional harm. For example, are people getting MRSA (a hospital-acquired infection) because of poor hygiene?

Unacceptable care example

We found repeated safety issues at one care home. Our inspectors saw members of staff lifting people from their wheelchairs by holding them under their arms. This is not safe practice and increases the risk of injury.

Staff told inspectors they weren't sure about some residents' medical conditions because they were given no instructions, support or guidance. And there was no system in place to make sure people got the fluids they needed to keep them hydrated. Records for fluid intake were inconsistent and incomplete. One member of staff had been administering medication without any training, putting people using the service at great risk.

Some staff files contained no application forms, references or updated disclosure and barring checks, and there was no evidence that staff had completed health questionnaires to show they were fit and suitable to work at the home.

There were not enough qualified, skilled and experienced staff to meet people's needs. Staffing levels needed to reflect the dependency levels of people and be reviewed on a daily basis.

In our approach to safety, we have been consulting Don Berwick's task force on achieving zero harm and talking to the Health Foundation about their research into measuring and monitoring safety, with a view to working with them to develop our approach to measuring and monitoring safety, leadership and culture.

▶ By **effective** we mean that people's needs are met, and their care is in line with nationally-recognised guidelines and relevant NICE quality standards or that effective new techniques are used which give them the best chance of getting better or living independently. For example is there an effective 'enhanced recovery' programme following surgery?

Unacceptable care example

A number of women with breast cancer were recalled by an NHS trust due to issues surrounding their test results. We found that their processes to assess and assure themselves of the quality of service had not been effective or robust enough.

There had been poor communication between pathologists, the clinical governance committee and the board of directors. The pathology department had been without a leader for five years, with the role being covered by locum staff, and a number of permanent posts were not filled. Equipment used by the department was outdated. Decision making in the clinical governance committee was not always clear. The hospital's action plan in relation to mortality rates was not being clearly monitored by the board and had not been subject to in-depth analysis.

On effectiveness, we will be informed by the work of NICE, the Social Care Institute for Excellence (SCIE) and professional organisations with an active interest in this area.

▶ By **caring**, we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs. For example, do care home staff understand people's individual needs, spend time talking to them and make sure they have the opportunity to take part in activities that they enjoy?

Unacceptable care example

At one care home, we saw that there was very little stimulation for people using the service. Staff did not interact positively with people or engage with them in any meaningful way. One member of staff came into the lounge shortly after starting her shift, walked straight past the 12 people sitting in the room without speaking or acknowledging any of them, and sat down at a table. After 10 minutes had gone by, we asked her if she had spoken to any of the people using the service since she began her shift. She said she had not. Staff spoke more to one another than they did with people using the service.

Our approach to monitoring how caring a service is will be informed by Compassion in Practice – the new three-year vision and strategy for nursing, midwifery and care staff led by Jane Cummings, the Chief Nursing Officer for England and Viv Bennett, Director of Nursing at the Department of Health.

▶ By **responsive**, we mean that people get the 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. For example, is a GP surgery open at times to suit the needs of the local population?

Unacceptable care example

We arrived at a care home at 5.30am because concerns had been raised with us about the times people were woken by staff. We found that some residents were already awake and dressed. Staff members had also started to attend to some people's personal hygiene needs. They told us they had been instructed to do this by senior staff.

It was clear that some people were not always involved in making decisions about their own care. Their care plans did not record what time they preferred to, or usually woke up, what time they liked to go to bed or when they needed help with hygiene.

Some of the care plans had a brief statement about the person's independence, but not enough information to help staff support people to remain as independent as possible. When one resident went to make their own cup of tea, a member of staff told them not to as it was their job.

We will also work closely with bodies that speak on behalf of people who use services, such as the Healthwatch network, to develop our approach to assessing responsiveness and to ensure that the focus of our assessment across the five key questions is firmly rooted in the experiences and views of people who use services.

▶ By **well-led**, we mean 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. The focus of this is on quality. For example, does a hospital board make decisions about quality care based on sound evidence and information about their services, and are concerns discussed in an open and frank way? Is there a good complaints procedure that drives improvement?

Unacceptable care example

Inspections at an NHS trust found issues of poor management, in particular failing to properly train and supervise staff across three hospitals.

A number of staff had not received clinical supervision or the appropriate professional development support that would enable them to be suitably skilled and confident to carry out their role. Trust-wide records showed significant gaps in mandatory staff training, including moving and handling, safeguarding of adults and children, resuscitation and infection control.

At two of the hospitals there were other problems. In one, patients were not always being admitted to the right ward because of a shortage of beds. Patients with a range of conditions were being treated on the stroke ward, with a significant impact on those people who needed specialist stroke care.

In the other, patient records contained inconsistent information, and in some cases there was a lack of evidence to show that care and treatment was being appropriately planned and delivered.

Well-led will encompass an assessment of aspects of governance, leadership and culture as part of our inspections. Our initial focus will be on effective governance, drawing on our current standards of assessing and monitoring the quality of service provision. In assessing whether NHS services are well-led, we will be working with Monitor, the NHS Trust Development Authority (NHS TDA) and NHS England to ensure that our approaches are both consistent and complementary. The NHS TDA and Monitor will continue to lead on all aspects of financial sustainability and corporate governance. We will develop our approach to quality governance, assessing leadership and culture on a slightly longer timeframe, based on evidence of what is most important at organisation, service, team and individual levels and in collaboration with experts in the field.

How do the five questions fit with the Outcome Frameworks?

The government has published Outcome Frameworks for the NHS, for adult social care and for public health. These set out the measures against which the health and care of the population will be judged. Our five questions are complementary to the Outcome Frameworks, as they look at the care provided by an individual provider, rather than the overall heath and care status of a population (which will be dependent on many different providers, as well as other factors).

A better system for organisations applying to provide care services

The terrible abuse that was allowed to happen at Winterbourne View hospital showed that providers need to be fully accountable for making sure they can deliver personalised, local and high-quality services for people. The system and checks we use when providers apply to register with us need to be stronger, to make sure that those who intend to provide care are focused on high-quality care and understand the commitment they are making to people about the care they will receive.

▶ We will introduce a better system for providers applying to register with us to provide care. We will do this by making sure that:

- The process of registering with CQC is effective and efficient, partly through building efficient digital services that will transform the way all providers get involved and communicate with us.
- Providers who already deliver good quality care can offer new services easily.
- There is a more robust test for providers whose ability to deliver quality care is less clear.
- Those we register make a commitment to deliver safe, effective, compassionate, high-quality care.
- Named directors or leaders of organisations are personally held to account for that commitment. This is in addition to making sure providers and registered managers are held to account for the care they provide.
- Those we register show us that they have good plans for how they will provide care, including an effective system for spotting and dealing with problems. They must also show us that they focus on the right things when they employ staff, such as their qualifications, clinical supervision and continuing professional development, and that they are committed to listening and acting on the views and experiences of people who use their service.

▶ From July 2013 we will start to apply this different system to those offering services for people with learning disabilities. We will learn from this when we adapt and extend it to other types of services in the future.

▶ We will work towards making sure that when those who provide care services register a change of name or a new owner, they cannot do this in a way that hides any previous or current concerns about the quality and safety of the service from CQC or from the public.

▶ The Department of Health is proposing to make changes to regulations that support these improvements and which would make it easier for CQC to take tough action, including prosecution.

Why we are focusing on people with learning disabilities

Winterbourne View exposed an appalling story of abuse. CQC undertook a series of inspections of similar facilities and found further examples of people being "assessed" for periods of many years with a model of care that was frankly wrong.

Many of these services are located in the independent healthcare sector, and we know from our 'State of Care' reports that this is an area where far too many providers fail to meet our standards.

The CQC is a signatory to the Concordat that has come out of Winterbourne View. As part of the government's commitment to bring about change, the Care Services Minister, Norman Lamb, has made it clear that this model of care should no longer be commissioned.

In registering learning disability services, we will focus on the following:

- Being more rigorous at the point of registration. All new services will need to outline their model of care, show how they will deal with concerns about quality, and say who is responsible at various levels of the organisation for quality.
- We will not simply look at new registrants. We will also apply the same processes and assessments to existing providers.
- We will develop the knowledge and skills of our current inspectors and registration staff so that they have a good understanding of what an appropriate model of care looks like.
- Although the provision of care and its quality is the absolute responsibility of the provider, we recognise that commissioning is vital in this specialist area. We will routinely discuss our inspections with those commissioning packages of care.
- We are working with the Joint Improvement team funded by the Department of Health and the Local Government Association – with the aim of supporting commissioner assessments of all people with learning disabilities currently in the system.

Intelligent monitoring of information and evidence about the quality and safety of care

We do not always make the best use of all the information available to us in terms of directing our regulatory activity. We will rethink and redesign the way we use information. In the future, we will be clearer about the indicators that are most important in monitoring the quality of care and focus on the information that matters for each type of care.

▶ We will make better decisions about when, where and what to inspect by using information and evidence in a more focused and open way. We will monitor this information continuously to anticipate, identify and respond more quickly to services that are at risk of failing with respect to the quality of care they provide.

▶ We will continue to gather information from national and local data and intelligence sources, past inspections, and from local authority overview and scrutiny committees. We will also make sure we understand the reality of people's individual experiences of care, including working closely with local Healthwatch and local voluntary groups. Information from people who use care services about the quality and safety of their care, including concerns and complaints, will be a vital source of information. The outcome of the Clwyd/Hart review of NHS complaints will help us to shape our approach. We will take full account of information from care staff, including 'whistleblowers'. We will continue to listen and act on the concerns of whistleblowers through our dedicated whistleblowers' helpline.

▶ You can read more about our extensive proposals for making better use of information and evidence in our intelligent monitoring of NHS hospitals in section 3. We will consider how these proposals can best be applied to other sectors. We know that the availability of national data varies – we will take this into account as we design how we make best use of intelligence. We will consult

on each proposed set of indicators as they are developed and continue to develop our approach as more information becomes available.

Simple, clear standards to help us judge the quality and safety of services

In the past, our approach has been to concentrate on a legal statement about whether or not a provider is complying with standards of quality and safety. In future we will go beyond statements of legal compliance, and tell people in clear and simple language what we think about the quality and safety of the care given by that provider.

▶ We will make sure the public are clear about the safety and quality of care they can expect from their health and social care services. We will simplify our approach to reflect the five questions we will ask about the quality and safety of services.

▶ These standards will help us to judge whether or not services are safe, effective, caring, responsive to people's needs and well-led when we are registering, inspecting and rating services. However, we will use them to support our professional judgements about these five key areas rather than to record 'compliance' or 'non-compliance' with standards.

▶ We have reflected on the findings and suggestions made by Robert Francis in terms of having clear and simple standards against which care can be judged. He talked in his report about the use of 'Fundamental Standards' and how these would sit within a broader set of enhanced and developmental standards. We have looked at these suggestions and we propose that we would build on his proposals to look at:

- Fundamentals of care
- Expected standards
- High-quality care.

▶ To be successful, these levels must be owned by those charged with delivering the very highest standards of care to people. We will therefore be actively engaging with clinical professionals and representative bodies to ensure the standards are meaningful to those delivering front-line care, alongside our engagement with people who use services.

▶ All care services will be required by law to meet the fundamentals of care and the expected standards. We will make sure that the bar for each of these levels is very clear.

▶ The fundamentals of care represent the basic requirements that should be the core of any service. They should help to set the context for delivering compassionate, safe care.

Fundamentals of care

▶ In its response to the Francis Inquiry, *Patients First and Foremost*[1], the government committed to draw up a new set of fundamental standards of care that will sit within the legal requirements that providers of health and adult social care must meet to be registered with CQC. The government is also committed to a full consultation on these new standards, and we have a number of questions on which we need people's views.

▶ The fundamentals of care will set a clear bar below which standards of care should not fall. These will focus on the very basics of care that matter to people and will be easily understood by all. There will be immediate, serious consequences for services where care falls below these levels, including possible prosecution. Anyone should be able to recognise a breach of the fundamentals of care, even in the absence of specific guidance.

▶ We want to start a genuine public discussion of what these fundamentals of care should be. The examples below are purely to stimulate this debate:

- I will be cared for in a clean environment.
- I will be protected from abuse and discrimination.

1. www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

- I will be protected from harm[2] during my care and treatment.
- I will be given pain relief or other prescribed medication when I need it.
- When I am discharged my ongoing care will have been organised properly first.
- I will be helped to use the toilet and to wash when I need it.
- I will be given enough food and drink and helped to eat and drink if I need it.
- If I complain about my care, I will be listened to and not victimised as a result.
- I will not be held against my will, coerced or denied care and treatment without my consent or the proper legal authority.

It is our intention that the new regulations will allow CQC to prosecute breaches of fundamentals of care without the need to issue a warning notice first.

We know that not all of the fundamentals of care will feel equally relevant to all sectors and would welcome your views on this.

Expected standards

Expected standards set out what anyone using a service can expect as a matter of course. They set a higher bar than the fundamentals of care and will relate directly to whether a service is:

- Safe
- Effective
- Caring
- Responsive
- Well-led

We will look at whether any of our existing 'essential standards' could be reflected in the new expected standards. For example:

- There will always be enough members of staff available to keep me safe and meet my health and welfare needs.
- My personal records will be accurate and kept safe and confidential.

Where services do not meet them, we will require improvements to be made, using our legal powers as necessary. **Section 4** describes how these expected standards, alongside the fundamentals of care, will be given legal force through a small number of registration requirements. We will be using this opportunity to have as few regulations as possible, to reduce bureaucracy and meet the government's 'Red Tape Challenge'.

Minimising bureaucracy and administrative costs

CQC is a core member of the NHS Confederation's initiative which aims to reduce bureaucracy in the NHS by at least a third. Our new approach to inspection is designed with this objective firmly in mind.

- We will work with the Department of Health to radically streamline and reduce the regulations which set out fundamental and expected standards of care, and the guidance that we issue to support them.
- By approaching inspection from the perspective of peer review – clinical staff engaging with clinical staff – we will make it feel much less like 'being done to'.
- We will coordinate with existing visits and inspections, such as Royal College visits, to minimise duplication and overlap, for example through joint visits and re-use of each other's findings.
- Our approach to information only uses existing information, and does so in a more targeted, intelligent way than before.
- We will continue to respond to the healthy living and social care strand of the Red Tape Challenge and work with the Focus on Enforcement team within the Better Regulation Executive.

2. We recognise that certain interventions and treatments can involve a degree of harm that is inevitable and that errors may occur. However, we would expect a provider to take appropriate steps to minimise the risk of harm. A provider would breach the fundamentals of care if they did not follow nationally recognised procedures and practices to prevent or avoid harm, or they tolerated harm in a way that is unreasonable – for example through unchecked reckless practice or neglect.

- We are working closely with Monitor, the NHS TDA and NHS England to review information flows, foundation trust authorisation process and fit and proper person tests, to align these where appropriate. We are developing approaches to assessing culture, leadership and governance which aim to be common as far as possible and consistent in all regards.
- We are an 'early adopter' for a new approach to impact assessment which the Better Regulation Executive is promoting. Our regulatory impact assessment alongside this consultation does not just set out our estimates and invite challenge. Instead, it identifies the areas where impacts will change and invites provider representative bodies to advise us on how great those impacts are likely to be. We will engage with those bodies and take their assessment of impacts into account in our final proposals.

Following this consultation, the Department of Health will issue a draft of the new regulations for further discussion in the autumn, and CQC will issue draft guidance on the expected standards in parallel. The guidance will contain some examples of what is, and is not, acceptable while making it clear that providers will not be able to 'tick boxes' and expect good ratings.

The guidance will replace the existing, detailed *Guidance about compliance* and will recognise the different care experiences possible, ranging from treatment in a hospital to visiting a GP or living in residential care. It will make it clear that a person's wellbeing must be considered, particularly where people are generally cared for longer term, at home, in hospital or in residential care.

Example: Judging whether a maternity service is meeting expected standards

This example is for illustrative purposes only.

Is care safe?

- The provider learns from any safety incidents that have occurred and changes practices in response.
- Staffing levels and skill mix are set using recognised tools, for example those recognised by the Royal College of Midwives and Royal College of Obstetrics and Gynaecology guidelines.

Is care effective?

- Care is delivered at the right time and by staff with the right qualifications and training. For example, do all women have a dedicated midwife who stays with them throughout established labour and birth?
- Care is delivered in line with recognised, evidence-based guidelines (for example, NICE and Royal College guidelines) and achieves the expected outcomes for mothers and babies.
- Care is delivered in a planned way in accordance with assessed needs, and the experiences of women, their partners and families are monitored.

Is it caring?

- Women, their partners and families report that staff are caring, and staff are observed to be caring.

Is care responsive?

- Care is delivered in response to the population that the provider serves, as well as individuals' changing needs.

Is care well-led?

- The maternity services have clear clinical leadership and all staff work in partnership.
- The provider manages the risks related to the delivery of a maternity service effectively. It understands where its risks are at service level through to Board level and the Board supports changes to be made to minimise risk and provide a good service.

High-quality care

The definition of high-quality care will be led by organisations such as NICE. For example, NICE quality standards, which are a concise set of statements designed to drive and measure priority quality improvements within a particular area of care, set out what high-quality care looks like. Our inspectors will use good practice guidance developed by these other organisations to identify and describe whether a service is providing high-quality care. We will also look for where providers are using new ways of providing good, innovative care.

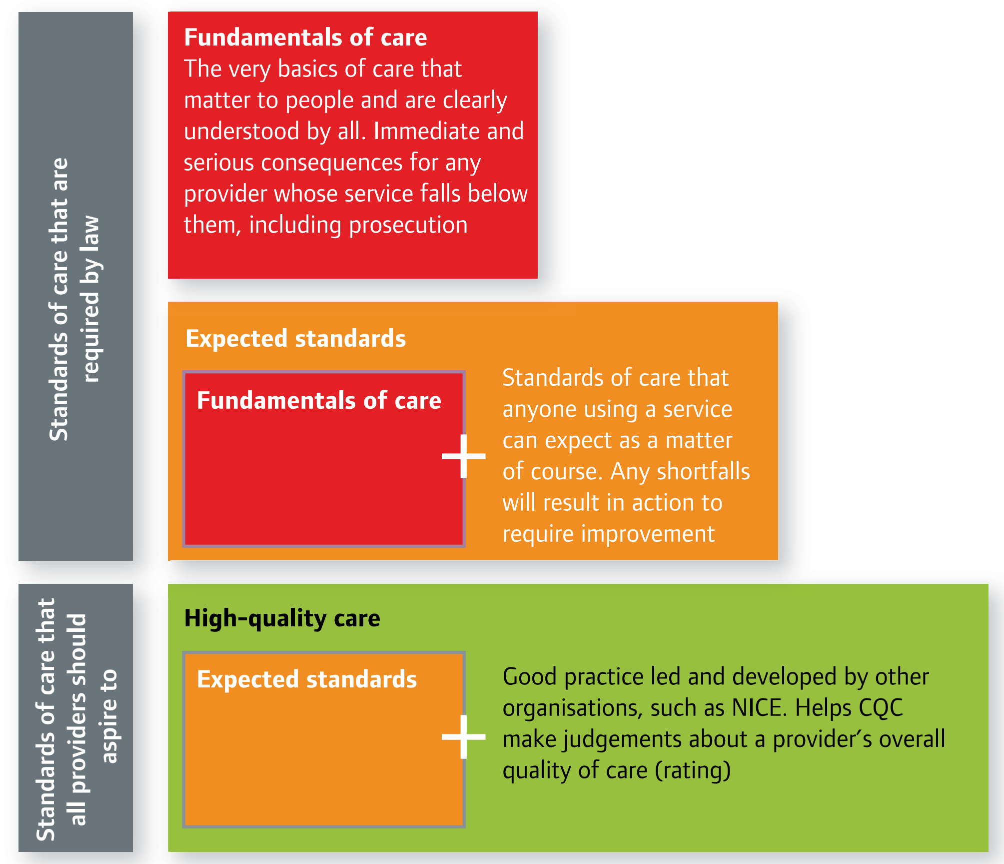
Ensuring that regulation encourages innovation in good practice

Regulation should not discourage innovation, but provide a framework to assure that the risk of untried approaches is safe. We will do this by developing expert, knowledgeable judgement and by avoiding 'black or white' interpretation of standards.

As well as using experts in our inspection teams, we will also use expert advisors when we consider applications for new services. Our registration process will place more emphasis on providers declaring how they will assure safety and who will be responsible for that. We will check that is credible, and then hold the provider to account for it through our inspections, but we will not dictate how they do so.

When we inspect, our reports will not focus only on concerns. They will highlight where there is innovative practice that others could learn from. The ratings that we issue will also recognise it: we will expect any provider who achieves an 'outstanding' rating to demonstrate innovative practice.

FIGURE 2: FUNDAMENTALS OF CARE, EXPECTED STANDARDS, AND HIGH-QUALITY CARE



Expert inspection teams, led by Chief Inspectors of Hospitals, Social Care and General Practice

▶ We are appointing powerful Chief Inspectors of Hospitals, Social Care and General Practice to lead national teams of inspectors who specialise in particular types of care. The Chief Inspector of Hospitals was a central recommendation of *Patients First and Foremost*. One of the country's leading clinicians, Professor Sir Mike Richards, will be our Chief Inspector of Hospitals, bringing his extensive experience and knowledge of clinical delivery to our inspections of hospitals.

▶ Our Chief Inspectors will shine a powerful light on the quality and safety of care, working closely together to improve people's care as they move between different parts of the health and social care system. Their teams will include independent clinical and other experts, such as people with in-depth experience of using care services. Our inspectors will use data and evidence, including information from the public and people who work in a service, and from our partners in the system, to help them decide where, when and what to inspect.

▶ On our inspections we will speak to more people who use services and frontline staff to hear about the reality of the care they receive, to senior managers and to board members. We will also inspect at nights and at weekends services that provide 24-hour care, as we know there is often less supervision at these times and people can experience poorer care.

▶ Our inspectors will use professional judgement, supported by objective measures, to assess the quality and safety of care. They will also issue a rating which will highlight good and outstanding care, expose mediocre and inadequate care and encourage services to improve.

▶ We will improve the links between our work under the Mental Health Act and how we regulate mental health services to protect the human rights of people who are in vulnerable circumstances, particularly those who, because of concerns about their safety and the safety of others, have had their freedom restricted by being detained and treated against their will. This will mean greater alignment of Mental Health Act activity and inspection visits and more involvement of Experts by Experience in Mental Health Act monitoring.

▶ We are also committed to strengthening the protection of people with learning disabilities, whether or not they are detained. We will give particular attention to making sure we hear the views of people on mental health wards.

▶ We also wish to strengthen the understanding of the Mental Capacity Act by providers, inspectors and commissioners. This Act underpins the care of two million people in health and social care settings and we want to ensure that its principles are promoted and people with mental capacity issues receive care of the same standard as anyone else.

▶ We work closely with other inspectorates, in particular Ofsted in respect of children's health and care services and HMI Prisons, HMI Probation and HMI Constabulary in respect of people in prisons, young offender institutions and police custody. This is important work that helps all partners shape their understanding of the care being provided.

▶ How often we inspect, how long we spend on an inspection, and the size and membership of the inspection team will be based on the 'risk' of the service – the type of care being offered, the vulnerability of the circumstances of people who use it, the information we have about a service, and its current rating. We will inspect services less often if we are confident that they are offering safe, high-quality care and can continue to do so. We will focus less on the number of inspections we carry out and more on the number of days we spend inspecting services.

The action we will take

▶ We will expect and encourage those who provide care to be open and honest about issues and problems that are affecting the quality and safety of people's care. We expect them to respond positively to feedback and to take action to put things right where necessary. We are clear that it is the responsibility of those who run and work in the service to improve it.

▶ We will follow up on all of our inspections and judgements to make sure that a service has improved or remains high-quality care. Our Chief Inspector of Hospitals will play a key role in working with local partners such as Quality Surveillance Groups and through risk summits to help decide the action we will take where care is below the standards.

▶ We have a range of existing powers we can use to make sure the service takes action. For example, we can issue a formal warning requiring improvements within a certain timescale and if necessary, we can suspend a service or cancel its registration.

▶ In the future, our powers in relation to NHS trusts and NHS foundation trusts (acute, mental health, community health and ambulance trusts) will change as we work more closely with Monitor and the NHS TDA. You can read more about this in section 3 of this document.

▶ In other services, we will have new powers from April 2014 to:

- Hold Board members to account for failing to honour their commitments to provide safe, high-quality care. This could result in them being removed from their posts.
- Prosecute a provider for failing to provide fundamental levels of care, without having to issue a formal warning first (this is reliant on legislation being passed by Parliament).
- Make sure the service is open and honest with the people who use the service and their families about things that have gone wrong and why they happened – this will be covered by the new 'duty of candour' planned for inclusion in revised CQC regulations.

▶ The Department of Health will shortly consult on the accountabilities of board members in parallel to this consultation, which are planned for inclusion in the revised CQC regulations.

▶ We will make sure that our partners in the system take action. This could include asking a professional regulator such as the General Medical Council or the Nursing and Midwifery Council to act, or referring the failure to the Health and Safety Executive which could lead to investigation and prosecution. We set out more information on the action we will take in section 3 of this document.

Better information for the public

▶ Our inspection reports will explain the reason for the inspection and describe our findings, assessment and judgments on whether a service is:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led.

▶ They will include a simple summary of the main points for each of the five questions so that people can quickly understand the quality and safety of the service, together with more detail. They will set out clear areas of excellence and areas where improvement is required and explain what will happen next. As the next section discusses, this will also include a rating to help people compare services.

How we will involve people who use services in developing the new fundamentals of care, expected standards and the information the public need

- The views of the public are vital. We plan to engage widely with people who use services and the public, representative groups and national and local charities about the detail of this consultation.
- We will work closely with Healthwatch England and hold workshops with them to get their views and ideas and channel public feedback.
- We will hold small focus groups to explore public understanding of the proposed changes, what they think constitute the fundamentals of care, and what information is of most value at the point of choosing care.
- We will be hosting a number of events for the public and representative groups across the country to give us their feedback face-to-face, and also a one-day detailed engagement workshop with up to 20 members of the public.
- We will host online discussions with our Public Reference Group and our 'people who use services' advisory group, and a range of surveys and exercises on our website, to explore the expectations of the public about what standards of care are meaningful to them and where they would expect to find the information they need.
- We will also meet with a number of community groups via CQC's SpeakOut network.

Ratings to make clear the quality of care and to help people choose between services

▶ Over the next three years we will develop a ratings system for most providers of health and social care. Our ratings will develop to become the single, authoritative assessment of the quality and safety provided by an organisation. They will be primarily based on the judgements of our inspectors about whether services are safe, effective, caring, responsive to people's needs and well-led, and will take into account all the information we hold about a service and the findings of others. We will develop them in partnership with the public, partner organisations, providers of services, clinical and other experts. This will build on the work carried out by the Nuffield Trust in *Rating Providers for Quality: a policy worth pursuing?* (March 2013). This report set out advice on a rating system for GP practices, hospitals, care homes and providers of home care.

▶ We may also use the accreditation schemes or findings of any clinical audit or inspections by other organisations such as the Royal Colleges (for example, of Surgeons, Physicians, Psychiatrists, etc) to contribute to ratings. We will actively develop this approach with the Royal Colleges.

▶ We will also be keen to draw on the insight and day-to-day understanding of partners such as local authorities, health and wellbeing boards, overview and scrutiny committees, and of commissioners such as clinical commissioning groups and GPs in their interaction with the services they commission.

▶ Ratings will be updated as a result of inspections by our expert teams. In healthcare, this is a fundamental change from the annual rating system of the previous regulator. How often inspections take place will depend on the last rating and our continuous monitoring of services.

▶ We will publish the information on which the rating is based.

▶ We will make clear on our website when a service is being inspected so that the public understands that our judgement and rating might change. We will publish any new rating as quickly as possible following our inspections. Our aim will be to make sure the public has access to timely, independent, clear, accurate information about the quality and safety of their local services.

