Leeds Health & Wellbeing Board

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Report of: **Chief Officer Health Partnerships**

Report to: **Leeds Health and Wellbeing Board**

Date: **29th January 2014**

Subject: **Quality, Safety and Safeguarding mechanisms for Health and Care Services across Leeds**

Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The report is presented as an overview of the mechanisms to ensure Quality, Safety and Safeguarding across Health and Care services in Leeds.

2. The picture it paints is complex, reflecting the various local and national bodies tasked with taking a lead on different aspects of the Quality, Safety and Safeguarding process. This report is intended to show current arrangements, and how they fit together across the partnership.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the Quality, Safety and Safeguarding arrangements in place across Leeds that are available to take forward any matters that the board might wish to refer in future.

- Be assured that there is a comprehensive group of bodies in place to monitor and drive up quality, safety and safeguarding in Leeds.

1 Purpose of this report

1.1 The report sets out a brief summary position of the Quality, Safety and Safeguarding arrangements in place across Leeds. It is provided to the HWB Board in assurance that the appropriate mechanisms and bodies are in place to protect people within the Leeds health and social care system; it does not detail the current performance of these systems, mechanisms and bodies, and does not seek to provide information as to the safety and quality of care within Leeds hospitals, care homes, educational establishments and elsewhere. This assurance is to be sought through the ongoing work and reporting of the bodies referenced here.

2 Background information

2.1 Board members will no doubt be aware that significant political, public and policy focus has recently been put on quality of health and care services and the safety of patients within the care of hospitals, social care, and other care settings. Prominent national examples of the failure of such care have been shown and thoroughly investigated through the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, by Robert Francis QC (the Francis Report), published in February 2013, and the Department of Health's 'Transforming care: a national response to Winterbourne View hospital' report, published in December 2012.

2.2 In addition to the above mentioned reports, the Francis Report was a catalyst for several additional national reviews of safety and quality of care, including:

- The Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh,
- The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish,
- A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick, was published in August 2013.
- A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart,
- The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan, was published in October 2013.

2.3 The government response to the Francis Report ('Hard Truths: The journey to putting patients first') was published in two volumes. Volume One (published March 2013) identifies its broad response under the following five headings:

- Preventing problems. This includes developing a new culture of openness and candour, listening to patients, and safe staffing.
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated.

Volume Two (published November 2013) responds to each of the 290 Francis recommendations in turn. Only 9 of the recommendations were not accepted, and even with those, the Government agreed the principle or intention behind each recommendation, but would rather achieve it in a different way. All the others (281) were accepted, accepted in principle, or accepted in part.

2.4 In terms of children's care and safety, key recent policy drivers include the outcomes of the Victoria Climbie Inquiry (Laming inquiry), Peter Connolly Inquiry, (Munroe review), both of which fundamentally shape ongoing work within the Children's Trust partnership in Leeds and the work of the Leeds Safeguarding Children's Board.

2.5 A useful definition of high quality care is found in the the Darzi report 'High Quality Care for All' (2008), which defines it as consisting of 3 elements:

