The Robert Francis Inquiry Recommendations and Government Response Summary UPDATE

Date of Meeting: 13 August 2013
Agenda item: 13a

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>The Robert Francis Inquiry Recommendations and Government Response Summary UPDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update the CCG Governing Body on progress with recommendations and Governments response to second Francis Inquiry.</td>
</tr>
</tbody>
</table>
| REPORT WRITTEN BY: | Dr Helen Hibbs, Chief Officer  
Manjeet Garcha, Executive Lead Nurse |
| REPORT PRESENTED BY: | Manjeet Garcha, Executive Lead Nurse |
| KEY POINTS: | This report summarises the Governments’ response to the second Francis Report and identifies issues to be incorporated in the CCG Implementation Plan. |
| | The above report is Volume 1 of the full report and the Commissioner issues are highlighted in Chapter 7 pages 589-688. |
| | The full response from the Government in relation to the second Francis Inquiry can be found at:  
| RECOMMENDATION TO THE GOVERNING BODY: | Note the contents of the report and interim action plan (appendix 1).  
Ensure any appropriate actions are being taken.  
Ensure this remains a high priority for the CCG. |
| GOVERNING BODY ACTION REQUIRED: | ☐ Decision  
☑ Approval  
☑ Assurance |
| **View of patients, carers or the public and the extent of their involvement** | N/A |
| **Implications on resources** | N/A |
| **Legal implications** | Risk of litigation and exposure to sub optimal care. |
| **Implications on quality and safety** | Impacts on risk assurance, equality impact assessments (access and inclusion), NHS Operating Framework areas of Quality, Reform and Finance, Patient and Public Involvement and Communication and Engagement. |
| Assurance framework number | |
| Risk Register number | |
1. Purpose of the report

1.1 To update the CCG Governing Body on progress with recommendations and Governments response to second Francis Inquiry.

2. Recommendations

2.1 That the Governing Body note the contents of the report and action plan.

2.2 That the Governing Body ensure any appropriate actions are being taken.

2.3 That the Governing Body ensure this remains a high priority for the CCG.

3. Background

3.1 Executive Summary

The CCG continues to receive assurances on the previous Francis Report action plans via Clinical Quality Reviews and Quality and Safety Committee. This report details the plans the CCG has in place to ensure that all recommendations from the second inquiry by Robert Francis QC and the Governments response are fully considered and the CCG Board are updated. It also notes the Wolverhampton city wide response.

3.2 Introduction

A report was provided to the CCG Board in March 2013, advising the Board of the key issues arising from the second Francis Inquiry and the implications for the CCG. A further report was considered in June 2013 when it was decided that more time should be devoted by the governing body to debate the issues. A city wide Health and Wellbeing day was held on 31 July 2013 to debate and discuss the response of the local authority, Royal Wolverhampton trust, the Black Country Partnership NHS Foundation Trust and the CCG to the serious issues discussed in the report. This paper seeks to summarise the key recommendations the government’s response and to discuss the CCG response to the recommendations going forwards.

3.3 Key findings of the Francis report

The report concludes that a fundamental change in culture is required to prevent a system failure from happening again and many of the changes can be implemented within the current system. The report makes 290 recommendations, which focus primarily on securing a greater cohesion and culture across the system; however no single recommendation should be regarded as the solution to the many concerns identified: The inquiry’s recommendations set out requirements for oversight and accountability to ensure implementation of its proposals. It talks about creating the right culture, which aspires to prevent harm to patients and provide excellent care and a common culture of caring, commitment and compassion. The importance of
making patients the main priority in all that the healthcare system does is highlighted. The report proposes significant changes to the current division of regulatory responsibilities. The report contains 21 recommendations specifically for commissioning organisations, with six of these specifically around the role of commissioners in performance management and oversight of quality. There are also other recommendations which though not specific to commissioning, impact on the CCGs role

3.4 Key Recommendations for CCGs are:

Commissioners have a responsibility for monitoring the delivery of standards and quality on behalf of and in partnership with patients.

Commissioners should agree a method for measuring compliance and redress for noncompliance of standards and when selecting indicators and the means for measuring compliance, commissioners must closely engage with patients to ensure their expectations and concerns are addressed. Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis and must require the providers to provide quality information. Commissioners must have the capacity to undertake their own or Independent audits, inspections and investigations and should be entitled to intervene in the management of a complaint on behalf of a patient where it appears it is not being managed satisfactorily. Commissioners should be accountable to the public for the scope and quality of the services they commission and fully involve and engage the public in their work. Commissioners should have powers of intervention when substandard or unsafe services are being provided

3.5 Summary of the Government’s response to the second Francis Inquiry (appendix 2)

On the 26th March 2013 the Department of Health released “Patients First and Foremost-The Initial Government Response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry”. The Executive Summary is enclosed at appendix 2.

3.6 At the beginning of this report the Government sets out a Statement of Common Purpose that was signed by the chairs of key organisations across the health and care system. It renews and reaffirms the commitment to the values of the NHS, as set out in its Constitution, and includes pledges to work together for patients, to always treat patients and their families with compassion, dignity and respect, to listen to patients and to act on feedback. It asks all organisations within the health and care system to join them in signing up to this statement of common purpose.

