Meeting	Health and Well-Being Board
Date	23rd January 2014
Subject	**Francis Inquiry Update**
Report of	Barnet CCG Chief Officer
Summary of item and decision being sought	An update on the Government's response to Mid Staffordshire NHS Trust. 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.

Officer Contributors	Vivienne Stimpson, Director of Quality and Governance John Morton, Chief Officer, Barnet CCG
Reason for Report	To provide assurance to the Health and Well-Being Board that the CCG continues to consider and reflect on the implications of the Mid Staffordshire NHS Trust reports and system wide change necessary to improve patient safety, clinical effectiveness and patient experience.
Partnership flexibility being exercised	None
Wards Affected	All
Status (public or exempt)	Public
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1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes and supports the steps Barnet CCG is taking to address the findings of the Mid Staffordshire Inquiry. This report details the government's response to the inquiry into the events at Mid Staffordshire NHS Trust and the broad system wide changes underway to address its findings.

2. RELEVANT PREVIOUS DISCUSSION AND WHERE HELD

2.1 Barnet CCG Board meeting held on 4th April 2013

2.2 Barnet Clinical Quality and Risk Committee in March 2013

2.3 Barnet CCG Board on 4th July 2013

2.4 Barnet CCG Board on 28th November 2013

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNTIY STRAGEGY; HEALTH AND WELL-BEING 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.

4.2 Equalities implications 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 Action 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 its 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 July and November 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.

10. INTRODUCTION

10.1 Initial Response to the Francis Inquiry Recommendations: Phase I

The Francis report highlighted that despite monitoring systems in place, failure to provide safe care had taken place at Mid Staffordshire NHS Trust over a long period of time. The immediate concern was to identify if similar quality and patient safety failures existed at other trusts. As a result the Keogh review was instigated where hospitals with high mortality rates were visited as part of a special inspection. It also set in motion a programme of initiatives that aim to achieve a culture change to a more caring and compassionate NHS and create safeguards to prevent, or for early detection of trusts failing in their provision of good quality of care.

In the first phase the focus was on creating greater transparency and supporting the CQC in developing and setting up a new inspection and surveillance regime so that quality and safety failure would be detected earlier. The Government started formulating legislation and actions to address failing trusts and commissioned leadership programmes for nurses and midwives, clinicians and managers to equip the NHS workforce with skilled leaders, with the right values, behaviours and competencies, across all levels of the system as well as strengthening the patient's voice. The following initiatives have been implemented prior to the formal Government Response to the Francis Report which was released on 19 November 2013.

10.2 Greater Transparency and Availability of Quality Data

To increase transparency and availability of quality data NHS England published clinical outcomes, including mortality data, by consultant, for 10 medical specialties, and has begun to publish data on the Friends and Family Test. It further announced the extension of the Friends and Family Test (FFT) to mental health, community and GP settings by the end of December 2014 to cover all NHS services by the end of 2015.

Barnet CCG is presently in discussion with all providers regarding their preparations for implementing the FFT across a wider range of services as part of the 2014/15 National Commissioning for Quality and Innovation (CQUIN) incentive. On-going assurance is also being undertaken regarding the results of the FFT across inpatient, A&E and Maternity services for 2013/14. Results will be published nationally in February 2014.

The need for better monitoring of patient safety and quality of care was addressed by the CQCs implementation of a new risk surveillance system and inspection regime. This involved:

- Appointment of 3 Chief Inspectors by the Care Quality Commission (CQC) for:

- Hospitals
- Adult social care
- Primary care

- Commencing the first wave of inspections for 18 Trusts
- Consulting on and implementing a new system of ratings to be used for inspections and a method of on-going surveillance for quality of care
- Consulting on and use in "shadow form" a new set of fundamental standards. Once approved by parliament, the fundamental standards will enable prosecutions of providers to occur in serious cases, where patients have been harmed because of unsafe or poor care, without the need for an advanced warning notice.

10.3 Changes to CQC Inspections and Risk Surveillance

In July 2013, a new CQC inspection regime was introduced. This included expert-led inspections with greater emphasis on listening to patients, service users and staff. Inspection visits will also take place at night and at weekends, with more unannounced inspections.

Mental health inspections will begin with wave one pilots in January to March 2014; followed by a second wave in April to June 2014. Ratings will be published from October 2014 for the NHS and January 2015 for the independent sector. Adult social care will also be included in inspection which will begin with wave one pilots in spring 2014 followed by a second wave in summer 2014. All social care services will have been rated by March 2016.

