Humber and North Yorkshire Health and Care Partnership

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Item 8

Report to:	Integrated Care Board
Date of Meeting:	13 July 2022
Subject:	Quality Handover
Director Sponsor:	Executive Director of Nursing & Quality
Author:	Teresa Fenech, Executive Director of Nursing & Quality

STATUS OF THE REPORT: *(Please click on the appropriate box)*

Approve ☐ Discuss ☒ Assurance ☒ Information ☒ A Regulatory Requirement ☒

SUMMARY OF REPORT:

This report summarises key areas of regulatory and statutory responsibilities included in the handover of these responsibilities from Clinical Commissioning Groups (CCGs) to the Integrated Care Board (ICB), and our inherited performance position in meeting these requirements.

RECOMMENDATIONS:

Members are asked to

- receive the information,
- to note our position in relation to some of our regulatory and statutory responsibilities
- to note the work required to urgently address breaches in the statutory areas

ICB STRATEGIC OBJECTIVE (*please click on the boxes of the relevant strategic objective(s)*)	
Realising our vision	☒
Improving outcomes in population health and healthcare	☒
Supporting broader social and economic development	☒
Tackling inequalities in outcomes experience and access	☒
Delivering our operational plan 2022/23	☒
Developing our ICS	☒

IMPLICATIONS (*Please state N/A against any domain where none are identified*)	
Finance	Potential but not yet understood
Quality	Impacts upon the quality of services the ICB is providing
HR	Requires support for recruitment into key roles.
Legal / Regulatory	Direct impact as setting out the breaches in meeting some statutory requirements
Data Protection / IG	N/A
Health inequality / equality	The range of statutory responsibilities discussed in this paper predominantly affects some of the most vulnerable members of our population
Conflict of Interest Aspects	N/A
Sustainability	N/A

ASSESSED RISK:

Reputational risk to ICB
Regulatory risk – 'well led' assessments

MONITORING AND ASSURANCE:

Predominantly via Quality Committee

ENGAGEMENT:

Not applicable

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☒ Yes ☐

If yes, please detail the specific grounds for exemption

Humber and North Yorkshire Health and Care Partnership

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Quality Handover

Background

As the ICB became a statutory body on the 1st of July it acquired the responsibility for a range of regulatory, statutory, national policy and contractual requirements, previously the responsibility of the CCGs.

The ICB quality committee met in the afternoon of the 1st of July to formally receive the handover of these responsibilities. Each CCG submitted a detailed template outlining their position for handover.

The following information summarises this information for the system, across regulatory and statutory functions. Further work will be required to review the detailed, predominately narrative reports, covering a range of clinical service issues. We will need to develop our reporting across this range of clinical service issues to provide ICB level data on areas such as Infection rates, sepsis rates, pressure ulcer rates etc. These will be used in the relevant clinical forums to drive improvements.

In this paper the clinical service issue included is that of the number of serious incidents still open at the time of handover.

1. Regulatory responsibility

	Category 1: Regulatory		
CCG document sub-categories			
CCG	Enforcement notices	Regulation 28 notices	FTSU / Whistle blowing
Vale of York	0	0	0
North Yorkshire	0	1	0
East Riding	0	0	0
Hull	0	0	0
North Lincolnshire	0	0	0
North East Lincolnshire	0	0	0
TOTAL FOR ICB	**0**	**1**	**0**

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i. Enforcement Notices.

Enforcement is one of the core components of CQCs operating model. Enforcement powers are used by CQC in order to protect people, who use regulated services, from harm and the risk of harm, and to ensure that they receive health and social care services of an appropriate standard.

Section 31 warning notices, which advise providers that enforcement action may be taken can be used by CQC to allow providers to provide evidence that concerns have been addressed.

Enforcement action may range from the imposition of a condition to a service; preventing new admissions to a service until improvements have been made for example, through to closure of the service in full. Prosecution may be used where a criminal offence is suspected.

There were no enforcement notices across the ICB at the point of handover from CCGs.
There was one recently concluded prosecution of a care home provider, however.

ii. Regulation 28 notices

Coroners' regulation 28 reports set out concerns regarding the circumstances of a death of a patient and will be addressed to the individual or organisation that the coroner believes needs to take action to prevent future deaths.

At the time of handover there is 1 Regulation 28 notice from North Yorkshire Place.