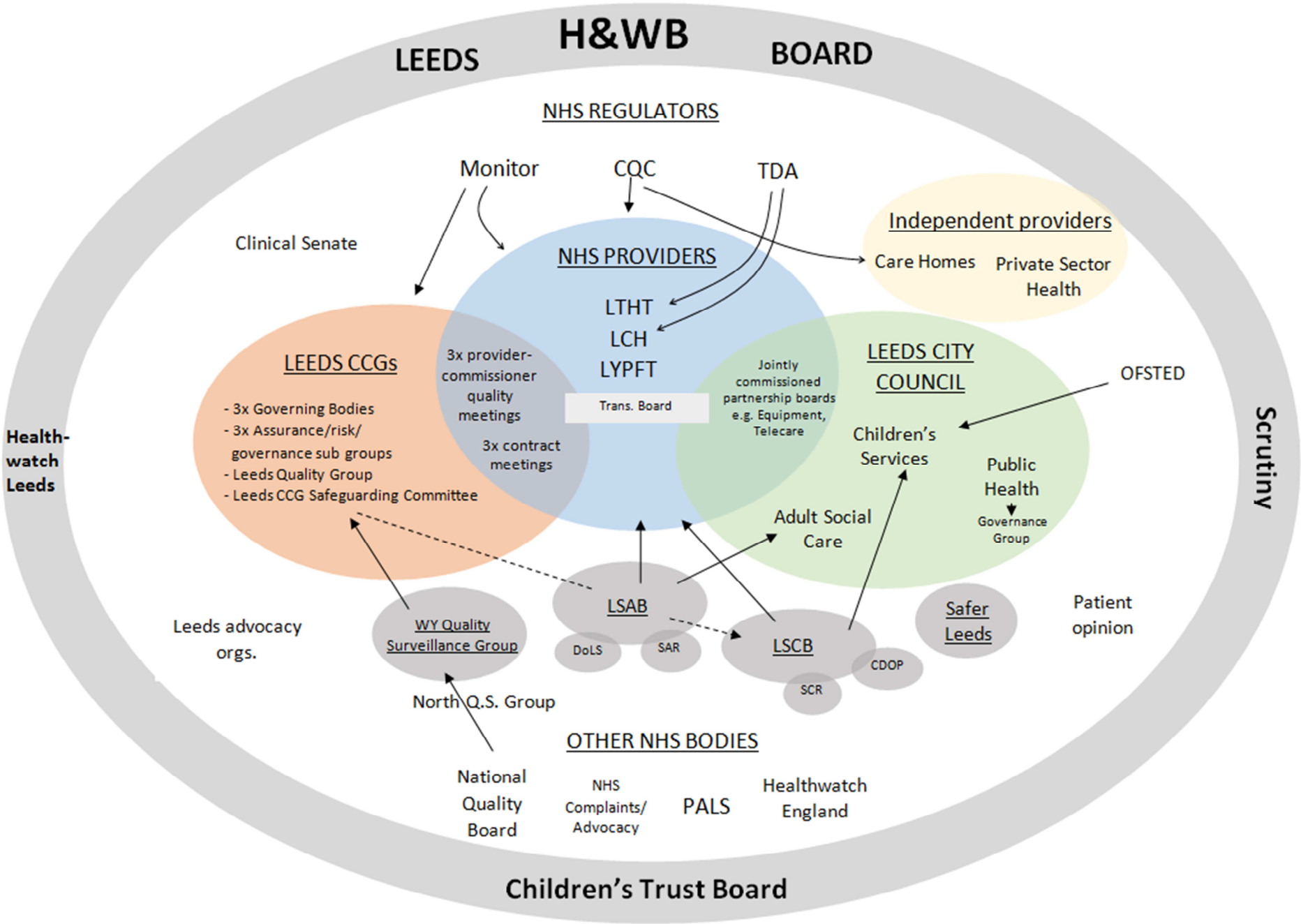
- Safety
- Effectiveness
- Experience

This definition has been accepted by the NHS to define what Quality is, with all 3 elements seen as equally important. Quality is a moving target, with continuous initiatives and innovations to support enhanced delivery. The emphasis on quality within health and social care settings is increasing, and as identified by the Francis report there needs to be provision and resource in the system to support and identify quality frameworks. Quality frameworks and governance should support the commissioning and contract process and Quality and safeguarding measures should be included in the development of any strategies, organisational plans and developments of service.

3 Main issues

3.1 As for every local area, there are a number of bodies and mechanisms ensuring quality, safe and secure services in Leeds, with different roles, responsibilities, geographical footprints and accountabilities. The following visual map provides an overview for the board of the Leeds Quality and Safety 'landscape', showing relevant national and local quality/safety bodies, local commissioners, and local providers, with the concomitant overlaps, accountabilities and connections drawn between them. Alongside this diagram, a brief explanation of the key bodies is given in tabular form. A glossary of organisational acronyms is provided at section 4.6.1.

Indicative Overview of Leeds Quality, Safety and Safeguarding Bodies



Summary of Key Local Bodies

Meeting Title	Owned by	Purpose	Reports to/feeds into	Attends
Quality Framework NHS				
Provider Quality Meetings LTHT LTPFT LCH	CCG's	Contractual monitoring of Quality levers CQUIN's Patient Experience Plus any other Quality issues	CCG Quality Group subcommittee of Governance performance and Risk, sub group of board. NB. *Leeds West have an assurance committee Also feeds into Contract Management Groups for each provider.	Providers, CCG
Quality Meeting per CCG	CCG's	To review any issues within all main providers	Governance performance and risk, sub group of the board	CCG
Leeds Quality Group	All CCG's	To review quality agenda across Leeds with input from external agencies.	CCG boards as required.	CCG, CQC, Invited attendees
Quality Network meeting	NHS England	Operational meeting of the West Yorkshire Quality Surveillance Group	Quality Surveillance Group	CCGs, NHs England, CQC, Local Authorities, Monitor, TDA
West Yorkshire Quality Surveillance Group	NHS England	Triangulation of quality issues across region	North of England Quality Surveillance Group	CCGs, NHs England, CQC, Local Authorities, Monitor, TDA
Safeguarding				
Leeds Safeguarding Committee	CCGs	Monitors statutory requirements of NHS organisations	Governance, Performance and risk committees	CCGs, Providers, Leeds City Council, Public Health
LSCB	Partnership	Statutory body	N/A	CCGs, Council, Public Health, Third sector, Education, Police, Providers NHS England
LSAB	Partnership	Partnership working to monitor safeguarding adults	N/A	CCGs, Council, PH England Third sector, Education, Police, Providers

