HEALTHIER COMMUNITIES SELECT COMMITTEE			
Report	Lewisham Clinical Commissioning Group (LCCG): Action Plan to implement the prioritised recommendations in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013		
Ward	All	Item No.	6
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Class	N/A	Date	11.12.13

1. Recommendations

1.1 The committee is asked to note the;

a) Summary of the Government's response to the Francis report.
b) Nine recommendations the Government have chosen not to support.
c) LCCG's support of the remaining 281 recommendations.
d) LCCG Francis Action Plan approved by the CCG Delivery Committee in September 2013;

And

e) Support the planned Lewisham People's Health Summit planned for March 2014.

2. Purpose

2.2 The paper details how NHS Lewisham CCG will implement the recommendations relevant to itself as a commissioner of health services.

3. Background

3.1 The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 chaired by Robert Francis QC made 290 recommendations to the Secretary of State for Health to improve patient safety in the NHS. All NHS organisations have been required by NHS England to respond to the "Francis Report" and to publish an action plan detailing how the recommendations will be implemented.

3.2 In its initial response to the Francis Report "*Patients First and Foremost*" the Government set out plans to prioritise care, improve transparency, and ensure that where poor quality care was detected, there is clear accountability and clear action. The Government also commissioned six independent reviews to consider key issues identified by the inquiry;

- Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England.
- *The Cavendish Review:* An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish
- *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*, by Don Berwick
- *A Review of the NHS Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart
- *Challenging Bureaucracy* led by the NHS Confederation

- The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

3.3 Since the publication of the Francis Report the Government has also introduced a number of changes to improve the NHS. These include:

- The Care Quality Commission (CQC) has appointed three Chief Inspectors; of hospitals, adult social care and primary care.
- The Chief Inspector of Hospitals has started a first wave of inspections which will include the new Lewisham and Greenwich NHS Trust
- The CQC has consulted on a new system of ratings
- Legislation has been placed before Parliament to introduce a new failure regime which will include quality as well as finance
- Legislation has been prepared to give the CQC greater independence
- The CQC has consulted on a new set of fundamental standards; these standards will enable prosecution of providers where patients have been harmed because of unsafe or poor care.
- NHS England has published guidance to commissioners on involving patients and the public in decisions about their care: *Transforming Participation in Health and Care*
- NHS England has for the first time published clinical outcomes by consultant
- New nurse and midwifery leadership programmes have been developed
- A new leadership programme has been launched to attract clinicians and others to the top jobs in NHS England
- Senior leaders and Ministers at the Department of Health have been gaining frontline experience in health and care settings.

3.4 In November 2013 the Government published its full response to the Francis Report and the six other reviews listed above. The Government have accepted all but nine of Sir Robert Francis's recommendations. In their response, *Hard Truths: The Journey to Putting Patients First*, the Government have promised new actions in the following areas:

- Monthly reporting of ward by ward staffing levels and other safety measures
- Clearer signposting for patients to complain with independent support, including from Healthwatch
- Trusts will report quarterly on complaints and actions taken
- A statutory duty of candour on providers and a professional duty of candour on individuals through changes to professional codes of conduct
- Consultations on changes to the NHS Litigation Authority risk pooling scheme; meaning that Trusts will have to reimburse some or all compensation costs when they have not been open about an incident
- Legislation on a new offence of 'Wilful Neglect" so that those responsible for failures can be held to account
- A new fit and proper person's test which will act as a barring scheme
- Reductions in bureaucratic reporting requirements
- A new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the necessary training and skills
- New legislation to create a criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading.

3.5 The Government declined to support recommendations that related to the merging of the CQC and Monitor to create a single Regulator; instead the Government plan to create a single failure regime. It also declined to support those that would have given

commissioners new powers of intervention, changed the organisational structure of Healthwatch, created a criminal offence to obstruct statutory duties and those that would have led to the registration of healthcare assistants.

3.6 The recommendations the Government have not supported are;

Recommendations 19, 61 and 64 – Merger of system regulatory functions. The response says: "We do not intend to merge regulatory functions [of the Care Quality Commission and Monitor] through the development of a single regulator. Rather we intend to implement a single failure regime with clear roles and responsibilities."

