Health and Wellbeing Hertfordshire

HERTFORDSHIRE COUNTY COUNCIL

Agenda Item No.

7

HEALTH AND WELLBEING BOARD

Wednesday 26th June 2013 at 1.30pm

The Mid Staffordshire NHS Foundation Trust, lessons, recommendations and implications for the Hertfordshire Clinical Commissioning Groups

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1. Purpose of report

1.1 The purpose of this report is to brief Health and Wellbeing Board members on the implications of the Francis inquiry recommendations to Clinical Commissioning Groups; to understand the progress being made by the two local Clinical Commissioning Groups and to consider how the Health and Wellbeing Board can support and influence progress towards demonstration of accomplishment.

2. Summary

2.1 The Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. Published on 6th February 2013 it makes 290 recommendations designed to change the failings it found and aims to create a common patient centred culture across the NHS, with a zero tolerance approach to providing poor and unsafe care to patients and criminal prosecution for breaching fundamental care standards. All organisations are asked to consider the recommendations and announce at the earliest practicable time, their decision on the extent to which they accept the recommendations and what they intend to do to implement those accepted.

2.2 The Francis Inquiry makes clear the expectations on commissioners; to drive quality improvements, effectively monitor the quality of service provision, hold

providers to account, re-provide services where there are concerns and advise regulators where fundamental standards have been breached.

2.3 The report sets outs Francis's recommendations for Commissioners, key findings from the inquiry, lessons learnt and key actions to be taken.

- Wider system – warning signs ignored/not escalated nor recognised by a range of external organisations, including CQC, CHCC, Monitor, PCT, SHA. In respect of the PCT and SHA he comments that both organisations were in transition during this time.
- The Board and other leaders within the Trust failed to appreciate the enormity of what was happening. Reacted too slowly if at all to some matters of concern and downplayed the significance of others.
- Clinicians were not engaged
- Patients not heard with inadequate processes for dealing with complaints and SIs

2.4 Each of the local Clinical Commission Groups provide an update of the actions they have taken to date and how they plan to move forward with the recommendations.

2.5 Further detail and background in Appendix below.

3. Recommendation

3.1 The Health and Wellbeing Board are asked to:

- Support the work already being undertaken by the CCGs.
- Take some time to consider what influence and contribution it too can make to the Francis recommendations based on its collaborative authority and responsibility to drive Health and well being.

APPENDIX

The Mid Staffordshire NHS Foundation Trust, lessons, recommendations and implications for the Hertfordshire Clinical Commissioning Groups

Introduction:

The Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. Published on 6th February 2013 it makes 290 recommendations designed to change the failings it found and aims to create a common patient centred culture across the NHS, with a zero tolerance approach to providing poor and unsafe care to patients and criminal prosecution for breaching fundamental care standards. All organisations are asked to consider the recommendations and announce at the earliest practicable time, their decision on the extent to which they accept the recommendations and what they intend to do to implement those accepted.

This Report provides a summary of the key elements and recommendations within the Report that have direct implications for the Clinical Commissioning Groups. It does not cover other far reaching recommendations for the wider system, which include professional regulation, medical training and education, coroners and inquests, the Health and Safety Executive, or requirements for providers and Department of Health Leadership.

The Francis Inquiry makes clear the expectations on commissioners; to drive quality improvements, effectively monitor the quality of service provision, hold providers to account, re-provide services where there are concerns and advise regulators where fundamental standards have been breached.

The challenge for the CCGs will be in ensuring that bureaucracy is kept to a minimum, whilst being determined to see real quality improvements across all providers.

Background:

Two independent inquiries were carried out by Robert Francis, following appalling failings in the care provided to patients in Mid Staffordshire Hospital between 2005 and 2009 where up to 1,200 more people died than at similar Trusts.

The first inquiry published in 2010 found that the most basic elements of care were neglected, while the Trust focused on cost cutting and hitting government targets.

The second inquiry examined the failure of regulators, supervisory and commissioning bodies to recognise, escalate and act on the poor care patients were receiving.

Recommendations for Commissioners:

Commissioners of services must ensure that services are well provided and are provided safely

Commissioners supported by the NCB and clinicians should develop enhanced quality standards for local providers, over and above the fundamental standards determined by the CQC. These can be incentivised.

Local commissioners must be adequately resourced to enable proper scrutiny and enable audits, inspections and investigations as required of services or individual cases. Commissioners must have access to complaints, quality accounts and providers Quality Risk Profiles and concerns should be shared with regulators

The responsibility for driving improvement in the quality of services rests clearly with commissioners.