The Care Quality Commission is now using a surveillance system to rate hospitals' quality of care in bands ranging from outstanding to inadequate. For this the services are being risk assessed and those found to have higher risk scores will then be inspected. CQC's surveillance uses 3 sets of indicators to determine this risk. The first set will include mortality rates, Never Events and results from staff and patient surveys, as well as information from the public. This set of indicators trigger action by inspectors. The second set of indicators contains a wider range of data that supports and provides explanations for information in the first set. This includes nationally comparable information such as results from clinical audits and information from accreditation schemes. Information from people who use services, including whistle-blowers, is used when deciding where to inspect.

The first set of bandings was published in October 2013. All Trusts have been categorised into one of six summary bands, with Band 1 representing the highest risk and band 6 the lowest risk. Barnet and Chase

Farm Hospitals have been categorised into band 3, Royal Free Hospital NHS Foundation Trust have been categorised as band 2 and Royal National Orthopaedic Hospital has been given a banding of 5. All risks and elevated risks that have been identified as a result of the bandings have been discussed with Providers at the clinical quality review group meetings.

By the end of 2015 the Care Quality Commission will have conducted inspections of all acute trusts. There will be 4 categories of judgements following CQC inspections:

1. Outstanding: sustained high quality care over time across most services, together with good evidence of innovation and shared learning.

2. Good: the majority of services meet high quality standards and deliver care which is person-centred and meets the needs of vulnerable users.

3. Requires Improvement: significant action is required by the provider to address concerns.

4. Inadequate: serious and/or systematic failings in relation to quality.

Trusts aspiring to Foundation Trust status will have to achieve 'good' or 'outstanding' under the Care Quality Commission's new inspection regime to be authorised. Monitor and the Care Quality Commission will also implement a joint registration and licensing system in April 2014.

Failure to meet fundamental standards as identified through the CQC inspection and surveillance will initiate the failure regime. Clinical unsustainability will be grounds for failure procedures, including placing organisations in special measures, just as financial unsustainability is at present. The Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority will publish further guidance on how they will work together to address quality issues after April 2014. The new inspection and surveillance regime is currently operating in "shadow form". Pending parliamentary approval, changes to CQC risk ratings and application of special measures and failure regimes in failing trusts will be confirmed through the Care Bill.

10.4 Addressing 'Failing' Providers

The Government has started legislating to give greater independence and extend powers of intervention to the CQC. Expert inspections of hospitals with the highest mortality rates, led by the NHS Medical Director, have been undertaken and revealed unacceptable standards of care. Eleven hospitals were placed into 'special measures'. Legislation to introduce a responsive and effective failure regime which addresses failing providers is being progressed through Parliament. Quality failures are being given the same importance as financial failures.

10.5 Leadership and Accountability

New nurse and midwifery leadership programmes have been developed. By April 2015 10,000 nurses and midwives will have attended the programmes. A fast track leadership programme to recruit clinicians and external talent to top jobs in the NHS in England has been launched.

By the end of the 2013, 96% of senior leaders and all Ministers at the Department of Health will have time in health and care settings and gained frontline experience. The government has announced that every hospital patient is to have the name of their responsible consultant and nurse above their bed. The Government also intends to introduce a named accountable clinician for people receiving care outside hospitals, starting with vulnerable older people.

10.6 Commissioning

NHS England has published guidance to commissioners, *Transforming Participation in Health and Care*, on involving patients and the public in decisions about their care and their services.

10.7 Response to Francis Inquiry by NHS Barnet CCG

In the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013), Robert Francis QC, the Inquiry Chair, called for a 'fundamental culture change' across the health and social care system to put patients first at all times. Set out in 290 recommendations, the inquiry called for action across six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour. Following the initial publication of the Francis Inquiry earlier in 2013, the government formally accepted 281 of the 290 recommendations from the public inquiry. 'More openness, greater accountability and a relentless focus on safety'. At this time, Barnet CCG formulated a response that addressed all recommendations specific to commissioner responsibilities and this was set out in an action plan that was submitted to Barnet CCG Governing Body in July 2013.

Progress has been made in the following themed areas. Each area covers a number of the original recommendations outlined as specific to commissioning organisations.