Recommendation 137 – Commissioners' powers of intervention. The response says: "To give regulators and commissioners equivalent powers of intervention would blur the distinction of … roles and risk causing confusion in the system, resulting in inaction because of assumptions that another body is intervening to address a problem."

Recommendation 145 – Local Healthwatch structure. The response says: "We believe that local Healthwatch organisations should be set up in a way that best meets the needs and reflects the circumstances of their local communities; taking a top-down approach and imposing a fixed structure would undermine the need for flexibility."

Recommendation 183 – Criminal offence to obstruct statutory duties. The response says: "The government does not intend to criminalise untruthful statements to commissioners and regulators made by healthcare professionals."

Recommendation 209 – Registration for healthcare support workers. The response says: "There is no solid evidence that demonstrates that healthcare and care support workers should be subject to compulsory statutory regulation, given the safeguards that are already in the system."

Recommendation 212 – Developing standards for healthcare support workers. The response says: "This recommendation is a step toward regulation (see recommendation 209) and for the same reasons, we are rejecting this recommendation."

Recommendation 213 – Dismissing unsatisfactory staff following breach of code of conduct. The response says: "We do not believe that regulation of health care assistants and support workers will improve the quality of care."

3.7 This action plan is LCCG's response to the most pressing recommendations that apply to commissioners.

4. Method

4.1 In May 2013 LCCG established a working group to review the Francis Report and prepare a response and action plan. The working group comprised a lay member of the Governing Body, two clinical director members of the Governing Body the Nurse Director, Corporate Director and Head of Integrated Governance.

The working group review the Francis Report and the Government's response, "Patient's First and Foremost."

The working group have;

- Identified which of the 290 recommendations are directly relevant to LCCG
- Prioritised the directly relevant recommendations into five levels of urgency;

  1 = relevant but not this year

  2 = priority for this year

  3 = immediate priority

  4 = already in place/completed

  5 = good idea/aspirational

4.2 A review of those actions prioritised at level 2 and 3 (priority for this year and immediate priority) have been analysed and an action plan developed which has been divided into four key work streams;

1. Cultural changes/values – links to the Organisational Development Plan
2. Public Engagement – links to the Public Engagement Strategy
3. Quality Assurance – links to the Quality Assurance Framework
4. Use of information – requires a new Information Strategy.

4.3 The action plans have been linked to our commissioning intentions (2014/15- 2015/16) to ensure that the implementation of the work is part of our "business as usual" and the governance arrangements reflect this;

- The Organisational Development Plan is monitored by the Strategy and Development Committee
- The Public Engagement Strategy is monitored by the Public Engagement Group (PEG), which reports to the Strategy and Development Committee
- The Quality Assurance Framework is monitored by the For Learning and Action Group (FLAG) – our main quality assurance group - which reports to the Delivery Committee
- The Information Strategy will be monitored by the Strategy and Development Committee

5. Stakeholder Involvement

5.1 The LCCG is planning a public engagement event for March 2014, the Lewisham People's Health Summit to discuss quality in healthcare and learn from the public.

6. Next Steps

6.1 Initiate the work streams and the action plans.

6.2 Consult with the public at an event in March; Lewisham People's Summit on improving quality in Healthcare.

6.3 Agree specific and practical projects with our main providers to deliver the spirit of the Inquiry report and to bring immediate improvements to patient safety. E.g. Patient Falls Workshop.

Lewisham CCG: Action Plan to implement the prioritised recommendations in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013

Four key thematic work streams:

In developing the draft action plan below it was clear that five key work streams are required or need to be enhanced to implement the Francis recommendations. Themes 1 (cultural change) and 2 (public engagement) are closely linked.