Commissioners need to identify whenever possible alternative sources of provision

Commissioners should be able to stop services that do not accord with the contract and stop services in breach of fundamental standards or require it to be provided in a different way.

Commissioners not the providers should decide what needs to be provided in conjunction with clinicians, GPs and other commissioning bodies.

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Commissioners should in contracts, require the boards of providers to seek and record the views and advice of its nursing and clinical directors, of the impact on the fundamental standards of proposed major change to clinical or nurse staffing arrangements.

Commissioners must involve the public in commissioning and enable their views to be taken into account and therefore must improve their public profile through public membership lay members, patients forums, public patient surveys

GPs must take on a monitoring role on behalf of their patients or providers . They require internal systems enabling them to be aware of patients concerns, so that they do not just consider individual cases and must keep themselves informed of the standards of service available at various providers.

Commissioners should apply fundamental standards to each item of service commissioned agree a method of measuring compliance and redress for non-compliance. In selecting indicators the focus should be on what is reasonably necessary to safeguard patients and engage closely with patients, past, present and potential but require convincing evidence NCB will develop metrics in conjunction with commissioners

Commissioners should ensure decision making process are transparent and hold public meetings

Consideration should be given to commissioning patient advocates and support services for complaints against providers

In performance management of providers there must be clear and ambiguous lines of referral and information

Commissioners must require providers to ensure that through identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.

Key Findings

The key findings from the Inquiry, on which the priorities for commissioners have been based, are summarised below:

- Wider system – warning signs ignored/not escalated nor recognised by a range of external organisations, including CQC, CHCC, Monitor, PCT, SHA. In respect of the PCT and SHA he comments that both organisations were in transition during this time.
- The Board and other leaders within the Trust failed to appreciate the enormity of what was happening. Reacted too slowly if at all to some matters of concern and downplayed the significance of others.
- Clinicians were not engaged
- Patients not heard with inadequate processes for dealing with complaints and SIs

Poor Governance

- Lack of clinical governance and risk management
- Lack of focus on standards of service
- Inadequate risk assessment
- Inadequate nurse staffing levels and poor leadership
- Wrong priorities focused on by the Trust - prioritised finances and Foundation Trust (FT) application over the quality of care

Lessons learned

- Negative culture
- Lack of openness
- Lack of consideration for patients
- Defensiveness
- Looking inwards not outwards
- Secrecy
- Misplaced assumptions
- An acceptance of poor standards
- A failure to put the patient first in everything that is done.

Key actions required to address issues:

- Common values putting the patient first – the NHS Constitution reinforced through leadership training
- Simplifying regulation – transferring the functions of regulating the governance of healthcare providers and the fitness of persons to be directors, governors (or equivalent) from Monitor to the CQC.
- Clearer fundamental core CQC standards
- Enforcement of compliance – compliance reported in QA, with the cessation of services by commissioners which are not consistently meeting these.
- Non-compliance that leads to death or serious harm prosecuted as a criminal offence
- Changes to the FT application process, with the requirement to meet all criteria and proceeded by a CQC inspection.

- Disqualification of Directors deemed to be unfit
- Effective complaints and incidents process, with the requirement that complaints and incidents that potentially breach a fundamental standard being made accessible to the CQC, Commissioners, HOSC communities, and Health Watch.
- Learning from complaints must be made known to complainants and the public
- Enhanced public and patient engagement – this must be stronger with better information provision and access arrangements for Heath Watch.
- Health Overview and Scrutiny Committees to be given power to inspect providers
- Openness transparency and candour should become a statutory obligation and should be imposed on healthcare providers, doctors and nurses, through codes of conduct.
- Directors must be truthful in any information given to a regulator or commissioner, with it being made a criminal offence to deliberately mislead or omit key information given to a regulator
- Focus on compassion in nurse recruitment with pre training requirements and revalidation requirements
- Healthcare workers should be registered
- Fitness to practise requirements to be strengthened
- Quality accounts to declare compliance against fundamental standards, signed by all Directors and scrutinised by the CQC
- Leadership college or training systems to be established.

Actions taken by East and North Hertfordshire CCG

Following publication of the Francis Inquiry, the Director of Nursing and Quality presented a report to the Governing Body in March, outlining the findings and recommendations from the Inquiry alongside a gap analysis of the CCG's position in relation to the recommendations highlighted above. The Governing Body accepted all the recommendations and since then a more in depth action plan has been developed to ensure all requirements have been captured, including actions required to be taken by providers, this will be monitored by the CCG Quality Committee but the focus is on ownership of the issues, rather than simply the delivery of yet another action plan.

