Barnsley Clinical Commissioning Group

BARNSLEY HEALTH & WELLBEING BOARD
25TH APRIL 2013
THE FRANCIS REPORT

1.	**PURPOSE OF THE REPORT**
	The aim is to brief the Health & Wellbeing Board regarding the main recommendations of the Francis Report published on 6th February 2013, the implications these have for the Clinical Commissioning Group (CCG) and the work that is being undertaken to address these.
2.	**EXECUTIVE SUMMARY**
	The Mid Staffordshire NHS Foundation Trust public inquiry report (referred to as the Francis Report) was published on the 6th February – three years since the findings of Robert Francis QC's independent inquiry into the trust were published in 2010. The Report focused on not just the failings at one trust but how these went unchecked for a significant period of time and the role commissioners and regulators played in this. The Report made 290 recommendations and a summary of the main themes is provided in this report. An analysis of the recommendations and the implications these have for the CCG was considered by the March Quality & Patient Safety Committee and the recommendations agreed by the April Governing Body. Whilst the Francis Report is a damning indictment of systemic failures to protect the public its recommendations are a vital opportunity to ensure lessons are learnt to strengthen the culture of care and the accountability for it's safe delivery that the public we serve so rightly deserve.
3.	**THE BOARD IS ASKED TO:** • Note the summary of the Francis Report recommendations and the CCG's plan to address them within the subsequent months

Report of: Mark Wilkinson

Designation: Chief Officer

Report Prepared by: Brigid Reid

Designation: Chief Nurse

1.	**SUPPORTING INFORMATION**	
1.1	**Links to the Assurance Framework**	
	This section will be populated when the CCG has an agreed Board Assurance Framework.	
1.2	**Links to Objectives**	
	To have the highest quality of governance and processes to support its business	x
	To commission high quality health care that meets the needs of individuals and groups	x
	Wherever it makes safe clinical sense to bring care closer to home	
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	x
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £. These partnerships will be with: Patients, the public, Practices, Providers, the Local Authority, the local voluntary sector and other stakeholders as required	x
1.3	**Links to NHS Constitution**	
	The NHS provides a comprehensive service available to all.	
	Access to NHS Services is based on clinical need, not an individual's ability to pay.	
	The NHS aspires to the highest standards of excellence and professionalism	x
	The NHS services must reflect the needs and preferences of patients their families and their carers.	x
	The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population	x
	The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources	
	The NHS is accountable to the public, communities and patients that it serves	x

2	**BACKGROUND**
	The full executive summary of The Francis Report is available via http://cdn.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf and the 15 recommendations related to Commissioning for Standards are identified in Appendix A. The Report's recommendations include:- **A structure of fundamental standards and measures of compliance:** • A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue. • These standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, which healthcare providers must comply with. • Non compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk • To cause death or serious harm to a patient by non compliance without reasonable excuse of the fundamental standards, should be a criminal offence. • Standard procedures and guidance to enable organisations and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations. • These fundamental standards should be policed by the Care Quality Commission (CQC) **Openness, transparency and candour throughout the system, underpinned by statute, to assist a common culture of being open and honest with patients and regulators.** The measures recommended include:- • A statutory duty to be truthful to patients where harm has or may have been caused • Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient • Trusts to be open and honest in their quality accounts describing their faults as well as their successes • The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence • It should be a criminal offence for the directors of Trusts to give deliberately misleading information to the public and the regulators • The CQC should be responsible for policing these obligations **Improved support for compassionate, caring and committed nursing** • Entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients • Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard • Nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level • Healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so.

Stronger healthcare leadership

- The establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct
- The ability to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts
- Establishment of a registration scheme to regulate the eligibility of staff who can be directors of NHS organisations

On 26th March 2013 The Secretary of State for Health announced the Government's initial response to the Francis Report as follows:-