Yellow	**1. Cultural changes / values – links to the Organisational Development Plan (Yellow)** To write and implement an "openness and transparency strategy" to inform our publications scheme ensuring we do more than meet the duty of candour.
Yellow	**2. Public Engagement – links to the Public Engagement Strategy (Yellow)** To implement the Public Engagement Strategy ensuring that a key aim is to inform the CCG's understanding of patient safety and experience.
Orange	**3. Quality Assurance – links to the Quality Assurance Framework (Orange)** To review the Quality Assurance Framework to ensure that every service line for every provider is underpinned by a clear, measurable set of fundamental quality standards (including safeguarding) that are monitored in year frequently and issues escalated appropriately and that our Continuous Quality Improvement projects inform our commissioning intentions.
Blue	**4. Use of information – requires a new Information Strategy (Blue)** To write and implement an "information strategy" to identify, collect, analyse, present and secure all the information the CCG requires to first understand the quality of services it commissions. Secondly, deliver all its corporate objectives.

Work stream 1. Cultural changes / values – links to the Organisational Development Plan

Rec No.	Recommendation	CCG Priority	Action	Who by	Completion date
1	• All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;	3	Agree how we publish and when we publish our response to Francis		
2	The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: • A common set of core values and standards shared throughout the system; • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; • A system which recognises and applies the values of transparency, honesty and candour; • Freely available, useful, reliable and full information on attainment of the values and standards; • A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system	2	Review standards are reported as part of QOF Identify a cultural barometer tool for use by providers and by the LCCG		
4	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	2	Ensure core values from constitution are prioritised in all CCG policies and strategies		
7	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	3	Review contracts of employment and amend		
8	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	3	Review contracts of employment and amend for CSU employees		
12	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer	2	Review incident reporting policies at all providers ensuring that staff are supported to		

Rec No.	Recommendation	CCG Priority	Action	Who by	Completion date
	needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.		raise incidents and concerns		
173	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	2	Review implementation of COI policy		
263	It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.	2	Review with providers how they ensure that health care professionals are required to provide this information		

Work stream 2. Public Engagement – links to the Public Engagement Strategy

Rec No.	Recommendation	CCG Priority	Action	Who by	Completion date
129	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.	2	Agree fundamental standards with the Public Engagement Group		
136	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 can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	3	Review the support CCG provides to Health Watch and other groups		

Work stream 3. Quality Assurance – links to the Quality Assurance Framework

Rec No.	Recommendation	CCG Priority	Action	Who by	Completion date
124	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 substandard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.	2	Review all contracts to ensure that they include "fundamental quality standards" with agreed methods of measurement and clear redress for non-compliance Identify relevant quality standards that are not included within the contract.		
125	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 incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.	2	Improve the process for agreeing CQUINs to ensure that the agreed standards meet CCG objectives and demonstrate real quality improvement		
139	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental 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.	2	See above action for 124		
256	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	2	Agree a quality improvement programme with membership to promote and monitor proactive follow up after discharge		
128	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.	2	Ensure that the CCG has access to specialised clinical advice		
127	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.	3	Support the work of the Quality Surveillance Group		
143	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.	3	Review the quality dashboard Following third quarter report to test that outliers and trends can be identified as required		

Rec No.	Recommendation	CCG Priority	Action	Who by	Completion date
132	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.	2	Review QOF and Quality Report and information supplied to CQRGs Develop a gap analysis to identify which data we have and where we have gaps. Develop a programme of audit, including clinical audit with providers. Utilise and maximise the data available from Health Watch.		
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.	2	Review provider contingency plans		
140	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.	2	Review CCG systems / put in place systems for sharing information with CQC and TDA and Monitor and Quality Surveillance Group		
137	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.	2	Review contracts to ensure that we have this provision		
141	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.	2	Review systems for escalating Concerns with providers when contractual issues over quality cannot be resolved with the provider		

Work stream 4. Use of information – requires a new Information Strategy

Rec No.	Recommendation	CCG Priority	Action	Who by	Completion date
40	It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	2	Improve the FLAG quality report to include narrative details of key provider complaints		
255	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	2	Review how providers share patient feedback in real time		
36	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.	2	Agree an information strategy – developing real time information and sharing information with other commissioners and regulators and the Quality Surveillance Group		
142	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.	2	See 36		
40	It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	2	Improve the FLAG quality report to include narrative details of key provider complaints		