▶ Our Chief Inspectors will use the expert findings, ratings and judgements of their teams of inspectors, together with information and evidence held by CQC and our partners in the system, to enable CQC to provide a single, authoritative assessment of the quality and safety of care of the services we regulate.

▶ We will begin by rating providers of acute services from December 2013, with an aim that all these providers receive a rating before the end of 2015. We will begin to introduce ratings for mental health trusts during 2014 and begin to introduce ratings for all other NHS trusts, for example community healthcare and ambulance trusts, during 2015 /16.

▶ We will also start to introduce ratings for adult social care services from 2014/15 and for most other remaining services from 2015/16. We have not yet decided whether we will rate services such as dentists and those that provide cosmetic surgery.

▶ You can read more detail about our proposals for rating acute hospitals in section 3.

Investigations and reviews of particular aspects of care

▶ In the past, we have tended to use our investigation powers in relation to an individual provider. In future we intend to use our investigation powers to take a more strategic look at care pathways and how people are cared for when they move between services. For example, we could investigate the care of older people with complex health issues who need to use more than one service. We will explore options for carrying these out in partnership with other organisations.

▶ Investigations will also be used to identify the causes of actual or potential systemic failures in quality and safety in a local area or region – for example, the pressure on maternity services in a particular area.

▶ We are developing a better system of deciding which particular aspects of health and social care we should focus on. Our inspections and reviews of particular aspects of care may, for example focus on people's access to mental health services during emergencies, and whether swift, effective assessments are available which include looking at alternatives to admission to hospital.

▶ We will also look at how well particular care services work together within a region for people, for example early diagnosis, specialist services and long-term care of people with dementia.

Judging the full range of care a person receives: why we want to focus on integration

In establishing the Chief Inspectors of Hospitals, Social Care and Primary Care, we think we will bring a sharp and specialist focus to the quality and safety issues in each of these specific areas. Balanced with this, we will ensure that we do not work in silos.

We know that people do not use services in isolation. We think it is vitally important to look across a range of services and whether or not they work in a coordinated way for the benefit of service users.

For that reason we will strengthen our thematic work.

How we will do this

Our thematic approach enables us to:

1. Take a national overview of health and social care – an example of this might be looking at emergency access to mental health services, and whether swift, effective assessments are available which include looking at alternatives to admission to hospital.

2. Select a set of whole local health and social care systems, looking at how they function together and whether the expected level of integration exists – an example of this might be looking at the range of services that a person with dementia might use in a number of geographical areas, from primary care and early diagnosis, through to specialist services, and what people need in terms of long-term care.

Our inspection powers will allow us to look at whole systems, care pathways and transitions between services, including looking at how services are commissioned and the role of partner organisations.

All three of the new Chief Inspectors will need to contribute to these processes, and this will be part of their role.

Consultation questions

General

1. What do you think about the overall changes we are making to how we regulate? What do you like about them? Do you have any concerns?
2. Do you agree with our definitions of the five questions we will ask about quality and safety (is the service safe, effective, caring, responsive and well-led)?

Fundamentals of care

3. Do you think any of the areas in the draft fundamentals of care above should not be included?
4. Do you think there are additional areas that should be fundamentals of care?
5. Are the fundamentals of care expressed in a way that makes it clear whether a standard has been broken?
6. Do the draft fundamentals of care feel relevant to all groups of people and settings?

Section 3: How we will inspect and regulate NHS and independent acute hospitals

CQC is part of a broader system of regulation and improvement in the NHS. Our role in the system is both to highlight where care is good or outstanding and to expose where care is inadequate or requires improvement.

However, we do not act alone. Providers are responsible for the quality of their services and for driving improvement. Other national bodies, including Monitor and NHS TDA, and commissioning bodies play a key part in making improvement happen. This matters – a judgement by CQC that a local service is failing should not be seen as a 'life sentence'. Services can and should improve, and the NHS system has a duty to support this.

The changes we are making to our approach will ensure that we fulfil our role in this broader regulatory system. The first significant step has been the appointment of a Chief Inspector of Hospitals, who will oversee the development of the new inspection model and the ratings system.

Surveillance of the quality and safety of care in acute hospitals

- We will monitor information and evidence to anticipate, identify and respond more quickly to acute hospitals that are failing, or are at risk of failing.
- Our approach will be to use indicators to raise questions about the quality of care provided in an acute hospital. The indicators on their own will not be used to draw definitive conclusions or judge the quality of care – that will be a matter for inspection. Instead the indicators will be used as 'smoke detectors', which will start to sound if a hospital is outside the expected range of performance or is showing declining performance over time for one or more indicators. We will then assess what the most appropriate response should be.

Professor Sir Mike Richards will be the new Chief Inspector of Hospitals

The Chief Inspector will be responsible for assessing and judging how well hospitals put the quality of care and the interests of patients at the heart of everything that they do.

He will oversee a national team of expert hospital inspectors that will carry out targeted inspections in response to quality concerns, and regional teams of inspectors who will undertake routine inspections on a regular basis of all hospitals. He will also lead the development of a ratings system for acute hospitals and mental health trusts.

Mike Richards has a track record of supporting patients and entrenching patient safety and compassion at the heart of hospitals, where they belong. He brings with him the confidence of clinical leaders, staff and managers throughout the NHS, which will be crucial to the success of the Chief Inspector of Hospitals role. He will sit on the CQC Board and make key judgements on quality in hospitals.

Mike Richards has transformed cancer treatment in this country and played a big part in changing perceptions about what patients have a right to expect from hospitals. He has shown persistence and success as a leader in his pursuit of needed and challenging change. He has been instrumental in championing peer review and engaging clinicians to drive improvement.

He joins CQC from NHS England, where he was appointed as lead Director with responsibility for reducing premature mortality across all conditions.

In 1999 he was appointed as the first National Cancer Director at the Department of Health, leading the development of the NHS Cancer Plan, the first comprehensive strategy to tackle cancer in England. He also led the development of the End of Life Care Strategy.

Prior to his appointment to the Department of Health, Mike Richards was a Consultant Medical Oncologist at Guy's Hospital specialising in breast cancer (1986 – 1995) and Sainsbury Professor of Palliative Medicine at St Thomas' Hospital (1995 – 1999).

▶ We have identified a small set of indicators by looking at the key quality and safety issues for NHS hospitals and identifying the data available to measure them. We have based them around the five main questions we will ask about services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

We recognise, however, that many indicators, complaints for example, will cut across more than one or all of these questions.

▶ There is potentially an unlimited set of indicators that we could monitor in relation to acute hospitals. We have grouped the indicators into three sets according to their importance. The first set will be used to identify potential concerns and trigger a response from us. The second set includes a wider range of information, including nationally comparable data, which we will check if any of the first set signal concerns. The third set will be used to test and improve the others

and may include analysis which is not routinely available.

Our three sets of indicators

▶ The first set of indicators (see figure 3 on page 25) will be the centrepiece of our new model. It will include data and evidence such as mortality rates, never events, specific results from the national NHS staff and patient surveys, information from whistleblowers, information from individual members of the public who make complaints, raise concerns and provide feedback, and information from Quality Surveillance Groups.

▶ They have been selected because they are things that have a high impact on people and because they can alert us to changes in those areas. An example of a trigger would be higher than expected deaths for people who have had operations that would not normally carry that level of risk. We have set out some examples of possible indicators for mental health services in table 1 on page 26.

▶ Any indicator in this set which points to a potential concern or a decline in quality over a period of time will trigger questions from us. Our response will vary depending on the concern. For example we may ask the trust responsible for the hospital for more information and explanation; we may carry out an inspection; or in extreme cases we may suspend a service.

▶ The indicators are used to pursue lines of enquiry; regulatory judgements leading to ratings will take place only after any inspection has been carried out.

▶ We will also make sure that we explore the full potential of the results of the 'Friends and Family Test', which asks people how likely they are to recommend a ward or A&E department to friends and family if they needed similar care or treatment to assess quality.

How will we use people's experiences of services?

The reality of people's experiences of care will be a key source of information for CQC. As well as being a core focus of our inspections, we will use people's experiences to help determine which hospitals and services we will inspect and the issues that we will follow up on inspection. We will analyse individual patient experience alongside the national survey programme and Friends and Family Test. Sources include:

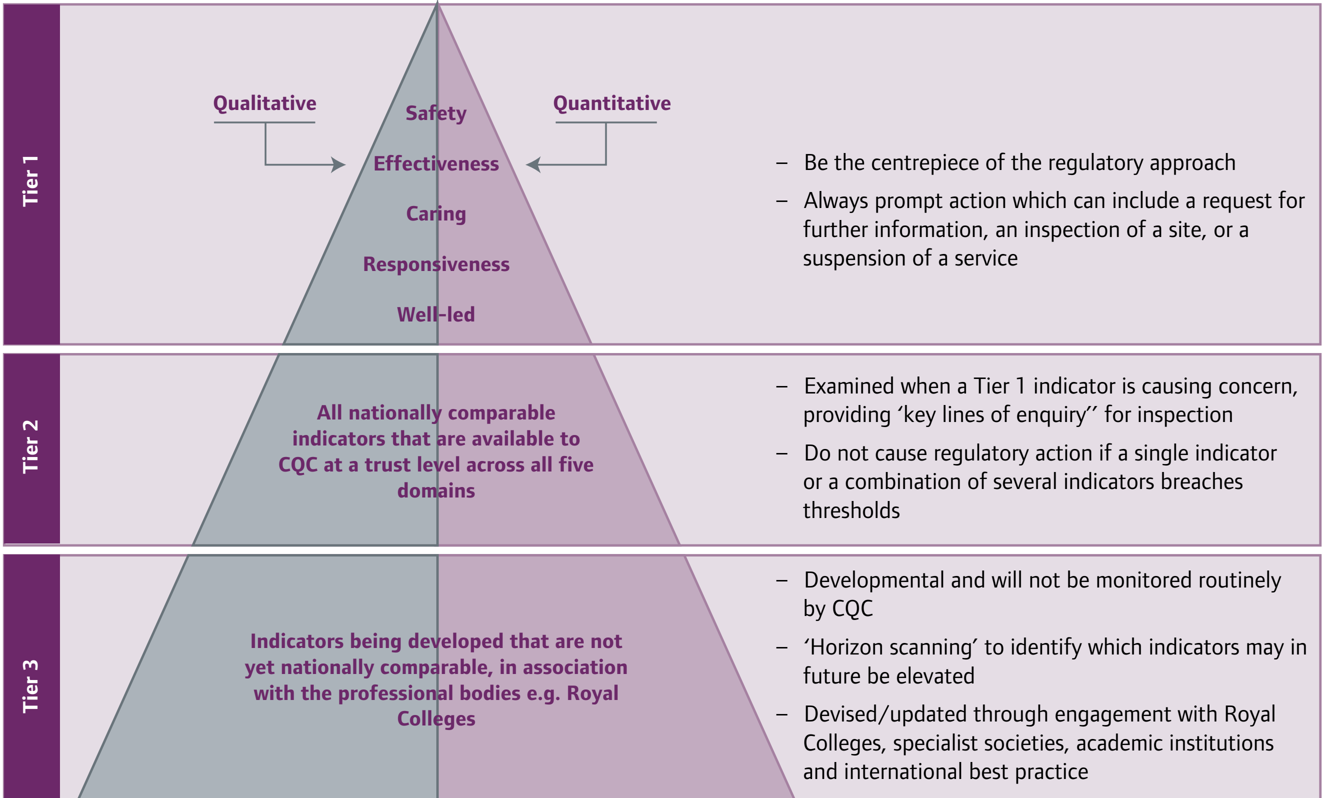
- Healthwatch England recommendations
- Complaints investigated by the Ombudsman
- Number and themes of complaints made to CQC's National Customer Service Centre
- Share Your Experience comments submitted via CQC's website
- Comments posted on NHS Choices and Patient Opinion (starting with negative comments)
- Experiences shared through patient organisations
- Concerns raised directly by staff.

▶ The second set of indicators will include a much wider range of intelligence which on their own may not trigger action by us. We will check them if the first set of indicators signal a concern, to help understand the issues raised and decide what an inspection should focus on. This second set of indicators will include nationally comparable data such as results from National Clinical Audits, admission profiles for each NHS trust, wider sets of patient and survey results, and information from accreditation schemes.

▶ The third set will include indicators that are not yet nationally comparable, are not routinely available or which are the result of 'one-off' data collections. We will use this set to horizon scan for those indicators which may be useful in the future as part of the first or second set of indicators.

▶ While we have grouped our indicators around the five main questions we will ask about services, we recognise that many indicators will cut across more than one of those questions – for example comments submitted via the 'Share Your Experience' form on CQC's website.

FIGURE 3: INDICATORS TO TRIGGER ACTION IN OUR REGULATION AND INSPECTION OF ACUTE HOSPITALS



▶ We will refine these indicators through this consultation and engagement and by scanning new information sources and refining our analysis. We would welcome views on the proposed indicators and intelligence.

▶ We will apply the same approach to NHS mental health trusts, community health trusts and ambulance trusts and will consider how the methodology can best be applied to social care, independent healthcare and primary care providers. We know that for certain organisations and sectors there is less national data available – and we will take this into account as we design how we make the best use of intelligence for these sectors. We will consult on our proposals for each type of organisation as they are developed.

▶ Please see the annex to this consultation for our proposals for the first set of indicators for NHS acute hospitals. For illustrative purposes only we have set out some examples of possible indicators in table 1, focusing on one of the five questions: Is the trust safe?

TABLE 1: ILLUSTRATION OF POTENTIAL SAFETY INDICATORS FOR ACUTE AND MENTAL HEALTH TRUSTS

Dimension	Acute NHS trusts	Mental health trusts
Rate of deaths is higher than expected	Deaths of people who have low risk conditions Deaths of people who have undergone low risk procedures (e.g. hernia repair)	Deaths of people in contact with the service Deaths of people who are detained in hospital under the Mental Health Act
Never events*	Includes for example: A surgical intervention performed on the wrong site Surgical instrument unintentionally retained after an operation In-hospital death of a mother as a result of a haemorrhage following an elective caesarean section	For example: Suicide using curtain or shower rails by an inpatient in an acute mental health setting A patient who is a transferred prisoner escaping from medium or high secure mental health services where they have been placed for treatment on a Home Office restriction order
Reporting of incidents	Lower reporting than expected of key safety incidents	Lower reporting than expected of key safety incidents Severe harm as a result of restraint where practice has not complied with the Mental Health Act Code of Practice
Avoidable infections	Avoidable infections – e.g. C.difficile and MRSA	

* Never events are preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

▶ We are committed to being transparent about how we will monitor services and we will share the analyses with NHS trusts, commissioners and other regulatory bodies in the health and social care system. However we want to place as much information in the public domain as possible. We would therefore welcome feedback on how much of the information and analysis used in our monitoring model we should make public as a matter of routine.

Changes to how we inspect NHS and independent acute hospitals

▶ The Chief Inspector will lead teams of specialist hospital inspectors, clinical and other experts who will carry out inspections on a rolling basis.

Planning an inspection

▶ Before carrying out any inspection, our inspectors will review all the information we hold about a hospital, plan which parts of the hospital they will inspect, and bring together the independent experts they need to make up their inspection team. For example, they may include clinical consultants, directors of nursing, chief executives or board members of other hospitals, and trained members of the public who have a lot of experience of hospital care. Some of the inspection team will be CQC employees, others will be independent experts who join our teams for a certain number of days each year. The teams will vary in size but will usually be bigger than they are now.

▶ Our inspectors will decide whether or not to tell the hospital that they are coming. Currently all of our inspections are unannounced so that the hospital cannot prepare for our visit. This can make it more difficult to speak to people in the local community or to set up discussions with staff beforehand. In future, whether or not we let the hospital know we are coming will depend on what we are inspecting and why. For example, inspections to follow up on whether improvements have been made will mostly be unannounced; inspections in response to serious concerns may be unannounced in the first instance but we may go back to speak to more staff, managers, patients and others and we will let them know in advance. Our expectation is that the majority of inspections will remain unannounced.

Carrying out inspections

▶ Our inspections will be carried out on a rolling basis and will look at whether or not services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led.[3]

▶ How often we carry out inspections will vary based on each hospital's performance. We will inspect as often as is needed to follow up on any concerns and to make sure the rating is up to date. We will inspect at weekends or during the night where we think it is needed. A hospital with a lower rating will be inspected more often than a hospital with a higher rating.

▶ Our new hospital inspection teams will also carry out targeted inspections in response to serious concerns identified by CQC, our partners in the system or the public. These inspections may focus on particular services, clinical areas or aspects of care.

3. Our assessments of 'well-led' in acute hospitals will focus on quality, not financial governance, which is part of the role of Monitor and the NHS TDA.

▶ We will also carry out inspections which look at particular types or aspects of care across all services – for example care of people with dementia.

▶ Our inspections of hospitals will vary in terms of the things they look at and the time they take, but they will take as long as is needed – typically 15 days, with an average of 6-7 days on site – to make a thorough assessment of the quality and safety of care. In the vast majority of cases, inspections will be longer and more thorough than our current approach of a small team of inspectors being on site for one or two days. Our inspectors will spend more time talking to people who use the service, to staff, senior managers and members.

▶ Some of our inspections will remain shorter and more focused. For example, if we need to follow up on a particular area of concern we would inspect for less time and with a smaller team.

▶ The inspection judgements that we make from October 2013 and any ratings that we publish before April 2014 will be based on our new framework of expected standards and fundamentals of care. However, because the new framework and supporting guidance will not be underpinned by changes to Regulations until April 2014, any action that we take will be taken using our existing framework. We will explain more about how we will do this later this year.

Working with others

▶ We are looking at how we will work with other organisations in our inspections of acute hospitals. Other organisations visit hospitals and assess the quality of services, including accreditation schemes such as those awarded by Royal Colleges or other specialist organisations. These tell us a great deal about the quality of services.

▶ We are considering:

- Drawing on the evidence that other organisations such as the Medical Royal Colleges gather through clinical audits or peer review and asking them to carry out visits on our behalf that would look at particular aspects of care. We would work with these

organisations to develop how this would work in more detail.

- Involving experts from other organisations to join our inspection teams to advise on what we should be looking at and what is best practice in particular areas of care.
- Using the findings of other organisations that carry out clinical audits and accredit hospitals as evidence that would contribute to a hospital's rating or help us decide when, where and what to inspect.

▶ Our Chief Inspector of Hospitals will make sure we make the most of 'peer review' – the findings and opinions of other experts – in our findings.

▶ Our teams will share information about the hospitals in their area with local partners, including commissioners, professional regulators, local Healthwatch, lead Quality Surveillance Groups, local authorities, health and wellbeing boards, overview and scrutiny committees and others. They will also share information with others who have insight into people's experiences of the quality and safety of care locally, including local MPs. They will make sure that people's views and experiences of care are a top priority for all.

The action we will take to tackle poor care

▶ As described in *Patients First and Foremost* the government intends to introduce a single failure regime that will place the same emphasis on addressing failures in quality of care as there is on financial failure.

▶ As part of this, the action we will take to identify and tackle serious problems with poor care in NHS trusts and NHS foundation trusts will have three phases. It may be triggered by a specific incident but can equally be a consequence of a trust being in either of the bottom two rating categories.

▶ Firstly, if the Chief Inspector of Hospitals believes that a trust requires significant improvement, the board of the trust will be issued with a warning notice which requires them to improve within a fixed time period.

▶ Secondly, if the trust and those who commission its services are unable to resolve the problems themselves, the Chief Inspector will formally request Monitor or the NHS Trust Development Authority (NHS TDA) to take action to protect people, to deal with the failure, and to hold individuals to account. For example, Monitor or the NHS TDA may bring in expert clinical support to make the improvements. We would consider this as equivalent, for the trust concerned, to the 'special measures' that Ofsted operate for schools.

▶ Lastly, if care still fails to improve, the Chief Inspector, through CQC will be able to direct Monitor or NHS TDA to appoint a special administrator, suspending the board of the trust as a result. Special administration will provide a framework for determining how best to secure a comprehensive range of high-quality services that are sustainable in the long term.

▶ In the event of closure of services, the provider and Monitor or the NHS TDA will work with NHS England and local clinical commissioning groups to make sure that local people have access to alternative safe, high-quality hospital care.

▶ In all these cases, it is for Monitor and the NHS TDA together with the provider to decide what action is needed to improve the service. CQC will judge if the action has been effective in improving the quality of care.

▶ We will begin to introduce this programme from October 2013 through a protocol setting out how CQC, Monitor and NHS TDA will coordinate our respective powers of intervention. It will be underpinned by legislation when the Care Bill completes its Parliamentary passage.

▶ CQC will retain the ability to stop a service from providing care if it if is putting people at immediate risk of harm. We are also working with Monitor and the NHS TDA to make sure there are clear procedures for acting on less urgent concerns.

Below is an example of how this might work in practice.

Phase 1

▶ CQC becomes aware of a number of complaints about local emergency care services at an NHS non-foundation trust and certain key indicators of effectiveness are dropping. CQC shares these with local partners and the NHS TDA, and decides to bring forward its inspection and finds that emergency services are poorly managed and poorly led. The emergency department feels and looks far too busy and hygiene procedures are not always observed; junior doctors are regularly working above their rostered hours; frontline staff can be rude to patients due to strain and overwork; and there are concerns that although the situation is not dangerous, the service is not as effective as it could be.

▶ As a result the Chief Inspector of Hospitals judges that emergency services are not meeting expected standards of care. These findings are shared with NHS TDA and commissioners, who request the trust improve and provide support.

▶ While exploring the concerns about emergency services, the Chief Inspector identifies further concerns about the capacity of management at the trust and the Board to monitor effectively the quality of the services provided across the trust. As a result of these concerns the trust is issued with a warning notice and is given six months to make the significant improvements required. Working with commissioners, it develops an action plan to address the quality failures. The judgement of the inspection is that the hospital should be rated 'Requires Improvement'.

Phase 2

▶ CQC inspects the A&E service again, on a Saturday night. The situation has not improved. Patients complain about having to wait a long time and the rudeness of the staff; a number of key personnel, such as consultants, have left or are planning to leave; the management team has not stopped services getting worse and acknowledge that they are struggling to bring about the required improvements. CQC also now has concerns about emerging problems in the Medical Assessment Unit where it is difficult to find suitably capable staff to cover weekends and nights.

▶ A local risk summit is convened, and confirms a number of concerns and no plan that commands confidence to deal with them. CQC judges that the necessary improvements have not been made to the quality of A&E care. Further intervention is now required and CQC formally requests the NHS TDA to do so.

▶ The NHS TDA considers what further intervention is needed to make sure improvements are made. As part of this they review the skills and competences of executive and non-executive board members and decide to bring in short-term support to the management team, liaising with CQC.

Phase 3

▶ A further CQC inspection in six months' time reveals that improvements have still not been made. The NHS TDA decides whether or not the Secretary of State should be advised to place the trust into special administration to address the serious problems at the trust (this would include suspension of the board) and to consider options for securing long-term, high-quality services.

Ratings for NHS acute hospitals

▶ Earlier in this document, we set out our proposal to begin publishing ratings for NHS trusts from December 2013.

▶ Ratings for NHS trusts and NHS foundation trusts will be based primarily on inspection judgement, and informed by a series of indicators, using data already available and the findings of others. The findings of others could be accreditation schemes, clinical peer review as well as the judgments of other regulators. We will consult on these proposals in detail later in the year.

▶ We will produce ratings and the information on which the ratings are based at a level which recognises the complexity of NHS services and is useful to people who use services as well as those who provide and commission NHS care. We are therefore proposing to provide ratings for certain

individual services (for example, emergency or maternity services) as well as each hospital. We would also like to provide ratings for each of our key questions – is the service:

- Safe?
- Effective?
- Caring?
- Responsive to people's needs?
- Well-led?

▶ This would mean that, where sufficient evidence was available, a trust would have five ratings each at the level of an individual service, a hospital, and the whole trust. We would welcome people's views on how this could work and whether this would be useful or overly complex.

Rating	Description of trust and hospital rating	Description of a service level rating
Inadequate*	Serious and systemic failings in relation to quality, and fundamentals of care are not met on an ongoing basis across multiple domains. Urgent intervention is required.	Serious and systemic failings in relation to quality, and fundamentals of care are not met on an ongoing basis across multiple domains. Urgent intervention is required.
Requires improvement	Fundamentals of care are breached and/or 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.	Fundamentals of care are breached and/or expected standards are not being met in one or more domain. Significant action by the provider is required to address the problem.
Good	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.	No fundamentals of care breaches. Any breaches in expected standards in any domain (not fundamental) are acted on quickly and effectively by the provider. Care is generally judged as good. There is evidence that the service is meeting high-quality standards.
Outstanding	No fundamentals of care breaches. No inadequate services with most services rated as 'Good' or 'Outstanding'. Any breaches in expected standards (not fundamental) are acted on quickly and effectively by the provider. There is a range of evidence that the service is sustaining high-quality care** over time across most services in the organisation. There is evidence of innovation. No governance or finance issues from Monitor or NHS TDA.	No fundamentals of care breaches. All expected standards across all domains are met. There is a range of evidence the service is sustaining high-quality care** over time across most specialities. There is evidence of innovation.

* If an acute hospital is in phase 2 of the programme for failing NHS hospitals, it will be judged to be in the equivalent to what Ofsted term 'special measures', in addition to its inadequate rating.

** For example consistently meeting NICE quality standards or Royal College standards through clinical peer review

Ratings scale

▶ We propose issuing ratings of services, hospitals and trusts, and of our five key questions, on a four-point scale.

▶ The proposed ratings scale reflects principles we will apply in response to providers not meeting expectations and how we recognise excellence in 'outstanding' organisations. Judgements against each of our five questions will be treated equally, and services and hospital ratings will be aggregated into a single organisational level rating.

▶ When there are breaches of the fundamentals of care, we will not consider them in isolation. We will consider if the breach occurred as a result of isolated human error or because of a systemic failure within a service, hospital or organisation (for example, inadequate staffing levels). We will also look at the speed and quality of the response of the provider and its staff to the breach and the impact of that response to determine how this should be reflected in ratings at service, hospital and organisational level. We expect breaches of the fundamentals of care in 'good' trusts to be the result of isolated human error and recognise the need to be proportionate in such circumstances. We will ensure our judgements of these cases will be clear and transparent.

▶ We also propose that a 'good' trust may still retain its organisational ranking with a low number of services 'requiring improvement', but only if fundamentals of care breaches do not reflect systemic failure and we have confidence in the response of the provider. 'Outstanding' organisations must be able to demonstrate the sustained delivery of high-quality care across the majority of services and demonstrate innovation. You cannot be an outstanding trust if you have breached the fundamentals of care.

Issuing and reviewing a rating

▶ From October 2013, CQC will start to inspect and regulate NHS acute hospitals in the ways set out in this document. From December 2013 we will begin to rate NHS acute trusts and NHS foundation acute trusts, aiming to complete them before the end of 2015 .

▶ We will inspect 'outstanding' hospitals every 3-5 years; 'good' hospitals every 2-3 years; hospitals where 'improvements are required' at least once a year, and those rated as 'inadequate' as and when needed.

▶ Our monitoring of NHS hospitals could identify concerns which trigger inspections at any time and this could lead to a review of the rating. The outcome of a review may be that the rating is judged a fair reflection of quality and safety, that the inspection is not broad or in-depth enough to change the overall rating or that the rating needs to be changed. Ratings are more likely to be reviewed where systemic poor practice is found, or if a recurring problem is not satisfactorily resolved. Therefore, not all inspections will result in a rating being issued or changed.

▶ We will develop a formal rules-based methodology to determine when a rating should be changed based on our evidence and judgement.

