HEALTH AND PARTNERSHIP SCRUTINY COMMITTEE
11 June 2013

ITEM NO. 6

SECURING QUALITY IN HEALTH SERVICES (FORMERLY ACUTE SERVICES QUALITY LEGACY PROJECT)

SUMMARY REPORT

Purpose of the Report

1. To consider the report on the findings and recommendations from the Acute Services Quality Legacy project.

Summary

2. In September 2012, the Tees Valley Joint Health Scrutiny Committee received a briefing on the Acute services Quality Legacy Project. The project was part of the process for Primary Care Trusts to transfer commissioning responsibility to Clinical Commissioning Groups (CCGs) and it covered the PCT clusters across County Durham and Darlington and Tees Valley. At that meeting the Shadow Health and Wellbeing Board endorsed the approach that the commissioning of care and services should be based upon best evidence with regard to clinical quality.

3. The overall objective of the project was to enhance the commissioning of acute hospital services by reaching consensus on the key clinical quality standards in acute hospital care that should be commissioned by CCGs. The project was concerned with acute hospital services provided by County Durham and Darlington NHS FT, South Tees NHS FT and North Tees and Hartlepool NHS FT. It did not look into clinical quality standards in mental health services, community based services or primary care.

4. The project aimed to produce a report that would describe the agreed clinical quality standards in the context of the financial and workforce resources that are expected to be available to support implementation of the standards. The key messages and recommendations from the final report are set out in the main report below. The project report was received at the final meetings of the County Durham and Tees PCT clusters in March 2013 and the process of taking forward the report recommendations is now being led by the Clinical Commissioning Groups (CCGs) across County Durham, Darlington and Tees. Since it is no longer part of the transition process from PCTs to CCGs, the project has been renamed as follows 'Securing Quality in Health Services'.

Recommendation

5. It is recommended that :- the Health and Partnerships Scrutiny Committee receive and discuss the report and agree to receive further reports in due course.

Background Papers

Acute Services Quality Legacy Project – Final Project Report March 2013
Appendix 3 – Clinical advisory Groups Outputs
(Both available on line)

Rosemary Granger, Project Director, NHS Darlington Clinical Commissioning Group

S17 Crime and Disorder	There are no implications arising from this report.
Health and Well Being	The final outcomes and recommendations from this project will support the continued improvement of hospital care through the implementation of clinically led quality standards within economic and workforce resources available.
Carbon Impact	There are no implications arising from this report.
Diversity	There are no implications arising from this report at this point.
Wards Affected	All
Groups Affected	All
Budget and Policy Framework	N/A
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	N/A
Efficiency	N/A

MAIN REPORT

Acute Services Quality Legacy Project [ASQLP] Final Report - Summary of key messages and recommendations

Introduction

6. Both commissioners and providers of acute services face a similar set of challenges over the next five to ten years. Our population will be older, with more long term conditions being treated by a state funded NHS that is ultimately tied to the performance of the national economy. These services will also be operating as part of a wider system with social care which itself faces significant challenges related to national financial constraint.

7. We are fortunate however to start from a strong starting position. Our current main providers consistently deliver high quality services, meet national performance targets related to waiting times and cleanliness and operating efficiently within their means. However we know that we can do better. The ASQLP work looked to our clinical community to define what the best possible care should look like in our hospitals and begin to outline the next steps of how we should go about delivering them, given the likely financial future and the workforce that will be available to us.

8. The findings and recommendations set out in the project report have implications that range from potential changes to be made to provider contracts through incorporating the agreed clinical quality standards, to potential service reconfiguration across County Durham and Tees Valley.

Economic and workforce

9. Following years of growth, demand for acute services is currently high for both elective and non-elective care.

10. There will be a significant increase in prevalence across the major long term conditions over the next ten years and a greater proportion of the population will be over the age of 65 and this will have an impact on the utilisation of acute services to a varying degree in the different service areas.

11. This growth will put pressure on commissioners' allocations over the next ten years as an older population with more co-morbidity will consume more health resource, unless effective demand and long term condition management are implemented. This analysis does not take into account potential increased spend on high cost drugs and new medical technologies in the acute setting that may require further investment from commissioners.

12. Forecasts show that providers can maintain a financially stable position over the next five years as long as cost improvement plans deliver to target. Failure to deliver these targets will have implications for trusts' operating surplus/deficit position and ultimately the length of time they can rely on cash savings to keep them solvent.

13. This means that new funding is unlikely to be available to expand the access to services of the very highest quality as providers look to maintain the current levels of quality within the resources they have access to.