3.2 Statutory Quality, Safety and Safeguarding System Bodies in Leeds

3.2.1 National Quality Board and the West Yorkshire Quality Surveillance Group

NHS England has established a national and regional structure to monitor the quality of care across providers. The national Quality Board (NQB) brings together the Care Quality Commission (CQC), Monitor, NHS Trust Development Agency (TDA), the National Institute of Health and Care Excellence, Public Health England, and other professional bodies.

A network of Quality Surveillance Groups (QSG) has been also established across the country to bring together different parts of health and care economies locally and in each region in England to routinely share information and intelligence to protect the quality of care patients receive. This takes place on a West Yorkshire footprint with meetings being held monthly. This is attended by NHS commissioners (including specialised commissioning) and other stakeholders including Local Authorities, Healthwatch, CQC, Monitor and Education Training Board.

3.2.2 Leeds Safeguarding Adults Board

The objective of a Safeguarding Adults Board (SAB) is to help and protect adults with health or social care need who cannot protect themselves from the risk of abuse due to those needs. This objective includes preventing incidents, supporting an adult to manage the risks they face, or developing and implementing protection arrangements for adults who are unable to manage the risks they face, even with help.

Abuse includes physical, sexual, emotional/psychological, financial or discriminatory abuse (acts which are actively committed), or acts which are not done that should be, sometimes referred to as acts of omission, but more usually referred to as neglect. Abuse can take place in any setting, by people who are known or unknown to the adult at risk.

In the context of health or social care services, the risk of harm can be due to either individuals or an organisation. In the case of an organisation, this could be because abuse by one or more individuals goes unnoticed or unchallenged by the organisation's management systems. What may start as innocent errors can develop into poor practice, which over time may become the norm, and copied by others, and even justified when questioned by colleagues. In these situations the term "institutional abuse" is used to describe a problem which is beyond the responsibility of a single person. Sometimes external challenge is required, and service improvements are usually required to change practice and attitudes to reduce the risk. When a concern involves a regulated care service, the relevant CQC inspector is always notified of Safeguarding Adults concerns, invited to safeguarding meetings and sent copies of minutes.

When such concerns arise, there are a number of investigative mechanisms which can be used (complaints, disciplinary procedures, "serious incident" procedures, criminal procedures or investigation by a professional regulator, the Care Quality

Commission (CQC), the Disclosure and Barring Service (DBS), the Charity Commission or the Department of Work and Pensions), each with different terminology and methodology. It is **essential**, however, that whenever an adult with health or social care needs is at risk of harm from abuse or neglect, an alert is made into safeguarding adults procedures whether or not any other mechanism is involved. This is clearly stipulated in existing guidance, such as the NHS Serious Incident Framework (March 2013).

This should not result in duplication of investigative effort – such effort should be co-ordinated across processes – but it does ensure that protective arrangements can be put in place to prevent harm to adults who may be at risk now or in the future. It also provides statistical data on levels of safeguarding adults risk to adults with health and social care needs.

The statutory framework for SABs

SAB's have been in place in every area for some years operating under the national "No Secrets" statutory guidance, published in 2000, with Directors of Adults Social Services holding statutory responsibility for overseeing partnership arrangements. The Care Bill, currently making its way through Parliament, will enshrine the requirement in law. This Bill identifies the core membership of a SAB as the Local Authority, Police and CCGs, and allows for any other member that the local authority, having consulted with the other core members, considers appropriate.

The Bill also requires SABs to publish a strategic plan and an annual report, and to undertake Safeguarding Adults Reviews (distinguishing them by title from LSCB SCRs) to learn lessons from cases where serious harm or death has occurred to an adult at risk, abuse or neglect is suspected, and there is reasonable cause for concern that parties have not worked together to safeguard the adult.