Consultation questions

Intelligent monitoring of NHS acute hospitals

7. Do you agree with the proposals for how we will organise the indicators to inform and direct our regulatory activity?

8. Do you agree with the sources we have identified for the first set of indicators? Please also refer to the annex to this consultaiton.

9. Which approach should we adopt for publishing information and analysis about how we monitor each NHS trust? Should we:

   - Publish the full methodology for the indicators?
   - Share the analysis with the providers to which the analysis relates?
   - Publish our analysis once we have completed any resulting follow up and inquiries (even if we did not carry out an inspection)?

Inspections

10. Do you agree with our proposals for inspecting NHS and independent acute hospitals?

Ratings

11. Should the rating seek to be the 'single, authoritative assessment of quality and safety'? Although the sources of information to decide a rating will include indicators and the findings of others, should the inspection judgement be the most important factor?

12. Should a core of services always have to be inspected to enable a rating to be awarded at either hospital or trust level?

13. Would rating the five key questions (safe, effective, caring, responsive and well-led) at the level of an individual service, a hospital and a whole trust provide the right level of information and be clear to the public, providers and commissioners?

14. Do you agree with the ratings labels and scale and are they clear and fair?

15. Do you agree with the risk adjusted inspection frequency set out which is based on ratings, i.e. outstanding every 3-5 years, good every 2-3 years, requires improvement at least once per year and inadequate as and when needed?

General

16. The model set out in this chapter applies to all NHS acute trusts. Which elements of the approach might apply to other types of NHS provider?

Please also see the questions in the annex to this consultation.

Section 4: Changes to CQC's regulations

CQC's registration requirements are set out in secondary legislation, known as regulations. These regulations give CQC the legal power to register, judge and take action against those who provide and manage care.

This section sets out proposals by the Department of Health and CQC for making changes to those regulations to underpin CQC's new operating model.

This section of the consultation document **applies to all providers registered by CQC**.

There are three main changes to CQC's regulations:

▶ The introduction of fundamentals of care, and other organisational requirements about providers, as CQC registration requirements. The registration requirements will be simpler, and fewer in number, than the current CQC registration requirements which they will replace. We also aim to make it simpler to prosecute providers when these fundamentals of care are breached.

▶ The introduction of a statutory duty of candour as one of the organisational requirements on all providers registered with CQC, fulfilling the commitment made in *Patients First and Foremost*.

▶ Strengthening the powers to hold to account providers that allow unacceptable standards of care to occur, responding in particular to the events at Winterbourne View, but also at Mid Staffordshire. The Department of Health will publish a separate consultation shortly that will set out in detail the proposed changes, including the introduction of a new fit and proper persons test for directors of boards.

Turning the fundamentals of care into registration requirements

▶ Section 2 set out how changes will be made to the registration requirements so that they establish a clear baseline below which standards of care must not fall. Following this consultation, the Department of Health will publish regulations in draft during the autumn for further discussion. These will then be debated in Parliament, and the aim is to enact them in secondary legislation in April 2014.

▶ The new legislation will aim to allow CQC to prosecute breaches of the fundamentals of care without the need to issue a warning notice. This new power will sit alongside CQC's other existing powers of intervention, such as a clear programme for failing NHS trusts and the range of civil enforcement powers for all other providers.

Duty of candour

▶ Those who provide care services should tell people who use the service and their families about any problems that have affected the quality and safety of the care, and explain why they have happened. A contractual duty of candour was introduced into NHS contracts from April 2013 and in *Patients First and Foremost* the government committed to a statutory duty of candour on health and social care providers. A spirit of candour is vital to ensuring that problems are identified and dealt with quickly. A requirement to be open already exists in the professional codes of practice for managers, doctors and nurses. It is already the responsibility of boards in provider organisations to support openness. This approach was not apparent at Mid Staffordshire.

▶ The government intends to introduce a statutory duty of candour as a CQC registration requirement on all health and social care providers. It will require providers to make sure staff and clinicians are open with people who use services and their families where there are failings in care and to provide an explanation for it. This will underline the importance of transparency, openness and candour, and provides a mechanism for making sure that all of the provider's employees act in accordance with the duty.

▶ The registration requirement should be sufficiently clear that CQC could prosecute an organisation without having to issue a warning notice. The new registration requirement should mean CQC can take action against a provider that was not open with people who use services about failings in care.

Consultation questions

Duty of candour

17. Do you agree that a duty of candour should be introduced as a registration requirement, requiring providers to ensure their staff and clinicians are open with people and their families where there are failings in care?

18. Do you agree that we should aim to draft a duty of candour sufficiently clearly that prosecution can be brought against a health or care provider that breaches this duty.

19. Do you have any other comments about the introduction of a statutory duty of candour on providers of services via CQC registration requirements?

Section 5: Consultation questions

This section repeats the consultation questions we have asked throughout this document.

How to respond to this consultation

You can give us your views and comments by post, email or on our website using the addresses below, by **Monday 12 August 2013**.

Section 2

General

1. What do you think about the overall changes we are making to how we regulate? What do you like about them? Do you have any concerns?
2. Do you agree with our definitions of the five questions we will ask about quality and safety (is the service safe, effective, caring, responsive and well-led)?

Fundamentals of care

3. Do you think any of the areas in the draft fundamentals of care above should not be included?
4. Do you think there are additional areas that should be fundamentals of care?
5. Are the fundamentals of care expressed in a way that makes it clear whether they have been broken?
6. Do the draft fundamentals of care feel relevant to all groups of people and settings?

Section 3

Intelligent monitoring of NHS acute hospitals

7. Do you agree with the proposals for how we will organise the indicators to inform and direct our regulatory activity?
8. Do you agree with the sources we have identified for the first set of indicators?
9. Which approach should we adopt for publishing information and analysis about how we monitor each NHS trust? Should we:
   - Publish the full methodology for the indicators?
   - Share the analysis with the providers to which the analysis relates?
   - Publish our analysis once we have completed any resulting follow up and inquiries (even if we did not carry out an inspection)?

Inspections

10. Do you agree with our proposals for inspecting NHS and independent acute hospitals?

Ratings

11. Should the rating seek to be the 'single, authoritative assessment of quality and safety'? Although the sources of information to decide a rating will include indicators and the findings of others, should the inspection judgement be the most important factor?
12. Should a core of services always have to be inspected to enable a rating to be awarded at either hospital or trust level?
13. Would rating the five key questions (safe, effective, caring, responsive and well-led) at the level of an individual service, a hospital and a whole trust provide the right level of information and be clear to the public, providers and commissioners?
14. Do you agree with the ratings labels and scale and are they clear and fair?
15. Do you agree with the risk adjusted inspection frequency set out which is based on ratings, i.e. outstanding every 3-5 years, good every 2-3 years, requires improvement at least once per year and inadequate as and when needed?

General

16. The model set out in this chapter applies to all NHS acute trusts. Which elements of the approach might apply to other types of NHS provider?

Section 4

Duty of candour

17. Do you agree that a duty of candour should be introduced as a registration requirement, requiring providers to ensure their staff and clinicians are open with people and their families where there are failings in care?
18. Do you agree that we should aim to draft a duty of candour sufficiently clearly that prosecution can be brought against a health or care provider that breaches this duty.
19. Do you have any other comments about the introduction of a statutory duty of candour on providers of services via CQC registration requirements?

The following questions relate to the Impact Assessments that accompany this document.

Impact Assessments

20. Do you have any comments on the draft Regulatory Impact Assessment?
21. Do you have any comments on the draft Equality and Human Rights Duties Impact Analysis?

The following questions are set out in the separate Annex – *Proposed model for intelligent monitoring and expert judgement in acute NHS trusts*

A1. Do you agree with the principles that we have set out for assessing indicators?

A2. Do you agree with the indicators and sources of information?

A3. Are there any additional indicators that we should include as 'tier one' indicators?

A4. Do the proposed clinical areas broadly capture the main risks of harm in acute trusts? If not, which key areas are absent?

A5. Do you agree with our proposal to include more information from National Clinical Audits once it is available?

A6. Do you agree with our approach of using patient experience as the focus for measuring caring?

How to respond to this consultation

You can respond to our consultation in the following ways. Please send us your views and comments by **Monday 12 August 2013**.

Online

Use our online form at:
www.cqc.org.uk/inspectionchanges

By email

Email your response to:
cqcinspectionchanges@cqc.org.uk

By post

Write to us at:

CQC Inspection Changes
CQC National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please contact us if you would like a summary of this document in another language or format.

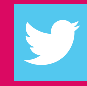
How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA


Follow us on Twitter: **@CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk/inspectionchanges**.

Please contact us if you would like a summary of this report in another language or format.

Agenda Item 8

Appendix 2

Annex to the consultation: changes to the way CQC regulates, inspects and monitors care services

Proposed model for intelligent monitoring and expert judgement in acute NHS trusts

June 2013

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.

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Introduction

▶ We are making significant changes to how we monitor, inspect and regulate care services to make sure they provide people with safe, effective, compassionate, high-quality care. This document focuses on the changes we are making to how we will monitor NHS acute services. It sets out our initial proposals for key indicators – which we call 'tier one' indicators – for NHS acute hospitals. We will monitor these indicators as part of our surveillance process to help us decide where and what to inspect. We want to test and develop these indicators with as wide a range of stakeholders as possible.

▶ The surveillance process will not draw definitive conclusions about the quality provided in a hospital, but will raise questions about the quality of care provided. The indicators will be used as 'smoke detectors' which will start to sound if a hospital is outside the expected range of performance or is showing declining performance over time for one or more indicators. We will then assess what the most appropriate response should be.

▶ We have set out our model of surveillance of the quality and safety of care in NHS acute hospitals in our main consultation document, *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care services* at **www.cqc.org.uk/inspectionchanges**. This sets out how we will organise the potentially unlimited set of indicators that we could monitor in relation to hospitals into three tiers. Tier one from this model are those indicators we consider to be the most important for monitoring risks to the quality of care in acute hospital services.

▶ We have identified this set of indicators by looking at the key quality and safety issues for NHS hospitals and identifying the data there is available to measure them. We have based them around the five main questions we will ask about services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

We recognise that there is also a range of information sources that may cut across more than one of these questions. For example, comments submitted via the 'Share Your Experience' form on CQC's website could relate to any of the above questions. We have presented these mainly textual sources under the heading of 'qualitative intelligence'.

▶ We first describe the principles behind the selection of these indicators, and an overview of the methodology we have used to identify each set of indicators for each of the five questions. Figure 1 provides an overview of the tier one indicators.

FIGURE 1: OVERVIEW OF 'TIER ONE' INDICATORS FOR NHS ACUTE TRUSTS

Qualitative – Dimension		Quantitative – Dimension
N Complaints and whistleblowing O Safeguarding P Negative comments on social media Output from inspections Q Media R Disruption to management S Patient and user T representatives – Healthwatch – Patient organisations Strategic partners U – Monitor/NHS TDA/NHS England – Quality surveillance groups	i Safety	A Deaths in low-risk conditions B Never events C Under-reporting of safety incidents D Avoidable infections
	ii Effectiveness	E Mortality F Complications, sub-optimal, outcomes and avoidable morbidity*
	iii Caring	G Patient view of caring
	iv Responsiveness	H Access measures I Discharge and integration
	v Well-led	J Staff surveys K Staffing L Utilisation M Monitor rating

* Additional indicators in development to ensure coverage of the identified 57 clinical areas.

Development approach

▶ In order to identify the most important indicators for inclusion in this model, we have started by defining an ideal set of areas or dimensions for each of the five questions we will ask about services – are they safe, effective, caring, responsive and well-led? We have then identified datasets and existing indicators by testing their suitability using a set of principles (set out in table 1). These principles represent a high bar for any indicator to pass. In the short term, the indicators may not be sufficiently well defined to pass each of these principles. We have therefore been pragmatic in defining the first set of indicators. We also recognise that the analysis of the data will not be right all of the time – it may produce 'false positives' and 'false negatives'.

▶ While we have grouped our indicators around the five main questions we will ask about services, we recognise that many indicators will cut across more than one or all of those questions, for example the Friends and Family Test.

▶ We have undertaken some initial engagement with a number of NHS trusts and experts in the field of quality measurement. We will continue to engage with the widest range of stakeholders possible to help inform the content and use of the first set of indicators. We will also work to improve the robustness of the indicators through time, for example by working with NHS England and with the Royal Colleges to access information from clinical audits.

TABLE 1: PRINCIPLES FOR THE DEVELOPMENT OF INDICATORS

Pragmatic: The indicator must cover the key elements of each of the five key questions as far as possible, keeping as close as possible to the remaining principles.	**Effective**: The indicator should be targeted in a way that it does not disincentivise behaviour on a personal, hospital or system level.
Relevant: 'Measures the correct thing' – the indicator should meaningfully measure the performance quality of a defined service area.	**Actionable**: The result of the indicator can be used to make operational or management decisions.
Robust: The indicator is derived from data which is difficult or undesirable to manipulate, e.g. legal penalties or financial consequences.	**Scientifically sound**: 'Measures correctly' – the indicator should have high specificity and sensitivity, and should be scientifically defined to give valid and reliable results.
Timely: Data should be available on a sufficiently timely basis (frequent) to allow a response in an appropriate timeframe (time-lag), e.g. monthly.	**Comparable**: The indicator can be compared internally (to previous time periods) and externally (to other providers).
Clinically accepted: The indicator should be recognised as valid and relevant by the clinical community, e.g. in medical literature, by medical bodies.	**Easily gathered**: Data should be simple, quick to collect and minimise the regulatory burden, e.g. collected routinely from existing clinical or administrative systems.

Safety indicators

We first identified all safety indicators that exist today within the NHS. We also looked at international systems to check whether they measured safety in a way that we could learn from. We also considered the issues that could potentially discourage the reporting of safety issues and took this into account in the selection of indicators for this domain. This has meant that as far as possible we have avoided including indicators that are based on voluntary data collections.

▶ Having identified a full list of available indicators, we then filtered against three criteria:

- Is there a strong incentive to report the information (such as a legal requirement)?
- Is the indicator robustly reported today?
- Does the indicator cover a reasonably wide definition of safety within the trust?

Effectiveness indicators

▶ Effectiveness is complex to measure given the wide range of clinical specialities within an NHS acute trust and the range of outcomes that can be measured. In addition, there are a huge number of areas for which national datasets are not yet available and where definitions of outcomes of treatment are debated. For the purposes of the monitoring model we have focused our measurement on risks of harm from poor quality care and treatment. Our approach is to use indicators that are clinically relevant rather than relying on overall hospital measures alone. We have defined the clinical areas we will focus on in the first set of indicators and then we have defined indicators for each of these areas.

Defining clinical areas

▶ We started by identifying the main causes of mortality in hospitals in England. We then combined this analysis with the clinical areas that account for the highest number of patients

treated each year in hospitals in England. We looked at these two indicators overall and also for maternity, children, mental health and older patients. The latter group were selected as they are more vulnerable in hospital settings than the general patient population. From this analysis we concluded that it would be reasonable to focus on the first 50% of activity and mortality, as this provided significant coverage of clinical services within an NHS trust. We then refined the list of clinical areas using multiple reference sources, including:

- German Inpatient Quality Indicator system (also used in Switzerland and Austria)
- Dr Foster alert categories
- Existing NHS groupings (e.g. CCS and HRG sub-categories)
- Testing with clinicians.

▶ The resulting clinical areas are shown in table 2.

TABLE 2: PRIORITISED CLINICAL AREAS

Clinical areas		
Trust level 1. Mortality at a trust level 2. Weekend mortality 3. Sepsis **Cross-cutting areas** 4. Intensive care 5. A&E and trauma care 6. Anaesthetics and surgical services 7. Diagnostics 8. End of life care 9. OT/Physio/SALT/Nutrition **Specific pathways** 10. Elderly pathway 11. Paediatric pathway 12. Cancer pathway (excl. surgery) **Cardiac conditions and care** 13. Acute myocardial infarction 14. Heart failure 15. Cardiac surgery 16. Cardiac arrhythmia 17. Pacemakers & defibrillation 18. Cardiac ablation **Stroke** 19. Stroke **Nervous system conditions and care** 20. Craniotomy 21. Epilepsy 22. Parkinson's	**Neck & Head & ENT** 23. Procedures on the ear, nose and throat 24. Procedures on the head and neck **Respiratory conditions and care** 25. Pneumonia 26. Chronic obstructive pulmonary disease 27. Lung resection 28. Asthma **Gastro-intestinal tract conditions and care** 29. Cholecystectomy 30. Herniotomy 31. Resections of the colon and rectum 32. Gastric and oesophageal resections 33. Pancreatic and liver resections 34. Conditions of the upper GI tract **Vascular conditions and care** 35. Carotid vascular surgery 36. Aneurysms 37. Lower limb bypass graft 38. Lower limb angioplasty 39. Amputation **Maternity and women's health** 40. Delivery 41. Newborns	42. Procedures on the female reproductive organs **Musculo-skeletal conditions and interventions** 43. Elective hip surgery 44. Elective knee surgery 45. Spine and back 46. Fracture of neck and femur **Urogenitary care and conditions** 47. Nephrectomy and partial nephrectomy 48. Cystectomy and bladder procedures 49. Procedures on the prostate 50. Renal failure **Endocrine, metabolic and nutritional disorders** 51. Diabetes 52. Malnutrition and dehydration **Haemotology** 53. Anaemia **Ophthalmological conditions and care** 54. Cataract surgery **Skin conditions and care** 55. Skin diseases **Mental health** 56. Depressive disorders 57. Psychoses

Defining indicators for each clinical area

▶ For each of these clinical areas, we identified the key risks of harm that we could potentially measure. We prioritised indicators based on whether there were clearly defined outcomes and by using the principles set out in table 1 above. In general, mortality indicators meet these criteria better than other indicators of clinical effectiveness as mortality is routinely recorded and available from administrative data. We propose to measure mortality for all clinical areas where this appears to be a good measure of the effectiveness of care.

▶ To identify indicators for clinical areas where mortality is not an appropriate measure of effectiveness, we compiled a list of measures used in national and international systems. We identified over 2,000 indicators from across the UK, US, German and Australian health systems and from speaking to clinicians. We prioritised indicators from this very long list using our indicator development principles (in table 1) and the following questions:

- Does the indicator measure an outcome for the patient as opposed to a process?
- Does the indicator relate to avoidable morbidity?
- Does the indicator measure serious long-term consequences?
- Does the indicator measure a leading cause of morbidity?

▶ We have identified approximately 200 potential indicators across the clinical areas. However, the vast majority of these indicators are either not measured in the NHS today, or are not measured in a way that meets the criteria we have laid out. Therefore, we have identified an initial set of indicators and we will continue to develop indicators for all of the identified clinical areas. We propose to use emergency readmission rates for those clinical areas where there is no data for the more specific clinical indicators we have identified.

▶ In the longer term we will work with partners in order to develop better measures of effectiveness. In particular, we would like to make greater use of national clinical audits and to work with NHS England and the Royal Colleges to make more of this information available.

Caring indicators

▶ For these indicators we have focused on an individual's experience of the care that they receive rather than an institutional or process view of people's experiences. We have identified questions from the National Inpatient Survey and from the Friends and Family Test as the most reliable measures of caring. In order to have indicators for this domain that are relevant, timely and comparable, we would like to work with NHS England to explore how we can increase the frequency, consistency and granularity of the results. We would also like to propose that the following question is included in future: "Did you experience any problems with the quality of care you received in hospital that were not resolved?"

▶ It is important to note that there are other aspects of caring that are picked up within the qualitative indicators, such as themes from complaints, which are set out in the indicator listing below.

Responsiveness indicators

▶ To measure responsiveness, we have identified four potential areas to assess: access to services, discharge from services, responsiveness to individual patient needs (e.g. individual care plans) and responsiveness to the community's needs (e.g. integration with primary/community services). We identified that access to, and discharge from services are currently the areas of responsiveness that are most amenable to indicators.

Well-led indicators

▶ To identify indicators for this domain we started by creating a long list of potential indicators based on sources of organisational stress, internal indicators of stress and external indicators of stress. We then identified the list by applying the indicator principles and comparing these with indicators of poor quality. However, there appeared to be few clear correlations. We will, over time, refine this list based on our findings.

Qualitative indicators – cross-cutting all domains

▶ In parallel with the development of indicators for the domains described above, we have identified a range of sources of qualitative intelligence that will be included as tier one indicators of risks to quality of care. Each individual piece of intelligence from these sources may relate to different aspects of each of the five domains of quality, so we have grouped them together. These sources will be treated as equally important to the domain level indicators above.

Proposed indicators

▶ Tables 3-8 below set out our proposed indicator sets for each of our five key questions as well as for cross-cutting qualitative information sources.

TABLE 3: SAFETY – PROPOSED SET OF FIRST INDICATORS

	Dimension	Indicators
A	Deaths in low risk conditions/ procedures	Dr Foster deaths in low risk conditions (e.g. asthma)
		Short list of key low risk procedures/conditions (e.g. Hernia repair)
B	Never events	Never events
C	Under-reporting	Under-reporting of safety incidents for which reporting legally required
D	Avoidable infections	C. Diff incidence
		MRSA incidence
		MSSA incidence
		E.coli incidence

TABLE 4: EFFECTIVENESS (BY TRUST AND CLINICAL LEVEL)

		Dimension	
Group	**Clinical area**	**E. Proposed indicator – mortality rates**	**F. Proposed indicator – non-mortality**
Trust level	Mortality at a trust level	1. Summary hospital mortality indicator 2. Hospital standardised mortality ratio (HSMR)	
	Weekend mortality	1. HSMR on weekdays 2. HSMR on weekends	
	Sepsis	1. Sepsis (primary or secondary diagnosis code)	
Cross-cutting areas	Intensive care	1. Mechanical respiration >24 hours (excluding new borns)	
	A&E and trauma care	1. Pelvic fracture	
	Anaesthetics and surgical services	1. Vascular surgery (30 day mortality)	1. Surgical site infection – Hemiarthroplasty 2. Surgical site infection – Hip Prosthesis 3. Surgical site infection – Knee Prosthesis
	Diagnostics		
	End of life care		
	Occupational therapy/ Physiotherapy/ Speech and language therapy/Nutrition		
Specific pathways	Elderly care pathway	1. Primary diagnosis of pneumonitis 2. Acute Myocardial Infarction 3. Pneumonia 4. Septicaemia 5. Chronic obstructive pulmonary disease 6. Fractured neck of femur (FNOF) 7. Heart failure 8. Colorectal surgery (within 12 months of procedure date) 9. Dementia patients (primary or secondary diagnosis code)	

		Dimension	
Group	**Clinical area**	**E. Proposed indicator – mortality rates**	**F. Proposed indicator – non-mortality**
	Paediatric pathway	1. Post-operative deaths in children (all procedures) 2. Pneumonia (primary diagnosis), without cystic fibrosis diagnosis; or with tumour 3. Cardiac interventions in children and young adults (under 30 years)	
	Cancer pathway (excl. surgery)		
Cardiac conditions and care	Acute myocardial infarction	1. Acute Myocardial Infarction (AMI)	
	Heart failure	1. Heart failure	
	Cardiac surgery	1. Aortic valve replacement without open heart surgery 2. Isolated coronary surgery with AMI 3. Isolated coronary surgery without AMI 4. Coronary angioplasty (PTCA)	
	Cardiac arrhythmia		
	Pacemakers & defibrillation		
	Cardiac ablation		
Stroke	Stroke	1. Stroke (primary diagnosis)	1. % of patients scanned within 1 hour
Nervous system conditions and care	Craniotomy	1. Craniotomy for cerebral bleeding 2. Craniotomy for meningioma 3. Craniotomy for other conditions	
	Epilepsy		1. Emergency readmission – % within 30 days following discharge – Epilepsy 2. Mean length of stay (LOS) for patients admitted for Epilepsy

		Dimension	
Group	**Clinical area**	**E. Proposed indicator – mortality rates**	**F. Proposed indicator – non-mortality**
	Parkinson's		
Head & neck ENT	Procedures on the ear, nose and throat		
	Procedures on the head and neck		
Respiratory conditions and care	Pneumonia	1. Pneumonia – (primary diagnosis)	
	Chronic obstructive pulmonary disease	1. Chronic obstructive pulmonary disease (primary diagnosis) without tumour (bronchial carcinoma)	
	Lung resection	1. Partial resection of lung for carcinoma of the lung	
	Asthma		1. Emergency readmission – % within 30 days following discharge – Asthma 2. Mean length of stay (LOS) for patients admitted for Asthma
Gastro-intestinal tract conditions and care	Cholecystectomy		
	Herniotomy		1. Proportion of patients whose mobility decreases after hernia 2. Proportion of patients whose pain/discomfort has increased after hernia
	Resections of the colon and rectum	1. Colon resection of carcinoma without complications. 2. Rectum resections of carcinoma (cancer) 3. Colorectal resections, with diverticula without abscess / perforation 4. Post-operative mortality within 90 days for patients who had returned to theatre within 28 days of the primary surgery	

Group	Clinical area	Dimension E. Proposed indicator – mortality rates	F. Proposed indicator – non-mortality
	Gastric and oesophageal resections	1. Complex interventions in the oesophagus	
	Pancreatic and liver resections	2. Total pancreatic resections	
	Conditions of the upper GI tract	1. Ulcers of stomach, duodenum or jejunum 2. Gastro-intestinal haemorrhage	
Vascular conditions and care	Carotid vascular surgery	1. Carotid endarterectomy	
	Aneurysms	1. Aortic aneurysm, no abdominal rupture, open surgery 2. Aortic aneurysm, no abdominal rupture, endovascular intervention 3. Clip and coil aneurysms, intracranial	
	Lower limb bypass graft	1. Operations on lower limb arteries with claudication 2. Operations on lower limb arteries with rest pain 3. Operations on lower limb arteries with necrosis or gangrene	
	Lower limb angioplasty		
	Amputation	1. Amputation of the foot, no trauma 2. Lower limb amputation, no trauma	
Maternity and women's health	Delivery		1. Proportion of women experiencing 3rd or 4th degree perennial tears
	Newborns		
	Procedures on the female reproductive organs		

		Dimension	
Group	**Clinical area**	**E. Proposed indicator – mortality rates**	**F. Proposed indicator – non-mortality**
Musculo-skeletal conditions and interventions	Elective hip surgery		1. Proportion of patients whose mobility decreases after hip surgery 2. Proportion of patients whose pain/discomfort has increased after hip surgery
	Elective knee surgery		1. Proportion of patients whose mobility decreases after knee surgery 2. Proportion of patients whose pain/discomfort has increased after knee surgery
	Spine and back		
	Fracture of neck of femur	1. Fractured neck of femur – primary diagnosis	
Urogenitary care and conditions	Nephrectomy and partial nephrectomy	1. Nephrectomy	
	Cystectomy and bladder procedures	1. Cystectomy (removal of the bladder) – simple	
	Procedures on the prostate		
	Renal Failure	1. Acute renal failure (primary diagnosis)	
Endocrine, metabolic and nutritional disorders	Diabetes		1. Emergency readmission – % within 30 days following discharge
	Malnutrition and dehydration		
Haemotology	Anaemia		
Ophthalmolo-gical conditions and care	Cataract surgery		
Skin conditions and care	Skin diseases		
Mental Health	Depressive disorders		
	Psychoses		

TABLE 5: CARING DOMAIN

	Dimension	Existing inpatient survey questions to be used in the short/medium term
G	Overall experience	How was your overall experience? How likely are you to recommend our ward/A&E Department to friends and family if they need similar care and treatment (Friends and Family Test)
	Trusting relationships	Did you have confidence in the nurses and doctors treating you?
	Involvement in decision making	Were you involved as much as you wanted to be in your treatment and care?
	Compassionate care	Did you find someone on the hospital staff to talk to about your worries and fears?
	Meeting physical needs	Did you get enough help from staff to eat your meals? Do you think the hospital staff did everything they could to help control your pain?
	Treatment with dignity and respect	Overall, did you feel you were treated with respect and dignity while you were in the hospital?