14. Even if commissioners were to receive increases to their allocations and providers had efficiency requirements at pre-Comprehensive Spending Review levels, national and regional workforce constraints may have more impact on the ability to deliver higher quality standards.

15. These national and regional workforce considerations are further compounded by supply and demand of particular grades and skills of the current and future workforce within the acute sector in County Durham, Darlington and Tees.

Clinical

Acute Paediatrics, Maternity and Neonatal Services

16. Endorse the Royal College of Obstetricians and Gynaecologists (RCOG) standard of 168 hours (24/7) consultant presence as the ultimate goal for maternity services across County Durham Darlington and Tees. This standard was supported by the majority of the Clinical Advisory Group (CAG) but there was a minority view that 98 hours consultant presence should be established as the standard for units with less than 4000 deliveries a year. The Project could not find enough evidence to inform a recommendation that goes against the Royal College standard, therefore the Project supports the RCOG standard and majority view of the CAG. Given the scale of this challenge however, there is a recognition that this needs to be delivered in a staged way, with 98 hours as an interim step for units with less than 4000 deliveries a year as part of a phased approach to implementation.

17. Endorse the key quality standard of 1:1 Midwife care for women in established labour.

18. Ask Clinical Commissioning Groups to consider the steps they may take in the next contracting round to address some of the gaps in quality standards through the use of CQUIN incentives and agreeing small scale service improvement work with individual trusts.

19. Agree to a further feasibility analysis to understand the implications of implementing the standards across County Durham, Darlington and Tees. This assessment should take into account the role of Midwife Led Units and how best to support an increase in home-births.

20. Agree to inform the LETB to adjust commissioning plans to increase the numbers of midwife training places to mitigate against risks in future workforce shortages.

Acute Care

21. Endorse the key quality standards recommended by the CAG as those that define high quality care, for example: Emergency admissions seen and assessed by a relevant consultant within 4 hours in hours and 12 hours out of hours; Emergencies to have access to key diagnostics 24/7: for critical cases – imaging and reporting

within 1hr of request, for non-critical cases – imaging and reporting within 12hrs of request.

22. Endorse the recommendation for acute trusts to collaborate in establishing an interventional radiology service available 24/7.

23. Agree that the critical care element of the Acute Care CAG continue until final recommendations can be made.

End of Life Care

24. Endorse the key quality standards recommended by the CAG as those that define high quality care, particularly those that relate to the 24/7 availability of an appropriately trained nurse to provide practical support, responding within one hour, with access to necessary medicines and home equipment for End of Life cases. In addition the CAG recommends the appropriate use of the Liverpool Care Pathway in all care settings including the sharing of results.

25. Endorse the recommendation for collaboration across the acute trusts to establish a 7 day per week service providing specialist palliative care advice.

Long Term Conditions

26. Given the scale of the likely challenge ahead due to the ageing population, the rising prevalence of LTCs and the wider membership of organisations involved, a new project focusing on LTC management should be initiated across health and social care. This project should include community services, mental health and primary care providers as well as acute trusts.
27. The project will add value to the existing work on long term conditions led by CCGs, by establishing a consensus on the scale of intervention needed and the quality standards to be achieved.
28. Further work in this area would include more detailed work on the financial and workforce challenges to provide a better understanding of the required scale of transformation and the development of concrete plans to achieve this, learning from success locally, regionally and nationally.

Planned Care

29. CCGs should review the Planned Care Briefing Paper to identify and continue to understand unexplained variations in referrals from Primary Care and clinical practice in secondary care
30. Where appropriate CCGs should look to use information to inform patient choice and commissioning levers to encourage competition to drive quality in Planned Care. This includes the introduction of new providers into the market to stimulate innovation
31. CCGs should however consider the financial implications for current providers that any movement of activity away from them may have (either to other current or new providers) when making changes to elective pathways.

Next steps:

32. CCGs have agreed to build on this legacy work and will take this work forward in line with the duty placed upon them to commission high quality sustainable services. It has been agreed that this work will continue to be a commissioning led process and as such, Darlington CCG will lead the work on behalf of the six CCGs across County Durham, Darlington, Tees and Hambleton, Richmondshire and Whitby (the latter CCG is involved due to the scale of their patient flows into the Tees Valley area). The project will also feed into, and supported by the work of the Area Team of NHS England.

33. The objectives for the next phase of work which is expected to be complete by the end of the summer 2013, are to assess the feasibility of, and options for, implementing the standards and progressing implementation. This work will further explore the views about implementation set out in the report, with a particular focus on the views of Royal Colleges and local clinicians that some quality standards around medical and nursing workforce may not be met within the current configuration of services.