The ICB has received its first regulation 28 notice on 5th July and relates to North Yorkshire Place.

iii. Freedom to speak up reports.

Freedom to speak up, (FTSU), also known as whistleblowing policies, were introduced following the review of whistleblowing in the NHS conducted by Sir Robert Francis.

FTSU guardians support staff to raise concerns and ensure that their voices are heard.

There were no open FTSU reports at the time of handover.

2. Statutory Responsibility

I. Safeguarding

CCG document sub-categories	Safeguarding					
CCG	MH Homicides	Adult reviews	Domestic homicide	safeguarding practice reviews	Looked after chldren	Child death overview panels
Vale of York	1	3	0	1	400	34
North Yorkshire	2	3	2	2	431	0
East Riding	0	5	3	4	346	36
Hull	1	2	3	2	879	30
North Lincolnshire	0	1	1	0	188	10
North East Lincolnshire	0	2	7	2	604	9
TOTAL FOR ICB	**4**	**16**	**16**	**11**	**2848**	**119**

a. Mental Health Homicides

These are independent investigations into homicides that are committed by patients in receipt of treatment for a mental health illness.

The purpose of the reviews being to thoroughly review the treatment received by the patient so that we can be clear if anything went wrong with the care of the patient, reduce the risk of a similar event happening again and make recommendations for improvements to service delivery.

At the time of handover there were 4 open MH Homicide cases.

b. Adult Safeguarding reviews

A Safeguarding adults review (SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. SARs are a requirement of the Care Act 2014.

There are 16 SARs in progress at the time of handover, with an additional case pending and being scoped.

c. Domestic Homicide

A domestic homicide review (DHR) is a multi- agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been in an intimate relationship or a member of the same household as themselves.

There are 16 DHRs open at the time of handover.

d. Safeguarding practice referrals

Where a child has died or been seriously harmed and abuse or neglect of the child is known or suspected, a multi-agency review will be carried out to review practice and identify learning to minimise the risk of similar future incidents.

There are 11 open safeguarding practice reviews at the time of handover

e. Looked after children

We have a range of responsibilities to promote the health and well being of looked after children, set out in the statutory guidance. These include the planning and commissioning of health services for looked after children, individual health assessments, care planning and reviews, amongst others. In addition to statutory guidance, the National Institute of Heath and Care excellence has published guidance for all agencies involved with looked after children. At the time of handover, we have identification of the number of looked after children but no ICB perspective on adherence to NICE guidance or how we are meeting minimum statutory requirements for each area of responsibility. We do have reports and findings from statutory reviews conducted jointly by CQC and Ofsted which we will use as a starting point to understand the improvements that may need to be made.

There are 2848 looked after children across the ICB at the time of handover.

f. Child Death Overview panels

The deaths of all children (under 18), must be reviewed by a multi-agency panel, convened in the locality the child resided. The main purpose of these panels is to learn from these deaths and minimise where possible the likelihood of reoccurrence. Vale of York numbers include North Yorkshire data.

There are 118 child deaths before panels at the time of handover.

II. LeDer

CCG document sub-categories	LeDer
CCG	LeDer open cases
Vale of York	24
North Yorkshire	0
East Riding	11
Hull	13
North Lincolnshire	6
North East Lincolnshire	9
TOTAL FOR ICB	**63**

These are learning from deaths reviews undertaken following the death of an individual with autism and/or a learning disability, over the age of 18 years. The ICB is now responsible for ensuring that these are conducted, and action is taken on the findings of these reviews. There are timescale requirements for undertaking these reviews and across the ICS we are not currently meeting these requirements. Recent NHSE guidance on undertaking these reviews sets out that reviewers must be employed but independent, and this must be their primary, possibly exclusive role. As an ICB we do not meet these requirements with employed staff working as part of the general teams and some places having outsourcing contract arrangements – which have been cancelled by NHSE over fear that they are not compliant with national guidance and could potentially breach information sharing agreements, although we believe that there are safeguards in place to protect against this.

It is likely that as an ICB we will be in breach of the range of requirements around these reviews until staff are recruited and trained and outsourced provision is brought in house. There is the potential for additional cost requirements to meet the national guidance.

National reports indicate that up to 45% of deaths reviewed as part of this process, are identified as avoidable. More detailed ICB reports will identify our position in relation to avoidable deaths and actions we need to take.