TABLE 6: RESPONSIVENESS DOMAIN

	Dimension	Indicators
H	Access measures	A&E waiting times under 4 hours
		Referral to treatment times under 18 weeks: admitted pathway
		Referral to treatment times under 18 weeks: non-admitted pathway
		Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test
		All cancers: 62 day wait for first treatment from urgent GP referral
		All cancers: 62 day wait for first treatment from NHS cancer screening referral
		All cancers: 31 day wait from diagnosis
		The proportion of patients whose operation was cancelled
		The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason
I	Discharge and integration	Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds

TABLE 7: WELL-LED

	Dimension	Indicators
J	Staff surveys	NHS staff survey – responses to question asking if "Care of patients is top priority?"
		Junior doctor survey – overall satisfaction score
		Survey of trainee nurses (TBD)
K	Staffing	Staff sickness rates
L	Utilisation	Bed occupancy
M	Monitor ratings (NHS TDA to be developed)	Governance risk rating of red
		Financial risk rating of 1 or 2

TABLE 8: QUALITATIVE INTELLIGENCE (CROSS-CUTTING OUR FIVE KEY QUESTIONS)

	Dimension	Indicators
N	Complaints and whistleblowing	Complaints submitted to providers Complaints investigated by the Ombudsman DH Ministerial correspondence unit – number and themes of complaints/ whistleblowing reports Number and themes of complaints made to CQC National Customer Service Centre Whistleblowing reports made to CQC National Customer Service Centre
O	Safeguarding	Incidents related to abuse
P	Negative comments on social media	Negative comments submitted via 'Share Your Experience' form on CQC website Number and themes of negative comments on NHS Choices and Patient Opinion
Q	Outputs from inspections	Views of inspector Comments from patient and staff interviews Findings from partner organisations, including from Quality Surveillance Groups (QSG)
R	Media	Press articles (local and national) Social media comments
S	Disruption to management	Changes in control Unplanned changes in leadership
T	Patient and user representatives	Healthwatch recommendations to CQC Other patient organisation recommendations to CQC
U	Strategic partners	Intelligence from Monitor/NHS TDA/NHS England Output from Quality Surveillance Groups (QSGs)

Consultation questions

A1. Do you agree with the principles that we have set out for assessing indicators?

A2. Do you agree with the indicators and sources of information?

A3. Are there any additional indicators that we should include as ‘tier one’ indicators?

A4. Do the proposed clinical areas broadly capture the main risks of harm in acute trusts? If not, which key areas are absent?

A5. Do you agree with our proposal to include more information from National Clinical Audits once it is available?

A6. Do you agree with our approach of using patient experience as the focus for measuring caring?

The consultation closes on **Monday 12 August 2013**. Please see the main consultation document at **www.cqc.org.uk/inspectionchanges** to read the other questions and for details of how to respond.

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Read more and download this report in other formats at **www.cqc.org.uk/inspectionchanges**.

Please contact us if you would like a summary of this report in another language or format.

Consultation Impact Assessments – Appendix 3

- A new start – Consultation on changes to the way CQC regulates, inspects and monitors care services
- Equality and Human Rights Duties Impact Analysis (decision making and policies)

A new start

Consultation on changes to the way CQC regulates, inspects and monitors care services

Initial regulatory impact assessment

This Initial Regulatory Impact Assessment has been published to support the proposals contained within the consultation document on CQC's new approach to inspection and regulation. Stakeholders should read this document in full before reading this impact assessment.

This document sets out the initial high level cost and benefit impacts on providers, people and CQC as a basis for starting further engagement with stakeholders throughout this consultation process.

Introduction

The Care Quality Commission (CQC) is committed to making sure it carries out its statutory duty in a way that puts people who use services at the centre of their work. Part of this process includes learning from past actions and changing their current approach to the monitoring, inspection and regulation of providers in order to remain fit for purpose.

The Mid Staffordshire NHS Foundation Trust Public Inquiry identified that people and their families were let down at every level by the individuals and organisations that were meant to protect and care for them. The inquiry uncovered examples of appalling care and a lack of compassion, humanity and leadership. Robert Francis' report on the public inquiry made recommendations for the commissioning, supervisory and regulatory bodies, including CQC.

CQC is committed to rolling out a number of key changes to the way it regulates and inspects providers, including addressing key recommendations made in the Francis Report. CQC's initial thinking around how it could implement some of the changes can be found in the main consultation document, which also includes high level proposals for comment from stakeholders.

This impact assessment has been designed to accompany the consultation paper and acts as a systematic initial assessment of the impact of the proposals outlined in the consultation paper. Before you read this paper you should read the full

consultation paper, which can be downloaded from:
www.cqc.org.uk/inspectionchanges

Purpose of this Initial Regulatory Impact Assessment

The purpose of this initial impact assessment is to help identify the practical impact of the draft consultation proposals on stakeholders. It aims to engage stakeholders in determining the impact on them, with a plan for this analysis to influence the design of the final proposals. Figure 1 below illustrates the high level process by which we plan to assess these impacts and who these impacts are likely to fall on:

Figure 1: Stakeholder Regulatory Impact Mapping of Consultation Proposals

At every stage of the analysis there are likely to be changes to the impact of the proposals of CQC's new inspection and regulatory regime. A key purpose of this initial impact assessment is to help identify where the potential impacts of CQC's proposals are likely to fall, as well as their anticipated scale and magnitude on stakeholders.

It should be made clear that the illustration of the cost and benefit impacts within this initial impact assessment are 'high level' estimates. CQC plans to roll-out a larger programme of engagement with stakeholders to fully assess these costs and benefits. CQC will provide more details of this in the coming months.

The ultimate aim of this engagement is to influence the design and implementation of the final regulatory model. It also satisfies an aim of the government's Better Regulation Executive (BRE) to trial a new method aimed at improving engagement with the sector so that those affected provide CQC with their own assessments of the likely costs and benefits.

Proposals and Impacts for the new CQC regulatory model

In this section CQC provides a brief summary of the proposals for its new approach to monitoring, inspection and regulation, and a brief description of who these proposals apply to, as well as how stakeholders may be affected by these. Stakeholders should refer to the main consultation document if they require a fuller description and rationale for these proposals.

Stakeholders should note that because CQC has firmly committed to implementing these key changes, this impact assessment focuses on the implementation of these changes so that it maximises the positive outcomes for people, while also minimising any regulatory burden on providers from the way CQC administers these changes. It is the proposed content of these key changes that CQC asks stakeholders to comment on, so that they can shape the formation and roll-out of these key changes in a way that achieves these ends.

Unless otherwise stated, the following proposals will generally affect all providers who fall under CQC's regulatory remit. However there will also be some distinct differences to the way CQC will apply these changes by sector to take into account of differences.

Figure 2 below summarises initial high level proposals around five core policy areas to which CQC is firmly committed:

Figure 2: Summary of agreed changes and proposals for content

Proposed Detail

• New provider application assessed more rigorously • New provider applicants must meet expected standards • All providers must meet fundamentals of care as part of registration	• Fundamental levels of care by which no provider must breach and/or fall under • Standards of care that service users can expect as a bare minimum	• Chief Inspectors for Hospitals, Social Care and General Practice • Move towards expert-led differentiated inspections • Indicators used to inform inspections • Duty of Candour	• Ratings for NHS Trusts & FTs to be issued on a four point scale • Ratings to cover services, hospitals & trusts • Potential to roll-out this approach to other sectors	• CQC given power to prosecute without warnings if fundamentals of care breached • Fit & Proper Person Test for Directors

Key change: Introducing changes to registration

CQC will introduce a number of registration changes which aim to make sure the registration process is more rigorous.

Rationale
This was agreed by the Department of Health (DH) in *DH Winterbourne Review Condordat: Programme of Action.* It helps to make sure that providers who are unlikely to provide an acceptable level of care are not allowed to hold a CQC registration.

Proposals
CQC proposes that the registration process will be more rigorous for all new providers wishing to be registered, as well as existing providers wishing to register additional services. This will include making better use of information as part of the registration process and drawing in specialist clinical or professional advice where needed to help assess if the service meets accepted good practice.

We propose to assess new providers against a set of expected standards of care as well as ensure that all providers (both current and new) continue to comply with the fundamentals of care and the broader registration requirements.

The Department of Health will develop the new registration requirements and will hold a separate consultation relating to these in the coming months.

Who is affected?
The introduction of these registration changes will affect all new providers wishing to be registered by CQC, as well as existing providers wishing to register additional services.

How are they affected?
Under these proposals we would expect there to be additional costs for new providers applying to be CQC registered. In some cases this more rigorous test may mean a small number of potential entrants will not be allowed into the sector to provide specific services or others might be delayed in making their entrance to the sector. Existing providers wishing to register additional services could face increases in cost depending on the amount of information required at the point of application.

Costs to CQC are likely to increase as it will spend more time scrutinising applications to make sure business models are robust and that the provider is likely to provide an acceptable level of care so as to not breach fundamentals of care once registered. These costs could increase for CQC if it refers applications to specialists when a decision cannot be made.

People are likely to be the key beneficiaries of these registration changes as only new providers who meet the new requirements will be able to provide services – this could correspond to better services and increases in quality of care from such new entrants. People will also be able to gain more clarification on what would be

expected from providers based on core fundamentals of care and expected standards imposed on such providers.

Key change: Introducing fundamentals of care

CQC will introduce fundamentals of care which make explicit the level of care which no provider must breach. These will be universal to all providers registered with CQC who provide health and adult social care services. Fundamentals of care are part of the registration requirements. They are the foundation of good care but not the extent of good care.

Rationale
This was agreed by the Secretary of State and the Department of Health in its response to the Francis Report. Introducing fundamentals of care should facilitate providers understanding of what is and is not expected of them in relation to their provision of care services.

Current proposals
Fundamentals of care set out the basic standards of care that should never be breached; any breach should be seen as unacceptable. CQC will make sure they are driven by the interests of people who use services. Should a provider be found to be breaching any of these fundamentals of care, CQC will have formal powers to take action, including prosecution in the worse cases of poor care delivery. The Department of Health will be consulting on these standards in the coming months.

Who is affected?
The introduction of a set of fundamentals of care will apply to all providers that fall under the remit of CQC.

How are they affected?
All providers will need to comply with these fundamentals of care. It is anticipated that these will not impose additional costs on the majority of providers, as those who already deliver an adequate level of care should currently be meeting these standards. However, there could be additional costs to the worst performing providers in the form of enforcement action, which could range from warning notices instructing providers to improve, to fines and in the worst case revoking the provider's registration with CQC.

There are likely to be minimal costs to CQC as a result of the introduction of fundamentals of care. The likely costs would stem from the development of guidance and approaches to monitoring compliance with these fundamentals of care. However, there could be variable cost elements as a result of taking enforcement action depending on how many providers have breached these fundamentals.

Both people and providers are likely to benefit from the introduction of fundamentals of care. For example, people would have a clearer understanding of what to expect from providers in terms of fundamental safety and quality of care. Similarly providers

should benefit from having greater clarity on what is expected of them, as well as having concrete knowledge as to the level that quality of care must not fall.

Key change: CQC's new model of inspection

CQC's inspection model will change to take into account the differences in the sectors that are regulated by them. CQC will move towards a system of differentiated regulation which will include different ways of inspecting different sectors.

Rationale
CQC has listened to external scrutiny and reviews of its work such as the Kieran Walshe evaluation work and recognised the importance of regulating different sectors in different ways.

Proposals
CQC will appoint three Chief Inspectors to oversee the different sectors that fall under their remit. These will be:

- Chief Inspector of Hospitals
- Chief Inspector of Social Care
- Chief Inspector of General Practice .

The Chief Inspectors will be responsible for forming judgments about the quality of providers, devising and operating a new risk-based, intelligence-driven inspection model, managing the delivery of inspections and acting as the CQC's public face and authoritative voice on the status of care quality within and across providers.

CQC also propose to move away from generalist inspections and towards inspections that are expert-led and by inspectors who specialise in particular service areas. This will be supported by the development of a revised intelligence risk model which will help to identify those organisations at greatest risk of delivering poor quality care. We will make use of data and information and develop key indicators which will help to facilitate the conditions under which CQC will inspect organisations of different risk and their subsequent performance under the proposed inspection regime. These proposals will all contribute to CQC's aim of moving to a system of differentiated regulation, achieved in part by making such changes to the way they inspect different sectors that fall under their regulatory remit.

Who is affected?
CQC's new model of inspection will apply to all providers that fall under its regulatory remit. NHS and independent hospitals services will be impacted by the work of the Chief Inspector of Hospitals. Providers of adult social care will come under the scrutiny of the Chief Inspector of Social Care, as will primary medical services be affected by the Chief Inspector of General Practice.

How are they affected?
Costs will heavily depend on how the inspection methodology develops. For example, if the inspection model determines a provider is to have double the number

of inspections in three years than it currently has then costs to providers (and CQC) will also rise. Figure 3 illustrates the costs providers are likely to face depending on judgement by the Chief Inspectors (note that the categories are purely for illustrative purposes are likely to change based on any methodology proposed by the Chief Inspectors):

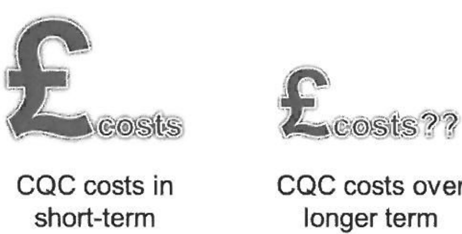
Figure 3: Differences in costs to providers based on Chief Inspector judgement

Likely Costs to Providers

CQC will face higher initial costs associated with carrying out these longer more intensive inspections. There could also be costs associated with transitioning towards expert-led inspections in the form of training costs and establishing access to wider expertise. Figure 4 illustrates the costs to CQC which shows that short-term costs are likely to be higher than longer-term costs (this assumes that the level of standards do not change):

Figure 4: Differences in short-term and longer term costs to CQC

Likely Costs to CQC



People are likely to be the key beneficiaries as these differentiated ways of inspecting different sectors should reduce instances of poor quality care and bad practice as these are more quickly picked up and dealt with.

Key change: Introduction of ratings

CQC will introduce a series of provider ratings which will help inform both patient choice and commissioning decisions.

Rationale
The Care Bill re-introduces legislation from the Health and Social Care Act 2008 which will allow CQC to publish ratings for health and social care providers. This builds on the work carried out by the Nuffield Trust in, *Rating Providers for Quality: a policy worth pursuing? (March 2013)* and sets out advice on a rating system for hospitals, care homes, providers of home care and GP practices.

Proposals
Ratings will be an expression of CQC's regulatory judgments with the purpose of encouraging improvement and supporting people who use services and commissioners to compare services and make choices. To achieve this CQC will publish provider ratings on their website, giving clear and transparent rationale for our judgments.

CQC plans to consult with stakeholders in the coming months on the detailed methodology for creating ratings for all NHS trusts and proposals for CQC's approach to adult social care ratings.

Who is affected?
In time, the introduction of a set of ratings should apply to all providers of health and adult social care. For now, we will begin with rating NHS acute trusts and aim to introduce new style inspections from October 2013. These inspections will allow CQC to begin publishing shadow ratings from December 2013.The programme will extend to all NHS trusts over time and begin rating adult social care later in 2014/15 and primary care in 2015/16. Ratings may also be extended to dental practices and cosmetic businesses in future.

How are they affected?
It is estimated that there would be some additional costs on these providers to comply with an initial inspection in order to establish a preliminary rating on the provider. It is also anticipated that there will be some additional costs on such providers for providing any information to CQC that would aid any decision in producing a rating.

Commissioners and people who use services are likely to be the key beneficiaries of provider ratings as a key objective of this policy would be to support informed choice. For commissioners, ratings would offer the key benefit of better understanding of the quality of service, and the outcomes they are commissioning, when deciding how much of their budget to spend with specific providers. For people who use services, the introduction of a provider rating would better support making informed choices between providers, which should hopefully help to raise the quality bar amongst different providers. There are also some benefits to providers as the introduction of ratings would help facilitate peer-review and benchmarking so they can see how they

are performing in comparison to others and identify areas where they might want to improve.

Key change: Corporate Accountability Proposals

There will be more of a focus to hold providers to account for failing to honour their commitments to provide safe quality care.

Rationale
Subject to the passing of the Care Bill, CQC will be granted a range of new powers from April 2014 which will help facilitate the development of any actions aimed at holding providers to account should they not be providing an acceptable level of care.

Proposals
We plan to specifically hold Board Members to account should the provider not be providing an acceptable level of care. We would also expect all directors to be "fit-and-proper" as well as ensuring that providers are open and honest with people who use the service and their families about things that have gone wrong and why they happened.

The Department of Health will shortly consult on the accountabilities of the Board members in parallel to the consultation published alongside this initial Regulatory Impact Assessment.

Who is affected?
All directors and board members of providers will be affected if they come under CQC's regulatory remit.

How are they affected?
We do not anticipate there to be any additional to costs to providers if they currently provide an acceptable level of care to patients. However, board members and directors who are held responsible for any care quality failings could be impacted financially should they be removed from posts. Such organisations could face greater scrutiny and will likely see their costs increase should CQC decide to take any actions, such as prosecution, associated with the care quality failings.

CQC, users of services as well as their families are likely to be the key beneficiaries of these proposals. For CQC we would likely benefit from a reduction in quality failings stemming from poor direction from board directors. Users of services should benefit as swifter action is taken against senior management for any user subject to poor quality care, and should also act as a deterrent to other providers which could help bring the level of care up to an acceptable standard.

Changes specific to acute hospitals provided by the NHS and independent organisations

In this section we set out the high level cost and benefit impacts of the proposed changes on stakeholders that will only apply to acute hospitals provided by the NHS and independent organisations.

Chief Inspector of Hospitals

The Chief Inspector of Hospitals will undertake a number of duties that are likely to impact on stakeholders. Specifically these are:

- Judging the performance of all hospitals in England, including NHS hospitals and independent sector hospitals.
- Publishing ratings on hospitals.
- Playing a central role in the assurance that the fundamental standards are being met by all trusts. Where trusts are in breach of these standards, the Chief Inspector will determine what action should be taken, including whether a trust is entered into a failure regime.
- Leading a new national NHS inspection team that will undertake in-depth, intensive inspections; the principal focus of these inspections will be on organisations that are of concern to CQC.
- Leading regional teams of dedicated inspectors who will undertake routine inspections on a regular basis of all hospitals/NHS trusts.
- Responsible for overseeing the development of a methodology for inspections, the operational delivery of the inspection programme, and for raising the quality of the inspections that are performed so that they are able to properly identify areas of concern and issues of compliance.
- Working closely with NHS England, Monitor, the NHS Trust Development Authority and the NHS Information Centre for Health and Social Care to determine the sets of data which will be used to contribute to judgements and ratings about hospitals and NHS trusts.

How are acute hospitals likely to be affected by these proposals?

It is not possible to assess what the size and scale of the impacts are likely to be on acute hospitals at this stage, however there are likely to be a number of costs around the following themes including:

- Information provided to the Chief Inspector to facilitate any of the proposals above.

- Any costs should providers be found in breach of any of the fundamentals of care in order to take action to meet these standards and that this effort is maintained in the future.

NHS acute trusts, foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

The surveillance model – developing risk indicators for NHS trusts and foundation trusts (FTs)

The surveillance model is being developed with the core purpose of developing a series of risk indicators for NHS trusts and FTs which aims to identify providers most at risk of providing poor quality care or breaching fundamental standards. The proposals likely to have impacts on stakeholders include:

- Developing a model which allows CQC to anticipate and respond more quickly to services where standards are dropping or that are showing signs of failing.
- Developing a series of indicators and intelligence for the model based on three tiers:
    - Tier 1: signalling a decline in quality or immediate concern will prompt a response by CQC.
    - Tier 2: checked if tier 1 indicators signal concern. Used to help understand the issues raised and to focus key lines of enquiry.
    - Tier 3: development set of indicators and analysis which will be used to test and improve sets of indicators that CQC have in tier 1 and 2.
- Trialling the model for NHS acute trusts to identify the indicators for each of the five domains. This will include scoping the key quality and safety issues for the sector and identifying available data to measure these. This approach will subsequently be applied to NHS mental health trusts, community health trusts and ambulance trusts in future.

How are acute hospitals likely to be affected by these proposals?

All acute hospitals will directly be affected by these proposals. The single biggest cost impacts to such providers could be associated with providing and collating information requests which would help inform the development and monitoring of these three tiers of indicators and intelligence contained within the proposed model. There could also be IT and other system and process costs associated with capturing the information which would differ depending on the trust.

There will be benefits to users of services as the surveillance model should be able to detect potential problems associated with the provision of care services, which will allow swifter action to be taken by inspection teams via instruction from the Chief Inspector of Hospitals.

NHS acute trusts, foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

The inspection methodology for acute NHS and independent hospitals

The current inspection model will change to take into account the differences within the different sectors that CQC regulates. The proposals likely to have impacts on NHS trusts are:

- A move to target intensive inspections at organisations that are identified as 'higher risk' which would include those with significant or longstanding problems and trusts applying to become foundation trusts.
- A change in the average length of time taken to undertake an inspection – which could be 15 days, with an average of 6-7 days on site – to make a thorough assessment of the quality and safety of care.
- A development of a set of triggers for inspections which would identify which providers would need an intensive inspection, as well as development of any methodology leading to the decision to undertake an announced or unannounced inspection.

How are acute hospitals likely to be affected by these proposals?

We will be carrying out a fuller consultation on proposals for CQC's inspection methodology later in the year. However, it is likely that acute hospitals who fall under CQC's intensive inspection regime will face higher costs relating to increases in staff time spent providing information and supporting the inspection team. Costs could also increase in proportion to the number of inspections taken place, as well as any costs associated with having to take actions based on the recommendations put forward in the inspection report.

NHS acute trusts, foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

Acute NHS and FT ratings

We will introduce ratings for all NHS acute trusts and FTs starting with the publication of ratings for these trusts from December 2013 over a two-year period. The proposals likely to have impacts on NHS trusts and FTs are:

- Ratings for NHS trusts are made at domain, service, hospital and trust levels.
- Ratings to be awarded on a four-point scale, ranging from trusts which are classified as "Outstanding" to Inadequate" because they have either breached a fundamental standard and/or many services are not meeting quality standards.
- Frequency of subsequent ratings reviews to be determined by the first initial rating (which sets the benchmark for the provider in question). Higher rated trusts will have less frequent inspections, in the absence of any concerns raised by surveillance.
- All trusts to be under intelligence based surveillance that can trigger inspections at any time which may lead to a change in their rating.

How are NHS trusts and FTs likely to be affected by these proposals?

We will be carrying out a fuller consultation on proposals for the development and roll-out of ratings for NHS trusts and FTs later in the year. However it is highly likely that providers who are given "good" or "outstanding" ratings are likely to face less cost impacts than providers who don't meet the criteria to be awarded these ratings. Costs could also increase in proportion to any review that lowers a provider's ratings, as costs will decrease in relation to a trust improving its rating through better performance.

Acute NHS trusts and foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

Introduction of a single failure regime

NHS trusts and FTs who continue to perform badly will be subject to a single failure regime, the details of which will be developed in partnership with Monitor and the NHS Trust Development Authority (NHS TDA). Our initial proposals that are likely to impact on NHS trusts are:

- Provision of a new formal notice which is underpinned by legislation (subject to the passing of the Care Bill) which will require the board of the NHS trust or

foundation trust with its commissioners to improve if CQC thinks significant improvement is required in the quality of care provided.

- Referral of the trust to Monitor or the NHS TDA to take the appropriate action if the trust fails to achieve the necessary improvements – this could mean Monitor or the NHS TDA bringing in expert clinical support to make the improvements.
- If care still fails to improve, the Chief Inspector, through the CQC, will be able to direct Monitor or the NHS TDA to appoint a special administrator, suspending the board of the trust as a result.

How are NHS trusts and FTs likely to be affected by these proposals?

Only NHS trusts who enter the integrated failure regime will face cost implications, which is assumed to be a small minority. These costs will depend heavily on the type of enforcement action, or sanctions, placed on the NHS trust but are likely to stem from making the necessary improvements for alleviating poor performance and/or the production of any turnaround plan should one be requested. CQC will be consulting on their use of enforcement powers separately, the results of which will contribute to the development of the integrated failure regime.

Acute NHS trusts and foundation trusts are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

Next steps

The information on likely cost and benefit impacts contained within this initial regulatory impact assessment are preliminary and likely to change in the coming months as proposals are worked up more fully. CQC plans to hold a series of engagements in the coming months to further quantify the effects of these proposals on stakeholders. More information on this will be provided at a later stage.

Equality and Human Rights Duties Impact Analysis (decision making and policies)

Equality Act 2010
Human Rights Act 1998

1.	
Identifying Name (name of project, policy, work, or decision)	**A new start: Consultation on changes to the way CQC regulates, inspects and monitors care services**
Intended outcomes (include outline of objectives or aims)	Following the fundamental review of our model and approach to regulating health and social care services, we are planning to make major changes to our regulatory model, particularly to make sure that our inspections and ways of assessing providers are more tailored to the different sectors that we regulate. This consultation will set out our high level thinking on: • Applicable to all health and adult social care sectors that come within the scope of regulation: o The fundamentals of care - a clear bar below which care should never fall. o A more rigorous test for those applying to offer new health or social care services. o Better use of information and evidence (which we call surveillance) to decide when, where and what to inspect. o The role of the Chief Inspectors in leading expert teams. o The action we will take in response to poor care. • Changes to our model for regulating NHS trusts and foundation trusts including: o A focus on developing our inspection model for NHS acute hospitals. o Developing our rating of NHS providers. o The introduction of a programme for failing hospitals to make sure that action is taken to protect people and to hold those responsible to account. The responses to the consultation on our strategy for 2013 to 16 have helped us shape many of the proposals in this new consultation, so views from this are referenced within this impact analysis. We want to engage widely through this

	consultation to seek views on our high level proposals, which will shape the detailed plans for developing our inspection and regulation of health and social care services with an initial focus on NHS trusts and foundation trusts.
Who will be affected? (People who use services, CQC staff, the wider community)	The changes will help us to fulfil our purpose which is to make sure that health and social care services provide people with safe, effective, compassionate, high quality care and that we encourage services to improve. The changes will therefore affect both people who use health and social care services and providers of those services. The fundamentals of care and the key principles of the new regulatory model will apply to all regulated providers. The consultation will also include a specific focus on what changes will mean for NHS acute hospitals and NHS providers of specialist mental health services (the NHS sectors identified by the Francis report as the priority areas for developing more effective inspection and regulation).

2.	
For the record	
Who carried out the analysis	Lucy Wilkinson and Nicola Vick
Current Version number	0.07
Date analysis completed:	13th June 2013
Name of responsible Director/Head	Philip King, Director of Regulatory Development
Date analysis was signed off by Director/Head:	[signature] 13th June 2013
Involvement & EDHR sign-off name	Nigel Thompson, Head of Involvement and Equality and Human Rights
Date of EDHR sign-off	13th June 2013 [signature]

3.	
• Does the work affect people who use services, employees or the wider community? (This is not only refers to the number of those affected but also by the significance of the impact on them)	Yes
• Is it a major piece of work, significantly affecting how functions are delivered?	Yes
• Will it have a significant effect on how other organisations deliver their functions in terms of equality or human rights?	Yes
• Does it relate to functions that previous engagement has identified as being important to particular protected groups or human rights?	Yes
• Does or could it affect different protected groups differently?	Yes
• Does it relate to an area with known inequalities or breaches of human rights?	Yes
• Does it relate to an area where equality objectives have been set by CQC?	Yes

4.
Do the answers above indicate that this work is relevant to equality or human rights? If yes skip this box and continue below. If no, document the reasons below and forward this EHRDIA to Involvement & EDHR team for sign-off
Yes

5.	
Engagement and involvement • Have you involved people who use services, staff and other stakeholders? • What are the key findings of your engagement relating to equality and human rights? Include known representation across the characteristics protected in the Equality Act: age, disability, gender, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion and belief, and sexual orientation.	
Target Group	**Summary of Involvement**
People who use services	• 240 people who use services took part in our strategy review consultation through specific events targeted at people who use services. Where relevant, their views from the strategy consultation have been incorporated into section 6 of this analysis. • This included some targeted consultation with particular groups that may be less likely to respond to a public consultation through our SpeakOut Network – including community groups for: o Orthodox Jewish community in Manchester o South Asian communities in West Yorkshire and East Midlands o Gypsy and traveller community in East Anglia o Self-advocates with a learning disability in London o Young lesbian, gay and bisexual people in West Yorkshire o Women fleeing domestic violence in the East Midlands o African Caribbean people and families of children with sickle cell anaemia in the West Midlands o Older people in East Anglia. • This analysis also draws on the findings of an evaluation of equality and human rights in the current CQC regulation model. Ten experts by experience participated in this evaluation. • People who use services will be able to respond to this version of the analysis during the formal consultation period – as this analysis will form part of the consultation documents. We will also be undertaking some more targeted consultation with specific groups.