10.8 Accountability/Oversight and Leadership

The CCG proposed that in relation to embedding the values and principles demonstrated within the NHS Constitution, it would work with providers to ensure that quality schedules are met as part of the contracting process. The CCG requests monthly performance reports from all its providers. These reports contain the metrics that demonstrate provider performance in delivering the NHS constitution to patients around access, quality and safety of health services and dignity in care.

Providers are also including data that relate to workforce indicators in their reporting to commissioners as part of the quality schedules within the standard contract. They include data on agency use, staff appraisal, staff absence and are monitored on a quarterly basis. Providers that are not do this are being strongly encouraged by commissioners to do so.

Issues relating to patient safety and reported serious incidents are discussed monthly at each clinical quality review group held between commissioners and providers as part of the contractual process. Providers are encouraged to discuss organisation-wide learning as a result of the investigations carried out, as well as the development of mechanisms for feeding back to staff to encourage an open and transparent reporting process for near misses and safety concerns.

Barnet CCG Director of Quality and Governance recently met with Royal Free Hospital to take further evidence regarding outstanding action plans in response to a number of grade 2 legacy Never Events. (A function transferred to CCGs from NHS London as part of the transition). The meeting was extremely positive and the Trust fielded a number of clinical experts to present the required evidence. The Trust's feedback was that they really valued the opportunity to meet with commissioners as well as the opportunity to discuss learning from safety incidents across various service lines.

10.9 A Systematic Approach to Performance and Management and Standard Setting

In relation to the policing of compliance with standards, direct observation of practice, direct interaction with patients, Barnet CCG are working collaboratively with their commissioning partners to conduct regular 'walk the pathway visits' to provider organisations that will facilitate direct observation of patient care. Visits already

undertaken have received positive feedback from providers and have fostered a more open discussion between providers and commissioners in relation to the quality of commissioned services.

Plans are in place for a regular schedule of visits throughout 2014/15. Barnet CCG Director of Quality and Governance recently conducted a walkthrough with senior clinicians at Central London Community Healthcare NHS Trust. This followed concerns that were raised by a member of the public and a subsequent review by the Director of Nursing into the standards of care provided on inpatient wards at Edgware Community Hospital. This has enabled commissioners to become more directly involved in the way providers are working to meet standards across a number of healthcare settings including the development of a more open dialogue across the system regarding how commissioners can support providers to do this.

11.0 COLLATION OF SOFT INTELLIGENCE AND PATIENT FEEDBACK

A number of the recommendations made in the inquiry relate to the need to deliver a more effective response to complaint management. Information regarding complaints is routinely discussed at clinical quality review group meetings, and patient feedback from other sources is triangulated with complaints data to gain a better understanding of the patient's experience of services and where they may be pockets of concern that need further investigation, including possible themes that may be emerging. All Barnet providers are collecting data on real time patient feedback through the Friends and Family Test and the outcome of this is discussed at the clinical quality review group meeting on a quarterly basis along with complaints data. North and East London CSU is developing a provider complaints dashboard to include all metrics that relate to complaints management. This will allow for comparison of provider performance across the North Central London sector as well as across Barnet.

The CCG has also implemented a 'Purple Card' system across all Barnet GP practices that allows for real time information to be collected from patients regarding any concerns that they may have about their experience of healthcare services received locally. The results of these are reviewed by the CCG's governance team and monitored for any emerging trends. These are also discussed at the CCG's Clinical Quality and Risk Committee. A number of other sources are also used to gather patient feedback such as Care Connect and the CCG is working with its partners to triangulate this data with a range of sources received through more formal channels such as provider complaints.

11.1 Commitment to Review the Organisational Culture

This theme sets out the principles on openness, transparency and candour. All healthcare providers across Barnet CCG have now submitted evidence of their maturity matrixes and Trust responses to the Francis inquiry that have been approved at Trust Board level. A visible focus is evidenced at clinical quality review meetings in relation to provider responsibility to delivering a programme of cultural change across the system and the need to work more closely with their commissioners. All providers have now shared their plans for responding to the inquiry with the CCG.

Barnet CCG have included a clause in all their Job Descriptions and contracts of employments regarding the duty of candour for staff. The CCG are also working on a 'Being Open' policy that will set out in detail the responsibility that the CCG has regarding this duty of openness with the public.

12.0 UPDATE TO GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

This is the second Government response to the Francis Inquiry, *Hard Truth: The journey to putting patients first* (November 2013) which now provides a detailed response to the 290 Inquiry recommendations.