Vale of York numbers include North Yorkshire data.

Across the 5 places shown above there are 63 open learning from deaths reviews.

III. DoLs/LPS

The deprivation of Liberty Safeguards (DoLs) will soon be replaced by the Liberty protection safeguards (LPS). In essence the responsibilities of the NHS are to ensure that the correct procedures and legal applications are in place to protect the liberty of vulnerable individuals who lack capacity. Whilst it is recognised that the existing DoLs arrangements are intensive and cumbersome, it should be noted that there are significant delays with our existing DoLs processes, running the risk of not adequately protecting the liberty of our patients

	DoLs / LPS		
CCG	In progress	In place	Applications for Review
Vale of York	21	11	3
North Yorkshire	55	24	34
East Riding	3	2	47
Hull	0	0	0
North Lincolnshire	7	44	3
North East Lincolnshire	475	0	0
TOTAL FOR ICB	**561**	**81**	**87**

There are 561 applications classified as 'in progress' but this includes a number where the process has yet to start. There are 87 applications for review with an additional 7 cases currently with the courts.

IV. CHC

People with long-term complex health needs may qualify for free NHS funded care, arranged by social care. This is known as NHS Continuing Care (CHC). All patients in receipt of CHC will have at least an annual review of their existing care and support packages.

	CHC					Children's continuing care	
CCG	Fully funded	Jointly funded	Personal health budget	Fast track cases	dispute resolution cases	Caseload	CHC performance
Vale of York	155	224	53	83	24	21	94%
North Yorkshire	358	297	163	69	27	27	84%
East Riding	296	135	128	112	27	7	69%
Hull	398	64	29	0	10	49	97%
North Lincolnshire	114	98	41	59	2	8	85%
North East Lincolnshire	152	38	66	50	8	6	40%
TOTAL FOR ICB	**1473**	**856**	**480**	**373**	**98**	**118**	**78%**

A continuing care package for children will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.

There are currently 1473 fully funded cases and an additional 856 for whom joint funding arrangements with social care are in place. Additionally, a further 480 patients are receiving a personalised health budget, allowing patients greater flexibility in how their healthcare is managed.

There are performance requirements relating to CHC relating to the timeliness of assessments. Current performance ranges from 40% to 97% across the places.

A new National framework for CHC was published on 5th July 2022 setting out explicit and comprehensive responsibilities for the ICB. We will review this framework and in developing new ICB wide arrangements for CHC, ensure that we can meet these requirements.

3. Service Issues.

1. **Serious Incidents**

Serious incidents in healthcare are adverse events, where the consequence to patients, families and carers, staff and organisations are so significant or the potential for learning so great, that a heightened level of response is justified. This response includes an open and transparent investigation of the incident to understand what happened and to identify action needed to prevent its reoccurrence.
Investigations open at the time of handover will need to be completed, the learning identified, and actions put in place before they can be closed. The quality committee will monitor progress to closure of these Sis.

There are 565 open Sis at the time of handover.

2. **Other service issues for future reporting**

Over time we will need to develop reporting for the ICB footprint on a range of clinical indicators. These include.

- Complaints
- Breaches of mixed sex accommodation
- HSIB maternity reports
- Individual funding requests
- Clinical indicators such as infection rates, pressure ulcer rates etc
- Compliance with safe staffing requirements.

Relevant clinical forums will be used to drive improvements using this baseline data as a staring point. The quality committee will routinely receive reports around these areas and the board via appropriate reports.

Some of this information is available at the point of handover but not all and there are differences in how and what has been included in the handover, which will need to be worked through.

Summary

There is a vast array of regulatory, statutory, policy and clinical service monitoring responsibilities for the ICB. For some of these areas national guidance is being updated or being newly developed to clearly set out our accountabilities and responsibilities.

The handover of the responsibilities that previously sat with CCGs gives us an understanding of our starting position in relation to meeting of these responsibilities. As this paper sets out, we are falling short in meeting our responsibilities from this inherited position and action is needed to address gaps and drive improvements in our performance so that we can better meet the needs of our populations.

The factor contributing most to our underperformance is workforce. As of May 2022, there were 97 vacancies across the nursing directorate teams, including CHC teams. We will need to work at pace to address these gaps.