Actions already taken include:

- A statement of commitment to the Francis Inquiry recommendations has been placed on the CCG website.
- A workshop on the issues identified by Francis has taken place for all GP Quality Leads.
- Inclusion within the Quality Schedule of provider contracts, an overarching requirement to meet the recommendations within the Francis Report.
- A refocusing on what key intelligence is required to inform the CCG in relation to the quality of service provision and the strengthening of accountability and structure and investment in resources available to monitor quality of providers.
- Monitoring of improvement actions in relation to Francis as a standing agenda item, at all provider quality meetings.

- Unannounced inspections of providers have been carried out by the CCG where concerns have been identified and a programme of routine announced and unannounced visits has been developed.
- Development of a Patient Network (Quality Committee) whereby members following training are supported to gather patient stories on behalf of the CCG and a strong patient focus within the CCG.
- Production of a Quality Assurance Strategy that clearly outlines the CCG approach to quality post Francis.
- Full attendance by the CCG at Area Team Quality Surveillance meetings, to share intelligence.
- A hot line for GPs to report concerns has been re launched.
- A process of regular review and scrutiny of key provider's complaint summaries is being rolled out.

Actions taken by Hertfordshire Valleys CCG

Following publication of the Francis Inquiry, the Director of Nursing and Quality presented a report to the Board in March 2013, outlining the findings and recommendations from the Inquiry. The Board received the gap analysis of the CCG position in relation to the recommendations highlighted above in May. The Board accepted all the recommendations and is now in the process of working with the Quality and Patient Safety Committee to develop a more in depth action plan, it will be presented in early July. The plan will be clinically led to ensure all requirements have been captured, including actions required to be taken by providers.

When we talk about providers it is, of course, essential to remember that whilst the Francis inquiry focused on the failings of an Acute Trust, we as commissioners, must place our attention on all commissioned services across health including mental health, ambulance services, primary care services, community health care, nursing and care homes and private hospitals.

The CCG recognises that a transactional plan alone will not capture all the lessons learnt from Francis about Negative culture; Lack of openness; Lack of consideration for patients; Defensiveness; Looking inwards not outwards; Secrecy; Misplaced assumptions; An acceptance of poor standards and A failure to put the patient first in everything that is done. The CCG has therefore set itself the ambition of developing a question that challenges us as commissioners to ask ourselves something like '*how do I know that what I do each and every day demonstrates compassionate care and a quality patient experience for patients*?' And through our providers we'd like to know 'how do you demonstrate that each of your patients receives compassionate and safe care which gives them an excellent patient experience?' Once agreed the plan will be monitored by the CCG Quality and Patient Safety Committee.

Actions already taken include:

- Inclusion within the Quality Schedule of provider contracts, an overarching requirement to meet the recommendations within the Francis Report.

- A refocusing on what key intelligence is required to inform the CCG in relation to the quality of service provision and the strengthening of accountability and structure to monitor quality of providers.
- Monitoring of improvement actions in relation to Francis as a standing agenda item, at all provider quality meetings.
- Unannounced inspections of providers have been carried out by the CCGs where concerns have been identified and a programme of routine announced and unannounced visits is in the process of being developed.
- Some of our Patient and Public Involvement groups have been involved in Francis discussions and these discussions will be developed further to help us gather patient stories on behalf of the CCG and ensure a strong patient focus within the CCG.
- Production of a Quality Assurance Strategy that clearly outlines the CCG approach to quality post Francis.
- Full attendance by the CCG at Area Team Quality Surveillance meetings, to share intelligence.
- A hot line for GPs to report concerns.
- A process of regular review and scrutiny of key provider's complaint summaries is being rolled out.

Conclusion:

The first inquiry stated it should be patients – not numbers – which counted. The second inquiry upholds that view, it calls for a culture of change and requires all commissioning, service providers, regulatory and ancillary organisations in health care to consider the recommendations and announce its decisions on the extent to which it accepts the recommendations and what it intends to do to implement them. Thereafter publish on at least an annual basis a progress report. It also outlines the key role that commissioners need to play in ensuring the delivery of safe, effective care that patients are satisfied with. The CCG's recognise and accept responsibility for their leadership role within the system, to ensure safe, high quality services are delivered and that the voices of their patients are heard and are used to inform service improvement.

Recommendations:

The Health and Wellbeing Board are asked to :-

1. Support the work already being undertaken by the CCG's.
2. Take some time to consider what influence and contribution it too can make to the Francis recommendations based on its collaborative authority and responsibility to drive Health and well being.

SR/JN June 2013