Staff	• 417 CQC staff took part in our strategy review consultation. Where relevant, their views from the strategy consultation have been incorporated into section 6 of this analysis. • Staff equality networks and equality leads in Operations were asked to contribute evidence for section 6 of this analysis and will be specifically alerted to the consultation on this analysis. • This analysis also draws on the findings of an evaluation of equality and human rights in the current CQC regulation model. 80 staff (including 49 inspectors) participated in the evaluation.
Other stakeholders	• Over 1500 organisations and individuals took part in our strategy review through various methods (in addition to the 240 people who use services attending specific events) Where relevant, their views from the strategy consultation have been incorporated into section 6 of this analysis. • Stakeholders will be able to respond to this version of the analysis during the formal consultation period – as this analysis will form part of the consultation documents

6.	
Evidence List the main sources of data, research and other sources of evidence reviewed to determine impact on each protected characteristic or human rights. If there are gaps in evidence, state what you will do to close them in the Log of Equality & Human Rights Actions	
Human Rights (refer to Guidance for examples)	Throughout the consultation on our strategy people who use services, and others, commented that we need to take account of equality, diversity and human rights when developing our new approach. They also said that we need to refer more to how we intend to take this into account[1]. In response to this, we have made it clear that one of CQC's principles is to promote equality, diversity and human rights. We also need to make sure that we communicate how we are doing this to our staff, providers, people who use services, the public and other stakeholders. In the consultation, there was also wide agreement that CQC should focus its attention on situations where people are more likely to have their rights breached – leading to the fundamentals of care not being met for these people. Sometimes, this was expressed in terms of 'risk' and 'vulnerability' but several participants felt that this approach 'put the thinking in the wrong box' and that the focus should be on rights and dignity. Three factors were highlighted by consultation participants where they thought that CQC needed to have a particular focus on the rights of people using the service: • **The type of service:** e.g. where there is little oversight of

[1] Raising standards, putting people first: response to the consultation The next Phase – our strategy for 2013-2016 2013) Care Quality Commission

people delivering the service – either because it is a 'closed' institution or because the service is delivered in people's own homes or where people have no choice but to use the service – if they are detained under the Mental Health Act.

- **The ability of people using the service to self-advocate:** including not only disability but, for example, whether the person can speak English.
- **The risk of discrimination for a group of people using a service:** for example people may be at risk on the grounds of ethnicity, sexual orientation or religion and belief – regardless of the ability of the person to self-advocate and therefore providers may not be meeting required standards for these groups of people.

In the consultation document we have committed to prioritising changes to the way we regulate services where people are most likely to find themselves in vulnerable circumstances – these are the services where people are most likely to have their human rights breached. Our new model will help us to focus on situations where people are most vulnerable to having their rights breached. Firstly, better surveillance including specific indicators for groups of people more likely to be in vulnerable circumstances will help us identify services where people may be at risk of having their rights breached. Secondly, the changes will enable us to make expert judgements through improved inspection methods and thirdly, they will give us new powers to take action where standards are not being met that may lead to a breach of human rights for people using the service.

Some of the 'drivers' for the development of our new model for regulating NHS services, such as the Francis report, are closely linked to human rights. The Government's initial response to the Francis report focuses on *'key actions to ensure that patients are 'the first and foremost consideration of the system and everyone who works in it' and to restore the NHS to its core humanitarian values.'* The statement of common purpose in the response reaffirms the key human rights concepts of respect and dignity as a key value for the NHS.

Human rights, such as the 'FREDA' principles of fairness, respect, equality, dignity and autonomy and rights under the Human Rights Act are embedded in the current standards which we use to regulate health and social care providers.

- The introduction of standards for the fundamentals of care and development of guidance to explain the new expected standards of care (which will replace the current regulations) could help to clarify expectations around human rights. The proposed fundamentals of care which link to equality and human rights are listed in section 7. We will need to pay attention to standards which enable CQC to take action on 'risk to rights' (e.g. rights to independence) as well as standards around 'risk of harm' which can include human rights elements – such as standards around neglect which have an impact on dignity and freedom from inhumane or degrading treatment. Standards relating to 'risk of harm' (i.e. freedom from….) can be easier to regulate than positive rights (i.e. freedom

to....)

- We will develop and publish a clear approach to human rights in order to clarify the equality and human rights requirements in the new model. This approach will then help inspectors look at their regulatory work using a human rights perspective and help people who use services and providers to know how the standards link to protecting and respecting people's human rights. By doing this we are abiding by the first two principles of human rights based approach to health. Firstly to put human rights principles and standards at the heart of policy and planning and secondly to empower staff and people who use services with knowledge, skills and organisational leadership and commitment to achieve human rights based approaches.[2]

- The 5 new key questions that we will ask about services are
  - Are they safe?
  - Are they effective?
  - Are they caring?
  - Are they responsive to people's needs?
  - Are they well-led?

  There are important human rights issues contained within all five of these high-level questions. The questions are clearly focussed on putting people who use services at the centre of our regulatory activity – so the new questions should help us to focus on the key human rights issues for people who use services.

- Our human rights approach will assist CQC staff to see the linkages between key human rights principles of fairness, respect, equality, dignity and autonomy, rights under the Human Rights Act and the 5 key questions. This will provide staff with the basis for considering human rights in their work.

- The proposals to differentiate our regulation between different service types should help to clarify expectations on equality and human rights for different services. The move from generalist to specialist inspectors and teams, alongside more in depth inspections where NHS services are at higher risk, could help to make sure that we build capacity for more confident, professional judgement-making on standards relating to equality and human rights for specific types of services.

- The introduction of ratings provides an opportunity to lever improvement in human rights for people who use services above the requirements of the expected standards

[2] For a full list of principles in a Human Rights based approach see Human Rights in Healthcare – a framework for local action (2007) British Institute for Human Rights and Department of Health

Age: (include younger as well as older people, safeguarding, consent and child welfare)	We know that older people are more likely to use health and social care services than the rest of the population.[3] From our own work (such as dignity and nutrition inspections) and the work of others (such as the Equality and Human Rights Commission Inquiry, *Close to home: An inquiry into older people and human rights in home care*) we also know that older people can experience poor outcomes from using health and social care services, in relation to age equality and human rights. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting people's needs on the grounds of age and protect human rights such as dignity, privacy, respect, independence and participation. Any changes to the way that we regulate health and social care services is likely to have a high impact on equality and human rights for older people. In particular, it will be important that the standards we use continue to enable us to take action on age equality and to protect the human rights of older people such as dignity, privacy, respect, independence and participation. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality and human rights for older people.
Carers: (impact of part-time working, shift-patterns, general caring responsibilities)	Carer status is not a protected characteristic under the Equality Act 2010. However, carers do receive some protection under the Act in relation to 'discrimination by association' with a disabled person or an older person. We recognise that our work in regulating health and social care services has the potential to have a huge impact on equality for the five million carers in England[4]. Checking that the needs of carers are met is sometimes outside the remit of the current regulations. The focus of these regulations is on the quality and safety of services for people who use services, except in specific circumstances, such as issues of information and consent when a carer is expressly acting on behalf of someone using the service. When reviewing the regulations, we could consider in our discussions with the Department of Health (who are leading the regulation review) whether the new regulations should or could support the needs and rights of carers more. We also recognise that if a provider better meets the needs of the person using their service, for example by providing them with appropriate care and cooperating with other providers, this can have a major positive impact on carers. Carers also use health services in their own right, for example hospital services. Checking that health care providers meet the individual needs of carers using their service is within the remit of CQC. Therefore any changes to the way that we regulate health and social care services could have a high impact on equality and human rights for carers.

[3] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

[4] Figures from Carers Trust: http://www.carers.org/key-facts-about-carers

Disability: (include attitudinal, physical and social barriers)	We know that disabled people use health services more than non-disabled people and that most social care services are provided to people that would be covered by disability equality legislation (including older disabled people, people with a learning disability and people using mental health services).[5] There are some gaps in data around disabled people's use of universal health services as disability is not monitored in some main health data sets such as hospital episode statistics. However, we know from many reports based on people's experiences, such as Sir Jonathan Michael's Inquiry, *Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities*, that some groups of disabled people also experience inequalities or discrimination in health care, including universal health care services such as acute hospitals. There are particular concerns about the rights of people with a learning disability when using specialist inpatient health services. Following the highlighting of serious abuse and appalling standards of care at Winterbourne View, a private hospital for people with a learning disability, we carried out a programme of 150 inspections of independent hospitals, NHS hospitals and care homes that provided care for people with a learning disability. Our national findings from this inspection programme show that there remains a significant shortfall between policy and practice. We found that nearly half the locations we inspected were not meeting the national standards of care that people should expect. Our findings demonstrate that services for people with a learning disability still need to improve. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of disabled people, that providers avoid unlawful discrimination and make reasonable adjustments when planning and delivering care and treatment and that they protect human rights such as dignity, privacy, respect, independence and participation. Any changes to the way that we regulate health and social care services is likely to have a high impact on equality and human rights for disabled people, both for people using specialist health and social care services and for disabled people using universal services, such as acute hospitals. In particular, it will be important that the standards we use continue to enable us to take action on disability equality and to protect the human rights of disabled people such as dignity, privacy, respect, independence and participation. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality and human rights for disabled people. We are prioritising services for people with a learning disability for some of our proposals. The more rigorous test for people applying to provide health or social care services will be first used in services for people with a learning disability so that we can use these new tests

[5] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

	quickly where there is unacceptable care in these services – care that can have an impact on whether people with a leaning disability have their human rights upheld.
Gender: (men and women)	We know that the pattern of use of health services is different for men and women. We also know that there are more women using social care services than men, due to gender differences in age profiles of the population[6]. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of gender. We do currently use some data around specific aspects of gender equality, such as the rate of use of mixed-sex wards in hospitals. In order to maintain our ability to promote gender equality, it will be important that the standards we use continue to enable us to take action on gender inequality when necessary. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote gender equality.
Gender Reassignment: (transgender and transsexual people, issues such as privacy of data and harassment):	A report from the Equality and Human Rights Commission shows that transgender people experience some specific difficulties in relation to their health care. Transgender people need to engage with health services during the transition process and, in addition may also use other health and social care services on the same basis as the rest of the population. There is little data in main health data sets about the experiences of transgender people using health services. In our current work on equality data, led by our Intelligence Directorate, we are carrying out some specific work to look at the information we hold about gender identity clinics. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of gender (including gender reassignment). Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for transgender people. In order to maintain our ability to promote equality for transgender people, it will be important that the standards we use continue to enable us to take action on inequality for transgender people when necessary. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote transgender equality.
Pregnancy and maternity: (impact of working arrangements, part-time working, infant caring responsibilities and breastfeeding)	We have a specific role in ensuring that the health services used by pregnant women meet government standards. Therefore any changes to the way that we regulate health and social care services may have an impact on equality and human rights for pregnant women. Some of the proposed changes to the NHS model could have a

[6] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

	positive impact on the human rights of women using ante-natal and maternity services, for example our approach to have more intensive inspection of high risk services should help ensure that women have basic rights, such as rights to dignity, privacy and equality upheld whilst using these services. Again, this positive impact will be dependent on making sure that that the new standards we use enable us to take action on human rights such as dignity, privacy and equality. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality and human rights for women using ante-natal and maternity services. We are proposing that in large hospitals, there will be a separate rating for some services – and we give maternity services as an example.
Race: (include differences between ethnic groups, nationalities, gypsies and travellers, language barriers)	We know that the pattern of use of health services is different for people in different ethnic groups. We also know that some minority ethnic groups consistently report lower satisfaction with health and social care services. From our mental health act monitoring work we also know that in some minority ethnic groups, people are more likely to experience negative outcomes, such as higher detention and seclusion rates, which can have an impact on the human rights of Black and minority ethnic people.[7] In the strategy review consultation, people raised issues of the over-representation of some minority ethnic groups in mental health services and the importance of gathering the views of these people when making judgements about whether services are meeting standards. We are proposing to improve the links between our Mental Health Act work and how we regulate mental health services and to give particular attention to the views of people on mental heath wards. We are also currently piloting approaches to equality monitoring in our Mental Health Act work to help us identify services where there may be particular equality issues. The regulations under which we currently register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of race and that providers avoid unlawful discrimination when planning and delivering care and treatment. Any changes to the way that we regulate health and social care services may have an impact on equality for people from different ethnic groups and has the potential to make a positive impact if learning from our experience of regulation to date can be incorporated into the new model. In particular, it will be important that the standards we use continue to enable us to take action on race equality. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote race equality.

[7] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

Religion or belief: (include different religions, beliefs and no belief)	The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of 'religious persuasion'. Other beliefs are also covered in other regulations about meeting individual needs. In our discussions with the Department of Health over changes to the regulations, we will raise alignment of terminology around religion and belief with the Equality Act 2010 – to align requirements and therefore make the requirements clearer for both providers and people who use services. Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for people of different religions and beliefs. In order to maintain our ability to promote equality on the grounds of religion and belief, it will be important that the standards we use continue to enable us to take action on any inequality when necessary. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality on the grounds of religion and belief for people using health and social care services.
Sexual Orientation: (include impact on heterosexual people as well as lesbian, gay and bisexual people)	There are some gaps in data around the experience of lesbian, gay and bisexual people when using health and social care services as sexual orientation is not monitored in some main health data sets such as hospital episode statistics. In our current work on equality data, led by our Intelligence Directorate, we are aiming to make the best use of available data. We know that there have been a number of studies and reports showing that lesbian, gay and bisexual people can experience discrimination and poorer outcomes when using health and social care services.[8] The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of sexual orientation. There can be particular difficulties in identifying lesbian, gay and bisexual people using health and social care services in order to assess the compliance of providers with this regulation. We will consider best approaches to addressing this difficulty as we develop our new regulatory approach. Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for lesbian, gay and bisexual people and has the potential to make a positive impact if learning from our experience of regulation to date can be incorporated into the new model. In particular, it will be important that the standards we use continue to enable us to take action on equality on the basis of sexual orientation. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality for lesbian, gay and bisexual people.

[8] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

7.	
Analysis Considering the evidence and engagement activity, set out below, the actual or likely effect of the policy, project or work under each of the general duties of the Equality Act. CQC must have due regard to the general duties in the exercise of all of its functions	
Effect on eliminating discrimination, harassment and victimisation (includes unlawful discrimination because of marriage or civil partnership status, as well as other protected characteristics)	The new model will assist CQC to have due regard to the elimination of discrimination – provided that the new standards continue to enable CQC to take regulatory action where there is unlawful discrimination or a failure of a provider to have due regard to meeting the needs of people who use services on equality grounds. In the consultation document, one of the proposed fundamentals of care is, 'I will be protected from abuse and discrimination'. There are opportunities in the development of the new model for more in-depth and specialist inspections which could have an impact on eliminating discrimination, provided this is embedded into the new model including the use of appropriate surveillance to identify risks to equality.
Effect on advancing equality of opportunity (includes removing or minimising disadvantages, taking steps to meet the needs, and encouraging participation in public life of people from protected groups)	The new model will assist CQC to have due regard to the advancement of equality of opportunity – provided that the new standards continue to enable CQC to take regulatory action where there is failure by a provider to have due regard to meeting the needs of people who use services on equality grounds. There are opportunities in the development of the new model for more in-depth and specialist inspections which could have an impact on advancing equality of opportunity, provided this is embedded into the new model. The introduction of ratings could also have an impact on improving equality in health and social care services above the level required to meet the essential standards.
Effect on promoting good relations between protected groups	There may be a potential positive impact through ratings – if, for example, ratings include wider issues about how providers carry out community engagement work.
Effect on compliance with Human Rights Act 1998	The new model will assist CQC to have due regard for our responsibilities to respect, protect and fulfil the rights of people using services that are covered by the Human Rights Act 1998 – provided that the new standards continue to enable CQC to take regulatory action on the same range of human rights issues that are covered under the current regulations. The proposed new fundamentals of care include the following standards which would have a direct impact on protecting human rights:

	- I will be protected from harm during my care and treatment.[9] - I will be cared for in a clean environment.[10] - I will be protected from abuse and discrimination.[11] - I will be given pain relief or other prescribed medication when I need it.[12] - I will be helped to use the toilet and to wash when I need it.[13] - I will be given enough food and drink and helped to eat and drink if I need it.[14] There are opportunities in the development of the new model for more in-depth and specialist inspections which could have an impact on protecting and fulfilling human rights, provided this is embedded into the new model, including the use of appropriate surveillance to identify risks to human rights. The prioritisation of changes in services where people are in vulnerable circumstances should also help to protect people at most risk of having their human rights breached.

[9] Relevant to European Convention on Human Rights Article 2 – Right to life and Article 3 – Right to be free from inhumane or degrading treatment (The Human Rights Act 1998 incorporates these European Convention of Human Rights Articles)

[10] Relevant to European Convention on Human Rights Article 2 – Right to life, Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

[11] Relevant to European Convention on Human Rights Article 3 – Right to be free from inhumane or degrading treatment and Article 14 – non-discrimination in relation to other rights

[12] Relevant to European Convention on Human Rights Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

[13] Relevant to European Convention on Human Rights Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

[14] Relevant to European Convention on Human Rights Article 2 – Right to life, Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

8. Log of Equality and Human Rights actions

Give an outline of the key actions based on any information gaps, challenges and opportunities identified during engagement and evidence analysis. Include any action required to address specific equality or human rights issues where the work may need adjusting to remove barriers or better advance equality as well as actions to mitigate any potential negative effects of the policy on particular groups . Include how the actual impact on equality and human rights will be reviewed after implementation of the policy or project. Add more rows if required. Refer to Guidance for more information

Action (If using a project plan this should be a new deliverable or new task within an existing deliverable)	**Start date**	**End date**	**Action Owner**	**Outcome** (relate back to analysis section – which equality or human rights issues will be addressed through this action)	**Success measure**	**Actual Completion Date**
1. Develop our human rights approach (which includes equality) for the 5 domains that we are using in the new model– to help us ensure that we address human rights issues in the fundamentals of care, our approach to regulating the new expected standards of care, ratings and evidence to support these	April 2013	Aug 2013	Lucy Wilkinson	Provides basis for the new model of monitoring, inspection and regulation to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	Human rights approach developed and agreed by CQC	
2. Apply the human rights framework to the fundamentals of care	May 2013	Aug 2013	Lucy Wilkinson/ Karen Wilson	Ensures our development of the fundamentals of care will have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	The fundamentals of care protect human rights and rights to equality	
3. Apply the human rights approach to new NHS inspection methodology; surveillance, tools and guidance for inspectors for both acute and mental health	May 2013	Sept 2013	Lucy Wilkinson/ Sue Macmillan/ Lisa Annaly	Ensures new NHS regulatory model has due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and	Our model to monitor, inspect and regulate NHS trusts and foundation trusts protects and	

NHS trusts and foundation trusts and incorporate learning from our evaluation of equality and human rights in reviews of compliance into this work				promote human rights	promotes human rights and rights to equality	
4. Pilot work to utilise values-based approaches in NHS inspection methodology with a view to incorporating this into new inspection methodology if successful (Joint work with MacMillan Cancer Care)	Q1	Q4	Nigel Thompson/ Lucy Wilkinson/ Matthew Trainer	Develops new NHS regulatory model in relation to the protection and promotion of human rights	We test a methodology which enables inspectors to focus on the values behind human rights in a health setting and how to use these on inspection	
5. Consult on our human rights approach and the way that it applies to expected standards and the NHS inspection methodology for both acute and mental health NHS trusts and foundation trusts in the next public consultation	Q3	Q3	tbc	Engagement to ensure new NHS regulatory model and the new fundamentals of care have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	Views of other stakeholders improve the way that our model to monitor, inspect and regulate NHS trusts and foundation trusts protects and promotes human rights and rights to equality	
6. Apply the human rights approach to developing ratings including how we assess whether services are high quality by using good practice developed by other organisations	Q3	Q3	Lucy Wilkinson/ Emma Steel	Ensures the new method for rating services has due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights and assessments of whether services are high quality considers good practice in relation to equality and human rights	Views of other stakeholders improve the way that our method for rating services protects and promotes human rights and rights to equality	
7. Consult on the human rights approach and the way that it has	Q4	Q4	Lucy Wilkinson/	Engagement to ensure the new method for rating services has	Our method for rating services protects and	

been applied to ratings			Emma Steel	due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	promotes human rights and rights to equality	
8. Utilise the human rights approach when we develop learning and development activity for inspectors and others around the new model	Q3?	Q4	Lucy Wilkinson/ Ruth Heron	Ensures that the equality and human rights elements of the new approach can be put into practice by CQC workforce	CQC staff are confident in promoting equality and human rights in their work using the new model	
9. Discuss with the DH some specific suggested revisions to the regulations relating to equality and human rights that are might be required – based on our experience of operating under the current regulations and aligning the wording of the regulations with other legislation (e.g. Equality Act 2010) for clarity for providers and people who use services	Q2	Q3	Lucy Wilkinson/ CQC Lead with DH	In assisting the Department of Health to define the new regulations, we contribute our regulatory experience to date around having due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	The new standards protect and promotes human rights and rights to equality	
10. Give specific consideration, when developing the detail of the new model, to addressing the difficulties with assessing whether providers meet the standards for lesbian, gay and bisexual people using their services (e.g. around discrimination and respect)	Q1	Q4	Lucy Wilkinson	We have had due regard to the need to due regard to the need to eliminate unlawful discrimination and advance equality of opportunity for lesbian, gay and bisexual people	Increasingly, we are able to judge whether health and social care services meet the expected standards for lesbian, gay and bisexual people using their services	
11. Continue to develop our approaches to assessing equality through our Mental Health Act	Q1	Q4	Debbie Mead	We have had due regard to the need to due regard to the need to eliminate unlawful discrimination	The information on equality that we obtain through our	

function and enable this work to inform our work to regulate mental health services				and advance equality of opportunity in the development of our regulation of mental health providers	Mental health Act function contributes to our regulation of mental health providers	

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		PATIENTS FIRST AND FOREMOST: THE INITIAL GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY		
DATE OF DECISION:		18 JULY 2013		
REPORT OF:		CHAIR, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dr Steve Townsend**	**Tel:**	**023 8029 6923**
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The report of the public inquiry into the Mid Staffordshire NHS Foundation Trust led by Robert Francis QC (the Francis report) was published in February 2013. The government has now published its initial response, and the key points from this response are summarised for the Scrutiny Panel's consideration.

RECOMMENDATIONS:

(i) That the Scrutiny Panel receives and notes the issues highlighted in "Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC - *Patients First and Foremost*".

(ii) That the Scrutiny Panel notes the work that is going on locally within the NHS and partner organisations to respond to the challenge of the Francis Report, supports its direction of travel and expects that the NHS and partner organisations foster a culture of care, with continuous improvement of quality, safety and patient experience.

REASONS FOR REPORT RECOMMENDATIONS

1. The Francis report and the government's response both raise a number of important issues for the local health and care system. As a high profile leadership board within the local system, it is appropriate for the Health and Wellbeing Board to consider the implications of the recently published

government response.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not to have the opportunity to comment on the Government response to the Francis report. This was rejected on the basis that the Francis Report and the government response of significant interest to the Health Overview and Scrutiny Committee.

DETAIL (Including consultation carried out)

3. The Francis Report into failings at Mid-Staffordshire NHS Foundation Trust between 2005 and 2008 was published on 6 February 2013. It tells the story of an appalling breakdown of basic patient care, which probably resulted in the death of about 500 patients. Even more disturbing, this breakdown occurred against the backdrop of the trust becoming a foundation trust, with the board's emphasis on financial management rather than patient care. Though the many regulatory and supervisory bodies had concerns about the trust's performance, they failed to prevent or deal with the problems.

4. The lengthy report identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. A number of causes were identified, including:
   - A culture focused on doing the system's business – not that of the patients;
   - An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
   - Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
   - Too great a degree of tolerance of poor standards and of risk to patients;
   - A failure of communication between the many agencies to share their knowledge of concerns;
   - Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
   - A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
   - A failure to appreciate the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

5. The report contained 290 detailed recommendations, the essential aims of which were to:
   - Foster a common culture shared by all in the service of putting the patient first;
   - Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;

- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they what they do and to ensure that the public is protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

6. The Department of Health has considered the inquiry report and published an "initial government response", in which the Secretary of State says: "Action is needed at each level to enable the excellent care that already exists in the health and care system to become the norm, and to become what every person can expect of the NHS". This is statement that the Health and Wellbeing Board would want to endorse across local health and care systems.

7. The government response sets out a 5 point action plan to "revolutionise the care that people receive from our NHS…" The 5 key points are:
    - Preventing problems
    - Detecting problems quickly
    - Tackling action promptly
    - Ensuring robust accountability
    - Ensuring staff are trained and motivated

   The main actions proposed under each of these heading are summarised below.

8. **Preventing problems**
    - Time to care.
      A commitment to decrease bureaucracy, enabling staff to spend more time with patients.
    - Safety in the DNA of the NHS – The Berwick Review

Professor Donald Berwick, a well-known American expert on health safety will be working with NHS England to ensure a robust safety culture in the NHS.

9. **Detecting problems quickly**

- The appointment of a Chief Inspect of Hospitals at the Care Quality Commission.
  This appointment will be made later this year, and the Chief Inspector will make an assessment of every NHS hospital's appointment, drawing on local views.

- Expert Inspectors, not Generalists.
  This measure will lead to more thorough inspections of hospitals. There will also be a "comply or explain" approach to known good practices such as nursing rounds.

- Ratings – A single balanced version of the truth
  The Care Quality Commission will work with the Nuffield Trust to develop a rating system, including clinical quality measures as well as financial ones. This will be similar to OFSTED ratings, and will include the Friends and Family Test.

- The appointment of a Chief Inspector of Social Care
  This Chief Inspector will adopt a similar approach to social care and rating care homes.

- Publication of Individual Speciality Outcomes.
  The publication of outcome measures about individual hospital departments will be extended to another nine areas.

- Penalties for Disinformation and a Statutory Duty of Candour.
  While the government has shied away from creating a criminal offence, as recommended by Francis, there will be a statutory duty of candour, which means that providers will have to inform people if their treatment has resulted in serious harm and provide an explanation.

- A Ban on Clauses Intended to Prevent Public Interest Disclosures
  NHS England has already instructed provider trusts not to use "gagging clauses".

- Complaints Review.
  A review of best practice on complaints to ensure that lessons are learnt by the NHS.

10. **Taking action promptly**

- Fundamental Standards
  The Care Quality Commission will draw up an explicit list of minimum basic standards, which will be readily accessible.

- Time Limited Failure Regime for Quality as well as Finance.
  If failing hospitals do not improve, ultimately they will be put into

administration (with arrangements to ensure continuity of care).

