MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 25TH APRIL, 2013

AT 9.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

Dear Members of the Committee,

Please find enclosed additional papers relating to the following items for the above mentioned meeting which were not available at the time of collation of the agenda.

Item No	Title of Report	Pages
5.	QUALITY AND SAFETY – A RESPONSE TO FRANCIS	1 - 34

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AGENDA ITEM 5

Meeting	Health and Well-Being Board
Date	25 April 2013
Subject	**Quality and Safety – A response to Francis**
Report of	Chief Officer, Barnet Clinical Commissioning Group (CCG)
Summary of item and decision being sought	This report provides a summary of the main issues raised from the public inquiry into the events at Mid Staffordshire hospital carried out by Robert Francis QC. It also includes the main recommendations from that report which have significance for the CCG, and sets out Barnet CCG's progress to assess its current priorities; and it advises of next steps.

Officer Contributors	Vivienne Stimpson Director of Quality and Governance John Morton, Chief Officer, Barnet CCG
Reason for Report	To provide assurance that the CCG has begun to consider and reflect on the implications of the second Francis Report and the most recent publication released by the National Quality Board and has identified the next steps.
Partnership flexibility being exercised	None
Wards Affected	All

Contact for further information

Vivienne Stimpson, Director of Quality and Governance Barnet CCG - Vivienne.stimpson@nclondon.nhs.uk

1. RECOMMENDATION

1.1 The Health and Wellbeing Board is asked to note and support the steps CCG Barnet is taking to address the findings of the Francis Report. This report details plans the CCG has in place to ensure that all the recommendations from the second inquiry by Robert Francis QC are fully considered and responded to at a Board level and highlights key areas for further action.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Barnet CCG Board meeting held on 4 April 2013.

2.2 Barnet Clinical Quality and Risk Committee March 2013.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 The specific issues outlined in this report will assist the Health and Well Being Board to deliver all key priorities in the Health and Well-Being Strategy. They will inform more specific commissioning plans developed both by the Council and Barnet Clinical Commissioning Group.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Barnet Joint Strategic Needs Assessment includes information on health outcomes for the local population. These will be addressed through implementing the Francis report and add context to Francis recommendations

5. RISK MANAGEMENT

5.1 The CCG needs to ensure the recommendations from this inquiry are fully considered in its role as a commissioning organisation.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 Additional resources may be needed to implement some of the recommendations in this report: these will need to be prioritised against CCG/LBB commissioning intentions and where appropriate funded from within existing NHS and local authority budgets.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A report was presented to the CCG Board in March 2013 to begin to engage with stakeholders.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 All providers are required to prepare a response to the Francis Report. Senior representatives from Barnet and Chase Farm Hospitals NHS Trust and Royal Free Hospital NHS Trust are in attendance at this meeting.

10. DETAILS

Background

10.1 This second and final report of the public inquiry into Mid Staffordshire NHS Foundation Trust published on the 6th of February 2013 provides detailed and systematic analysis of what contributed to the failings in care at the trust. It identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the trust's problems for so long, even when the extent of the problems were known. Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area, Mid-Staffordshire NHS Foundation Trust. During this period of time the Trust had come under close scrutiny in relation to its application for Foundation Trust status by the Department of Health, the Strategic Health Authority, Monitor, the Healthcare Commission, and the NHS Litigation Authority alongside local scrutiny groups and public involvement groups all of which had found that the Trust met the applicable standards and found no systematic failings. The truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them.

10.2 A focus on Patients

The Report recognises that what happened in Mid Staffs was a system failure, as well as a failure of the organisation itself. Rather than proposing a significant reorganisation of the system, the report concludes that a fundamental change in culture is required to prevent this system failure from happening again, and that many of the changes can be implemented within the current system. It stresses the importance of avoiding a blame culture, and proposes that the NHS – collectively and individually –adopt a learning culture aligned first and foremost with the needs and care of patients.

10.3 The report makes 290 recommendations, which focus 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'. However, no single recommendation should be regarded as the solution to patient safety.

10.4 Patients must always come first if the NHS is to deliver the best and safest care possible. Patient care is everyone's responsibility. Implementing some of the recommendations in the report will be difficult, but the right thing to do.

10.5 While the inquiry was confined to Mid Staffs, there is evidence there are other places where unhealthy cultures, poor leadership and an acceptance of poor standards are too prevalent. Robert Francis' first recommendation is for everyone in the NHS to consider and review what happens in their own organisation in light of the inquiry's findings, and identify any actions they may need to take to ensure what happened in Stafford does not happen in their organisation. We propose an

NHS Barnet CCG with the CSU produces its own action plan over the next three months and report to the Board in June 2013. This work will be led by the Quality and Clinical Risk Committee

10.6 The report stated desire for more transparency and real-time information for both the public and providers will ensure the spread of accountability at all levels of the NHS. In addition, by providing clarity over who is responsible for improvements in quality we have a real mandate for change. Robert Francis' view is that the whole system must now revolve around quality and that top-down management is no longer viable. To achieve this will take real commitment from CCGs. It is clear that the levers for the transformation of services are already embedded in the system.

