Agenda Item No. **12**

Health and Wellbeing Board

4 March 2015

Report title	Joint Strategic Needs Assessment Qualitative Summary: Patient Safety	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders	People
Originating service	Public Health	
Accountable employee(s)	Ros Jervis Glenda Augustine Tel Email	Director Public Health Consultant in Public Health 01902 554211 ros.jervis@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Note the Joint Strategic Needs Assessment qualitative summary on patient safety and quality.

1.0 Purpose

1.1 The purpose of this report is to provide a collated summary of patient safety derived from local assessment in response to the Francis Inquiry and the Safeguarding and Winterbourne View reports for Wolverhampton produced by Wolverhampton Clinical Commissioning Group and Wolverhampton Safeguarding Board respectively.

2.0 Background

2.1 The Health and Wellbeing Board agreed that the refresh of the Joint Strategic Needs Assessment for 2014 should include a desktop qualitative review of patient safety and quality for 2013/14. This topic was chosen because it is a theme that is relevant to the whole health and social care economy and has been raised in a number of reports and work streams.

2.2 The aim of this qualitative paper is to provide the Health and Wellbeing Board with assurance regarding patient safety and the quality of care delivery in the city, in relation to the Francis Inquiry, generic safeguarding of children and adults and the review of Winterbourne Review.

2.3 This paper will not replicate the content of the reports previously presented at various boards, but will provide a composite overview of patient safety and quality issues. Primarily this paper will highlight compliance with recommendations and any risks alongside proposed mitigation. Further in depth details can be found in the original reports.

2.4 *The Francis Inquiry*

2.4.1 The Francis Inquiry February 2013 made 290 recommendations aimed at improving the quality of patient care through cultural change, with the focus on the patient not the business of the organisation. The key recommendations include the delivery and monitoring of standards of care, a system built on openness, transparency and candour, stronger healthcare leadership and improved support for compassionate, caring and committed nursing

2.4.2 Wolverhampton Health Scrutiny Panel received update reports on the Francis Inquiry from Wolverhampton Clinical Commissioning Group (WCCG), the Royal Wolverhampton NHS Trust (RWT) and the Black Country Partnership Foundation Trust (BCPFT) in January 2015.

2.5 *Safeguarding Children and Adults*

2.5.1 There are two safeguarding boards within Wolverhampton, Children and Adults,

who co-ordinate a partnership approach to protecting and promoting the welfare of children and adults. Each board is required to produce and publish an annual report demonstrating the effectiveness of safeguarding in Wolverhampton.

2.5.2 The Wolverhampton Safeguarding Adults Board annual report was presented to the Health and Wellbeing Board in November 2014 and the Safeguarding Children Board annual report was presented in January 2015.

2.6 *Review of Winterbourne View*

2.6.1 The Department of Health review of Winterbourne View resulted in a Concordat Programme of actions for implementation by June 2014. The Concordat required commitment from health and care commissioners to transform services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them.

2.6.2 There is national leadership and local support for implementation of the Concordat. An update on the programme actions related to the review of Winterbourne View in Wolverhampton was presented to Wolverhampton Strategic Executive Board (SEB) in January 2015.

3.0 Qualitative Summary Findings: Francis Inquiry

3.1 The summary of the Francis Inquiry provided by RWT and BCPFT indicate that there has been investment in staff training and education to improve the standard of care delivered, increased staffing ratios, regular quality and safety reporting and a robust system for dealing with complaints.

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3.2 There are 102 of the 290 Francis Inquiry recommendations that are relevant to RWT with over 70% compliance reported. There is partial compliance of remaining recommendations with the assurance that full compliance would be achieved by March 2015. It would appear that the process of embedding the recommendations into core business with reporting and monitoring through the governance framework for the Trust will support achievement

3.3 The BCPFT report indicated that 84 of the 290 recommendations are applicable to their practice. Although there was no explicit quantification of the level of compliance, the narrative on progress to date and the implementation of automated monitoring of actions, indicates partial compliance and increased assurance for the BCPFT Board.

3.4 The WCCG report indicates that the commissioning organisation is monitoring the standard and quality of care delivered by provider units with tracking of patients receiving care outside Wolverhampton. An example of future plans to improve quality and safety is the arrangement of quality visits with the Care Quality Commission at night and weekends.

3.4 There were no specific risks highlighted regarding the implementation of the Francis Inquiry recommendations across provider and commissioning organisations in Wolverhampton. The collective reports provide assurance that there is compliance with the recommendation to ensure improving quality and safety in the delivery of patient care.

