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HEALTH & WELLBEING BOARD

SUPPLEMENTARY AGENDA

Wednesday 9 April 2014
1.30 pm – 3.30 pm

Committee Room 2 Town Hall

8. HAVERING RESPONSE AND IMPLEMENTATION OF FRANCIS REPORT RECOMMENDATIONS (Pages 1 - 12)

Presented by Alan Steward and Barbara Nicholls.

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	The Francis Report
Board Lead:	**Alan Steward**
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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Robert Francis QC described the extent of older people's care service failures that led to the inquiry, saying: "I heard so many stories of shocking care. These patients were not simply numbers they were husbands, wives, sons, daughters, fathers, mothers, grandparents. They were people who entered Stafford Hospital and rightly expected to be well cared for and treated. Instead, many suffered horrific experiences that will haunt them and their loved ones for the rest of their lives."

This paper provides an update to Health & Well-being Board on the progress made to address and implement the Francis Report recommendations across the Barking & Dagenham, Havering and Redbridge care and health economy. How the Clinical

Commissioning Group (CCG), partners and the NHS as a whole responds to this report is a critical test of the systems ability to make a real difference to improving patient safety and to caring for some of the most at risk people (previously referred to as vulnerable people) in society.

The overarching lesson from events at Mid-Staffordshire is that a fundamental culture change is needed to put people at the centre of the NHS. This is why the CCG and Local Authority have made a commitment to consider, fully review and implement the Francis Report recommendations.

The changes that are required to ensure that the CCG develops and fosters a culture of compassionate care in which patients are genuinely and consistently at the centre of everything we do cannot be managed or delivered through a discrete programme management approach. However, the CCG and Local Authority have made commitments to implement a number of specific early actions and changes arising from the Public Inquiry, and this paper focuses on progress with those actions.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- Note the progress report and the action taken by the LA/CCG to implement the recommendations to date
- Advise on any further activities/actions that are required
- To receive assurance that the progress made is in line with the commitments Havering CCG has given, and will have a key impact on the culture changes required to put patients/service users at the centre of everything we do.

REPORT DETAIL

1. Introduction

1.1 The purpose of this update report is to provide the Havering Health & Wellbeing Board (HWB) with a summary of the main issues and key recommendations raised in the second report from the public inquiry into the events at Mid Staffordshire Hospital carried out by Robert Francis QC.

1.2 The nurse director was asked to develop and implementation plan to the Francis Report recommendations, and this work commenced in April 2013. This report provides the Francis recommendation and action plan as developed by the BHR

system wide task and finish group (the group) and details progress made to date with implementation of the actions across the BHR social care and health economy. The plan is attached at appendix 1.

1.3 The group is now well established and this report details the preliminary progress made over the past 12 months.

2. Background

2.1 The report of the public inquiry, tells first and foremost of the appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies were brought to the regulators attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus of reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care. The report set out 290 recommendations but its overarching theme was clear: that a fundamental culture change is needed in the NHS to put patients first.

2.2 The government's initial response to Francis, *Patients First and Foremost*, was published by the Department of Health (DH) on 26 March 2013 on behalf of the health and care system. It set out how the NHS would begin to respond to Robert Francis's challenge to make patients 'the first and foremost consideration of the system and everyone who works in it'. It included a statement of common purpose, jointly developed and signed by a wide range of partners who share responsibility for patient care.

2.3 A more comprehensive response, entitled *Hard Truths: the journey to putting patients* first, was published in November of the same year, which presented a detailed response to each recommendation, and set out new actions planned by the government, including requiring commissioners to make better use of patient safety information, such as detailed patient complaints data. The recommendations of both government responses were considered and reviewed during the development of our implementation plan,

2.4 The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. Francis states that " Primary Care Trusts were not as effective as might have been expected in commissioning or monitoring delivery of care".

2.5 A BHR system wide task and finish group (the group) was established in September 2013, chaired by the Nurse Director and comprising members of BHR CCGs and Local Authorities. The group also sought the views of and engaged with providers, Lay members of the governing bodies, Healthwatch and Safeguarding

Board Chairs to review the recommendations in detail, agree priorities for delivery and to develop an implementation plan. The group confirmed our commitment to work in partnership, recognising that changing culture in the health and care system can only be achieved with the continued of support the various organisations locally. The task and finish group considered the failings detailed above and in doing so agreed the actions in the implementation plan.

2.6 The Chairs of all safeguarding boards, Healthwatch representatives and the Lay members of the Clinical Commissioning Groups (CCGs) have provided input to the development of the Francis Implementation BHR System Wide Plan.

