NHS
Haringey
Clinical Commissioning Group

MEETING:	Adults &Health Scrutiny Panel
DATE:	Thursday 27 February 2014
TITLE:	Haringey CCG briefing on Francis – one year on
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SUMMARY:

The Adults &Health Scrutiny Panel has requested an update on Haringey CCG's position with regard to responding to the final report into Mid Staffordshire NHS Foundation Trust (Francis Report) published 5 February 2013.

This report provides:

- A summary of the key findings of the public inquiry into Mid Staffordshire NHS Foundation Trust (Francis Report) published 5 February 2013.
- Actions taken by NHS England to address the concerns.
- A summary of key actions taken to date by Haringey CCG to improve oversight and accountability of the services it commissions.
- A summary of areas for focus during 2014/15 to ensure that the services commissioned by the CCG on behalf of the people of Haringey are of the highest quality and delivered with respect and compassion.

SUPPORTING PAPERS:

N/A

RECOMMENDED ACTION:

The panel is asked to:

- **NOTE** the update

Objective(s) / Plans supported by this paper: A key CCG's objective is to commission high quality valued and responsive services working in partnership with the public to make the best use of resources.

Audit Trail: This briefing paper will be used to refresh the CCG's approach to ensuring that commissioned services are centred on openness, trust and compassion.

Patient & Public Involvement (PPI): There was no patient involvement in this paper

Equality Analysis: n/a

Risks: n/a

Resource Implications: There are no particular resource implications

Haringey CCG briefing on Francis – one year on

"We need to embrace transparency and learning, unequivocally and everywhere, so as to build trust with the public and knowledge within the NHS. We need to embed compassion in every part of the NHS, placing patients' wellbeing at the centre of every decision we make. And we need to involve patients, their families and carers as much as possible in that process".

Jane Cummings, Chief Nursing Officer for England and NHS England Chief Nurse

1 Introduction

In December 2013 the Adults &Health Scrutiny Panel requested an update on Haringey CCG's position with regard to responding to the final report into Mid Staffordshire NHS Foundation Trust (Francis Report) published 5 February 2013.

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2 Background

The final report into Mid Staffordshire NHS Foundation Trust (Francis Report) published 5 February 2013 examined the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. It examined why problems at the Trust were not identified sooner and appropriate action taken.

The report built on the first independent inquiry also chaired by Robert Francis QC and highlighted 'a systematic failure of the provisions of good care' and confirmed that providing good, safe care is about both systems and people. The report concluded that a fundamental change in culture is required to prevent future system failures, and that many of the changes can be implemented within the current system. It stressed the importance of avoiding a blame culture, and proposed that the NHS, collectively and individually, adopts a learning culture aligned first and foremost with the needs and care of patients.

Robert Francis QC made 280 recommendations, which focused primarily on securing a greater cohesion and culture across the system, which *'will not be brought about by further "top down" pronouncements, but by the engagement of every single person serving patients'.*

On 26 March 2013 the Department of Health released *"Patients First and Foremost- The Initial Government Response to the report of The Mid Staffordshire NHS Foundation Trust Public Inquiry"*

At the beginning of this report the Government sets out a Statement of Common Purpose that was signed by the chairs of key organisations across the Health and Care system. It renews and reaffirms the commitment to the values of the NHS, as set out in the Constitution, and includes pledges to work together for patients, always treat patients and their families with compassion, dignity and respect, to listen to patients and to act on feedback. It asks all organisations within the health and care system to join them in signing up to this statement of common purpose.

Within the report the Government set out a five point plan, as follows: -

1. Preventing problems - putting in place a culture of zero-harm and compassionate care
2. Detecting problems quickly
3. Taking action promptly
4. Ensuring robust accountability- accountability for wrong doers
5. Ensuring staff are trained and motivated

A revised NHS Constitution published in March 2013 incorporates many of the changes that were consulted on, and will where possible, include further changes resulting from additional suggestions heard through consultation.

Since the Francis report two additional reports have been published, namely the Keogh and Berwick reviews (July and August 2013 respectively). Collectively all three reports recommend that:

- Patients need to be put first; listened to and involved.
- Staff need to be listened to, nurtured and supported.
- Quantitative data has strengths but is limited; emphasis placed on the value of qualitative data to add more meaning to intelligence.

- Regulation is not the answer. Where quality of care and patient safety are concerned, it is the culture of teams and organisations that counts.