The Leeds SAB

In Leeds, all NHS providers are members, as well as CCGs, the NHS England West Yorkshire area team, Adult Social Care, Police, Housing, Fire, Probation, Voluntary Sector, User Representatives, CQC. The Board has an Independent Chair from outside Leeds, who is an academic at Chester University.

The SAB currently has six sub-groups to carry out its development work. One of the sub-groups oversees the operation of the Mental Capacity Act requirements and the associated Deprivation of Liberty Safeguards. The Board has a three year strategic plan, an annual business plan and an annual report. Statistical information is gathered on the Adult Social Care information system and reported nationally on an annual basis, as well as in the Board's annual report.

In April 2013, the Leeds SAB adopted the West Yorkshire Policy and Procedures. The Leeds SAB also has additional guidance which can be found on its website along with the policy, procedures and template forms. The Council provides the single point of contact for all safeguarding adults referrals. Investigations are co-ordinated by Adult Social Care or NHS managers.

3.2.3 **Leeds Safeguarding Children Board**

Leeds Safeguarding Children Board (LSCB) is a statutory body established under the Children Act 2004. It is independently chaired (as required by statute) and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in the City. Its statutory objectives are to:

- Co-ordinate local work to safeguard and promote the welfare of children
- To ensure the effectiveness of that work

The Board as a consequence holds all partner agencies to account. Board members are collectively accountable for the work of the Board and severally accountable for the work of their own agency. The Independent Chair is appointed by the Chief Executive of the Local Authority in consultation with the Board, and is accountable to the Chief Executive. Membership is extensive, multiagency, specified in statute, and can be found in the Board's Annual Report.

The full Board currently meets bi-monthly and has a collective and corporate responsibility for fulfilling its statutory functions and for holding the system to account whilst 'holding the ring' on how the system works together. The Board has a series of sub-groups, listed in the Board's Annual Report.

The Board's Annual Report provides a 'whole system' analysis of the effectiveness of safeguarding arrangements, areas identified for improvement and progress made to improve outcomes for C&YP. It asks a series of questions:

- Are we doing the right things?
- Are we making sufficient progress?
- What are the emerging challenges?
- Are we managing risk appropriately and safely?

The LSCB works closely with the Children's Trust Board which is specifically accountable in Leeds for overseeing the development and delivery of the Children & Young People's Plan (CYPP). This Report identifies challenges for both the LSCB and the Children's Trust Board. Joint commissioning responsibilities around looked after children between health, children's services and education are managed by a number of mechanisms including the Joint Agency Decision and Review Panel (JADAR).

LSCB Learning and Improvement Framework

The LSCB developed an outline Framework for Learning and Improvement in November 2012:

- *Serious Case Reviews & Local Learning Lessons Reviews:* the LSCB is responsible for initiating a Serious Case Review (SCR) in circumstances where there has been a death of a child and abuse or neglect is known or suspected, or where there has been a serious injury and there are concerns about interagency working.

- *The Child Death Overview Panel:* the Panel reviews the deaths of all Leeds Children and provides an annual report to the LSCB, making recommendations for action and monitoring progress made.
- *Managing Allegations Against Professionals:* the Board receives an annual report from the Local Authority Designated Officer summarising the allegations that have been made of abusive behaviour made by children and young people against professionals that year and how they have been managed.
- *Assessment of Single and Multi-Agency Training*: the LSCB is responsible for ensuring that multi-agency safeguarding training provided across the partnership is comprehensive and effective.

LSCB Performance Management System

Ensuring the effectiveness of multi-agency working to safeguard and promote the welfare of C&YP is the second of the LSCB core functions. This requires the LSCB to develop its own comprehensive overview of the quality, timeliness and effectiveness of multi-agency practice which is facilitated through the LSCB Performance Management System and is made up of three components: monitoring partner compliance with the statutory requirement to have effective safeguarding arrangements in place; a Performance Management Framework based on the strategic priorities of the Board and including measures from the national Children's Safeguarding Performance Information Framework; and a multi-agency Quality Assurance and Audit Programme

The LSCB receives regular reports from the Performance Management sub group on performance and quality monitoring. These form the basis of the Annual Performance Report which in turn provides the core of the LSCB Annual Report. The LSCB also requires partners to undertake a self-assessment audit of compliance with s(11) of the Children Act 2004 (the 'Duty to Safeguard'). This is currently undertaken every two years, with monitoring of progress on areas identified for improvement in the intervening years. All agencies represented on the LSCB undertake this audit. Currently 190 non statutory (Voluntary, Community, Faith & Private) agencies in Leeds complete the audit. The LSCB also receives an annual report from the Children's Services Integrated Safeguarding Unit outlining education establishment compliance with s(157) / s(175) of the Education Act 2002.