Francis does not lay the blame at any individual's door - and the report is clear that Mid- Staffs was a reflection of a system-wide failure.

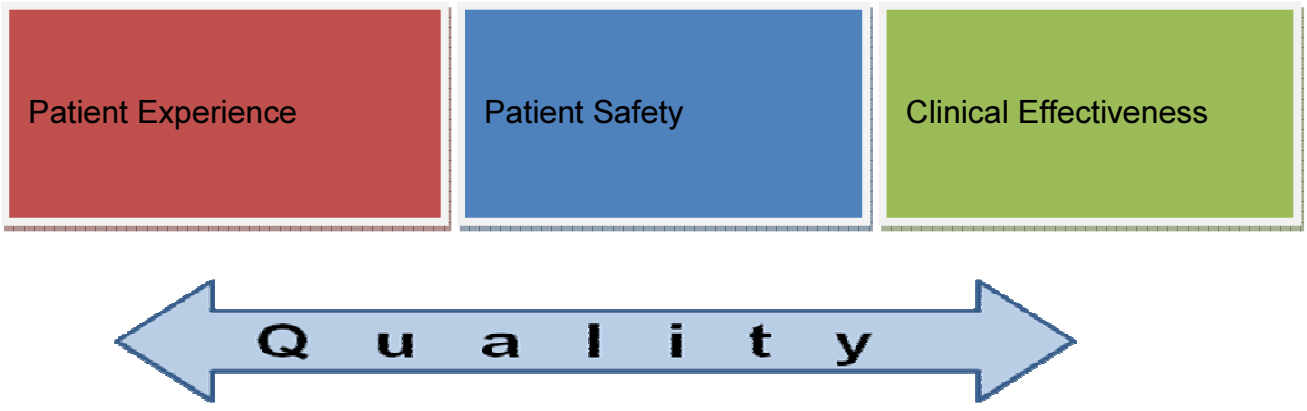
National Quality Board

10.7 The National Quality Board released a draft report in May 2012, which they finalised January 2013: Quality in the new health system; maintaining and improving quality. The report focuses on how the new health system should prevent, identify and respond to serious failures in quality and provides a collective statement from the NQB members as to:

- The nature and place of quality in the new health system.
- The distinct roles and responsibilities for quality in the different parts of the system.
- How the different parts of the system should work together to share information and intelligence on quality to ensure an aligned and co-ordinated system wide response in the event of a quality failure.
- The values and behaviours that all parts of the system will need to display in order to put the interests of the patient and public first and ahead of organisational interests.

10.8 The Health and Social Care Act 2012 is fundamentally changing the way the NHS, public health and care system in England is organised and run.

FIGURE 1: Definition of quality
High quality care requires all three dimensions to be present Clinical Effectiveness Patient Experience and Patient Experience
This definition of quality has now been enshrined in legislation through the Health and Social Care Act 2012.[10]



The NHS is organising itself around a single definition of quality: care that is effective, safe and provides as positive an experience as possible. This simple, yet powerful definition that arose out of the NHS Next Stage Review has now been enshrined in legislation. It lies at the heart of the first ever NHS Outcomes Framework and continues to help unite the ambitions and motivations of staff with the hopes of patients and the expectations of the public. It is also inherent in the related Outcomes Frameworks for public health and adult social care. The appalling failures at Mid Staffordshire NHS Foundation Trust and at the independent hospital, Winterbourne View, provide stark reminders that when we fall short on our responsibilities in respect of quality, the consequences for patients, service users and their families can be catastrophic.
At the same time, we must also recognise that the provision of high quality care is an inherently complex and fragile operation. Quality is systemic -the patient journey cuts across primary and secondary care, health and social care, links with public health services and involves multiple professionals.

11.0 Our Commitment to Quality

As Leaders of the local system of commissioning, regulation and performance monitoring we are, nevertheless, clear about our individual and collective responsibility for creating the conditions and the environment which allows quality to prevail and ensures that the interests of patients always come first. Overall, the health economy must:

- Reaffirm our commitment to the primacy of quality in the new system;
- emphasises the critical importance of values and behaviours in creating a system that is truly focussed on quality and always places the interests of patients ahead of individual or organisational ambition;
- sets out the central role that patients and service users must play in the oversight and scrutiny, design and measurement of high quality services; provides clarity around the distinct roles and responsibilities for quality of individuals and organisations across the new system architecture;
- presents a new approach for supporting collaboration across the system and facilitating the sharing of information and intelligence on quality through a new network of Quality Surveillance Groups; and ensures that there is a clear and agreed approach to taking swift and coordinated system-wide action in the event of a serious quality failure being identified, in order to rapidly protect patients and service users.

12.0 Summary of the recommendations

Ensuring implementation of the inquiry's recommendations

At the heart of the report is a determination that the inquiry's recommendations and findings be implemented. Its 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.
- 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.
- The Department of Health should publish a report, at least annually, collating information about the decisions, actions and progress reported by other organisations.
- The House of Commons Select Committee on Health should incorporate progress on implementation as part of their reviews of organisations in their normal business.