11. **Ensuring robust accountability**

- Health and Safety Executive to use criminal sanctions.
  It is of note that recommendation 87 of the Francis Report stated "The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare." The government response, however, gives it the role of considering criminal prosecution where the Chief Inspector identifies criminally negligent practice.

- Faster and more proactive professional regulation
  The General Medical Council, the Nursing and Midwifery Council, and other professional regulators will be reviewed in order to simplify and update legislation.

- Barring Failed NHS Managers.
  There will be a national barring list for unfit managers, based on the scheme for teachers.

- Clear responsibilities for tackling failure

12. **Ensuring staff are trained and motivated**

- HCA training before nursing and other degrees.
  This is not one of Francis' recommendations. The proposal is that every student who seeks NHS funding for a nursing degree should be required to work for up to a year as a healthcare assistant.

- Revalidation for Nurses.
  This mirrors the revalidation system that has just been introduced for the medical profession.

- Code of Conduct and Minimum Training for Health and Care Assistants
  Standards of training and a code of conduct for Health and Care Assistants have been published, and the Chief Inspectors will ensure that they are properly supported.

- Attracting Professional and External Leaders to Senior Management Roles
  The NHS Leadership Academy will encourage clinical professionals and people from outside the NHS into top leadership positions.

- Frontline Experience for Department of Health Staff.
  Within 4 years every civil servant in the Department will have "sustained and meaningful experience on the front line".

13. The response also contains a Statement of Purpose signed by the leaders of 14 professional bodies; a pledging to bring about the necessary personal and institutional change to prevent a further incident of this nature. In

addition the government is proposing that all NHS hospitals will indicate how they intend to the Inquiry's conclusions before the end of 2013.

Implications and Issues for the Local Health and Care System

14. The two reports that Robert Francis has written about the failings in Stafford have shocked those working NHS, and produced a resolve for change to prevent a recurrence. It is apparent that we need to change our culture, and it is debatable how much the top down approach of this report will achieve that. One theme of the second report was that there was a failure of management culture, which was not only focussed on finance at the expense of quality, but was prepared to bully anyone who questioned what was going on. There have been calls for the resignation of the Chief Executive of NHS England, Sir David Nicholson, who was for a short while Chief Executive of the Strategic Health Authority responsible for Stafford. In this context, it is a pity that NHS England was not a signatory to the Statement of Common Purpose.

15. Another theme of the Francis Report was that nursing staff spent too much time on administration at the direct expense of patient care. The commitment to reduce bureaucracy is admirable, but the inspection regime proposed sounds bureaucratic. There is a parallel with OFSTED, which may have improved standards in schools, but is onerous for teachers.

16. We also need to accept the challenges of improvement in a health service which is facing substantial financial challenges. Francis commented on the problems resulting from inadequate staffing. We need to be sure that this does not become a reason to retain inefficient practices rather than face the discomfort of moving to efficient ones.

17. Nonetheless, there are undoubtedly opportunities for the NHS and social care systems in Southampton, and we must nurture the genuine desire of those working in local organisations to do their best for their patients, clients and customers. In Southampton City CCG we are committed to make quality the central theme of everything we do, and to do so using the transparent, supportive, "no blame" approach. This has improved safety in, for example, the aviation world and is very much the approach taken by Donald Berwick. We have set up a clinical governance committee, and have regular meetings with local provider trust to discuss quality and safety issues.

18. Francis was particularly scathing about the patient representative organisations in Stafford, which were over-deferential and consumed by in-fighting. Whilst Southampton LINk avoided those traps, we need to ensure that Healthwatch develops into an effective patient representative, and holds health and social services to account.

19. The response has quite rightly highlighted that within the NHS it is common

to see complaints as irritations to be managed defensively rather than vital information for improvement. We await the results of the review of best practice with interest. As a CCG, we would be pleased to act as a recipient of any complaints, particularly those reaching councillors from their constituents. We have already had a similar conversation with one of our local MPs.

20. The failures in Stafford were detected by many organisations, but were viewed separately. The Wessex Area Team has set up a Quality Surveillance Group to ensure that it, local clinical commissioning groups, Monitor, the CQC and patient representative organisations meet regularly to discuss safety matters. Southampton City CCG is also going to meet next month with West Hampshire CCG, the Local Medical Committee and consultants from University Hospitals of Southampton Foundation Trust to discuss how we exchange “soft” information about poor performance, particularly when that involves individual practitioners. The Health and Wellbeing Board has considered the both the Francis Report and the Government response. The Board has supported the programme of local activities to respond to the challenge, and will be carefully reviewing progress in March 2014.

Conclusion

21. The events at Stafford Hospital have shocked the NHS, and led to a resolve to avoid a recurrence. There is much good work going on, though we need to ensure that momentum is maintained and leads to a change of culture in the NHS where quality and safety are considered much more systematically than they have in the past.

RESOURCE IMPLICATIONS

Capital/Revenue

22. None for the Scrutiny Panel. The costs of the implementing the actions required will be met from provider trust and CCG budgets.

Property/Other

23. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

24. The powers and duties of health scrutiny are set out in the Local Government and Public Involvement in Health Act 2003.

Other Legal Implications:

25. None.

POLICY FRAMEWORK IMPLICATIONS

26. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	None
2.	

Documents In Members' Rooms

1.	None
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	
2.		

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL			
SUBJECT:	HEALTHWATCH SOUTHAMPTON			
DATE OF DECISION:	18 JULY 2013			
REPORT OF:	MATTHEW WATERS – PEOPLE DIRECTORATE			
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
There are no issues of confidentiality

BRIEF SUMMARY

Southampton Voluntary Services (SVS) has commenced the management of the Healthwatch Southampton service, following a successful tender process carried out earlier in the year. This report outlines the tender process for the Healthwatch Southampton contract. In addition, Rob Kurn, SVS Health Development Team Leader, will give the panel an outline of Healthwatch Southampton's functions and plans.

RECOMMENDATIONS:

(i) That the panel note the commencement of the contract.

(ii) That the panel notes the functions and role of Healthwatch Southampton.

(iii) That the panel, following a discussion with Rob Kurn, SVS Health Development Team Leader, consider Healthwatch Southampton's future involvement with the panel.

REASONS FOR REPORT RECOMMENDATIONS

1. The tender process has been completed, in line with Southampton City Council's Contract Procedure Rules.
2. To inform the Health Overview and Scrutiny Panel of the arrangements for providing Healthwatch Southampton, through SVS, for the longer term.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. A range of alternative options were considered and rejected. These included:
    - Splitting the functions of Healthwatch into separate contracts. This was rejected on the grounds that there are significant benefits to Healthwatch in terms of gathering evidence, linking outcomes across all functions and the management of a single service. The splitting of functions would reduce these advantages.

- Negotiated tender arrangements. While this would have allowed a tender to be issued earlier, there would have been significant negotiation required after any tender process. This would have included negotiation on the final price.
- Grant aid was also considered, but rejected as this would have still required a decision on either:
    - grant aiding a single agency, of which none appeared to have all the skills to meet the requirements; or
    - grant aiding more than one agency and splitting the functions across those agencies, a decision already rejected.

DETAIL (Including consultation carried out)

4. The Health and Social Care Act 2012 required local authorities to establish local Healthwatch as a vehicle to succeed and build upon the Local Involvement Networks (LINks) as a voice for patients and the public on health and care services. In addition it will undertake the additional new roles of providing information, advice and signposting on services, and the NHS complaints advocacy. This paper provides an update on the arrangements for Healthwatch Southampton. Southampton Voluntary Services (SVS) has been successful following a tender process, and commenced the contract from 1st July 2013. Prior to 1st July, Southampton had interim arrangements in place, to meet all statutory requirements.

5. Healthwatch Southampton will be responsible for the following activities:
    - Community Engagement and Research
    - Evidence, Insight and Influence
    - Information and Advice
    - NHS Advocacy Service.

6. Through its membership of the Health and Wellbeing Board, Healthwatch Southampton will have influence at the decision-making table, helping to ensure public engagement in the strategic planning of health and social care services. It will also contribute to the development of the Joint Strategic Needs Assessment and the Joint health and Wellbeing Strategy for the City's population.

7. Healthwatch Southampton will also support individuals by providing information, signposting and advice about access to services and to help people to make choices about the type of treatment and care they receive within the choices that are available to them.

8. The award of the longer term contract to SVS enables a level of continuity to be achieved. SVS was providing the management for the LINk service. It will provide management of the full Healthwatch Southampton service, including any sub-contracting arrangements.

9. SVS will oversee the Independent Complaints Advocacy Service, but this will be provided on a day-to-day basis by SEAP. There are contractual arrangements ready for SVS and SEAP to use to ensure this occurs and is managed throughout the lifetime of the Healthwatch Southampton contract. In addition, Southampton Citizen's Advice Bureau will provide the signposting element of the service, under contract to SVS. There is also scope to request other agencies to provide specific elements of work to

support the service – e.g. if specific skills are required to engage particular client groups and communities. Appendix 1 gives a brief outline of Healthwatch Southampton's functions and roles.

10. Rob Kurn, SVS Health Development Team Leader, will give panel a brief presentation to the panel on Healthwatch Southampton's functions and plans for further development.

11. The panel are invited to have an open discussion on the role of Healthwatch Southampton and consider its future involvement with the HOSP.

RESOURCE IMPLICATIONS

Capital/Revenue

12. The council has set a revenue budget for 2013/14 of £200,000 for local Healthwatch.

Property/Other

13. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

14. The framework for local Healthwatch is set out in Sections 183 – 189 of the Health and Social Care Act 2012. Further requirements are set out in the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.

Other Legal Implications:

15. None

POLICY FRAMEWORK IMPLICATIONS

16. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	All

SUPPORTING DOCUMENTATION

Appendices

1.	SVS Briefing Paper: Healthwatch Southampton
2.	Service specification for Healthwatch Southampton

Documents In Members' Rooms

1.	None
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)

Agenda Item 10

Appendix 1

SVS Briefing Paper

healthwatch
Southampton

Introduction

Healthwatch is the new independent consumer champion for both health and social care. It will exist at 2 distinct levels – local Healthwatch, at a local area level, and Healthwatch England, at national level.

The aim of local Healthwatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch will also provide or signpost people to information to help them make choices about health and care services. It will also provide an independent complaints advocacy service (ICAS) for anyone wishing to pursue a complaint about their NHS treatment or care.

Healthwatch England

Healthwatch England has been set up as sub-committee of the Care Quality Commission (CQC). Its role is to be the national voice for people’s concerns about health and social care issues. Local experiences will inform its work at a national level through a national network of local Healthwatch organisations which will provide evidence and make recommendations to Healthwatch England.

Local Healthwatch (LHW)

The Health and Social Care Act 2012 set out that local Healthwatch would be established by April 2013 and would take over the statutory functions of Local Involvement Networks (LINks). Local Healthwatch would become the independent, influential and effective voice of the public, employing its own staff and involving volunteers to ensure local experiences are recognised and voices are heard. It will reach out proactively in communities to engage and involve local people, carrying out statutory functions as laid down by Parliament, keep accounts and make its annual reports available to the public.

Many voluntary sector organisations have been involved with LINks (SLINk in Southampton) and the relationship between the voluntary sector and Healthwatch should be one of mutual collaboration and support. The form this takes may vary depending on the organisational structure of local Healthwatch. Government regulation states that local Healthwatch organisations will be social enterprises but does not stipulate the form this should be other than it meets the criteria set out in the regulation[1].

Local authorities have been charged by Government with making arrangements for the setting up local Healthwatch.

Healthwatch Southampton

Southampton City Council went through a formal tendering process to establish the local Healthwatch but due to delays in the contracting process had put in place interim arrangements for Healthwatch from 1.4.13 to 30.6.13. From 1st July Healthwatch Southampton will be provided under the auspices of Southampton Voluntary Services which has been commissioned by Southampton City Council to provide this service in the city.

SVS worked in partnership with voluntary organisations locally to develop a model which combines carrying forward the past learning and strengths of SLINk, whilst more clearly defining the strategic direction and volunteering roles and widening the participation of key stakeholders. We see active engagement and involvement of local voluntary organisations and volunteers as key to Healthwatch Southampton's success. In particular we will have formal partnerships and subcontracts with SEAP for provision of the ICAS and with CAB for elements of the outreach advice and information service. Healthwatch Southampton will also work collaboratively with neighbouring LHWs where our local populations access services across local authority boundaries or where specialist services are commissioned over wider areas such as those offered at the UHST General Hospital.

Identifying local Healthwatch

There is a common branding for all Healthwatch organisations so regardless of where people live or organisations operate it should be easy to identify the local Healthwatch. They are all called Healthwatch followed by the local area name, e.g. Healthwatch Southampton and Healthwatch Hampshire.

There is a local Healthwatch organisation for every upper tier local authority area, i.e. that has responsibility for adult and children's services; and you can find your local Healthwatch by going to http://www.healthwatch.co.uk/find-your-local-organisation.

Healthwatch Southampton Functions

The functions of Healthwatch have been broken down into the following key elements. The voluntary sector will have opportunities to contribute to and support Healthwatch Southampton in a variety of ways. Suggestions are included below each of the functions.

- Gathering views and understanding the experiences of people who use services, carers and the wider community
  - Promoting Healthwatch to members or users so that they are aware of the opportunities to get involved
  - Making use of your own organisations activities and networks to gather information which could contribute to the work of Healthwatch

- Making people's views known
  - Ensuring that any specialist knowledge that users of services that you work with are able to add to evidence gathered by Healthwatch around a specific issue.

- Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinized
  - Volunteers will play an important role in Healthwatch's work and organisations working with people who have specialist knowledge will be a valuable asset in helping to shape health and care services.

- Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)
  - There are opportunities for organisations supporting people with specialist conditions to work collaboratively with Healthwatch to help understand the experiences of these service users.

- Providing advice and information about access to services and support for making informed choices
  - Healthwatch Southampton will be delivering this service in partnership with CAB outreach volunteers and there is a role for the wider voluntary sector in ensuring that its members and users and the wider community know how to access this service.

- Making the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion
  - The voluntary sector can play a role in supporting LHW to provide well evidenced information to HW England by collaborating around specific issues of concern.

NHS Complaints Advocacy

NHS Complaints Advocacy has previously been commissioned separately but ICAS is now combined within the overarching Healthwatch Southampton contract. SVS will subcontract this element to SEAP, the previous local provider, and will have a close working relationship with SEAP in order to gather data to inform evidence about health provision. Healthwatch Southampton will also signpost people to this service.

Health and Wellbeing Board

Health and Wellbeing Boards have been operating in a shadow form since 2011 and like Healthwatch formally came into being on 1st April 2013. Local Healthwatch has a statutory place on the Health and Wellbeing board. Like local Healthwatch, Health and Wellbeing Boards have been set up in every local authority area which has responsibility for adult and children's services.

Health and wellbeing boards (HWBs) have been set up to enable the better integration of health and social care services through a more collaborative approach to shaping how services are delivered.

The local Healthwatch representative is seen as having a key role in bringing the views of those using health and care services but will also have a role as a member of the HWB taking part in its decision making. Local Healthwatch is also seen by many HWBs as having a key role to play in the engagement of the wider public with HWBs. There is no statutory requirement for the voluntary sector to have a place on the HWB and despite SVS lobbying Southampton does not currently have voluntary sector representation but we will continue to make the case for this to be put in place alongside the informed consumer voice that Healthwatch Southampton will bring.

The HWB is required to produce a Health and Wellbeing Strategy for the local area and the Joint Strategic Needs Assessment (JSNA) is a key process by which the Strategy will be informed. Healthwatch Southampton will play an important role along with SVS for the the voluntary sector in informing the evidence base for the JSNA and ultimately the Health and Wellbeing Strategy.

Healthwatch Southampton is being set up at a time of considerable public expenditure spending constraints and severe pressures on public services which is having profound impact for local consumers. There will be many expectations of Healthwatch Southampton services but finite resources to meet all those so it will be important to ensure that there is a clear operational framework, strategic direction and prioritised work plan agreed and set for the service by the Strategic Group which will be established by SVS to oversee the delivery of Healthwatch locally, aided by an advisory group, and local members' views.

To have any chance of delivering genuine change Healthwatch Southampton needs the support of the voluntary and community sector, and SVS as its umbrella body, on a mutually beneficial basis so that the interests and concerns of our sector's beneficiaries and the people for whom we all work as well as the wider public engagement are reflected and taken forward to improve local service delivery and experiences. SVS hopes therefore that local voluntary organisations will continue to support it and Healthwatch Southampton as we move forward.

Opportunities for involvement

There will be 3 routes through which voluntary organisation can be involved

- Becoming members of Healthwatch Southampton, as well as SVS hopefully.

- Nominating and electing members to the Strategic Group
- Through involvement in specific work streams and focused activity, the organisational equivalent of volunteering roles for individuals.

The Strategic Group will be comprised of 9 members as follows –

- 3 members elected by the individual members (2 nominated from Southampton city residents, 1 from non city members)
- 3 members elected by voluntary sector member organisations
- 3 appointed members (1 by SVS Executive Committee, 2 to balance gaps in equalities or skills mix)

All members will go through a formal application process and vetting by a Nominations Committee to ensure they have the requisite skills, knowledge, and competencies to fulfil the role and commitment required. All members will be required to undertake a Disclosure and baring service check and any one disbarred from acting as a charity trustee, Company Director or not meeting the HMRC fit and proper person criteria will be ineligible to act as a strategic group member although other volunteering roles might be suitable for them subject to suitable risk assessment for the role.

In the formation period interim arrangement will be put in place until the first AGM when the full electoral process can be completed. Early elections will be held for the 3 voluntary sector constituency members and 3 previously elected members of the outgoing Slinks steering group will fulfil the individual members representatives role on a temporary basis.

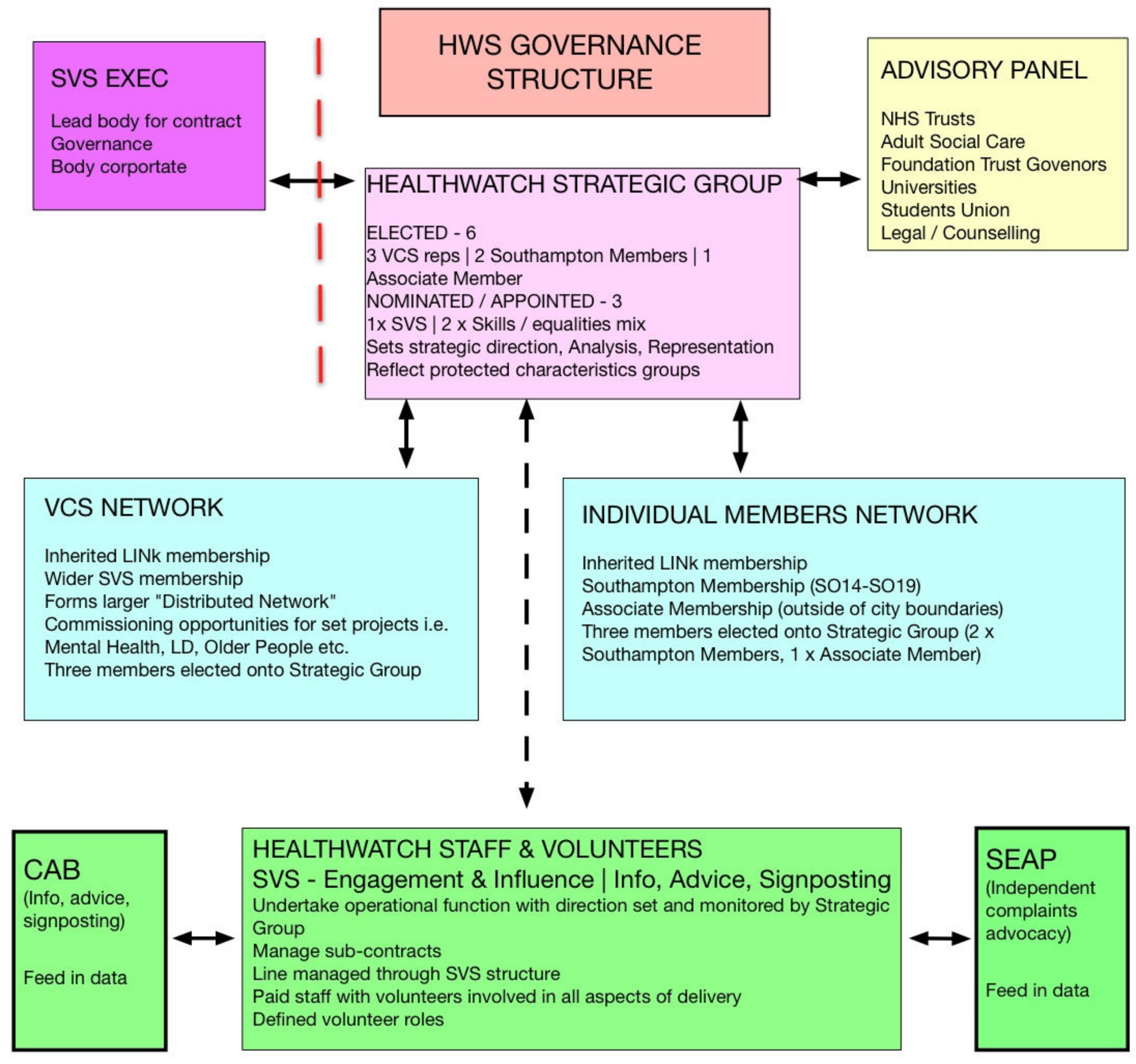
Eligibility for individual members election will be open to anyone over 18 years living in Southampton or using heath and social care services in the city although with the following exceptions -

- Health and Social care providers, and their employees, whose main function is to provide services to local Southampton citizens
- People who work in the commissioning of, or make strategic policy affecting , health and social care services in the city
- All board members of the city CCG, any NHS provider organisation and any SCC Councillors

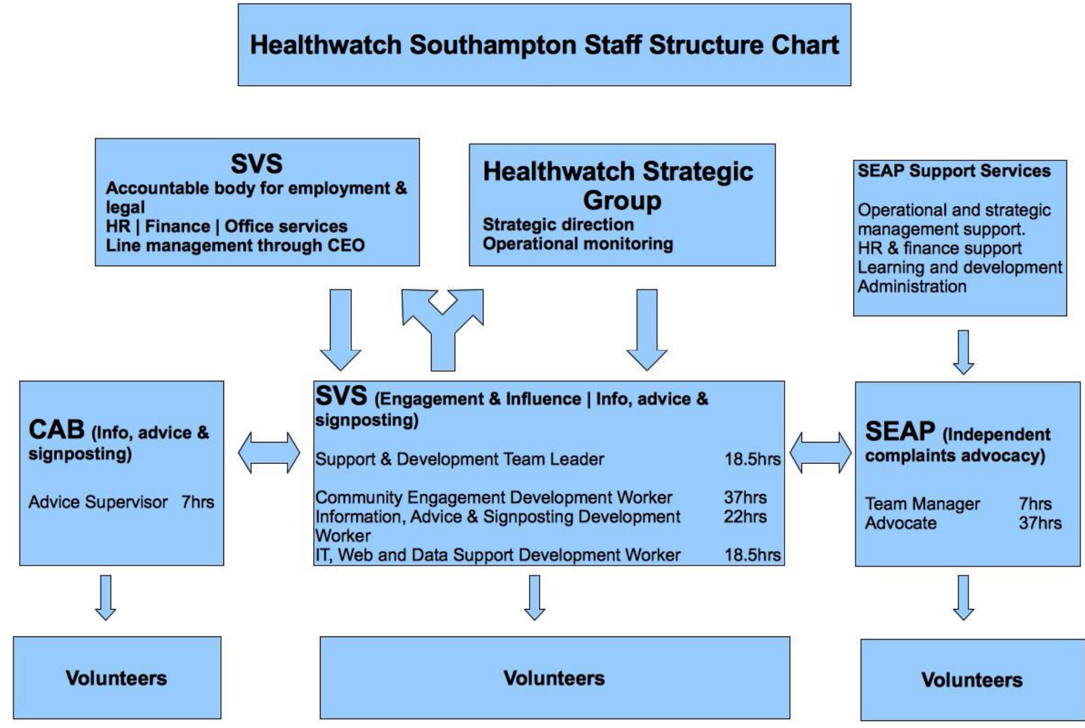
Eligibility for voluntary sector elected members will be to meet the same skills and competency requirements but not necessarily to be local residents or current service users. SVS will commence the election process for voluntary sector members at the earliest opportunity within the first 2 months of operation and all Healthwatch member organisations will be notified of the process imminently.