A key component of the LSCB Performance Management System is the 'Performance Management Framework' which collates data from across the partnership about safeguarding activity. Within the framework are 7 scorecards which collate performance information:

- Learn, Listen and Advise
- Know the story, Challenge the practice
- Learn and Improve
- The child's journey through the safeguarding system
- Children and young people subject to a child protection plan
- Children and Young People who are Looked After
- Children and Young People who go 'Missing' / at risk of Sexual Exploitation

Quality Assurance & Audit Programme

The LSCB initiated a Quality Assurance and Audit programme in 2012 designed to provide much more information about the quality of the work being undertaken and its impact on outcomes for individual children and young people. The following strands of work are currently being progressed:

- The Effectiveness of Child Protection Plans (Annual 25 case audit)
- The views of professionals involved in multi-agency child protection plans
- The effectiveness of care planning for children and young people who are 'looked after' (Annual 25 case audit)
- The implementation of actions from Child S SCR - the effectiveness of revised care and control policies in Specialist Inclusion Learning Centres
- The implementation of actions from Individual Management Reviews (SCR Child V)
- LSCB Chair visits to partner agencies in order to review case files and discuss issues with staff
- Review of safeguarding outcomes for the children of teenage parents who have been referred to the Leeds Teenage and Pregnancy Pathway.
- The extent to which the views of children and families inform agencies' service development regarding the safeguarding and promotion of children and young people's welfare.
- The findings from partner agency audits, reviews and external inspections are included in the LSCB Annual Report.

3.3 Commissioning for Quality and Safety in the NHS

The CCG's have established quality governance structures which continue to develop since April 2013. The CCG's are actively engaged with NHS England and contribute to the regional Quality surveillance structures. The CCG's are responsible for the contractual monitoring of Quality standards as seen in the national Standard contract 2013/14 as well as other quality initiatives. The Leeds Quality Group is a city wide meeting with medical directors and directors of nursing with representatives from CQC, Healthwatch and NHS England. This allows triangulation across providers and CCG's to monitor the quality of care within the city. This also promotes a joined up approach to action planning and monitoring. Quality sub-committees. Each CCG also has a quality committee, chaired by the Medical Director, which is subcommittee of the respective boards.

Other relevant mechanisms NHS commissioners have for improving quality of care include:

- *Contract monitoring of providers* – through quality premiums, the CQUIN process, and performance metrics
- *Clinical Senates* – through which clinical expertise is brought to the commissioning process around annual condition-based themes
- *Transformation programme* – which drives the transformation of services and works to improve quality and outcomes for patients within the context of planning for a sustainable health and social care system in Leeds.

3.4 Providing Quality and Safety

NHS providers

The three main NHS providers in Leeds, (Leeds Community Healthcare, Leeds Teaching Hospitals Trust, Leeds and York Partnership Foundation Trust) all have internal quality governance structures in place, with a substructure under their Boards that oversees the quality of services and a Governing Board member who acts as the accountable officer for quality within the organisation. In addition, a major quality assurance mechanism exists through the contracts held by commissioners with providers, and the on-going contract monitoring process (including national quality standards and CQUINs) provides incentive- and challenge-based opportunities for quality improvement. This is supported by a national framework to deal with 'never' and 'serious' events, the Patient Safety Thermometer, the NHS Outcomes Framework, and quality premiums.

The CQC inspect all healthcare services in England on the quality of care delivered in their settings. Inspections are usually unannounced, and occur according to a national framework. Following the Francis report and the subsequent national reviews identified in section 2, CQC have developed a new inspection approach which is used across all regulated services, and focusses on five key questions:
Is the service

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

The findings of inspections are disseminated through the provider quality structures, with Leeds-wide and regional issues escalated to the Leeds Quality Group and the West Yorkshire Quality Surveillance group respectively. The CQC sit on both these groups, ensuring regular meetings are held between regulators and providers in the system.

Social Care

Quality of Providers

Adult Social Care and CCG Continuing Health Care (CHC) both commission care home and home care services. They each have their own contracts and quality assurance processes, but also work together to ensure quality in services where they both have an interest. They have some common approaches and liaise regularly on monitoring, contract compliance actions and suspension of placements. These services are also regulated and inspected by CQC.