12.1 Creating the right culture and putting the patient first

The report highlights the importance of establishing a shared positive safety culture that permeates all levels of the healthcare system, which aspires to prevent harm to patients and provide where possible, excellent care and a common culture of caring, commitment and compassion. This requires:

- Shared values in which the patient is the priority of everything done
- Zero-tolerance of substandard care
- empowering frontline staff with the responsibility and freedom to deliver safe care
- strong and stable cultural leadership and organisational stability
- comparable data on outcomes
- expectations of openness, candour and honesty.

Leaders of organisations are expected to adopt the shared culture themselves, and be seen to do so. This should be supported by measures such as open board meetings, personally listening to complaints and an open and honest admission where there is an inability to offer a service. At a system level, this should be demonstrated by constantly considering how the wellbeing of patients is protected or improved by proposed measures.

12.2 Putting the patient first

The report underlines the importance of making patients the main priority in all that the healthcare system does. Within available resources, patients must be expected to receive effective services from caring, compassionate and committed staff, working to a common culture. They must also be protected from avoidable harm and any deprivation of their basic rights.

12.3 Fundamental standards of behaviour

The report proposes that fundamental standards of behaviour which apply to all staff that work and serve in the healthcare system, be enshrined in the NHS Constitution. Recommendations to achieve this include:

- Incorporating explicit reference in the Constitution to all professional and managerial codes by which NHS staff are bound, and an expectation that staff will follow and comply with standards relevant to their work.
- Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work.
- Professional bodies should work to provide evidence-based standard procedures for as many interventions and pathways as possible.
- Managers need to ensure that their employees comply with these requirements.

- Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary.
- Employers must insist on the reporting of concerns relating to patient safety – employees should receive feedback on any action taken.

12.4 An integrated hierarchy of standards of service

The report proposes establishing an integrated hierarchy of service standards to promote the likelihood that a service will be delivered safely and effectively. Standards would range from mandatory fundamental service standards to discretionary developmental standards, with clear expectation of zero-tolerance towards any organisation providing services that do not comply the fundamental standards. The standards should be evidence-based and measurable, and be clear about what needs to be done to comply.
They should also be subject to regular review and modification.

12.5 Responsibility for and effectiveness of, healthcare standards

The report highlights the importance of simplifying the regulation regime for NHS trusts to eradicate overlap and minimise the gaps between the functions of the different regulators. It proposes significant changes to the current division of regulatory responsibilities between Monitor and the Care Quality Commission (CQC), with the creation of a single regulator for all trusts, including foundation trusts. Monitor would retain its residual role as a regulator of the health economy. It suggests that these changes be implemented incrementally after thorough planning, and should not be used to justify reducing resources allocated to regulatory activity. It also stresses the importance of retaining the corporate memory of both organisations. Recommendations are:-

- Creating a single regulator for all trusts
- Monitoring compliance with standards
- Setting standards and developing evidence-based compliance
- Effective assessment of compliance with standards
- Effective assessment of compliance and enforcement of compliance with standards
- CQC independence, strategy and culture

12.6 Responsibility for, and effectiveness of, regulating health systems Governance

The report recognises that, "much high-quality, committed and compassionate nursing is carried out day in and day out, often with inadequate recognition." However it states, "it is clear that the nursing issues found in Stafford are not confined to that hospital but are found throughout the country' and argues the NHS needs to give the highest priority to 'reversing the scandalous decline in standards." The report focuses on the culture of caring requiring more focus on delivering compassionate care at the point of recruitment, in training and through annual appraisal. The report also examines and makes recommendations in relation to the role of nursing leadership and that of healthcare support workers.

This area of recommendations covers the following issues:

- Consolidating Monitor's regulatory functions
- Authorisation of Foundation Trusts (FTs)
- Role of FT governors
- Accountability of directors

12.7 Effective assessment of compliance and enforcement of compliance with standards

- Any service that does not consistently meet the relevant fundamental standards should not be allowed to continue.

- Effective enforcement should be ensured by installing a low threshold for suspicion, and no tolerance of non-compliance with fundamental standards.
- It should be a criminal offence where death or serious injury is caused by breaching fundamental standards.
- Failure to disclose breaches of fundamental standards should also attract regulatory actions.
- Interim measures:
- The CQC should be able to take immediate steps to protect patients where it has reasonable cause for concern about an issue, even if it is still investigating non-compliance.
- A public interest test should decide whether there are reasonable grounds to make the interim requirement or recommendation.