2.7 All three Local Authorities and CCGs report significant progress of actions in the plan. Progress against actions is detailed in Appendix 1. We recognise that success will require sustained action and leadership over a number of years. In this context, the table at Appendix 1 provides only a snapshot of progress and work continues on implementing and revising the actions.

2.8 During 2013/14 we have achieved:

- The CCG has published its response to the Francis Report on our website
- A quality assurance monitoring framework has been implemented for all our large and medium size contracts
- The CCG has welcomed patient and public feedback, have acknowledged service difficulties where they exists and have worked and encouraged providers to do the same.
- The sharing of quality and safeguarding information with the CCG and its partners has alerted us to potential quality concerns and enabled us to take immediate action
- The CCG has developed internal systems that enable the quality team to work with general practitioners to follow up concerns raised during patient consultations
- Clinical directors actively participate in the Clinical Quality Review Meetings and this has strengthened the CCG's clinical contract management

3. Next Steps

3.1 To continue to implement the agreed actions, with progress reviewed by the CCG's Quality and Safety Committee in April 14.

3.2 To continue to implement all completed actions within our current commissioning system and daily activities, such as quality assurance walk round visits to departments in Barking, Havering, Redbridge University NHS Trust and North East London NHS Foundation Trust. This will ensure that quality and patient centred care underpins all that we do as commissioning organisations.

IMPLICATIONS AND RISKS

Financial implications and risks:

The actions taken as a result of the Francis report will be funded from within existing resources. This report carries no direct financial implications or risks as is for information purposes only.

Caroline May – Strategic Finance Business Partner (Children, Adults and Housing).

Legal implications and risks:

There are no apparent legal implications in accepting the recommendations in the Report

Stephen Doye – Legal Manager

Human Resources implications and risks:

Not applicable

BACKGROUND PAPERS

The Mid Staffordshire NHS Foundation Trust Inquiry. Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. February 2010. Chaired by Robert Francis QC
http://www.midstaffsinquiry.com/pressrelease.html

The Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Robert Francis QC. February 2013. http://www.midstaffspublicinquiry.com/report

Patients First and Foremost. The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry. Department of Health. March 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

NHS Confederation Member Briefing. Government response to the Francis report.
http://www.nhsconfed.org/Documents/NHS%20CONFED%20BRIEFING%20GOV%20FRANCIS%20RESPONSE.pdf

Association of Directors of Adult Social Services (ADASS) Francis - Government response to be considered in relation to all health and social care services. 25th March 2013.
http://www.adass.org.uk/index.php?option=com_content&view=article&id=913&Itemid=489

Kings Fund. Francis Report Lesson learnt from Stafford.
http://www.kingsfund.org.uk/events/francis-inquiry?gclid=CI3hjdOy97YCFcXKtAod118A0w

Royal College of General Practitioners Position Statement on the Recommendations of the Mid Staffordshire NHS Foundation Trust public inquiry report.

Francis Report
Task & Finish Group
System Wide Implementation Plan

Week Commencing: 26 March 2014

RAG Key for monitoring progress

	Tasks and outcomes are completed
	Tasks and outcomes are on track, milestones met but not completed
	Tasks and outcomes have not been met or timescale slipped
	No update available

Goals	Francis Recommendation	Task	Due Date	Owner (s)	Status	RAG
All organisations must publish their response to the Report and Recommendations	1	Prepare and publish a response to the Francis report on organisational websites.	December	BDCCG	Response now on the CCG website	
				HCCG	Response now on the CCG website	
				RCCG	Response now on the CCG website	
		All organisations to prepare an annual report on the implementation of the Francis recommendations and to progress through internal governance mechanisms.	30 March 14	LBBD	Update report presented to HWB	
				LBH	In progress	
		Receive provider response to Francis Inquiry – BHRUT, NELFT, BH, PELC, Basildon University Hospital Trust. This should be included in the Quality Accounts	28 February 13	LBR	Progress reports programmed in for Health Scrutiny Committee	
Contracts for services must be clear on minimum standards and be Francis compliant	8, 13, 14, 124, 125, 127, 129, 130, 131, 132, 135, 136, 137, 205, 245	Review all contracts & ensure Duty of Candour or an equivalent requirement is included. 2014/15 Duty of Candour strengthened in NHS Standard contract. Francis specifically referenced in the 14/15 contracts.	31 January 14	BDCCG	Standard NHS contracts to be issued to all providers when new contracts issued.	
				HCCG	Contract negotiation process ongoing. New contracts will be issued for 14/15	
				RCCG	CSU to be asked to do this	
				LBBD	Public Health Contracts to have included as appropriate on renewal	
				LBH	This is a commissioning task and is in hand	
				LBR	DoC will be considered in the context of existing frameworks for adult social care which includes ongoing working relationships with CQC and Safeguarding Adults Board	
		Ensure there is sufficient commissioning capacity to quality monitor and performance manage all contracts. Processes for identifying risks and emerging risks need to be clearly defined. This must include the appropriate escalation of risks	24 January 13	BDCCG	The larger contracts have a formal quality and performance framework in place. Medium size contracts are now quality assured. Smaller contracts are being reviewed, quality indicators are being developed that act as an early warning system. For Care homes joint quality assurance visits are being completed by LBH and CCG. Strong links with the CQC have also been developed.	
				HCCG	The larger contracts have a formal quality and performance framework in place and we have	