3.7 The Government’s response starts from a simple premise and a simple goal that the NHS is there to serve patients and must therefore put the needs, the voice and the choices of patients ahead of all other considerations. It states that the quality of patient care will be put at the heart of the NHS in an overhaul of the health and care system in response to the Francis Inquiry. Health Secretary Jeremy Hunt announced how a culture of compassion will be a key marker of success, spelling an end to the distorting impact of targets and box ticking which led to the failings at Stafford Hospital.
3.8 Hospitals and care homes will be encouraged to strive to be the best, the basic values of dignity and respect will be central to care training; and, if things go wrong, patients and their families will be told about it.

3.9 New measures will be introduced to achieve this including Ofsted-style ratings for hospitals and care homes, a statutory duty of candour for organisations which provide care and are registered with the Care Quality Commission, and a pilot programme which will see nurses working for up to a year as healthcare assistants as a prerequisite for receiving funding for their degrees.

3.10 The initial Government response set out a five point plan, as follows:

1. Preventing Problems - putting in place a culture of zero-harm and compassionate care.
2. Detecting problems quickly.
3. Taking action promptly.
4. Ensuring robust accountability- accountability for wrongdoers.
5. Ensuring staff are trained and motivated.

3.11 It is likely there will be a further consultation later in the year on further changes to The NHS Constitution, with the aim of incorporating further recommendations made by Robert Francis QC.

3.12 City Wide approach

The health and wellbeing away day on 31 July 2013 considered the response of the key main providers in Wolverhampton.

The action plans were discussed:

The providers and commissioners were asked to consider how any gaps in evidence can be filled and how openness and transparency can be fostered.

The authorities discussed how to ensure clear lines of accountability and reporting can be maintained without unnecessary over inspection and duplication of reporting. This was taken as an action for the Health and Welling Board.

3.13 Gap analysis of the second Francis Inquiry and recommended actions

Chapter 7
A gap analysis has been commenced; this identifies the current position of the CCG in relation to the key commissioner recommendations.
3.14 Key cornerstone for the CCG is that the current governance systems and processes are strengthened with added focus on assuring:

- quality standards in contracts
- development of early warning signs
- collation of low level quality concerns from primary care
- dashboards with timely and accurate information in relation to quality. Developing the ‘expert commissioner’ ambition.
- Assessment of CCG Capacity
- Collaborative working and recognition of formal agreements with the Local Authority, National Commissioning Board, Public Health England, Care Quality Commission, Trust Development Authority and Monitor ensure joint working and the ability to escalate areas of work.

3.15 A number of Francis recommendations are already enshrined in legislation, old and new. Duty of Candour is a good example of this and the requirement of timely, open and transparent disclosure is in every contract with provider organisations.

3.16 The processes the CCG has in place in relation to the performance management of quality concerns and serious incidents within Commissioned providers and the CCGs approach to contract monitoring with the providers both assure that the CCG is already compliant/partially compliant with a lot of the relevant commissioner recommendations.

3.17 We also ensure compliance through the governance arrangements in place within the CCG including the committee structures, the expertise that sits within the CCG as well as the shared teams for quality and performance; alongside key documents such as the organisational development plan, patients and public engagement strategy, and policies referencing the CCG approach to whistle blowing and openness.

3.18 Finally the CCG’s intention to monitor the implementation of the Francis 2 reports recommendations within commissioned providers and the commitment to implement within the CCG and monitor the implementation within commissioned providers of any new legislation that arises from the Francis recommendations will further assure and ensure that the CCG is compliant with the recommendations.

3.19 Further action needed

One of the key areas where further action is needed is in relation to the review of CCG policies, staff contracts and code of conduct to ensure that they meet the requirements and the principles as set out through the Francis recommendations such as:

- Duty of candour
- Transparency
- No gagging clauses within redundancy settlements
- NHS Constitution
3.20 There is a need to review all policies to ensure that the importance of the patient’s voice is strengthened. This is work in progress currently.

3.21 The CCG should consider developing guidance for patients in relation to who to contact if they would like a commissioner led investigation into a complaint.

3.22 The CCG organisational development plan should be reviewed to ensure it captures the recommendations from Francis in relation to nursing leadership, competency and the culture of caring.

3.23 The CCG policy for the management of complaints should be reviewed to ensure that it incorporates and considers the recommendations from the Patient Association Peer Review into complaints at Mid Staffordshire NHS Foundation Trust.

3.24 The CCG should consider developing a contingency plan in relation to how it would address and manage the failure of a large provider.

3.25 Impact Assessments

The Francis Inquiry makes specific recommendations in relation to frail elderly people. It is clear from this inquiry alongside inquiries such as the one undertaken into Winterbourne View that the most vulnerable patients are at the most risk from harm. All CCG policies and reports should undergo a full equality impact assessment that recognises this.

4. Key Risks and Implications

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

4.2 The implementation of the recommendations from the second Francis Inquiry will be overseen by the CCG Quality and Safety Committee which will monitor the implementation of all Provider and CCG actions plans. Quarterly progress reports will go to CCG Board and monthly exception reports as appropriate.