12.8 CQC independence, strategy and culture

- Any attempts to abolish the CQC and create a new organisation should be avoided, and its role should develop on an evolutionary basis.
- The CQC needs to be seen as acting entirely independently of government, and the Government should only consider it necessary to intervene in the CQC in the most extreme circumstances.
- The relationship between the CQC and the Department of Health (DH) must be meticulously transparent and where issues relating to regulatory action are discussed, they must be properly recorded to allay any suggestion of inappropriate interference.
- Transferring power to define standards to NICE, or a similar body, may protect the regulator's autonomy while retaining powers for the Secretary of State to define outcomes.
- The structure under which the CQC is required to work is over-bureaucratic and does not separate clearly what is absolutely essential from what is merely desirable.
- The strategic direction of the new regulatory model being developed by the CQC is encouraging, but the leadership of the CQC should communicate this clearly to the public and its staff.
- CQC should review its processes to ensure that it is capable of delivering effective regulatory oversight and enforcement in accordance with the principles set out in the inquiry's report.
- The CQC should undertake a formal evaluation of how it would detect and act on the warning signs or other events causing concern similar to events that occurred at Mid Staffs, and open that evaluation to public scrutiny. .
- The culture within the CQC needs to change – there is a pattern consistent with a negative and closed culture of the sort they should be combating; it must be a model of openness, so that it can encourage employees in regulated organisations to come forward with concerns.
- The CQC board should have closer involvement with the healthcare professional community and patient representative groups.

12.9 Authorisation of FTs

- The processes of authorising FTs and monitoring compliance with FT standards should pass to the CQC, which should incorporate the relevant departments of Monitor
- The NHS Trust Development Authority (NTDA) must develop a clear policy requiring roof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a FT application
- No NHS trust should be supported to apply for FT status unless it meets the criteria for authorisation, including compliance with fundamental standards and a full physical inspection of its primary clinical areas and all wards.

- The stakeholder consultation process for assessing potential applicant NHS trusts for FT status should be jointly reviewed by DH, NTDA and Monitor.
- There should be a duty on applicants for FT status of utmost good faith to disclose any significant material information to the application, alongside ongoing obligations of transparency, openness and honesty.

13. Accountability of directors

All directors of all bodies registered by the CQC and Monitor should be, and remain a fit and proper person for the role.

Consideration should be given to including as criteria for fitness a minimum level of expertise and/or training.

Monitor and the CQC should produce guidance on procedures to be followed in the event of an executive or non-executive director being found guilty of serious failure in the performance of their office.

FTs should be required to have in place an adequate programme for the training and development of directors.

13.1 Commissioning for standards

The section on commissioning for standards pulls out the reflections and lessons learned by the primary care trust. The report suggests commissioning as a practice must be refocused to procure the necessary standards of a service as well as what it provides as a service (outcomes in quality as well as activity). Below are the recommendations for future commissioners:

- Commissioners should be closer to the public. The engagement of the public needs to be visible in the Commissioning process at Board level, through consultations, surveys and transparent decision making.
- Commissioners should set the commissioning agenda and make the final decision on what services are provided at a local level.
- Commissioners should be entitled to lay down a fundamental safety and quality standard/specification for services, as well as how the commissioner will measure compliance.
- In addition to fundamental standards, commissioners can promote improvement by requiring compliance with or development towards enhanced standards.
- Wherever possible, commissioners need to identify/make available alternative sources of provision so they are not constrained to one provider. To achieve this, commissioning may need to be undertaken collaboratively among commissioning groups to add collective weight to discussions with more dominant providers.
- Commissioners need specialist clinical expertise (not all of which can come from GPs), as well as procurement expertise to undertake their role effectively. Where commissioning groups are too small in themselves to acquire such support, they will need to collaborate with others.
- Commissioners must have the capacity and resources to monitor the performance of every commissioning contract on a continuing basis during the contract period, this may include:

1. quality information generated by the provider
2. commissioners undertaking their own (or independent) audits, inspections, and investigations
3. the possession of accurate, relevant, and useable information
4. monitoring compliance both with the fundamental standards and with any enhanced standards adopted.

- Commissioners must be entitled to intervene in the management of an individual complaint when they feel it is not dealt with satisfactorily (while the provider has primary responsibility). They must monitor complaints and their outcomes on as near a real time basis as possible.
- Commissioners should have contingency plans in place to mitigate risk from substandard or unsafe services.
- Commissioners should intervene where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from harm. These powers should align and compliment the role/action of regulators – acting jointly where needed. One method of action may be through the issuing of performance notices.
- The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive.
- GPs in primary care should undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services, developing an ongoing relationship and recording this through a systematic shared process. This will enable them to be aware of patterns of concern at a population level and effectively influence commissioning decisions.

13.2 Effective complaints handling

The report recognises that there should be a uniform process for managing complaints and that the "recommendations and standards suggested in the Patients Association's peer review into complaints at the trust should be reviewed and implemented nationally".

- Provider organisations must actively promote their desire to learn and act on comments and complaints. They must make it easy for those who wish to do so using a number of different methods.
- Overview and scrutiny committees, Local Healthwatch, commissioners and the CQC should all have access to complaints information. Where necessary, complaints should be investigated through an arms length independent investigation or where there are large scale clinical failures, the response should be coordinated through the National Quality Board.
- Commissioners should require access to complaints information at the time the complaints are made and should receive complaints and their outcomes "on as near real-time basis as possible"

13.3 Openness, transparency and candour

The report concludes that "insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding." The overall recommendations include:

- Full disclosure where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff – whether or not the patient asks.
- All organisations should review their contracts of employment, policies and guidance to ensure they reflect the need for openness, transparency and candour, as well as the National Patient Safety Agency's (NPSA) *Being open* guidance. At a national level, this would include reviewing the NHS Constitution and amending the Code of Conduct for NHS Managers.
- Conditions of registration or authorisation of healthcare organisations should be amended
  - to include a standard requirement that any information provided to the public about services, compliance with statutory standards and statistical results is truthful and not misleading. Compliance with the standard should be regulated by the CQC.
  - to oblige healthcare providers to provide all relevant information to enable the coroner

to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.