The response also addresses six independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

- *Keogh Review*
- *The Cavendish Review*
- *Berwick Report*
- *Review of the NHS Hospitals Complaints System*
- *Challenging Bureaucracy* (led by the NHS Confederation)
- *The report by the Children and Young People's Health Outcomes Forum*

12.1 Formal Response to the Francis Recommendation: Phase II

In its formal response to the Francis recommendations, published on 19 November 2013, the Government accepted nearly all recommendation made in the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. It recognised that the measures being put in place are only the start of a process to fundamentally change the culture to ensure safe and compassionate care across the whole of the NHS. This together with putting in place measures to identify early failing services, measures to turn them around, accountability and when necessary, criminal sanctions. The new measures, as identified in the response, in combination with the phase 1 initiatives are to provide the necessary safeguards to prevent catastrophic failure of services as seen in the Mid Staffordshire NHS Trust.

The measures are summarised below:

12.2 Workforce and Safe Staffing Levels

Staffing levels will be a core element of the CQC's registration regime.

12.3 Publishing Ward Level Staffing

From April 2014, and by June 2014 at the latest, NHS Trusts will be required to publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools. The first of these will take place by June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence (NICE) accredited tools.

12.4 NICE Produced Guidance on Safe Staffing Levels

By summer 2014, NICE will produce independent and evidence based guidance on safe staffing, and will review and endorse associated tools for setting safe staffing levels in acute settings. Similar tools will then be developed for non-acute settings.

12.5 Student Nurses

Student nurses will now be required to work as health care assistants for a year prior to entering NHS funded clinical education programmes. Health Education England will be introducing values-based recruitment.

12.6 Care Certificate for Healthcare Assistants and Social Care Support Workers

This will be implemented to ensure the right fundamental training and skills to give personal care to patients and service users. The Government has commissioned Health Education England to lead this work with Skills Councils and other delivery partners.

12.7 Staff Engagement, Health and Well-being

The Department of Health has commissioned the Social Partnership Forum to develop guidance for employers on good staff engagement which will contribute to developing positive cultures of safe compassionate care.

13.0 ACCOUNTABILITY

13.1 Accountability across the System

In the report, the Government states its intention to have in place a clear and well-functioning system of accountability. NHS organisations and all parts of the health and care system are to be held more accountable than before to ensure the conditions for creating a culture of safe, compassionate care.

13.2 Trust Boards

In addition to the ratings and inspections led by the CQC, the Boards of Trusts are responsible for holding both their own organisation to account and accounting to the public about its performance.

13.3 CCGs

NHS England will hold clinical commissioning groups to account for quality and outcomes and for their financial performance, and will have the power to intervene where there is evidence that they are failing, or are likely to fail, in their functions.

13.4 Fit and Proper Person's Test

Monitor already requires providers not to appoint as a Director any person who is an undischarged bankrupt, individuals who have served a prison sentence of three months or longer during the previous five years, and disqualified Directors. The introduction of a new fit and proper person's test for Board level appointments is based on the Professional Standards Authority's publication Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England will

be CQC regulated. It will enable the CQC to bar directors who are unfit, from individual posts at the point of registration. This will apply to providers from the public, private and voluntary sectors. NHS England will explore the development of parallel arrangements for CCGs.

13.5 Performance Management of Very Senior Managers in Hospitals for Failures in their Organisations

On occasion (but not always) performance management for failures in their organisation of very senior managers should result in the removal from a senior role. The Government, Care Quality Commission, the NHS Trust Development Authority and Monitor are to continue to work with NHS Employers and other interested and responsible organisations to strengthen the way that existing mechanisms operate through the redrafting of the Very Senior Managers model contract.

13.6 Wilful Neglect Applicable to Individuals and Organisations

In *A Promise to learn- A Commitment to act* Professor Don Berwick's paper recommended that there should be a new criminal offence 'in the very rare cases where individuals or organisations are unequivocally guilty of wilful or reckless neglect or mistreatment of patients'. The Government has endorsed this recommendation and will consult on proposals for legislation shortly.

14.0 OPENNESS AND TRANSPARENCY

14.1 Duty of Candour

Subject to Parliamentary approval, from 2014 every organisation registered with the Care Quality Commission will be expected to meet a new duty of candour. Additionally individuals will be held to a professional duty of candour through changes to professional codes and guidance. This is to include "near misses" where the professional regulators will develop new guidance to make it the professionals' responsibility to report 'near misses' for errors that could have led to death or serious injury, as well as actual harm, at the earliest available opportunity. The Professional Standards Authority will advise and report on progress with this work.