3 The Francis Report: One Year On

In the year since the publication of the Francis Report NHS England (NHSE) has led a number of national initiatives to address the concerns raised in this landmark report. These include:

- Launch of the Friends and Family Test, first in all inpatient wards and A&E units and now in all maternity services, to gather real-time patient feedback on which hospitals can take immediate action to improve their patients' experiences. The test will be rolled out to all parts of the NHS in the coming years.
- Roll out of the three year new plan for nursing, midwifery and care staff – the Compassion in Practice strategy, which includes the "6Cs" which are being implemented across all areas of care, training and practice.
- During 2013, NHSE's medical director, Professor Sir Bruce Keogh, carried out a review of the quality of care and treatment provided by 14 hospital trusts that are persistent outliers on mortality indicators, developing a new patient-centred approach to investigation that has been taken on by the CQC.
- NHSE's Board approved the development of a network of Patient Safety Collaboratives. These will ensure everyone involved in healthcare; staff, clinicians, patients, leaders, commissioners and regulators, are able to work together in a collaborative way to assess and improve safety, to build capability, and to focus on the actions that can make the biggest difference to patients[1].
- In response to the staffing guidance published by the Chief Nursing Officer and National Quality Board, every Trust in England has been directed to publish actual versus expected nurse, midwifery and care staffing levels and

[1] The programme to develop Patient Safety Collaboratives includes establishing a Patient Safety Improvement Fellowship scheme to develop 5,000 Fellows within a national faculty within five years.

to clearly explain how they have decided on their staffing numbers in each ward and clinical area.

- At the end of 2013, trusts in the North of England began regular publication of numbers of patients who develop pressure ulcers and patients that fall while in hospital. This will be combined with the results from the Friends and Family Test, the NHS safety thermometer, patient and staff experience surveys and patients stories, all in one place, to build up a picture of care quality and an excellent and open reporting culture.
- As part of a commitment to be open and transparent about patient safety incident reporting, NHSE has begun publishing data on never events in greater detail than ever before.
- NHSE has launched the new National Patient Safety Alerting System (NPSAS) which will ensure warnings of emerging risks can be rapidly issued. As part of the new process, by April 2014 NHSE will also begin publishing monthly data on trusts who fail to confirm they have complied with the required actions of an alert within the set timeframe.
- Quality Surveillance Groups (QSAGs) have been put in place across NHSE's 27 area teams and four regions, to share information and address quality of care. The groups are formed from a range of stakeholders and look at what data such as mortality rates and soft intelligence like patient opinions tell us about where there might be concerns about the quality of care, what patients and clinicians are worried about in terms of service quality, and what can be done to investigate and address those worries. NHSE is working with the new groups as they develop to set out national guidance for collaborative quality surveillance.
- In the last 12 months, NHSE have started publishing outcome data from consultants in 12 surgical specialties, with more to come, as well as more detailed data than ever before on GPs outcomes. This will extend and link data collection from all healthcare settings to provide a fuller picture than ever before of how well health services as a whole care for patients.
- NHSE plan to develop a new national safety website which will bring together, for the first time, all of the relevant safety information and make it

accessible for the NHS, patients, media and relatives alike. This will include information on staffing, pressure sores, falls and other key indicators, where possible, at ward level.

4 Actions taken by Haringey CCG to date

At the heart of the Francis report is a determination that the Inquiry's recommendations and findings be implemented and not suffer the same fate as many previous Inquiries. The report's first recommendation sets out requirements for **oversight and accountability** to ensure implementation of its proposals including all commissioning, service provision, regulatory and ancillary organisations in healthcare should reflect on the report and its recommendations and decide how to apply them to their own work.

Haringey CCG has begun this process following publication of the initial findings and will continue to reflect and act upon the report's findings. In partnership with local stakeholders such as Haringey Health Watch, Haringey CCG (HCCG) will share actions taken across the health and social care system locally and seek out best practice nationally to identify further ways to improve patient care.

The Francis report recommends that each organisation should announce at the earliest opportunity its decision on the extent to which it accepts the recommendations and what it intends to do to implement them. Each organisation should publish, at least annually, a report on its progress in achieving its planned actions.

Haringey CCG accepts the overall principles of the report. Soon after the publication of the Francis report in 2013, HCCG Governing Body (GB) reviewed a locally developed Francis assurance framework which set out the key actions for the CCG as a commissioning organisation. Further to this, the Quality Committee (subcommittee to the Governing Body) continues to consider the specific details/ findings of the report and the progress made by the CCG in responding to the key actions.

In March 2014 the GB will be presented with a refreshed assurance framework and a local action plan. The panel is asked to note that the development of framework and action plan has not prevented incremental improvements taking place but will ensure all gaps are identified across the recommendations more applicable to the CCG than others.

Below are some examples of the work HCCG has already begun This list is not exhaustive but acts as a foundation on which further improvements will need to be built.