- Healthcare organisations, regulators and commissioners should be banned from policies and contracts which seek, or appear to seek, to limit genuine public interest disclosure on patient safety and care ('gagging clauses').
- A statutory obligation should be imposed to observe a duty of candour on healthcare providers, registered medical practitioners, registered nurses and other registered professionals who believe or suspect that treatment or care provided has caused death or serious injury to a patient.
- An additional statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation.
- It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation to:

  - knowingly to obstruct another in the performance of these statutory duties; provide information to a patient or nearest relative intending to mislead them about such an incident

  - dishonestly make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties. The duty should be policed by the CQC, which should have powers to prosecute.

13.4 Caring for older people

The report concludes that “the true measure of the NHS’s effectiveness in delivering hospital care can be found in how well the elderly are looked after” and makes the following recommendations:

- Hospitals should review whether to reintroduce identifying a senior clinician who is in charge of a patient’s case, to help ensure there is clarity over who is in overall charge of a patient’s care. Nominating a named nurse for each patient for each shift is also recommended to improve the coordination of care.
- Emphasis is placed on the importance of team working, including recognising and valuing the contribution of cleaners, maintenance staff and catering staff.
- Regular interaction between nurses and patients should be systematised through regular ward rounds:

  - All staff need to be enabled to have constructive and friendly interactions with patients

  - Where possible, wards should have areas where patients and relatives can meet in relative privacy and comfort

  - There should be a greater willingness to communicate by email with relatives

  - The current common practice of summary discharge letters followed up by more substantive ones should be reconsidered

  - Information about a patient’s condition, progress, care and discharge plans should be shared with that patient and where appropriate those close to them.
- The care offered by a hospital should not end “merely because the patient has surrendered a bed”, patients should never be discharged in the middle of the night or without assurance that a patient will receive the care they need when they arrive at a planned destination. Discharge areas in hospital need to provide continued care to the patient.
- All visitors and staff need to be reminded to comply with hygiene requirements, including junior staff being encouraged to remind anyone, including senior staff.
- Arrangements and best practice for providing food and drink require “constant review, monitoring and implementation”.

- In the absence of automatic checking and prompting, the nurse in charge of the ward, or their nominated delegate, needs to over see the administration of medication, underpinned by a frequent check.
- Where possible, recording of observations on the ward should be done automatically as they are taken, with results immediately accessible to all staff electronically in a form.

13.5 Information

The report is clear about the positive role that information can play, encompassing issues such as: highlighting inadequate performance; accountability; informing the public; and supporting patient choice. Francis advocates an integrated system with common information practices, while acknowledging that the Government's information strategy "appears to contain most if not all" of his suggested elements.

- Any electronic patient information system should have the facility to collect performance management and audit data automatically; be designed in partnership between health professionals and patient groups; and have the capability to go "over and above nationally required minimum standards."
- All providers should appoint a board member that holds responsibility for information.
- Quality accounts should outline information in a standardised format to enable comparison. They should be subject to independent audit and all directors should sign a declaration to verify the contents. The CQC and/or Monitor "should keep the accuracy, fairness and balance of quality accounts under review", they should also have the ability to place a requirement on providers to make corrections where necessary.
- Information utilised for quality and risk profiles should be publicly available "as far as is consistent with maintaining any legitimate confidentiality."
- A consistent approach nationwide for gathering patient and public feedback about NHS services.
- The Health and Social Care Information Centre should have an enhanced role, with proposed tasks including, for example: independent collection, analysis, publication and oversight" of health information; the transferral of information functions from the NPSA to the Centre.
- All providers should implement information systems that can offer real-time performance data on services, specialist teams and consultants. The information should be published "to the extent practicable" and made fully available to both commissioners and regulators.
- It is stressed that "all healthcare professionals" should acknowledge their duty "to collaborate in the provision of information required" for treatment effectiveness data. Such information should be published and regularly.
- The DH, Information Centre and UK Statistics Authority should undertake a review of patient outcome statistics. The first two should collaborate on ensuring that summary hospital-level mortality indicators (SHMIs) "or any successor hospital mortality figures" are "recognised as national or official statistics."

13.6 Specific Recommendations for Commissioners

One of the key recommendations from the first enquiry was to review the operation of the commissioning, supervisory and regulatory bodies with respect to their monitoring function and ability to identify failure in the provision of safe care.

The report found that a critical gap in the system of oversight of quality and safety arose from the inability of the commissioners to collect information on provider quality and to understand and make use of the contractual mechanisms that were available to them. On the evidence available, the report found that this was endemic among commissioning organisations. Barnet Clinical Quality and Risk committee is refreshing the performance framework so that it collects more detailed and relevant information from providers.