				quality assured medium size contracts. Smaller contracts are being reviewed, quality indicators are being developed that act as an early warning system. For Care homes, we undertake joint quality assurance visits with LBH and CCG.		
				RCCG	There is capacity to manage – the governance structure is in place for all major contract management. Capacity issues have been identified with medium and smaller value contracts. This is on the risk register and plans are in place to mitigate the risks.	
				LBBD	There is capacity to manage public health contracts	
				LBH	There is capacity to manage contracts and this has been reviewed across all contracts. Quality performance governance frameworks are in place to monitor public health contracts such as school nursing, health visiting and sexual health services. CSU represent the CCG on the Quality and Suspension Committee. Provider performance is reviewed and monitored at this meeting.	
				LBR	This has been reviewed and can be recorded as green.	
		Escalation and reference points are in place for addressing and managing poor performance	31 January 13	BDCCG	Clinical quality review meetings and service performance review meetings are in place for major contracts. Contract management arrangements are being reviewed for some small contracts.	
				HCCG	We use the Clinical Quality Review Meetings (CQRM) and Strategic Performance Review (SPR) meetings with our major providers to do this. We are reviewing the contract management arrangements for small providers.	
				RCCG	This is done through the Clinical Quality Review Meetings (CQRM) and Strategic Performance Review (SPR) meetings. PELC has a combined meeting.	
				LBBD	Performance mechanisms in place across council contracting	
				LBH	This is addressed by the Quality and Suspension Board for all our contracts. Issues of concern are escalated to the Safeguarding Adults Board or LSCB. Winterbourne reviews of people with learning disabilities are undertaken and monitored through specific arrangements.	
				LBR	Reviewed and complete	
Develop system wide integrated processes for tracking and reporting on patient experience and safety	12, 252, 253, 254	Systems & processes are in place for tracking poor performance.	31 December 13	BDCCG	Complete	
				HCCG	Complete	
				RCCG	Complete	
				LBBD	Complete	
				LBH	Complete	
		The sharing of information is through the safeguarding boards, Quality Surveillance Group, LD Partnership Boards and the local operational systems. All agencies to review effectiveness at keeping people safe.	14 March 14	LBR	Complete	

		Identify and close gaps in monitoring. To consider and collaborate with Frailty Academy. Incorporate work from delayed cancer diagnosis audit – primary and secondary care	28 February 14	BDCCG	Collaborative cancer commissioning group established, which will focus on early diagnosis. Quality and Safety Committee responsible for tracking and reporting on patient experience and safety.	
				HCCG	This is a focus at both CQRMs and Quality and Assurance Committee. We are supporting the Frailty Academy through a Lead Clinical Director for Care Homes and have encouraged two care homes leaders to join the Frailty Action Learning set.	
				RCCG	This is done through the CQRMs. Gaps exists for smaller providers. Actions are in place to close the gaps	
				LBBD	Public Health reviewed and fine	
				LBH	This is done jointly between Quality Team and Safeguarding	
				LBR	Reviewed and reported complete. Gaps identified and closed.	
		Collaborate on design of system-wide model to develop a Clinical Quality Board Consider other models and learn from best practice. Integrated social care and health models reviewed. Kings Fund and UCLP research also reviewed.	31 Mar 14	All	Workshop held. Quality Improvement Board to be established to manage response across BHR economy. To go to ICC end of March	
Develop process for tracking patient experience by primary care as referrers and commissioners of services. This is to develop a sustainable, shared, mature patient and service users safety culture across the entire health and care system.	123, 134, 135	Monitor patients receiving acute treatment. Clinical insights on quality of services is captured from front line staff in general practice Work with CSU on reporting framework to CCGs. To be monitored by the Quality and Safety Committee	28 March 14	BDCCG	A formal system is in place, although this requires a review which will be completed at end of February 14	
				HCCG	Plans are in place to implement a formal system of capturing real patient experience. The financial resourcing issues are in the process of being resolved.	
				RCCG	This is done through a CQUIN, monitored by the CQRM. Still to develop a systematic process for capturing feedback and patient stories.	
		Develop internal systems to allow GP's to track areas of concern	28 March 14	BDCCG	Process in place for capturing practice feedback is through locality meetings and localities issues log.	
				HCCG	We use our locality meetings to capture practice feedback and considering further how this can be developed into an early warning system across the local health economy.	
				RCCG	This takes place through the 4 Locality Committee meetings	
Ensure open and shared communication of up-held complaints	109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122	Consider processes required to obtain adequate consent	28 February 14	BDCCG	CCG complaints policy in place. Review of consent policy in progress	
				HCCG	CCG complaints policy in place. Review of consent policy in progress	
				RCCG	This is detailed in contracts	
				LBBD	Public Health contracts where appropriate consent is built in i.e. sexual health, healthy adults etc	
				LBH	Normal practice	
				LBR	Public Health contracts: where appropriate consent is built in i.e. sexual health, healthy	