- There will be a new regulatory model under a strong, independent **Chief Inspector of Hospitals** who will introduce single aggregated ratings and also develop ratings of hospital performance at department level e.g. cancer services, maternity services. Assessments will include whether patients are listened to and treated with dignity and respect, the safety of services, responsiveness, clinical standards and governance including how complaints are handled. A new Chief Inspector of Social Care will ensure the same rigor is applied across the health and care system.
- A new set of **fundamental standards** will be introduced to make explicit the basic rights that anyone should expect of the NHS (produced by the Chief Inspector of Hospitals, working with NICE, patients and the public). Where these standards are breached, a new failure regime will ensure that firm action is taken swiftly. If it is not the Government has identified that the failure regime could lead to special administration with the automatic suspension of the Board.
- A new **statutory duty of candor is proposed** to ensure honesty and transparency are the norm in every organisation regulated by the CQC. The new Chief Inspector of Hospitals will be the nation's 'whistleblower- in-chief' and survival results for more disciplines including cardiology, vascular and orthopaedic surgery will be published. The introduction of legal sanctions at a corporate level for providers who knowingly generate misleading information or withhold information from patients or relatives is being considered. The government is awaiting the outcome of Don Berwick's review re Patient Safety reporting before considering potential statute to require reporting of all incidents by staff though the General Medical Council, the Nursing and Midwifery Council and the other professional regulators have been asked to tighten and speed up their procedures for handling breaches of professional standards.
- **Revalidation of Registered Nurses** will be developed (as doctors now are) to ensure their skills remain up to date and fit for purpose.
- The Chief Inspector of Hospitals will also ensure that hospitals are meeting their existing legal obligations to ensure that **unsuitable healthcare assistants are barred** and that hospitals are properly recruiting, training and supporting healthcare assistants, drawing on the recommendations being produced by Camilla Cavendish. Healthcare support workers and adult social care workers now have a code of conduct and minimum training standards www.skillsforhealth.org.uk/codeofconductandtrainingstandards
- A pilot will be undertaken regarding the feasibility and efficacy of making experience as a health care assistant as a prerequisite for entry to Registered Nurse education.

	Within the context of the announcements above the 15 recommendations relating to Commissioning for Standards were considered by the Quality & Patient Safety Committee in March as presented in Appendix B. The proposed actions were agreed at the April Governing Body and are being developed into a robust action plan which the CCG will monitor closely.
3	**DISCUSSION**
	Fundamentally the Francis Report is about the need for a culture of care and accountability for effective care delivery to be paramount in the commissioning, provision and regulation of all healthcare (not just hospital based). Already concerns have been raised about a significant increase in regulation activity potentially inhibiting the required shift in culture; notwithstanding the CCG has been required to ensure that certain recommendations are utilised within the 13/14 Commissioning Plan e.g. effective quality assurance of Provider Nurse and Medical Director sign off of their organisation's Cost Improvement Programmes (CIPs) to the effect that patient safety and experienced is not compromised. Through consideration of the 15 recommendations specific to commissioners (Appendix B) 8 specific actions were agreed by the Quality & Patient Safety Committee as the most effective way of prioritised and focused action that addresses the recommendations within the ethos of care and accountability desired. In addition to these actions the CCG is giving consideration as to how it best highlights its role to Provider Organisation staff to ensure that they are clear about how they can escalate patient safety concerns that they can demonstrate that their organisation has not effectively acted upon.
4	**RISKS TO THE CLINICAL COMMISSIONING GROUP**
	Assuring that the care commissioned and provided is of high quality is one of the key roles of the CCG therefore to give the Francis Report's recommendations due diligence is essential. It must also be recognised that in seeking the best way to gain that assurance the CCG needs to be mindful of the risks of overburdening providers with scrutiny and provide leadership with regards to the cultural shift required.
5	**CONSULTATION**
	The importance of the CCG's need to give due consideration to the Francis Report Recommendations has been highlighted to both the Governing Body (February 2013) and the Membership Council (March 2013). The recommended actions were considered at the March Quality & Patient Safety Committee and April Governing Body. Once the resulting Action Plan is agreed by the Governing Body in May they will be shared through Our Public Engagement Network (OPEN).
6	**APPENDICES TO THE REPORT**
	Appendix A Recommendations Related To Commissioning For Standards Appendix B Review of Recommendations relating to Commissioning For Standards

7	CONCLUSION
	Out with ensuing changes in standards and regulation the Francis Report Recommendations in relation to Commissioning have been given due consideration as to how Barnsley CCG best focuses on ensuring the provision of high quality services for the population it commissions healthcare on behalf of. It is proposed that prioritised progression of the identified actions in Appendix B will enable an effective foundation for the work ahead which places accessible and meaningful patient safety and experience data collection and utilisation as key to effective commissioning and contract delivery.

