Health and Wellbeing Board Update on behalf of Ipswich and East and West Suffolk Clinical Commissioning Group

Francis action plan progress update: Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013.

1. Introduction

1.1 In response to the public and widespread concerns about mortality and the standard of care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, two public inquiries were commissioned by the Secretary of State for Health in 2010 and 2013. These were chaired by Robert Francis QC and are referred to as the Francis inquiries. The first inquiry focused on giving families and staffs an opportunity to raise their concerns about the care or lack of care provided by the Trust, and to identify further lessons not already outlined by other previous inquiries.

1.2 The second focused on the operation of the commissioning, supervisory and regulatory organisations and other agencies, and considered culture and systems in the organisation in relation to their role in monitoring the provision of services at the Trust. It examined why problems at the Trust were not identified sooner and appropriate action taken. From this, Francis made 290 recommendations to the Secretary of State for Health based on the lessons learned.

The key learning from Francis for all organisations was:

- Lack of openness to criticism
- Lack of consideration to patients
- Defensiveness
- Focus on looking in not outwards
- Secrecy
- Misplaced assumption about the judgements and actions of others
- Acceptance of poor standards
- Failure to put the patient first in everything we do.

1.3 The CCG developed an action plan in response to the recommendations that was identified as relevant to the Clinical Commissioning Groups (CCG) and this was reported to the Governing Bodies and Clinical Executives.

1.4 The monitoring of this action plan is undertaken by Chief Nursing Office. The focus of this monitoring is to evidence that learning from Francis is “live” and being embedded in both CCGs.

2. Recommendations

2.1 The H&WB Board is asked to note the content of this report described by the CCGs in reviewing and assessing risk and actions relating to the recommendations of the Francis Inquiry Report.

FRANCIS REPORT – EXECUTIVE SUMMARY

REC NO.	THEME (SUB THEME)	RECOMMENDATION	ACTION	TIMESCALES
1 - 2	**Accountability for implementation of the recommendations - These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service**			
		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; 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.	All organisations should: • Announce its decision to accept the recommendations and what it intends to do to implement those accepted • Publish a progress report annually in relation to its planned actions • Identify a common set of core values and standards shared throughout the local system; • Involve all staff with those values and standards • Make freely available, useful, reliable and full information on attainment of the values and standards; • Utilise a tool or methodology (such as a cultural barometer) which helps to measure the cultural health of all parts of the local system	Complete March 2014 Complete On-going On-going September 2013
3 – 8	**Putting the patient first - The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.**			
		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.	NHS Constitution • 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	Complete

			the contracts of employment • 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.	Complete
9 - 12	**Fundamental standards of behaviour - Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.**			
		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon.	Following the reporting of incidents, staff to receive feedback, including information about any action taken or reasons for not acting.	Complete
13-18	**A common culture made real throughout the system – an integrated hierarchy of standards of service** **No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable**			
	Standard Setting	**Standards should be divided into**: • **Fundamental standards** of minimum safety and quality – non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. **Enhanced quality standards** – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources;	• All such standards would require regular review and modification • There should be a defined set of duties to maintain and operate an effective system to ensure compliance; • Review potential enhanced quality standards for the local system with the NHS Commissioning Board	Complete Complete

		• **Developmental standards** which set out longer term goals for providers – focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator.	• Review potential developmental standards for the local system with the NHS Commissioning Board	Complete
19 - 59	**Responsibility for, and effectiveness of, healthcare standards**			
	Responsibility for regulating and monitoring compliance	Measures formulated by the National Institute for Health and Clinical Excellence should include measures of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff.	• Mechanisms for monitoring and the performance of NICE measures established • Minimum establishment and skill mix in commissioned services to be determined and monitored • In monitoring compliance direct observation of practice, interaction with patients, carers and staff and audit of records should take priority over monitoring and audit of policies and protocols.	Complete Jan 2014 Complete
	Sanctions and interventions for non-compliance	**Zero tolerance:** A service incapable of meeting fundamental standards should not be permitted to continue. • Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. • Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches to the affected patient, relative and a regulator should	The provider should demonstrate that all reasonably practicable steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach.	Complete