14.2 Reduction or Removal of Indemnity Cover in Breaches of "Duty of Candour"

The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients.

14.3 A New Criminal Offence for Supplying or Publishing False or Misleading Information

Subject to Parliament, the Care Bill will make a criminal offence for the supplying, publishing or otherwise making available certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation. This will be applicable to care providers and to directors and senior managers who have consented or connived in (or are negligent in relation to) an offence committed by a care provider.

15.0 COMPLAINTS

15.1 Visible and Accessible Complaints Process

Hospitals are to make their complaints process more visible and accessible, including setting out more clearly and visibly:

- how to make a complaint
- how to get independent local support and
- informing patients of their right to complain to the Ombudsman if they remain dissatisfied

15.2 Trust Chief Executives and Boards to Take Greater Personal Responsibility for Complaints

Trust Chief Executives and Boards will be expected to take personal responsibility for complaints, for example by signing off letters and through receiving an update at each board meeting. Directors with responsibility for patient safety will be expected to give an update on complaints at each Board meeting. The Department of Health will work with NHS England to determine the most effective mechanism to achieve this. Board reports are to include the 'narrative and not just the numbers', so Boards can identify themes and recurring problems, and take action. Chief Executives are also to ensure greater clinical involvement is provided in handling complaints. This could be through offering patients a conversation with the nurse or doctor involved in the complaint, if that is something the patient wants.

15.3 Quarterly Publication of Complaints Data

Detailed information on complaints and lessons learned to be published quarterly, and looked at by CQC. This is to include the number of complaints received as a percentage of patient interventions, the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman and the lessons learned and improvements made as a result of complaints. The Health and Social Care Information Centre will put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals. Complaints will be a key part of the new Chief Inspector of Hospitals' inspections.

15.4 DH and NHS England to Obtain Feedback on Complaints Handling Satisfaction Directly from Patients

The Department of Health and NHS England are to introduce a regular and standardised way of asking people who have made a complaint how satisfied people are with the handling of their complaint, to enable comparison between hospitals.

16.0 REDUCING THE BUREAUCRATIC BURDEN

The bureaucracy review led by the NHS Confederation recommended three main ways to reduce unnecessary bureaucratic burden by:

- Understanding, reducing and actively policing the volume of requests from national bodies
- reducing the amount of effort it takes providers to respond to information requests
- increasing the value derived from information that is collected.

17.0 DIGITAL TECHNOLOGY TO REDUCE THE BUREAUCRATIC BURDEN

NHS England has introduced a Clinical Bureaucracy Index and Audit of Digital Maturity in Health and Care to support trusts in tracking how well they are using digital technology to reduce the burden of information collection on front line staff compared to their peers

18.0 STREAMLINING AND REDUCING THE BURDEN OF NATIONAL DATA REQUESTS

The Department of Health and every arm's length body signed a concordat for reducing the administrative burden arising from national requests for information. The concordat aims at ensuring that national requests for information are undertaken using a single transparent process and that there are significant year on year reductions in the cost and burden caused by requests for information to the front line.

19.0 BARNET CCG RENEWED ACTION PLAN

Further to the most recent publication detailed in the second part of this report, it is recognised that although the CCG have taken a number of steps in meeting their responsibilities to address the recommendations initially set out in the Francis report, due to the system-wide changes that are now in place since the later part of 2013 and those that are planned for 2014, a refreshed CCG plan is required. This is to ensure that Barnet CCG meet their own responsibilities as well as supporting the whole system in delivering the required changes. In response to all the proposed changes outlined above as well as work that has already taken place since early 2013, the CCG is leading a North Central London provider led workshop that will bring together all NCL providers and commissioners to enable the sharing and learning required to continue to drive up patient standards through a focus on continual quality improvement.

20.0 CONCLUSION

The Francis report identified that the disturbing events at Mid Staffordshire NHS Foundation Trust reflected wider systemic problems. The Government is addressing these by taking a broad, system wide approach to enable cultural change and through the implementation of the measures described in the response, to prevent such catastrophic failures of patients in future.

In supporting a programme of organisational and cultural change on such a transformation scale Barnet CCG has taken their responsibility extremely seriously and will continue to work with partner organisations to deliver the required change and to prevent further health care failings as identified at Mid Staffordshire.

21.0 BACKGROUND DOCUMENTS

None