13.7 Priorities and Next Steps

1. Patients must always come first. In the light of the Francis report the CCG will be refreshing the Quality Strategy to reflect the Francis report findings .

2. The CCG recognises that implementing some of the recommendations in this report may be difficult. This is why the CCG wants to take more time to consider some of Francis' recommendations, so they achieve the desired effect and improver care. To this effect over the forthcoming months the CCG will be holding a workshop with stakeholders to examine Francis further. An initial draft stock take is attached in Appendix A that examines our current position against the commissioning standard.

3. Robert Francis' first recommendation is for everyone in the NHS to urgently consider and review what happens in their own organisation in light of the inquiry's findings, and identify any actions they may need to take to ensure what happened in Stafford does not happen in their organisation or in the case of the CCG that this does not happen in any of the services that we commission. The CCG will be formally requesting a review from all commissioned services.

4. As a priority the CCG is ensuring that the quality standards going into all contracts for 2013/2014 are robust and reflective of the recommendations within the Francis report, this piece of work is currently underway.

5. The CCG is undertaking an assessment of all (CIP)Cost Improvement Plans in commissioned services to assure itself in relation to any impact on quality and safety for patients.

Together the aforementioned will inform a more detailed action plan to be presented at a future CCG/HWBB meetings.

14. BACKGROUND PAPERS

14.1 None

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Commissioning for Standards

Barnet CCG current position against standards 123-144

Commissioning for Standards			
Standard			**Current CCG Position**
123	Responsibility for monitoring delivery of standards and quality	GPs need to undertake a monitoring role on behalf of their Patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of Outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.	The CCG has put a structure in place to actively engage with GPs and their patients on a continuous basis. This builds on structures that the CCG has had in place previously. Each GP has an opportunity to gather feedback within each consultation; a patient feedback system is under development to allow the information gathered by GP's in consultation to be feedback into a systematic way into the quality and risk system of the CCG. The CCG has a schedule of planned communication and engagement events as well as a patient participation system which allows patients and GPs to come together on a regular basis and discuss experience and concerns with care.

Commissioning for Standards			
Standard			**Current CCG Position**
			The CCG's Clinical Quality and Risk Committee, chaired by a GP Board Member supported by the Clinical Director for Quality and Governance, together they have overall responsibility for and oversight of clinical quality issues; the Quality committee as a sub committee of the board, also has a role to report areas of serious risk or concern to the Audit Committee, and both bodies report directly to the CCG Board. The Director of Quality and Governance chairs the quality contract monitoring meetings which are in place with our main local acute and community providers, Royal Free Hospital Trust, Royal National Orthopaedic Trust and Central London Community Healthcare Trust and is responsible for the clinical review and sign off of all serious incidents. The Quality and Governance Director acts as Clinical Quality Chair and is

Commissioning for Standards			
Standard			**Current CCG Position**
			the strategic lead for quality within the CCG as well as championing Quality with all GP members. In addition the Clinical Director has agreed to use the role to champion quality in primary care as well as commissioned services, at regional and national levels; The CCG will look to further refine the role not only of the Quality Director but also the role of all GP members in relation to their monitoring role within the action plan.
124	Responsibility for requiring and monitoring delivery of enhanced standards	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received sub- standard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.	The Quality Strategy for the CCG approved in August 2012 (currently under review) emphasises the CCG 's recognition of the importance of establishing a shared understanding of quality and safety, and it's commitment to embedding quality throughout the commissioning process. To this end, the CCG will ensure that the quality standards set within the contracting process are aligned to

Commissioning for Standards			
Standard			**Current CCG Position**
			the strategy and outlining specific objectives to ensure that the quality standards for all contracts contain measures and reporting requirements in respect of patient experience, complaints, patient safety incidents, serious incidents. The CCG has always had quality standards in contracts, which Trusts currently provide assurances against. In light of the new standards the CCG aims to ensure that the existing quality standards are consistent and that reporting requirements against these are embedded into the contracts with providers for 2013-2014. We will ensure that they are reflective of CQC requirements and best practice.
125	Responsibility for requiring and monitoring delivery of enhanced standards	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentives such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the	As stated above the CCG has had quality standards around central areas such as patient safety, patient experience and clinical effectiveness in contracts. In light of the recommendations the standards

Commissioning for Standards			
Standard			**Current CCG Position**
		organisations for which they work.	for contracts will be revised to build on the current best practice and further develop these standards into new areas such as safe staffing, integrated care, care and compassion and collaborative working.
	Preserving corporate memory	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.	Robust structures are in place in relation to the facilitation of safe transition. The transition arrangements for PCTs into CCGs were set and are monitored by the Department of Health. However the CCG recognises that this current transition was very complex posing risks to the System. To this end, Quality was and is being monitored carefully during this period. In relation to organisational transitions between providers these are covered and governed by the CCGs policies on procurement. The CCG will input into any work undertaken by the NCB in relation to a code of practice for transition.