Healthwatch Southampton Diagrams

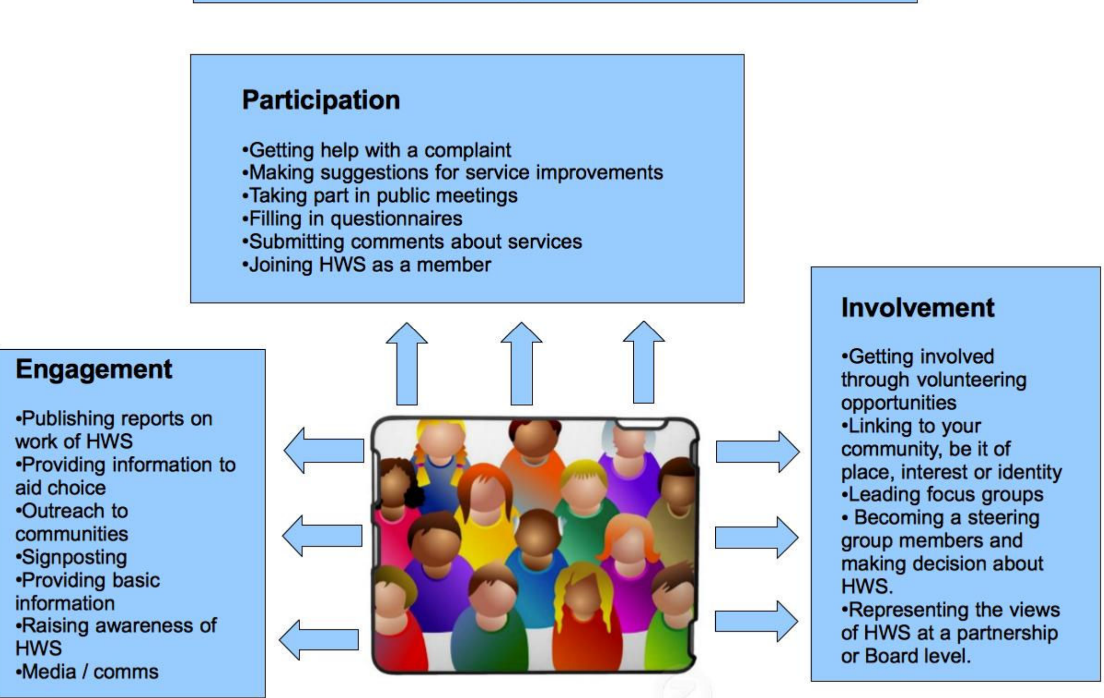
HWS Governance Structure



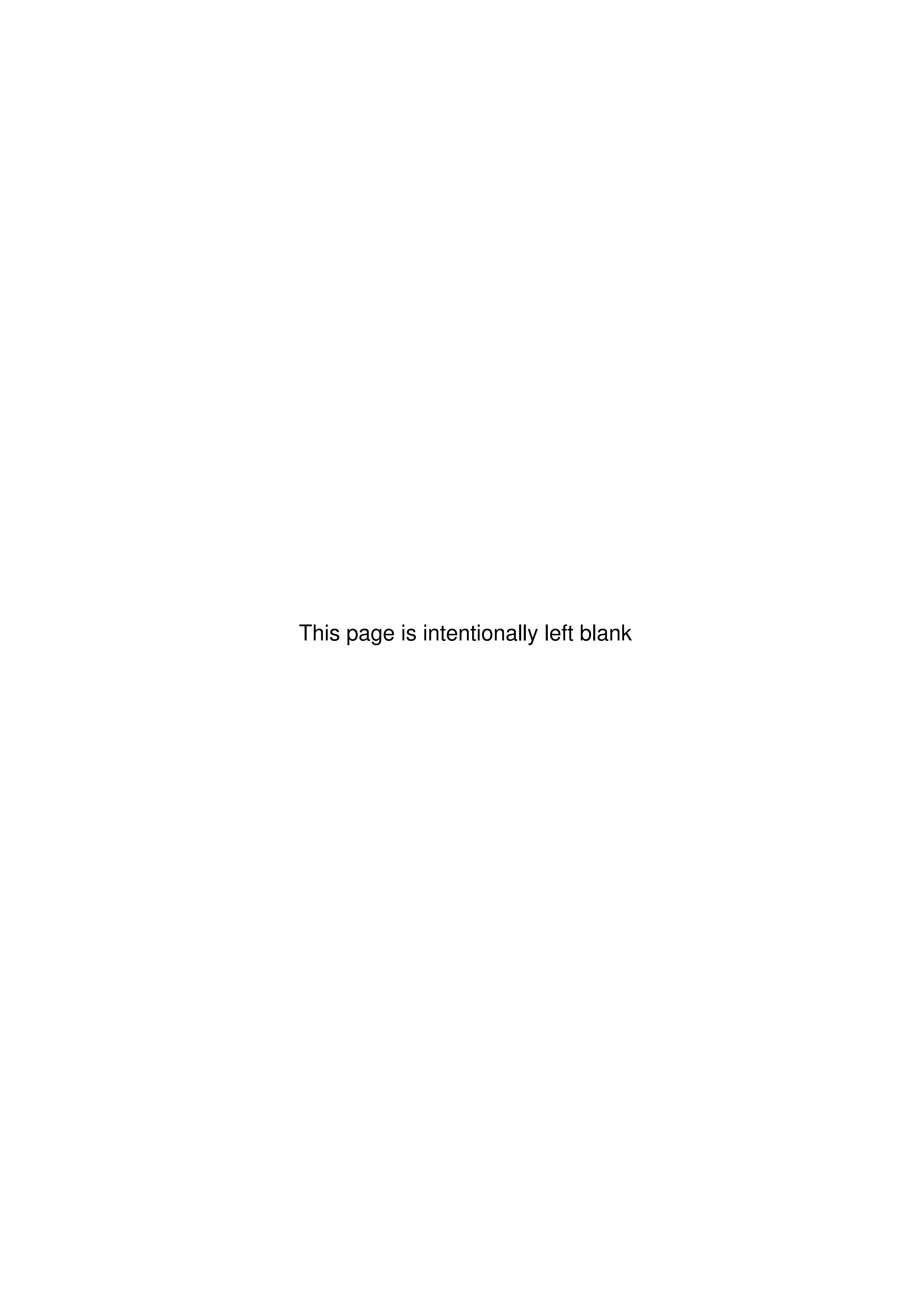
Healthwatch Southampton Staff Structure



HWS Offer to Southampton's Diverse Communities



J Ash, SVS Chief Executive, 26.6.13



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SERVICE SPECIFICATION

SCHEDULE 1

SERVICE SPECIFICATION

FOR

THE PROVISION OF SOUTHAMPTON HEALTHWATCH

Directorate of Health and Adult Social Care

March 2013

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Service Specification

1 Introduction

1.1 This specification details the service to be delivered by Healthwatch Southampton (HWS). It sets out our aims and ambitions for the service, and details the activities that are required to be undertaken and is informed by the views, opinion and vision of local people and stakeholders.

1.2 The Council requires The Service Provider to deliver high quality services working with the Council and Service Users to fulfil the requirements of this Service Specification and achieve the broad outcomes described in Section 12.

1.3 The Council is committed to ensuring that HWS is created, supported and continuously developed to ensure it meets the needs of the people it is established to serve.

1.4 Essential to that commitment is the ability of the organisation to take responsibility for assessing and continuously improving its performance in partnership with a full range of stakeholders including:

- people who use the service;
- organisations that it works with in partnership or as part of local networks;
- people whose role is to scrutinise the delivery of public services; and
- people who commission the service.

2 Background

2.1 Part 5 of the Health and Social Care Act 2012[1] [2] created Healthwatch to strengthen the collective voice of users of health and social care services and members of the public both nationally and locally.

2.2 Healthwatch consists of a national body, Healthwatch England (HWE) and 152 Local Healthwatches (LHW), one for each local authority area with social services responsibilities.

2.3 HWE is a statutory committee within the Care Quality Commission (CQC). It represents members of the public and LHW organisations and provides leadership and support to LHW. It can make recommendations to local authorities and give written notice if it is of the view that patient and public involvement activities are not being properly carried out in its area.

2.4 LHW is at the heart of the government's ambition for a health and care service that centres on patients and service users. It will have additional powers to those currently held by Local Involvement Networks (LINks) which it will replace.

2.5 Through its membership of the Health and Wellbeing Board, LHW will have more influence at the decision-making table, helping to hardwire public engagement into the strategic planning

[1] . The Act: http://www.legislation.gov.uk/ukpga/2012/7/part/5/chapter/1/crossheading/local-healthwatch-organisations/enacted

[2] Get in on the Act: http://www.local.gov.uk/c/document_library/get_file?uuid=81914af4-5de6-4ccb-93e2-3764523dd8b0&groupId=10171

of health and social care services from the start. It will also contribute to the development of the Joint Strategic Needs Assessment and the Joint health and Wellbeing Strategy for the City's population.

2.6 LHW will also support individuals by providing information, signposting and advice about access to services and to help people to make choices about the type of treatment and care they receive within the choices that are available to them. Along with other initiatives such as personal health budgets and the Expert Patient Programme the Government hopes this will enable people to take more control of their own health, treatment and care and understand and use the increased choices that become available to them.

2.7 Each LHW will be a 'body corporate'[3] (i.e. a legal entity) which is a social enterprise[4] able to employ its own staff and involve volunteers, so that it can become an influential and effective voice of the public in relation to health and social care.

2.8 Statutory powers and duties of each LHW, which enable them to carry out their Relevant Activities, are:

i) be representative of local people, representing the diversity of the community it serves and different users of services including children and young people [5] [6];

ii) have powers to request information from commissioners and providers of health and social care and a right to a reply within a specific time period;

iii) have the power to enter and view premises providing publicly-funded adult health and care services as part of its role in gathering evidence;

iv) signpost people to information about local health and care services and how to access them;

v) provide people with information about what they can do when things go wrong or if they have a complaint and providing independent advocacy to individuals who want to complain about the National Health Service (NHS) services (some local authorities may be commissioning the advocacy service as a separate service but Southampton is commissioning so that it is provided within this specification);

vi) be able to alert HWE, or the CQC where appropriate, to specific care providers, health or social care matters;

vii) have a role in ensuring the NHS's Equality Delivery System is met by local health providers;

viii) to comment on the Council's Local Account and the Quality Accounts of any health provider who has their headquarters within the city's administrative boundary;

ix) have a seat on the local statutory Health and Wellbeing Board[7]; and

x) have a duty to produce an annual report on their activities and finance and send a copy of their annual reports to the NHS Commissioning Board, relevant Clinical

[3] Governance: http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3735761/PUBLICATION-TEMPLATE

[4] Social enterprises: http://www.bis.gov.uk/assets/biscore/business-law/docs/g/11-1400-guide-legal-forms-for-social-enterprise.pdf

[5] Engaging with local people: http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3776878/PUBLICATION-TEMPLATE

[6] Engaging with children and young people: http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3776832/PUBLICATION-TEMPLATE

[7] Working with health and wellbeing boards: http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3734250/PUBLICATION-TEMPLATE

Commissioning Groups (CCG'S) and HWE among others specified in previous legislation.

2.9 Over recent years, Southampton LINk has undertaken a wide range of public and patient involvement activities to enable HWS to build on the knowledge and experience of the LINk. a legacy resource has been developed, summarising the activities and outcomes of the LINk. This will be made available to the Service Provider.

3 Context

3.1 Southampton is a major south coast city with a population of 237,470. It is an international port city with a diverse population. The overall health of the population in the city has improved greatly over the past 50 years. Yet in the wealthiest part of Southampton, in Bassett, a man can expect to live to 80.6 and women 84.0 years, while a few kilometres away in Bitterne, one of the cities poorer wards, male life expectancy is 75.3 and female 79.9 years. These differences in life expectancy of 5.3 and 4.1 years respectively for men and women are significant enough not to be a coincidence. Dramatic health inequalities are still a dominant feature of health in Southampton.

3.2 The profile of the City's population differs from the national average because of large number of students; over 17% of Southampton's population is aged between 18 and 24 years compared to just 9.5% nationally.

3.3 Southampton is a diverse City; in 2007 it was estimated that 17.3% of residents were of an ethnic group other than White British compared to 16.4% nationally. This is a higher proportion than in most of the Cities considered 'most similar' to Southampton. The annual school census in the City in 2010 revealed that 26.4% of pupils were from an ethnic group other than White British. In 2009/10 32% of live births in Southampton (where ethnicity was known) were non-White British or Irish. Looking at trends in ethnicity of live births, it is the other White background which has risen most significantly in recent years; rising from 8% on 2006/07 to 12% in 2009/10.

3.4 Those children under 5 years proportionately use the NHS more than other children. Growth in this group has particularly impacted on maternity and paediatric care and health visitor services. A quarter of all paediatric non-elective admissions are for those children under 4 years of age. Typically a GP sees each pre-school child six times a year and school aged children two or three times.

3.5 The number of pupils whose first language is not English has risen from 8.4% in 2007 to 12.7% in 2010 with 54 languages other than English spoken in city schools. In 2007 there were 427 pupils whose first language was Polish by 2010 this had risen to 902.

4 Vision of the Service

4.1 The vision for HWS is that it will be respected as a professional, independent consumer and public champion for health and social care, operating within a sound governance framework and is seen to be transparent, accountable and autonomous, with roles and responsibilities clearly defined.

5 Aims of the Service

5.1 The aims of HWS are that it will:

i) be representative of the diverse communities living in Southampton, including young people, and provide, through intelligence, a real opportunity for people to influence the future policy, planning, commissioning and delivery of publicly-funded health and social care;

ii) provide a high quality information and signposting service to help people access and make choices about services as well as provide a professional, person centred, independent complaints advocacy service to support people if they need help to complain about NHS services; and

iii) be a robust and credible player in the local health and social care economy by demonstrating that it has the appropriate level of skills and competencies required to deliver its statutory functions to the highest possible level. It will gain the trust of the general public as well as other health and social care stakeholder groups by being responsive and acting on concerns when things go wrong. It will operate effectively and efficiently so that the local authority can demonstrate value for money against an agreed set of outcomes.

6 Strategic Objectives of the Service

6.1 Gather views and understand the experiences of all who use services, their carers and the wider community.

6.2 Make people's views known, including those from excluded and under represented communities.

6.3 Promote and enable the involvement of people in the commissioning and provision of local health and social care services and how they are monitored.

6.4 Respond speedily and effectively to local developments in health and social care systems, undertaking specific pieces of work to capture and express the views of local people on changes in services levels and locations, and other major developments.

6.5 Provide non clinical advice, signposting and information to all Service Users about access to services and support in making informed choices.

6.6 Connect to, but not duplicate the activities of other engagement, signposting and information services, developing a 'network of networks'.

6.7 Work at a community, city-wide and regional level.

6.8 Provide a professional independent NHS Complaints Advocacy (NHSCA) service.

6.9 Develop effective roles for volunteers to contribute to outcomes.

6.10 Be a respected member of the Health and Wellbeing Board, Health Overview and Scrutiny Committee and Southampton's CCG[8].

6.11 Play an integral role in the preparation of the statutory Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategy on which local commissioning decisions will be based.

6.12 Recommend investigation or special review of provider services, either via HWE, or directly to the CQC.

6.13 Through its annual report, make the views and experiences of people known to HWE and provide a steer to help it carry out its role as national champion on behalf of the Secretary of State and of Parliament.

7 Scope of Service

7.1 HWS as an independent corporate body will establish an effective operating model to deliver four interrelated Services as listed below. Services will operate at a local, regional and / or national level as appropriate.

7.1.1 Community Research and Engagement

Reference strategic objectives 6.1, 6.3, 6.6, 6.7 and 6.9

7.1.1.1 Obtain and record the views of people about their needs for, and experiences of, local services.

7.1.1.2 Promote and support the active engagement of local people in the commissioning, provision and monitoring of local health care and social care services.

7.1.1.3 Recruit individuals and organisations to become members of HWS and provide regular membership 'news'.

7.1.1.4 Support and train volunteers to contribute to the work of HWS, including the appropriate use of enter and view powers.

7.1.1.5 Promote HWS to members of the public and statutory and voluntary organisations.

7.1.1.6 Work collaboratively with other organisations and develop a 'network of networks' to enhance the delivery of Services.

7.1.2 Evidence, Insight and Influence

Reference strategic objectives 6.2, 6.4, 6.9, 6.10, 6.11, 6.12 and 6.13

7.1.2.1 Develop and maintain effective systems and processes, including research and analysis capability, to establish evidence, provide reports and make recommendations about how health and social care services could or should be improved.

7.1.2.2 Use HWS's statutory powers to gain and give information as and when appropriate.

[8] Working with CCGs and GP practices: http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10171/3776652/PUBLICATION-TEMPLATE

7.1.2.3 Contribute professionally to HWB meetings and other Boards when invited to do so or as appropriate.

7.1.2.4 Comment on the Councils Local Account and Quality Accounts of relevant health services.

7.1.2.5 Inform the Joint Strategic Needs Assessment, Health and Well being Strategy and providers and commissioners of services of HWS's research findings.

7.1.2.6 Send HWS's Annual Report to Healthwatch England.

7.1.2.7 Represent the collective views of people, gathered through research, through a variety of mediums.

7.1.3 <u>Information and Signposting</u>

Reference Strategic Objectives 6.5, 6.6, 6.7 and 6.9,

7.1.3.1 Provide information and non-clinical advice to the public about health and social care services, including how to access them.

7.1.3.2 Signpost people to information not held by HWS through an established network of other organisations.

7.1.3.3 Enable people to exercise choice in which services they choose as their provider.

7.1.4 <u>NHS Complaints Advocacy (NHSCA)</u>

Reference strategic objective 6.8

7.1.4.1 NHSCA is a client centred, flexible service which empowers anyone who wishes to resolve a complaint about healthcare commissioned and/or provided by the NHS in England.

7.1.4.2 To use HWS's NHSCA, complainants have to be: a resident of Southampton (complaining about a service anywhere within England); or a resident of another local authority complaining about an NHS service delivered within Southampton.

7.1.4.3 Examples of complaints NHSCA can look into include:

i) failure to provide a service;
ii) receiving the wrong or poor treatment;
iii) delay that could have been avoided;
iv) faulty procedures, or failing to follow correct procedures;
v) rudeness and not apologising for mistakes;
vi) not putting things right when something has gone wrong.
vii) a lack of choice[9]

7.1.4.4 NHSCA can not look into complaints about government policy or legislation. Other area where there may be no legal power to provide Services are staff, commercial and contractual issues.

[9] The NHS Constitution specifies that: *"You have the right to choose the organisation that provides your NHS care when you are referred for your first outpatient appointment with a service led by a consultant."* There are certain exceptions to this but any NHS organisation failing to provide a choice could be subject to a complaint on that basis

8 Requirements of the Service

8.1 The requirements of Healthwatch Southampton are shown below.

8.1.1 <u>General requirements – across all service elements:</u>

8.1.1.1 Clear lines of representation and accountability, with community representatives integral to its leadership.

8.1.1.2 Build on existing successes with a managed transition from the existing LINk, any relevant PCT PALS activity and the existing ICAS arrangements.

8.1.1.3 Migrate appropriate information and data from existing LINks

8.1.1.4 Efficient and effective use of resources which are focussed on the delivery of high quality Services through the development of clear financial plans.

8.1.1.5 Led by people with the appropriate skills, knowledge and professional experience.

8.1.1.6 Utilise existing access points, skills and expertise particularly within the voluntary and community sector to exercise its statutory duties within Southampton.

8.1.1.7 Train staff and volunteers to a standard that they can carry out any statutory powers and duties, and in particular 'Enter and View and advocacy Services'[10].

8.1.1.8 All enquires, including NHSCA, will have an initial reply within two Working Days of receipt of the enquiry.

8.1.1.9 Collaborate with existing systems and organisations to avoid duplication where possible.

8.1.1.10 Provide access to all HWS Services through a range of accessible routes including social media, internet, telephone and face-to-face, and may include home visits or appropriate secure settings.

8.1.1.11 Clear decision making processes for assessing information and data and prioritising actions and work programmes to utilise resources effectively and appropriately.

8.1.1.12 HWS will provide the facility for people living in Southampton to become members of HWS. Members of HWS will be kept informed of HWS activities, have the opportunity to volunteer to participate in HWS activities (subject to appropriate checks and training) and become involved in the governance of HWS.

8.1.2 <u>Community Research and Engagement</u>

8.1.2.1 Link across the community through partnerships, HWS will actively promote itself to the local population to ensure inclusivity and draw on existing expertise and best practice.

8.1.2.2 Stakeholders, including the public, will understand the value of HWS and seek to utilise its expertise as appropriate.

8.1.2.3 Accessible within local communities: engaging with people through their experiences of / interest in local health and social care services or in particular topics or pathways.

8.1.2.4 Work in collaboration with other Local Healthwatch organisations, regionally and nationally.

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[10] Get in on the Act: http://www.local.gov.uk/c/document_library/get_file?uuid=81914af4-5de6-4ccb-93e2-3764523dd8b0&groupId=10171

8.1.2.5 Have a proven track record in ensuring and enabling community engagement methods and techniques.

8.1.3 Evidence, Insight and Influence

8.1.3.1 A well developed and regularly reviewed knowledge of the local health and social care landscape and infrastructure including how and where decisions are made.

8.1.3.2 Provide evidence and insight to influence improvement in commissioning and service provision locally, and where appropriate regionally and nationally.

8.1.3.3 Develop systematic methods, with the use of appropriate IT systems, of gathering and assimilating views, data and feedback from local, regional and national sources, where information exists and identify gaps.

8.1.3.4 Inform relevant organisations that gaps in their information exist and influence the development of appropriate information.

8.1.3.5 Develop clear processes to ensure high quality monitoring of health and social care services e.g. Enter and View of hospitals, care homes etc..

8.1.3.6 Provide professional and consistent representation on the Health and Wellbeing Board and other organisations and partnerships, particularly the CCG and Health Scrutiny Panel where invited to do so.

8.1.4 Information and Advice

8.1.4.1 Display a solid understanding of health and social care in the context of the wider determinants of health including housing, employment, education and domestic finance, for children, young people, family and all adult services.

8.1.4.2 Although independent HWS will work with local statutory and voluntary organisations, and where appropriate regional and national organisations, to identify what information already exists and how best to access it and present it to the public.

8.1.4.3 Provide a range of high quality health and social care information and non-clinical advice in accessible formats about service providers and health and social care professionals, including information about quality and performance, waiting times and feedback from other patients.

8.1.5 NHSCA

8.1.5.1 From April 2013 NHSCA remains free at the point of need, but will be a statutory responsibility of Local Authorities. It is a client centred, flexible service which empowers anyone who wishes to resolve a complaint about healthcare commissioned and/or provided by the NHS in England.

8.1.5.2 The NHSCA service telephone line has to be accessible to the public on the 1st April 2013, staffed for 5 days a week 9am to 5pm, with an answer phone at all other times.

8.1.5.3 In this section, “NHSCA” means Services providing assistance (by way of representation or otherwise) to persons making or intending to make a:

- complaint under a procedure operated by a health service body or NHS funded independent provider;

- complaint under section 113(1) or (2) of the Health and Social Care (Community Health and Standards) Act 2003;
- complaint to the Health Service Commissioner for England;
- complaint to the Public Services Ombudsman for Wales which relates to a Welsh health body;
- complaint under section 73C(1) of the National Health Service Act 2006;
- complaint to a Local Commissioner under Part 3 of the Local Government Act 1974 about a matter which could be the subject of a complaint under section 73C(1) of the National Health Service Act 2006; or
- complaint of such description as the Secretary of State may by regulations prescribe which relates to the provision of services as part of the health service and is made under a procedure of a description prescribed in the regulations, or gives rise, or may give rise, to proceedings of a description prescribed in the regulations.

8.1.5.4 NHSCA

- helps safeguard the rights of clients as set out in both health policy and law;
- empowers clients to self advocate as far as they are able;
- supports clients to get their views heard;
- supports clients in seeking resolution to issues which concern them;
- signposts to external advocacy support for clients wishing to complain against NHSCA provision; and
- uses client experiences to inform service development in the NHS

8.1.5.5 Advocates should have access to professional medico-legal support where appropriate.

8.1.5.6 Advocates should have access to personal external counselling.

8.1.5.7 A relationship with the client focuses on contact (via phone, email or face-to-face) at each of the following points or activities in the NHS complaints procedure:

- identifying what the available options and possible outcomes are, and deciding which option to take;
- making the complaint to the appropriate Trust(s), or GP(s), etc.;
- deciding how to proceed with the complaint, following the Trust's initial response;
- supporting clients during the local resolution phase by attending meetings or entering into correspondence;
- making a complaint to the CQC;
- supporting the Independent Review stage by attending meetings or entering into correspondence;
- making a complaint to the Health Service Ombudsman; and
- understanding the Health Service Ombudsman's final decision.

8.1.5.8 NHSCA will also support clients with a grievance related to any aspect of healthcare that falls under the jurisdiction of the Health Service Ombudsman, such as complaints about poor treatment, or service, provided through the NHS in England. The Ombudsman looks into complaints against NHS services provided by hospitals, health authorities, trusts, GPs, dentists, pharmacists, opticians and other health care practitioners. The Ombudsman can also investigate complaints against private health providers if the treatment was funded by the NHS. (For more information on the work of the Ombudsman, please go to www.ombudsman.org.uk)

8.1.5.9 Whilst the NHSCA does not provide on-going advocacy for clients outside of the health related complaint it will suggest appropriate referrals for clients who require alternative,

additional or specialist support, including referrals to PALS (where appropriate), professional bodies such as the General Medical Council, and to specialist support such as medico-legal advice, bereavement support, mental health support, etc.

8.1.5.10 NHSCA advocates must ensure that clients understand:

- the service is independent of the NHS and treats all interactions between clients as confidential, in line with HWS's confidentiality policy;
- what they can expect from the service and what the service expects from the client, through the early completion of the client/service contract when appropriate;
- limits of what NHSCA can achieve;
- what they can expect from the NHS complaints procedure and where other advocacy/support services can provide more specialist advice;
- when and how the advocacy service can be contacted;
- they can request to meet with an advocate to talk in confidence to them (except when other staff have to be present for reasons of safety or security); and
- they can make a complaint about any aspect of the NHSCA service and how to do so

8.1.5.11 NHSCA advocates must:

- only act or speak on behalf of a client if requested by the client
- discuss options with clients providing full and balanced information to enable then to make decisions and choices;
- help clients access the information they need;
- act, honestly and courteously, treating clients and NHS staff with respect;
- work within the law;
- adhere to the organisation's confidentiality policy;
- not disclose information about a client to others without consent;
- not sign anything or accept any verbal or written information that allows them to know information about a client which they cannot disclose to that client;
- not give anything away in negotiation without the consent of the client;
- not hold documents, money or valuables belonging to clients;
- not accept gifts from clients or other stakeholders; and
- ensure that accurate records are kept of all interactions with clients.
- enable clients to have access to their records

9 Location of Service

9.1 HWS will be required to operate from business premises within the City. It must provide suitable facilities for staff, volunteers and service users to include:

- work space
- telephone access
- internet access
- meeting space for consultation and group meetings
- storage for stationery and other office consumables

10 Eligibility Criteria

10.1 HWS will be accessible to anyone who is legally entitled to access health or social care services in Southampton, or anyone who cares for or represents anyone who has access to health or social care services in Southampton.

11 Referrals

11.1 The service will operate an open referral system so that service users may self-refer, or be referred by friends, family or a statutory organisation or another voluntary organisation.

12 Outcomes and Key Performance Indicators

12.1 The Council has developed a number of Outcomes and Key Performance Indicators (KPI's) and range of monitoring information required. The Service Provider's monitoring report will be in a format to be agreed with the Council and detail how each KPI has been met.