					adults etc.	
		Write to providers to formally enquire how they propose to implement these recommendations	12 February 14	BDCCG		
				HCCG	Contracting are drafting a letter template to send to providers	
				RCCG	Contracting are drafting a letter template to send to providers	
				LBBD	Public Health contracts been built in for future contracting discussions	
				LBH		
				LBR	Discussion will be built into Public Health contract monitoring discussions	
		Develop process for sharing upheld complaints when consent given	26 March 14	BDCCG		
				HCCG	Process in place including opening Governing Board meetings with a patient sharing their experience.	
				RCCG		
				LBBD	Public Health being discussed locally and nationally	
				LBH		
				LBR	Process for Public Health being discussed locally and nationally	
Revise LA Scrutiny process	145, 146, 147, 149, 150	Revise and implement local scrutiny processes	12 February 14	LBBD	Complete	
				LBH	Via Quality and Suspension Board and Safeguarding	
				LBR	Complete	
To ensure active involvement of clinical leaders in performance management of quality and safety	2, 11	Clinical leaders to attend CQRM meetings to strengthen focus on clinical outcomes and triangulation of quality indicators	29 January 14	BDCCG	Complete	
				HCCG	Complete	
				RCCG	Complete – Two Clinical Directors are members of the Quality and Safety Committee	
All patients in acute settings to have an identified consultant who is responsible for their care and to be seen by consultants	236, 238	Ensure acute and mental contracts contain this provision and that this is monitored through the CQRM's	31 March 2014	BDCCG	This is being discussed during the clinical contracting discussions and was discussed at the January CQRM.	
				HCCG	This is within the BHRUT contract and for A&E is monitored through the Emergency Care Standards Group.	
				RCCG	Barts Health contract is currently under discussion through the negotiation process	
Culture and organisational development. Culture must be defined, understood and accepted by all staff who work within our organisations. This should then be continually reinforced by leadership, training, personal engagement and commitment. Have clear workforce plans for recruitment, retention and development of staff to create a positive culture	7, 126, 179, 180, 191, 194	Review existing workforce development plans and build on these plans in conjunction with Human Resources. Recruitment and retention must be specific actions	26 February 2014	BDCCG	Initial governing body away day held to build concept of behaviour charter that puts the patient at the heart of all we do.	
				HCCG	Output of governing body away day shared with all staff at organisational staff briefing	
				RCCG	Check with CSU HR staff	
				LBBD	Borough based workforce plans being developed	
				LBH	Normal Practice	
				LBR	Normal practice	
		Examine how new vetting system impacts on recruitment and retention	26 February 14	BDCCG	The safeguarding assurance committee is reviewing this working with corporate services	
				HCCG	The safeguarding assurance committee is reviewing this working with corporate services	
				RCCG	The safeguarding assurance committee is reviewing this working with corporate services	
				LBBD	In progress	
				LBH	In progress	

				LBR	In progress	
Develop effective shared governance for quality and safety that demonstrates our commitment to quality	11, 244	NHS England's QSG to invite representatives from local authorities and Health Watch		NHS England	Complete	
		Identify system wide issues through intelligence sharing		BHR GGS Nurse Director	Strategically and operationally systems have been reviewed and changes made. Formal intelligence sharing now common practice.	
Patient and Public Involvement and insights to ensure service user and patient feedback drives quality improvement.		Locally led conversations with patients, service users and their families and carers about "what matters to you"	Ongoing	All	Each agency to identify methods of communication working with communication leads	
		Patient vignettes to go to every governing body meeting to present a patient perspective of receiving care	Ongoing	BHRCCG	This was discussed at all governing body meetings in January and is being progressed working with PPE lay members of the governing body's	

Action Plan to be updated every fortnight after each meeting of the Task and Finish Group
New actions to be agreed at Task and Finish group and added as needed

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