Commissioning for Standards			
Standard			**Current CCG Position**
127	Resources for scrutiny	The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.	The CCG has recognised the responsibilities it has in relation to the proper scrutiny of providers and has purchased the full support package from the Commissioning Support Unit. In addition to this, recognising the importance of scrutiny, the CCG has put in place a Quality and Performance Team that is shared with NEL CSU which is reflective of patient flow within those areas. This team will provide added value to the scrutiny of performance and quality within commissioned services and act as an expert resource for the CCG- ensuring the implementation of the strategic vision for quality. This team is partly in place now and working to ensure that the contracts for 2013-2014 are sound and robust. The CCG strategic plan and quality strategy sets out the CCGs ambition to do things differently, to commission for a culture of change

Commissioning for Standards			
Standard			**Current CCG Position**
			improvement, for CCGs to be a more visible presence at the trusts becoming involved in clinical audits, commissioning walk rounds and spot visits and sitting on internal governance committees within providers. This "hands on" approach will enable closer scrutiny and further development of the "critical commissioner" role the CCG intends to foster.
128	Expert support	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.	The CCG has a specific objective which highlights the importance of specialist clinical expert advice in the development and monitoring of contracts. The CCG has clinical leads with specialist skills in different specialist areas that act as part of this specialist advice. The CCG has recognised this need through the authorisation process and structured itself in a way to ensure that it has the expert resource available in relation to the areas of commissioning that the CCG is responsible for. Some of this has

Commissioning for Standards			
Standard			**Current CCG Position**
			been sourced through collaborative arrangements across North and East London through the Commissioning Support Unit and some of this specialist expertise has been kept within the CCG.
129	Ensuring assessment and enforcement of fundamental standards through contracts	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	The CCG has and will maintain and develop quality standards in contracts in line with the Quality Strategy. Providers are asked to provide assurance against these standards. Some of the assurances that the CCG receives are copies of internal reports, assurances from commissioner visits to the Trust, and involvement and membership of provider's internal governance committees. The CCG has processes in place currently using traditional methods alongside modern media to engage with and gain feedback and input from patients and the public. This history of patient and public engagement is well established within the CCG and mechanisms are being developed and embedded in

Commissioning for Standards			
Standard			**Current CCG Position**
			the organisation to ensure that all views captured are considered and fed in to each stage of the commissioning and c contracting cycle.
130	Relative position of commissioner and provider	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.	The CCG's role is to improve the health of the local population through its commissioning activity, and as a CCG has stressed the importance of commissioning for improved outcomes. It will requires providers to deliver such outcomes and provide services which are safe and of high quality. The CCG as a small organisation works with those providers to develop a shared vision, which is particularly mobilised through the Clinical Integrated Care Board, chaired by the CCG with members from provider trusts. This board has a shared vision for integration and quality, and providers work with the CCG to develop outcomes that are meaningful to patients. The CCG recognises the

Commissioning for Standards			
Standard			**Current CCG Position**
			strength of collaborative working with partners across the health and social care system and works towards having a joint vision for quality outcomes and patient care. The CCG holds the accountability and makes the final decisions on all commissioning decisions but this collaborative approach ensures all decisions are clinically led and provide high quality and safe patient care. The CCG will consider how to further advance quality improvement in developing the action plan.
131	Development of alternative sources of provision	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.	In line with the CCG's policies in relation to procurement the CCG undertakes procurement processes that are in line with the requirements as set out by the Co-operation and Competition Panel. The CCG has collaborative arrangements in place with other CCGs currently based on patient flow. These arrangements will continue. The CCG recognises the importance of ensuring that any alternative

Commissioning for Standards			
Standard			**Current CCG Position**
			providers meet the strong quality standards that are currently in all NHS contracts and that all procurement processes are underpinned by the principles of patient choice.
132	Monitoring tools	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.	As stated in section 127 above, the CCG has recognised the responsibilities it has in relation to the proper scrutiny of providers and has purchased the full support package NEL Commissioning Support Unit –as well as putting in place a shared Quality and Performance Team This team will provide added value to the scrutiny of performance and quality within commissioned services and act as an expert resource for the CCG- ensuring the implementation of the strategic vision for quality. This team is partly in place now and working to ensure that the contracts for 2013-2014 are sound and robust. The CCG also has a Quality Strategy

Commissioning for Standards			
Standard			**Current CCG Position**
			and operational plan in place, with a robust Performance Framework which sets the strategic direction in relation to how quality and performance will be monitored, improved and reported to the Governing Body. The CCG Clinical Quality Committee has the delegated authority in relation to the oversight and scrutiny of quality. This committee reports any areas of risk or exception to the CCG Governance Committee and Board. We will be looking to review our monitoring, audit and scrutiny processes in the action plan which will follow.
133	Role of commissioners in complaints	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	Current legislation enables CCGs to do this currently. The CCG also receives assurances from all providers in relation to how they handle complaints, a quarterly summary of all complaints including a trend and theme analysis