12.1.1 General requirements – across all service elements

Reference to *all* strategic objectives

	Outcome	Measure	Reported
12.1.1.1	The management committee is duly elected according to HWS's governing documents. Any management committee with volunteers will have service user representation.	*The establishment of a formal governing body which will include representation from the provider organisation and from the membership of HWS.* *Elections occur in accordance with HWS governance documents.*	*Immediately (As specified in governance documents)* *Annually or as specified in governance documents*
12.1.1.2	A joined up organisation providing a single point of contact for all agencies and partners as well as communities.	*Increase in number of partners in network and their geographical and topic coverage, with evidence of how people are using and accessing the service.*	*Quarterly*
12.1.1.3	Proactive in its inclusion of people and communities with clear evidence of systems and processes that do not exclude people by creating barriers to their involvement or engagement.	*Increase in diverse representation of communities of place and interest at all levels of the organisation mapped against local demographics from the census and public health data.*	*Quarterly*
12.1.1.4	A model of Board level decision-making that supports unbiased and evidence based prioritisation of issues.	*An audit trail that clearly demonstrates how priorities are identified, and what criteria are used, to assess those priorities against one another to determine which are taken forward by HWS.*	*Quarterly*
12.1.1.5	HWS membership increases year on year.	*Evidence of annual increase in individual and organisational membership.*	*Quarterly*

12.1.1.6	Members and clients provide feedback about their experience of HWS which is used to inform HWS service development.	*An audit trail of how comments, compliments and complaints are actively encouraged and collected and how they influence service development.*	*Annually*
12.1.1.7	Networked at a regional and national level.	*Attendance and engagement in relevant local, regional and national networks.*	*As necessary*
12.1.1.8	Services delivered in a timely fashion.	*More than 90% of enquiries answered within two Working Days.*	*Quarterly*
		Training and Skills	
12.1.1.9	Employees and volunteers given a programme of formal induction and on-going training, including to recognised professional standards where appropriate.	*Evaluated induction training provided within a month of joining HWS (volunteers and paid staff), including training in the statutory duties and functions of HWS.* *Enter and View training given to those registered to carry out this function.* *All advocates trained to a professional standard. Evaluated ongoing training programme in place to ensure all staff and employees are adequately skilled and can participate effectively when representing HWS at meetings. .*	*Initially and as necessary.* *Initially and as necessary.* *The training programme to be reviewed annually*
		Communication	
12.1.1.10	HWS is recognisable and relevant to local people with a high profile supported by the clear HWS brand and identity which makes it as easy as possible for local people to understand and know what HWS does, what it can do for them and how to access it.	*The purpose of HWS and how to access it is widely promoted.* *An increase in circulation of publicity material in new areas.*	*Quarterly* *Quarterly*
12.1.1.11	Use the Healthwatch brand identity on all publications and marketing material including when working with other Local Healthwatch organisations.	*All HWS literature has HWS branding on it.* *Established and effective relationships with neighbouring Local Healthwatches with cross-boundary working protocols in place.*	*Initially and reviewed annually.* *Initially and reviewed annually*
12.1.1.12	Accessible website, including social media routes, as well as more traditional routes for publicity, marketing and community engagement purposes.	*A current Communications Plan and Strategy in place and acted on.* *Evidence of meaningful engagement and communications through social media activity provided.* *Website meets recognised accessibility standard and other publicity is available in a range of formats when requested.*	*Initially and reviewed annually.* *Quarterly* *Initially and reviewed annually.*
		Equality and Diversity	
12.1.1.13	Services provided to excluded groups, vulnerable people and those with	*Evidence of an Equality and Diversity Policy with a process for unmet need to be continuously assessed*	*Initially and reviewed annually.*

	protected characteristics[11].	*Increase in number of members within each of the protected characteristics which are further broken down to identify specific ethnicities and disabilities.* *Increase in new NHSCA cases according to the protected characteristics*	*Quarterly* *Quarterly*
12.1.1.14	Demonstrate how HWS contributes to strategic commissioning decisions and other activities that reduce health inequalities.	*A system to continuously consider and review local health inequalities, alongside socio-economic and demographic data, with evidence of how HWS is using this information to reduce health inequalities.*	*Annually and as necessary*
12.1.1.15	The service must be delivered in a way that ensures it is accessible to all clients, respecting their confidences as needed.	*All premises and Services intended for public use to be Disability Discrimination Act compliant including, physical environments and modes of communication (e.g. audiotapes, symbols etc). Availability of an effective translation service.*	*Annually and as necessary*

12.1.2 Community Engagement and Research

Reference strategic objectives 6.1, 6.3, 6.6, 6.7 and 6.9

	Outcome	Measure	Reported
12.1.2.1	Has a well developed understanding of Southampton's' communities and the skills and methods required to engage them effectively.	*Has in place a Community Engagement Strategy And Plan which includes working with other local voluntary and community groups to access and understand local views and experiences. Evidences how these views are impacting on decision making through improved services.*	*Quarterly*
12.1.2.2	Proactively supports local people and patients, community and user groups, to become engaged in health and social care issues, using appropriate existing routes as well as HWS.	*Measured by an annual review to show awareness is continuously raised amongst professionals, communities and stakeholders who understand what HWS does and that it is bringing demonstrable improvement to peoples experiences of health and care services.*	*Annually*
12.1.2.3	Establish community engagement methods and practice to enable patients and local communities to engage in shared decision making with regard to commissioning, provision and monitoring of health and social care provider services.	*A programme of work in place specifically aimed at recruiting and training people from excluded and under-represented communities to build skills and confidence to actively participate.*	*Quarterly*
12.1.2.4	Actively obtain and present the views of those that are less well heard,	*Evidence of effective local networks that are used to facilitate access to targeted groups who are identified on an equalities impact*	*Quarterly*

11 As defined by the NHS's Equality Delivery System

	complementing and supporting existing networks and routes of engagement.	*assessment plan.*	
12.1.2.5	Leads by example and is not tokenistic in the way it engages with people.	*Others use HWS as a source of expertise on community engagement.*	*Annually*

12.1.3 <u>Evidence, Insight and Influence</u>

Reference strategic objectives 6.2, 6.4, 6.9, 6.10, 6.11, 6.12 and 6.13

	Outcome	Measure	Reported
12.1.3.1	A rigorous, recognised and respected member of the HWB.	*Active involvement on the Board and clear and transparent lines of representation and accountability to and from the HWB. Evidence through the annual review of the perceived impact of HWS on the HWB.*	*Initially and reviewed annually*
12.1.3.2	Influences commissioning and service developments through the presentation of qualitative information and evidence drawn from the experiences, feedback and views of local people.	*The use of HWS's evidence, information and reports at the HWB, within the Joint Strategic Needs Assessment and within the CCG business planning cycles.*	*Quarterly*
12.1.3.3	Reports are influential.	*Robust research governance protocols.*	*Initially and reviewed annually.*
12.1.3.4	Uses information and evidence to constructively challenge and question the commissioning plans and quality of services.	*Use its powers including right to reply letters and Enter and View, to seek information and clarification and to make reports and recommendations to support improvements and influence commissioning plans.*	*Quarterly*
12.1.3.5	Has capacity, infrastructure (Including IT) and skills to assimilate, understand and interpret different kinds of data and information.	*Presents information as evidence in the context of local health and well being data to support recommendations locally and to HWE and/or the CQC.*	*Quarterly*
12.1.3.6	Makes findings and recommendations publicly available in accessible formats and mediums.	*Findings and recommendations are published and presented in plain English with a clear review process in place and a process for stakeholders to influence and improve future data and publications.*	*Quarterly*
12.1.3.7	Continuously learns from the health and social care experiences of local people ensuring changes and improvements are made as a result.	*Has in place an information sharing protocol to ensure summary evidence and data is passed from the NHSCA function or provider and other relevant organisations about themes. With evidence to show how this information is being used to influence decision makers.*	*Quarterly*

12.1.4 Information and Advice

Reference Strategic Objectives 6.5, 6.6, 6.7 and 6.9

	Outcome	Measure	Reported
12.1.4.1	Actively seeks information that is requested and not already available through HWS.	*Record of types of enquiries made and summary of outcomes.*	*Quarterly*
12.1.4.2	Links to other sources of advice and information at a local, regional and national level.	*Range of material from other organisations available to the public or for use in research.*	*Quarterly*
12.1.4.3	Knowledge of the latest information and news	*Knows where to direct people, with capacity and systems in place to provide and publish up to date local, regional and national data and information.*	*Quarterly*
12.1.4.4	People are empowered to make informed choices.	*Feedback through customer satisfaction surveys.*	*Quarterly*

12.1.5 NHS Advocacy Service

Reference strategic objective 6.8

	Outcome	Measure	Reported
12.1.5.1	A safe transition and handover of 'live cases' from any existing providers of ICAS,	*Existing clients fully understand any changes and are protected through the process of transition to ensure that appropriate knowledge is passed on ensuring that a continuation of quality and consistency of support is experienced by the client.*	*Immediately*
12.1.5.2	Successful completion of cases and client satisfaction achieved	*All who wish to be are supported in pursuing a complaint against the NHS* *% of successfully completed cases in each period.* *% with "good" or "excellent" written in the customer feedback forms.* *10% of all cases will be reviewed – the council reserve the right to make random checks*	*Quarterly* *Quarterly* *Quarterly* *Quarterly*
12.1.5.3	Advocates must ensure that clients understand the service.	*Published prospectus outlining the NHS Complaints Advocacy service.*	*Initially and then annually*
12.1.5.4	Collects and reports anonymised data to develop evidence based themes.	*A report which summarises areas of complaint activity.*	*Initially and as necessary*

13 Transition Arrangements

13.1 Southampton City Council wishes to support a managed transition to HWS from existing services and will support with The Service Provider to help achieve this aim.

13.2 The council will work with The Service Provider to develop outcomes and key performance indicators (contained in Section 12), including agreement on reporting timetables and requirements.

13.3 Monthly Transition Meetings will be held between The Service Provider and the City Council for the first six months of the contract.

13.4 An exercise to capture S-LINk's legacy over the past four years has been conducted by S-LINk and The Service Provider will work with the previous Steering Group to implement agreed recommendations.

14 Glossary

The following terms shall have the following meanings:

CCG	Clinical Commissioning Group	**LHW**	Local Healthwatch
CQC	Care Quality Commission	**LINk**	Local Involvement Network
GP	General Practitioner	**NHS**	National Health Service
HWB	Health and Wellbeing Board	**NHSCA**	NHS Complaints Advocacy
HWE	Healthwatch England	**PCT**	Primary Care Trust
HWS	Healthwatch Southampton	**PALS**	Patient Advice & Liaison Service
ICAS	Independent Complaints Advocacy		
IT	Information Technology		
KPI	Key Performance Indicator		

DECISION-MAKER:		HEALTH OVERVIEW SCRUTINY PANEL		
SUBJECT:		GP SERVICES PORTSWOOD		
DATE OF DECISION:		18 JULY 2013		
REPORT OF:		DIRECTOR OF COMMISSIONING, NHS ENGLAND		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Julie Bagshaw**	**Tel:**	02380 725663
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STATEMENT OF CONFIDENTIALITY

BRIEF SUMMARY

This report outlines the issue, options considered and recommended for replacing GP services in Portswood, following notification received for one of the GP's wishing to terminate their contract to retire. Simon Jupp, Director of Commissioning NHS England will give an update to the Panel on progress to date to explore extending current GP contracts in Portswood.

RECOMMENDATIONS:

(i) That the Panel notes the issue for GPs in Portswood, the options considered and recommendation taken forward by NHS England.

(ii)

REASONS FOR REPORT RECOMMENDATIONS

1. As part of the HOSP's terms of reference the panel has a role to respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision.

2.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None

DETAIL (Including consultation carried out)

4. There are a number of sole practitioner or small practices in the Portswood area each holding varying list sizes of between 2100 and 3500 patients. It has long been identified that this is an area where problems could arise should one of the practitioners resign or retire form providing Primary Medical Services id this impacted on the other practices. Whilst efforts have

been made by Southampton City PCT, Southampton City CCG and the Area Team to facilitate federating the practices, no successful management plan has been forthcoming from the contractors themselves. None of the small practices are keen or able to take on further patients, therefore, should one practitioner retire out of the contract without a successor, the remaining practices have indicated they would also resign to avoid further work pressure. This would leave the Portswood area without continuing primary medical care. A majority of the GPs are nearing retirement age or suffer ill health leading to a desire to retire.

5. The Primary Care Commissioning team received notification at the end of March from Drs P & C Thomas, at Portswood Road Surgery, that they wish to terminate their GMS Contract and have given 6 months' notice. This will take effect from 30 September 2013.

6. The Area Team has had a number of discussions with practices, the CCG, and other local providers to inform the development of this paper, which uses a standard template published by NHS England for evaluation of options on practice closure.

7. There are six practices within the Portswood area:

Practice	Name of GP	Number of Patients	No GPs	Type of Contract
Portswood Road	Dr Thomas	2100	1 + p/t salaried	GMS
St Denys Practice	Dr Dickson	2828	1 + p/t salaried	GMS
Linfield Surgery	Dr Gallagher	3503	1 + 2 p/t salaried	GMS
Mulberry House	Dr Amarpala	3058	1 + p/t salaried	GMS
Highfield Health	Dr Low	4180	3	GMS
Alma Medical Centre	Dr Ord-Hume	9920	6	GMS

8. Southampton PCT had plans to develop a single site primary care hub as part of the new Sainsburys development on the site of the old bus depot, to house the Portswood Road, St Denys Practice, Linfield Surgery and Mulberry House practices. For a variety of reasons this did not take effect, partly due to the practices not engaging in the process and appreciating the wider strategic direction for general practice, leading to unwillingness to share back office functions/accommodation therefore creating a high cost development that became unaffordable. No other solution to the pressure experienced by the practices has been put forward by them.

9. Portswood Road Surgery (Drs Thomas) have requested to terminate their contract which takes effect 30 September 2013.

10. Dr Gallagher (Linfield House) became ill last year and whilst he has returned to work, he wishes to retire in the near future. He has two salaried GPs who have both handed in their notice which will take effect in the beginning of August. It is unsustainable for Dr Gallagher to continue to provide services in the medium term. Dr Gallagher currently provides the Violent Patient Scheme for patients within the city and beyond who have been removed form lists due to violent or threatening behaviour. He also manages a number of patients who have addictions to drugs and / or alcohol. It is anticipated following discussion with him that Dr Gallagher will tender his resignation during the summer, as a single handed contractor he is required to give only 3 month notice to terminate his contract. (NOTE DR Gallagher submitted resignation after preparation of this paper)

11. The St Denys Practice (Dr Dickson) and Mulberry House (Dr Amarapala) are in discussion to put forward a proposal to merge their contracts. They have shared their finances with each other with the long term aim to consolidate onto the St Denys Practice site and expand within the surgery to accommodate additional GPs. They do not feel in a position to expand further in the short to medium term.

12. It has been established that the Sainsbury's development can no longer accommodate the GP surgery. There is however a building next door which is being sublet. Details of these have been sought by NHS property services to inform any longer term plans for the area.

13. Since the inception of the NHS Plan in the 1990's, there has been a strategic direction to have bigger practices with populations of 20,000+, housed in large premises covering a large geographical area. Whilst this intent has been upheld it is generally accepted that PCTs have been unable to force this issue as it is for the GPs to grow into expansion as independent contractors and could only be influenced by PCTs or achieved through consensus. LIFT projects have aimed to secure premises for the purpose of housing a number of GP practices, but rarely have the GPs themselves engaged in sharing back office functions to drive efficiency and consistency. The changing nature of General Practice does not lend itself easily to sole practitioners and the Local Medical Committee is supportive of practice mergers and not of perpetuating the present small practice. Helen Parker in her internet blog for the Nuffield Trust (www.nuffieldtrust.org.uk/blog/) on May 23rd 2013 said:

    From discussions with GPs and policy makers, there appears to be some consensus that the current 'small scale' organisational model of general practice has served us well for the last 60 years or so, but health care needs have now outgrown it and larger scale models of provision are likely to be required. Additionally, there is a pressing need to ensure that general practice is an attractive career option, if we are not to witness our high quality primary care workforce crumble over the next few years.
    We therefore need to work out how to keep what is valued highly by patients about 'small scale' practice, such as continuity of care and identity with a local practice. At the same time, work needs to be done to examine organisational models that ensure the sustainability of the general practice business model, facilitate scope for extended primary care provision and development, support integrated care, and create attractive career paths for clinicians.

14. There were four options considered by NHS England, outlined in more detail in Appendix 1.

Option 1: Dispersal of Patients

Option 2: Short term contract in order to complete consultation and procurement process

Option 3: Procurement of stand alone practice

Option 4: Extension of current contract to provide branch surgery

15. The primary care commissioning team recommended that Option 4 be considered and approved by their Executive Team (Wessex). Authority was given to explore extending current contracts to cover services to patients in Portswood and delivery from one or more local premises.

16. Option 4 engages with a provider that is willing to take on the current patients in one or more of the existing premises and expand one of them to accommodate all of the patients in due course onto one site. The intention is to retain all of the local services including the violent, drug and alcohol patients and ensure most importantly provide stability within the locality.

17. The services will be retained within the locality as a 'branch' of an existing local provider who can provide the clinical leadership and financial stability to enable the strategic position of having a smaller number of larger more sustainable services within the Portswood area to be reached.

18. No local practices within the immediate neighbourhood or adjacent wards have indicated at CCG locality meetings or meetings with AT staff any interest in being involved in this solution. Providers in the adjacent ward have expressed interest in developing this option with us. Either party could consolidate its current contracts to work under one contract covering all surgery outlets it holds instead of the several it currently holds.

19. **Advantages of option 4**

1) Meets the strategic direction of having fewer small practices.
2) Ensures stability within the locality
3) Clinical leadership within the practice and improve patient outcomes and care
4) Financial stability across the locality
5) Ensuring choice for patients by having larger more stable practices

20. **Disadvantages op option 4**

1) Difficulty in engaging with a local provider
2) Ensuring that an agreeable financial settlement can be made across a number of practice contracts held by the provider
3) Ensuring that the provider can engage with the local community to improve patient care
4) Ensuring good clinical leadership
5) Has not allowed for formal competition*, however recent offers to the market of practice in Portsmouth has shown only one local practice interest at an affordable level. Offer of 2 year temporary contract in Southampton city secured only two proposals. The market seems therefore to have flattened with the current uncertainty and lack of morale in general practice.

**post drafting note: all practices in Southampton with overlapping or adjacent lists are being invited to express interest.*

21. It is recognised that patient engagement about service change is required. Any proposal to relocate services from Portswood Road the short distance to Linfield surgery for example to or any other local premises will need to be shared with HOSC if approved. The regional communication team have been alerted that their support will be required. They will encourage the new provider to work with patients to understand what they have valued about previous services, what they would like to retain and what they would like to see change so that can inform the provider's planning. They have explored if previous work on patient experience in the area is available to inform our options and have examined GP survey data which does not contain significant findings for improvement.

22. The opportunity for the locality to have established its own solution to this problem has not been forthcoming. Linked with the inability to force smaller practices to merge has inevitably resulted in the current situation whereby, when a small practice resigns from providing primary medical services it destabilises the local GP community with the remaining practices threaten to follow suit.

23. Of the four options explored, one will definitely destabilise the current practices, and any procurement is not easily achievable within the timescale now available. Even if successful, this goes against the grain of the strategic intent in re-procuring very small services and inevitably destabilises the patients.

24. The fourth option is the most appropriate within the context that the Area Team is faced with at present. A willing provider has been identified with experience of providing services in immediately adjacent localities and to challenging populations and other practices could be invited to express interest.

25. The panel are asked to note the issues, options and progress to date in replacing GP services in Portswood and consider if any issues need to be brought forward to a future HOSP meeting.

RESOURCE IMPLICATIONS

Capital/Revenue

26. None

Property/Other

27. None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

28. Not applicable

Other Legal Implications:

29. None

POLICY FRAMEWORK IMPLICATIONS

30. None

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	Portswood

SUPPORTING DOCUMENTATION

Appendices

1.	GP Surgeries, Portswood – options considered

Documents In Members' Rooms

1.	
2.	

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	Yes/No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.		
2.		

APPENDIX 1

OPTIONS FOR REPLACING GP SERVICES IN PORTSWOOD, SOUTHAMPTON.

Criteria for option appraisal

The Area Team should continue to support the strategic direction to have fewer but larger practices and maximise the opportunity to merge lists when they arise to move towards a transformation of general practice provision. Criteria derived from this strategic direction to inform selection of a preferred option to ensure access to high quality local primary care services for people in Portswood are:

- Services to be provided within the Portswood locality
- Registered lists to be at a large enough scale to ensure financial sustainability for providers
- Practices to be sufficiently large to ensure that there are more than two GPs working together in a provider service to ensure robust clinical governance.
- Services to be located to ensure that there is a choice of GP practice for patients within the area
- Practices to be large enough to offer support to new GPs and to encourage career development
- Provider to have experience of providing services to challenging patient groups, preferably as part of the locality health system.

Options Appraisal

Whilst this document focusses on the replacement of the Portswood road practice the imminent vacancy of the Linfield practice has influenced some of the option development. The opportunity to work with Dr Gallagher to plan his retirement to enable creation of a larger but still below national average list size should be pursued.

The options considered are;

1) Disperse the patients to the neighbouring practices
2) Short term stand alone contract to enable securing a longer term solution
3) Reprocure stand alone service to accommodate the current list
4) Extension to a current contract to provide a branch surgery

Option 1: Dispersal of Patients

Issues for Consideration	**Comments**
Current list size	2113
Local Capacity	There are 5 GP practices very close by with 3 Pharmacies along the same road as the surgery with another 5 pharmacies within half a mile to Portswood Road Surgery. None of the practices are operating a closed list.

Geographical Location	Drs P L Thomas & C A Thomas NB C is Linfield Surgery
Impact on other primary care providers	Dr Gallagher has indicated he will resign rather than accept dispersed patients. Dr Dickson has threatened to resign rather than accept dispersed patients
Premises Ownership	There is currently no lease at this practice. Premises and no commitment to occupation.
Practice employed staff	All the employed staff will be made redundant by their employer.
Value for Money	Dispersed patients would attract global sum payments at the GMS standard rate. (£66.25) Portswood road has had higher MPIG than neighbouring practices and this would not transfer. Premises costs savings would be made.
Deprivation Factors	Portswood is an area on the edge of the city centre which has high numbers of young adults (students) and 4% over 85s. 2% of the population live in communal households.
Population make up(practice)	As at 1 January 2013 this was 2,107 with a breakdown of ages as: 0-19 = 270 20 – 69 = 1449 70 – 85 plus = 388
Specific Specialised Services Currently Commissioned (Enhanced Services)	Local Enhanced Services which have now transferred to the CCG and Public Health as commissioners: • Anti-Coagulation • Near Patient Testing • Phlebotomy • Basket of Procedures • Complex Care Management • NHS Health Checks • The practice does not provide extended opening hours or health checks for those with learning disability. They provide low levels of long acting reversible contraception in house. All of the practices in the locality of this practice offer more Enhanced Services than those offered at Portswood Road Surgery.
Viability Option	No
Why?	There is insufficient clinical capacity and willingness to effectively disperse 2000 patient to other local practices large numbers of patients may destabilise current practice provision.

Option 2: Short term contract in order to complete consultation and procurement process

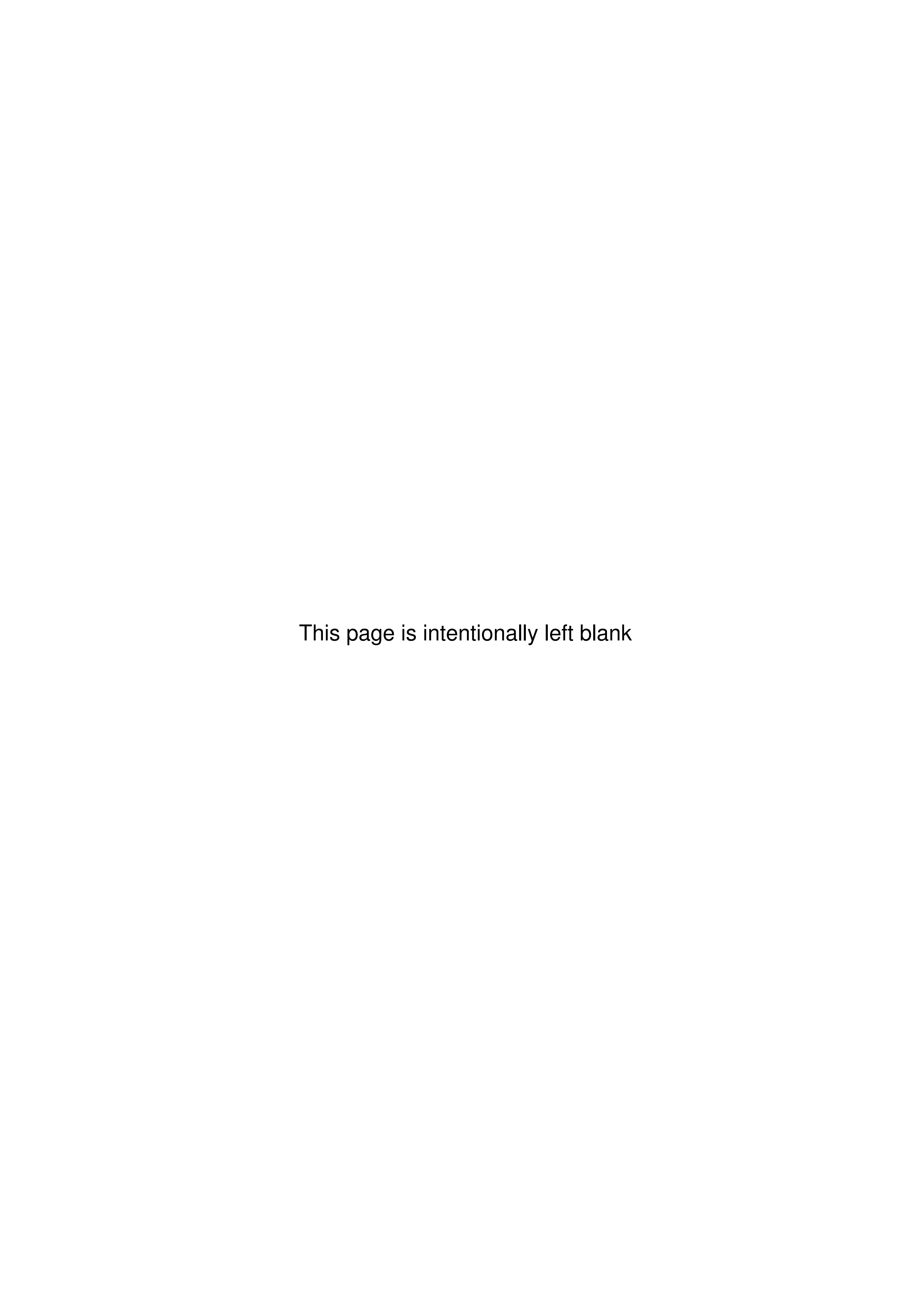
Issues for Consideration	**Comments**
Current list size	2113
Current practice capacity	The current practice premises will not be available to facilitate this option. The practice currently operates as a single WTE GP and is not an attractive financial proposition.
Premises Ownership	The lease term with the landlord will be terminated to coincide with the contract closure. The termination note has not yet been actioned. Security of tenure has been provided as long as Dr Thomas continues to honour the lease and rental payments.
Value for Money	Because of the short term nature of the offer a provider may require enhanced payments to accept transformation and quality risks.
Population make up	The current registered patients are 0-19 year old = 270 20 – 69 years old = 1449 70 – 85 years old plus = 388
Enhanced Services	Local Enhanced Services which have now transferred to the CCG and Public Health • Anti-Coagulation • Near Patient Testing • Phlebotomy • Basket of Procedures • Complex Care Management • NHS Health Checks A new provider could introduce further enhanced services not currently provided.
TUPE	Is likely to apply transferring risk of employment to a temporary provider.
NHS CB processes throughout arrangements	Engage with local practices to enquire if any of them wish to take on a short term contract ie APMS 1 year while the Area Team look at the future of this practice. Recent experience showed a very low level of market interest in a short term offer, with two years being minimum and 5 years being optimal. A short term lease for suitable property would be needed if it could be sourced with higher lease costs, fit out etc.
Viability of Option	Low ,
Preferred Option Why?	No, market disinterest, financial sustainability, clinical governance and patient safety/quality from perpetuating stand alone small list. Employment risks prevent small practices showing interest. Lack of premises to deliver service

Option 3: Procurement of stand alone practice

Issues for Consideration	**Comments**
Ability to grow the list	The list size has remained static for the last few years, there is competition from the number of practices in the area, at its current size it does not offer financial sustainability for a provider.
Nature of Contract	APMS – 5 year duration (with possibly option to extend to improve continuity)
Geographical Location Impact on other primary care providers	The new service will need to secure premises to cover the same patient population and will need to stay within the locality Pharmacies are within easy reach of the current practice. During procurement patients may prefer to register with a local GP rather than wait for an unknown new provider thus placing pressure on adjacent lists.
Premises	Current may not be available and are in any case unsuitable and non compliant with DDA. New premises could not be sourced and fitted within 3 months.
Value for Money	There is a risk that procurement for APMS produces higher cost services than GMS or PMS options, especially for small units where fixed staff costs are high. Capacity for and cost of running full market procurement for small services with limited local market is issue.
TUPE	A number of staff will need to be TUPE'd to the new organisation and may impact on bid costs. New provider must be able to provide GAD approved pensions for any staff in the NHS pension scheme or be entitled to offer NHS pensions.
Population Makeup	The current registered patients are 0-19 year old = 270 20 – 69 years old = 1449 70 – 85 years old plus = 388
Viability of Option	No, there is insufficient time to achieve and mobilise a full market tender within the notice periods that GPs are required to give.
Why?	Lack of fit with strategic direction to increase size of practice for clinical safety quality and financial sustainability. Market disinterest in small units due to high fixed cost and low profitability.

Option 4: Extension of current contract to provide branch surgery

Issues for Consideration	Comments
Ability to grow the list	A larger practice with 'service delivery points' across the city may attract patients and provide resilience for any population growth within the immediate city areas.
Nature of Contract	APMS – 5 year duration (with possibly option to extend to improve continuity)
Geographical Location Impact on other primary care providers	Service via branch surgery to be retained within Portswood. Pharmacies are within easy reach of the current practice. Less risk of large scale registration and impact on neighbouring practices.
Premises	Current may not be available and are in any case unsuitable and non compliant with DDA. An existing city provider may be more able to negotiate local premises solutions for example by also agreeing to provide services to Linfield patients and using that site.
Value for Money	A maximum cost is equivalent to current, if Linfield surgery utilised savings of Portswood premises costs could be achieved.
TUPE	May not apply if the service is relocated. HR advice will be required by providers. Existing providers can offer NHS pensions
Population Makeup	The current registered patients are 0-19 year old = 270 20 – 69 years old = 1449 70 – 85 years old plus = 388
Viability of Option	High, strategic fit providing a willing provider can be found. This is the preferred option.
Why?	Provides basis for consolidating list sizes into larger units, improving clinical governance and providing clinical leadership for quality and patient experience. Can be mobilised within timescales available.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