		also attract regulatory consequences. • Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.		
	Use of information about compliance by a regulator	• **Quality Accounts**	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them.	Complete
		• **Complaints**	• To provide the Care Quality Commission with reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards. • Ensure greater detail on the narrative of complaints is available as well as the numbers of complaints.	Complete
		• **Patient Safety Alerts**	Monitor and review compliance with patient safety alerts in commissioned services.	
		• **Serious Untoward Incidents**	Share information with the NHS Commissioning Board and CQC as required, including learning and implementation of recommendations.	
		• **Media**	Monitor media reports for commissioned services	
		• **Inquests**	Notification by Trusts to CQC of upcoming inquests	

60 - 86	**Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions**			
	Quality of care as a pre-condition for foundation trust applications	The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application**.**	Monitor local aspirant Foundation Trust providers to ensure that appropriate quality of care is being delivered.	Complete
	Improving contributions of stakeholder opinions	The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that: Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering a sustainable service compliant with fundamental standards.	Monitor local aspirant Foundation Trust providers to ensure that appropriate stakeholder consultation is in place.	Complete
	Requirements of training of Directors	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	Monitor local Foundation Trust providers to ensure that appropriate Director training and development is being delivered.	Complete
87 - 90	**Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings**			
	Information Sharing	• The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	Systems for reporting and monitoring of serious untoward incidents requiring investigation (SIRIs) are in place and reporting to Governing Bodies.	Complete

		• Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive		
90 - 108	**Enhancement of the role of supportive agencies**			
	Improvement of Risk Management	The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority.	Monitor and performance manage risk management systems in commissioned services.	Complete
	National Patient Safety Function	• Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts. • Individual reports of serious incidents which have not been otherwise reported should be shared with a regulator for investigation, as the receipt of such a report may be evidence that the mandatory system has not been complied with. •	• Monitor and performance manage incident reporting systems in commissioned services. • Systems for reporting and monitoring of serious untoward incidents requiring investigation (SIRIs) are in place and reporting to Governing Bodies**.**	Complete Complete
	Health Protection Agency	The Health Protection Agency and its successor, should coordinate the collection, analysis and publication of information on each provider's performance in relation to healthcare associated infections, working with the Health and Social Care Information Centre.	• Monitor and performance manage systems in relation to healthcare associated infections in commissioned services.	Complete

109-122	**Effective complaints handling - Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.**			
	Complaints handling and investigations	• The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS. • Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation. • Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: - A complaint amounts to an allegation of a serious untoward incident; - Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; - A complaint raises substantive issues of professional misconduct or the performance of senior managers; - A complaint involves issues about the nature and extent of the services commissioned	To ensure systems for handling and investigating complaints in commissioned services and the local health system is fit for purpose and monitored. Systems for reporting and monitoring of serious untoward incidents requiring investigation (SIRIs) are in place and reporting to Governing Bodies	Complete

123 - 138	Commissioning for standards			
	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.	GPs 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.	September 2013
	Monitor delivery of fundamental 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.	Agree a method of measuring compliance and redress for non-compliance	Complete
	Monitoring delivery of enhanced standards	Commissioners should promote improvement by requiring compliance with enhanced standards or development towards higher standards.	Incentivise improvements either financially or by other means to enhance the reputation and standing of clinicians and the organisations for which they work.	Complete
	Assessment and enforcement of fundamental standards through contracts.	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.	Select contract indicators and a means of measuring compliance with indicators, ensuring close engagement with patients.	Complete
	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	Develop a protocol and policy for commissioning from alternative providers and for consortia commissioning arrangements.	Complete
	Monitoring Tools	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period:	• Monitoring quality information generated by the provider. • Develop the capacity to undertake audits, inspections, and investigations. • Maintain accurate, relevant, and useable	Complete

		Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted.	information from which the safety and quality of a service can be ascertained.	
	Role of commissioners and complaints	Commissioners should 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.	To ensure systems for handling and investigating complaints in commissioned services and the local health system is fit for purpose and monitored.	Complete
	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. • Undertake regular surveys of patients and the public more generally. • Decision-making processes should be transparent: decision-making bodies should hold public meetings. • Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.	Complete
	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. Commissioners and regulators should 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.	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.	Complete

139 - 144	**Performance management and strategic oversight**			
		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.	Metrics need to be established which are relevant to the quality of care and patient safety across the commissioned services, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	Complete
145 - 151	**Patient, public and local scrutiny**			
		There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in Chapter 6: Patient and public local involvement and scrutiny. Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.	To note and develop collaborative working with local Healthwatch and Health and Wellbeing Boards.	Complete
152 - 172	**Medical training and education**			
	Training and training establishments as a source of safety information	The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.	Ensure effective systems in commissioned services exist to obtain feedback information and monitor recommendations for compliance with minimum standards of patient safety and quality of care.	Complete

	Proficiency in the English language	The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.	To respond to any Government recommendations and actions relating to standards for proficiency of English in the provision of healthcare services.	
173 - 184	**Openness, transparency and candour** • **Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.** • **Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.** • **Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.**			
	Principles of openness, transparency and candour	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	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, the patient should be informed of the incident, given full disclosure and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	Complete
	Implementation of the duty	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour.	• All organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and recommendations. • "Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in	Complete

			relation to public interest issues of patient safety and care. • Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency	
	Enforcement of the duty	A statutory obligation should be imposed to observe a duty of candour: • On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request; • On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. • There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or, either personally or on behalf of the organisation, where given incompliance with a statutory obligation on the organisation to provide it.	• All organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and recommendations	

185 - 213	**Nursing**			
	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the requisite qualities. • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do.	To ensure systems exist in all commissioned services to meet the recommendation.	Complete
	Strengthening the nursing professional voice	• All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse. • Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	Consideration of recruiting nurses as non-executive directors should be made. Board governance arrangements to reflect compliance with this recommendation.	Complete

214 - 221	**Leadership**			
		A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	Ensure enforcement of standards and accountability with any newly agreed code of practice.	TBC
222 - 235	**Professional regulation of fitness to practise**			
	General Medical Council and Nursing and Midwifery Council	Specific recommendations for actions by these two professional regulatory bodies.	To respond to and comply with any new requirements of professional regulatory bodies and ensure that all commissioned services are also compliant.	On-going
236 - 243	**Caring for the Elderly - Approaches applicable to all patients but requiring special attention for the elderly**			
		Key themes for implementation by acute services and the wider health and social care system include: • Identification of a senior clinician who is responsible for the patient • Teamwork • Communication • Continuing responsibility for care • Using patient feedback • Follow up of patients • Hygiene • Provision of food and drink • Medicines administration • Recording of routine observations	Ensure all commissioned services are monitored for performance against key themes and compliance with agreed standards and contracts specifications is assured.	Complete

244 - 272	**Information**			
	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	Board accountability – each provider organisation should have a board level member with responsibility for information. Systems for monitoring compliance with information management and governance in all commissioned services to ensure compliance.	Complete

273 - 285	**Coroners and inquests**			
	Information to coroners	• The terms of authorisation, licensing and registration and any relevant guidance should 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. • There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	Ensure all healthcare providers comply with the requirements of the recommendation and any subsequent guidance issued.	Complete
286 - 290	**Department of Health leadership**			
		The Department of Health should together with healthcare systems regulators take the lead in developing through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards as recommended in this report.	The CCG should participate, as part of a whole system approach, in support of the development of standards as recommended in this report.	January 2014