Commissioning for Standards			
Standard			**Current CCG Position**
			of this.
134	Role of commissioners in provision of support for complainants	Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	The CCG will await the response from the government in relation to this and comply with any new governmental guidance
	Public accountability of commissioners and public engagement	• Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement: • There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. • There should be lay members of the commissioner's board. • Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. • There should be regular surveys of patients and the public more generally. • Decision-making processes should be transparent: decisionmaking bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the	From April 1st 2013 the CCG became the publicly accountable body responsible for commissioning services for the local population. In relation to the specific points within this recommendation the CCG's current position is as follows:- • The CCG has a membership system, which operates across three areas of Barnet borough, North, West and South the areas come together as part of the overall NHS Barnet arrangement • There is lay membership on the CCG Board, including a lay member with specific responsibility for patient and public engagement. • The CCG consults with patient forums, both through Health Watch

Commissioning for Standards			
Standard			**Current CCG Position**
		community.	and Patient and Participation Groups(PPG's), and also through more specific forums as part of its service reform and redesign activities. • Surveys of patients and the wider public will take place; as well as other opportunities being taken to elicit feedback and views. • The CCG Board meets in public. The CCG Quality Strategy also has a specific objective in relation to transparent Commissioning that links into the organisational communication and engagement strategy. This objective speaks to the CCG's desire to be open and honest in everything it does, and with every decision made. It is also recognised that this is an area which will be reviewed further as part of the forthcoming action plan.
136	Public accountability of commissioners and public	Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning	As stated above, the CCG becomes the accountable commissioning body from 1st April. NHS Barnet CCG

Commissioning for Standards			
Standard			**Current CCG Position**
	engagement	can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	while in place worked towards this aim using both traditional methods alongside modern media to engage with and gain feedback and input from patients and the public. There are also a number of well established CCG Patient Participation Groups and a Patient Circle of advisors to the CCG. This objective clearly sets out the direction of travel for the CCG and this will be reflected in the action plan the CCG develops.
	Intervention and sanctions for substandard or unsafe services	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service	The CCG has levers described in contracts presently that give it certain powers of intervention; guidance and legislation in relation to safeguarding children and vulnerable adults also give CCGs such powers to intervene. The CCG has a developing early warning system with an escalation process that triggers any interventions at the appropriate time and level. These interventions can involve measures such as service

Commissioning for Standards			
Standard			**Current CCG Position**
			improvement plans, unannounced commissioner walk rounds and inspections of providers to the decommissioning of services. The CCG has used these powers of intervention and will continue to do so when and where there have been any concerns in relation to substandard or unsafe care.
138		Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.	The CCG is able with smaller providers to ensure that there are contingency plans in place for provision, and to be deployed when significant patient safety issues have been identified that are unable to be mitigated in a timely manner. This recommendation provides a challenge in relation to the provision of care by larger providers and ensuring contingency plans are in place in relation to these; and this will be reflected in the action plan the CCG develops.
139	The need to put patients first at all times	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental	The CCG hold 'Quality Care' delivery at the heart of what it does, throughout the Quality Strategy the

Commissioning for Standards			
Standard			**Current CCG Position**
		patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	CCG describes the importance and the ethos of putting the patient at the centre of everything we do. This strategy was approved by the Board in August 2013 in light of the Francis recommendations the strategy will be updated to outline the quality standards which have been set for all contracts in respect of patient experience, complaints, patient safety and serious incidents. The CCG has always had quality standards in contracts, against which Trusts currently provide assurances.
140	Performance Managers working closely with regulators	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	The CCG holds the patient at the centre of everything it does and commits to sharing pertinent information in relation to patient safety, quality and performance with relevant regulatory bodies. The CCG will work collaboratively across the health and social care system and is linking into the new architecture of quality monitoring that is emerging including the local and regional Quality Surveillance

Commissioning for Standards			
Standard			**Current CCG Position**
			Groups being established by the NCB which will include representatives from Monitor and CQC within its membership.
141	Taking responsibility for quality	Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.	The CCG would welcome an open dialogue with CQC and Monitor in relation to this recommendation and this aspiration will be reflected in the action plan the CCG develops.
142	Clear lines of responsibility supported by good information flows	For an organisation to be effective in performance management there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	The CCG is currently looking at what information it holds and has access to in relation to quality. It recognises its role both to assure itself of quality and safety in the services which it commissions, and also to work with member practices and the NCB Area Team to secure improvement in quality and safety in primary care. It is recognised that given the qualitative nature of quality information that this is an area that needs further development and this will be reflected in the CCG action

Commissioning for Standards			
Standard			**Current CCG Position**
			plan.
143	Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	The CCG has always had quality standards in contracts, against which Trusts currently provide assurances; the reporting requirements against these in the contracts with providers for 2013-2014 are reflective of CQC requirements and best practice. The CCG is currently looking at what information it holds and has access to in relation to quality; and, as stated above, it is recognised that this is an area that needs further development and this will be reflected in the CCG action plan.
144	Need for ownership of quality metrics at a strategic level	The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.	Within the CCG Quality Strategy the CCG articulated a specific aim and objectives in relation to the development of quality in primary care. The CCG recognises that to achieve this ambitious aim it will need to work closely with the NCB Area Team. The CCG will input into any work undertaken through the NCB in

Commissioning for Standards			
Standard			**Current CCG Position**
			relation to quality standards and this will be reflected in the CCG action plan.