4.0 Qualitative Summary Findings: Safeguarding Children

4.1 The annual report on safeguarding for children presented to the Health and Wellbeing Board in January 2015 was for the reporting year 2013/14, describing partnership objectives and achievements up to March 2014.

4.2 The report indicates that this multi-agency partnership is committed to prioritising safeguarding and has articulated a determination to strengthen prevention and early intervention, underpinned by staff training and education. This is despite reduced funding, new structures and commissioning arrangements impacting on the partnership structure. Further development of preventatives strategies using combined resources is planned for the coming year.

4.3 All partner agencies have documented achievement against objectives and details of improvement plans have been provided where barriers may impact on attaining the set objectives. Resources and capacity appear to be the main challenge, however, there is no evidence that this poses a major risk to the quality of service delivery that will significantly impact on the safeguarding of children in Wolverhampton.

5.0 Qualitative Summary Findings: Safeguarding Adults

5.1 The peer review of the adult safeguarding service in September 2013 highlighted a number of strengths and areas for consideration with an overall positive conclusion. This review provides assurance that there is strong partnership working arrangements which will enable significant progress in adult safeguarding in Wolverhampton. The 2013/14 annual report indicates that an action plan has been developed to address the areas of consideration highlighted within the peer review, enhancing the assurance process.

5.2 The annual report demonstrates a clear focus on staff education and training alongside raising awareness within partner organisations and through community groups.

5.3 Whilst challenges to achieving the priorities of the adult safeguarding board have been highlighted, there appear to be no specific risks to patient safety or the quality of service delivered.

6.0 Qualitative Summary Findings: Winterbourne View

6.1 The Winterbourne View update presented to SEB indicates that there is appropriate placement of patients in WCCG funded high and low secure hospital care as demonstrated by comprehensive Care and Treatment Reviews. The reviews assess safety, quality of care, discharge planning and appropriateness of hospitalisation.

6.2 This report indicates that there is compliance with the Winterbourne View recommendations in relation assessment of patient safety, quality of care and the provision of care within an appropriate setting.

6.3 There were no risks associated with patient safety or quality of care highlighted within this report.

7.0 Qualitative Summary Findings: Conclusion

7.1 In summary, the qualitative review of various reports provides assurance that the children and adult services across health and social care for 2013/14 are delivering quality care that strives to maintain patient/citizen safety through the achievement of set priorities and objectives and structured plans to mitigate against identified risks.

8.0 Financial implications

8.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2014/15 is £19.3 million

8.2 This report has not identified financial implications for the Public Health budget.

8.3 There are no additional financial implications for the Local Authority that have not previously been highlighted in the original reports presented to the Health and Wellbeing Board and Health Scrutiny Committee.

[NM/18022015/E]

9.0 Legal implications

91 There are no anticipated legal implications to this report.

[Legal Code: TS/19022015/G]

10.0 Equalities implications

10.1 There are no anticipated equalities implications to this report

11.0 Environmental implications

11.1 There are no anticipated environmental implications related to this report.

12.0 Human resources implications

12.1 There are no anticipated human resource implications related to this report.

13.0 Corporate landlord implications

13.1 This report does not have any implications for the Council's property portfolio.

14.0 Schedule of background papers

14.1 Links to the Health Scrutiny Panel updates on the Francis Inquiry and the Wolverhampton Safeguarding Board annual reports for children and adults are listed below:

14.1.1 Francis Inquiry Update
http://wolverhampton.moderngov.co.uk/ieListDocuments.aspx?CId=146&MId=223&Ver=4

14.1.2 Wolverhampton Safeguarding Children Annual Report
http://wolverhampton.moderngov.co.uk/documents/g4278/Public%20reports%20pack%2007th-Jan-2015%20Health%20and%20Wellbeing%20Board.pdf?T=10 page 29-112

14.1.3 Wolverhampton Safeguarding Adults Annual Report
http://wolverhampton.moderngov.co.uk/documents/s5357/Item%2010%20-%20Adults%20Safegaurding%20Annual%20Report%202013-14.pdf

http://wolverhampton.moderngov.co.uk/documents/s5333/Item%2010%20-%20Adults%20Safeguarding%20Board%20-%20Final%20Annual%20Report%2013-14.pdf

14.1.4 Wolverhampton Safeguarding Adults Peer Review: September 2013
http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=3309&p=0