- The CCG expects all commissioned services to use feedback to improve their services and work alongside the CCG to regularly inform, consult and involve patients, their families, carers and the public in the planning and review of services. During 2013 the CCG developed a Communication and Engagement Strategy (2013) which adopts a number of approaches to collecting views.
- In January 2014 the Haringey CCG Quality and Patient Safety Strategy (2014) was approved by the Governing Body. This strategy supports the CCG in keeping quality at the heart of all the CCG does. It communicates the vision, key drivers and ambitions for quality and it explains how the CCG will deliver this vision. It describes the CCG's commitment to continuous improvement of quality outcomes and encourages the development of robust quality assurance mechanisms, in order to provide assurance to the Governing Body about the standard of quality and patient safety in commissioned services and is available on the CCG website[2].
- The CCG is implementing an 'Insight and Learning Programme' to listen, record, triangulate, investigate, learn, act and share patient experience. The programme will include the presentation of patient and carer stories, 'walk the patient pathway' visits and a mechanism for our stakeholders and partners to send us 'quality alerts' to highlight a concern or example of good practice. It is hoped that the 'Insight and Learning Programme' will inform and support Healthwatch's schedule of Enter and View visits.

[2] http://www.haringeyccg.nhs.uk/

- Work has begun across North Central London (NCL) CCGs to ensure system improvement is sought out and knowledge and best practice are shared.
- The CCG has been participating in the local Quality Surveillance Group (QSAG) chaired by NHSE and is working with other CCG colleagues to identify system wide issues through intelligence sharing.
- A number of the Francis recommendations are already enshrined in legislation, old and new. Duty of candour [3]is a good example of this and is in every contract with our local acute and community providers.
- Locally developed 'key performance indicators' (KPIs) are being included in acute and community 2014/15 contracts to drive performance in key areas such as complaint handling, mandatory training and incident reporting.
- The CCG meets acute provides on a monthly basis to receive quality assurances. This assurance is sought across the 3 quality domains, patient experience, clinical effectiveness and patient safety. This information is combined with a range of quantitative and qualitative data and included in the CCG's integrated performance dashboard. The dashboard is discussed internally and reviewed at every meeting of the GB.
- The CCG is joining with NCL CCG's to facilitate a learning event with NHS commissioned services to review the collective local response to the implementation of the recommendations in the Francis Report. It is anticipated that through this wider engagement innovative solutions to more challenging areas will be found.
- Initial discussions have highlighted the need to embed openness and transparency into CCG processes. Additionally where possible and appropriate the sharing of intelligence about potential quality issues occurs more readily.
- The Francis Inquiry makes specific recommendations in relation to frail elderly people. It is clear from this inquiry alongside inquiries such as the one undertaken into Winterbourne view that the most vulnerable patients are at the most risk from harm. Haringey CCG and Haringey Local Authority are prioritising the care of older people and have placed particular emphasis

[3] The NHS Constitution includes a new passage which emphasises that "respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported".

on the quality of care provided in local nursing homes during 2013/14. The CCG has recently refreshed its approach by implementing the 'Quality Matters in Care Homes' programme. One of the aims of this service is to ensure that quality in Haringey nursing and residential care homes is systematically monitored and improving.

- The CCG is working with local acute providers to ensure robust arrangements are in place to manage and learn from complaints in a systematic way and to communicate how services are responding and changing to patient feedback.
- The CCG is constantly seeking ways to actively identify quality issues through innovative means, for example in February 2014 a system of quality alerts for General Practitioners will be introduced to raise concerns on behalf of their patients. This will identify opportunities to improve the care patients, particularly around communication and discharge processes.
- Close working with partner agencies for both children and adult safeguarding continues. The CCG is keen to triangulate safeguarding systems and processes with other quality alerts, in particular the CCG's response to the prevention of pressure ulcers.

5 Conclusion

As stated at the beginning of this document, the full implications of this public enquiry cannot be fully realised instantly or indeed within a year. In order to fully implement the recommendations a fundamental shift in culture is required; this will take time and continued commitment.

In order continue on this journey the CCG will focussing on the following areas during 2014/15 to strengthen oversight and accountability and ensure that the services commissioned by the CCG on behalf of the people of Haringey are of the highest quality and delivered with dignity and compassion.

- Ensure that the CCG Governing Body, Health & Wellbeing Board, and other forums continue to be briefed on the progress of this work programme and the issues it raises throughout 2014/15.
- Build on work started to ensure that patients' needs and the quality of

- care they receive is to the top of the agenda, always.
- Respond to Francis Report and Keogh and Berwick reviews in a meaningful way that will improve the care HCCG commission' for patients.
- Strengthen the way in which the CCG measures, monitors and reports performance of commissioned services to ensure organisations are held to account when the quality and safety of services falls below the expected standard.
- Embed the Insight and Learning Programme to drive performance and assure a compassionate and caring culture in commissioned services.

Jennie Williams Executive Nurse and Director of Quality and Integrated Governance

14 February 2014