Information Sharing between CQC and Commissioners

The CQC meets regularly (every 2 months) with Adult Social Care and Continuing Healthcare commissioners and Safeguarding Adults representatives to share

information on regulated services where one of them has concerns. As CQC inspects and regulates services across the country, this can bring invaluable intelligence when it is suspected that a problem may extend to, or originate from, outside Leeds. Information from these sharing meetings can be fed into service improvement planning requirements which can benefit both quality and safeguarding.

The CQC also meets regularly with NHS Commissioners of NHS provided services and is an active member of quality surveillance groups (QSGs) at both local and regional levels.

3.5 The voice of the patient/service user

Alongside the statutory and organisational methods described above for ensuring quality of care and safeguarding of vulnerable children and adults, there are a number of ways in which the voice of staff and patients/service users can be heard and concerns can be raised in a timely and responsive manner:

- Patient Advice and Liaison Services in provider settings
- 3rd Sector Advocacy Organisations e.g. Leeds Advocacy, A4MHD
- Healthwatch Leeds, (including the statutory right to 'enter and view' a care provider)
- Patient Opinion (an independent online resource)
- NHS Complaints Advocacy (delivered by LICHA in Leeds)

For staff and professionals within the system, The National Whistleblowing Helpline (08000 724 725) acts as a vehicle to raise a concern under the Public Interest Disclosure Act (1998), which protects those who want to make a disclosure about a risk to patient safety or other issue, in the public interest.

Patient experience is also a key component of the strategic management of commissioners and providers in the city, and forms part of the way the NHS listens to patients formally. Patient and Public Involvement (PPI) in CCG decisions is ensured through lay membership of Governing Bodies from PPI leads, whilst networks of patient assurance groups are being set up to involve local residents in the commissioning priorities of the CCG areas. CCGs are also working to develop patient involvement strategies. Primary Care patient involvement has a long history in Leeds, with many practice reference groups around GP practices feeding in experience and insight into individual services, practice-based commissioning, and increasingly the system as a whole. Major routes for patient involvement and experience of care to be fed into NHS providers in Leeds come through PALS, and through providers' Trust membership base.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Since this paper merely describes the mechanisms and arrangements for ensuring quality, safety and safeguarding in Leeds, consultation and engagement has not been necessary.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no implications for Equality, Diversity, Cohesion or Integration arising from this report.

4.3 Resources and value for money

4.3.1 There are no direct implications for resources and value for money arising from this report.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no legal or information access implications arising from this report. It is not subject to Call In.

4.5 Risk Management

4.5.1 There are a number of risks inherent within the quality, safety and safeguarding system in Leeds which the mechanisms described in this paper seek to minimise and mitigate:

- The risk of harm to a child or adult
- The risk of abuse to a child or adult
- The risk of poor quality services leading to worse health outcomes for children or adults in Leeds.

4.6 Glossary

4.6.1 The following acronyms are used in this report:

DoLS = Deprivation of Liberty Safeguards
CQC = Care Quality Commission
CQUIN = Commissioning for Quality and Innovation
LCH = Leeds Community Healthcare NHS Trust
LSAB = Local Safeguarding Adult's Board
LSCB = Local Safeguarding Children's Board
LTHT = Leeds Teaching Hospitals NHS Trust
LYPFT = Leeds and York Partnership NHS Foundation Trust
PALS = Patient Advice and Liaison Service.
SCR = Serious Case Review
QSB = Quality Surveillance Board
TDA = NHS Trust Development Authority

5 Conclusions

5.1 The landscape of quality, safeguarding and safety assurance is complex in any local area, with several layers of assurance round the system and a number of statutory and non-statutory bodies in existence. This paper is therefore presented to demonstrate the join-up between key services in Leeds and to paint a high-level picture of the connections between organisations.

5.2 There is additionally a need to emphasise that all organisations are working to embed some of the key post-Francis Report messages:

- There is 'no wrong front door' into safeguarding services
- Quality of service relies on all agencies developing an effective learning culture
- Transparency of data and information and is key
- Listening to the voice of the patient, alongside formal complaints, queries and anecdotal evidence, is as important as data in identifying areas of potential risk, harm or poor quality service.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the Quality, Safety and Safeguarding arrangements in place across Leeds that are available to take forward any matters that the board might wish to refer in future.
- Be assured that there is a comprehensive group of bodies in place to monitor and drive up quality, safety and safeguarding in Leeds.