RECOMMENDATIONS RELATED TO COMMISSIONING FOR STANDARDS

123 Responsibility for 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. They 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. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They ill need to take this continuing partnership with their patients seriously if they are to be successful commissioners.

124 Duty to require and 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. 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.

125 Responsibility for requiring and monitoring delivery of enhanced standards

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.

126 Preserving corporate memory

The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.

127 Resources for scrutiny

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.

128 Expert support

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.

129 Ensuring assessment and enforcement of fundamental standards through contracts
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.
130 Relative position of commissioner and provider
Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.
131 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.
132 Monitoring tools
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.

133 Role of commissioners in complaints
Commissioners should be entitled to 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, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.
134 Role of commissioners in provision of support for complainants
Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.

135 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. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account.
- There should be 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.

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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.

137 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. 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.

Appendix B

Recommendation	Current Position	Proposed Action
123 Responsibility for monitoring delivery of standards and quality	GPs do feedback expressed patient concerns with providers and their own views on patient outcomes but often at an anecdotal level and not systematically sought or reported. The CCG – as part of the authorisation process - has already identified the need to address this and ensure that these insights are triangulated with other data to enable 'patterns of concern' (and areas of high quality) to be picked up and acted upon.	**1.** Chief Nurse to develop action plan to a) systematically collate GP insights b) collate key patient safety and experience data from Providers c) triangulate a) and b) to note any 'patterns of concern' to trigger further action
124 Duty to require and monitor delivery of fundamental standards	'Item of Service' needs clarifying in terms of specificity Quality specifications (in line with CQC outcomes) are part of the contracts issued and monitored for compliance but until now this has been a separate and somewhat protracted process. For 13/14 some consideration has been given to requiring redress for service delivery non compliance e.g. A&E target but not at an individual patient level	**2.** Chief Nurse to a) Clarify integration of contract quality specification and monitoring b) For 13/14 prioritise key services where redress will be required for non compliance c) Review risks and benefits re individual patients mid year to inform 14/15 contract development
125 Responsibility for requiring and monitoring delivery of enhanced standards	The use of CQUINs and Best Practice Tariff currently are the main means of doing this i.e. solely financially	**3.** Linked to Patient & Public Engagement explore ways to ensure achievement and maintenance of high standards is celebrated and shared
126 Preserving corporate memory	As commissioners this has recently been achieved through the Legacy Quality Handover	**4.** Consideration of this approach to be adopted when:- a) Lead Clinicians/Officers change b) Providers change

127 Resources for scrutiny	Chief Nurse reviewing the remit and structure of the Quality team alongside data and access to service review that we currently require Providers to provide. Whilst CCG is considerably smaller than predecessor organisation if clarity of purpose can be maintained and resources effectively targeted this should be achievable	**5.** Chief Nurse to review capacity at end of Q1
128 Expert support	Beyond the use of the Clinical Support Unit (and recent consultancy re PMO) this has thus far not been utilised, consideration of HSMR data would be one such aspect where this should be considered	**6.** Need to identify the process for securing PRN
129 Ensuring assessment and enforcement of fundamental standards through contracts	See 123 and 124 – in addition use of Provider's Friends & Family Test results Need for consideration of engagement re this in line with our Strategy and to prevent duplication/promote meaning of this activity	Actions 1 and 3
130 Relative position of commissioner and provider	This is clearly stated in the CCG's Constitution (vision and values) and commissioning plans . Consider further exploration with Providers and Partners to ensure they understand this and we exercise appropriately so that clinical leadership through collegial working does not preclude expectations or exercise of accountability	
131 Development of alternative sources of provision	Whilst this is not an explicit aim it has already been explored e.g. in relation to poor performance of IAPT services	
132 Monitoring tools	See 124, 127 and 128 Concept of solely monitoring enhanced standards where they exist (and leaving fundamental standards to the regulators) needs further clarification	Actions 1, 2, 3 and 6

133 Role of commissioners in complaints	118 and 120 recommend that commissioners should have sight of complaint narratives; currently data provided by Providers is not sufficient (numbers and themes without further analysis) The suggestion of signposting CCG to complainants whilst the complaint is in progress needs careful consideration re expectations and capacity plus recent announcement of national review of complaints handling	**7.** **a)** Linked to Action 1 clarify what we require reporting from Providers re complaints **b)** Await outcome of national review before deciding further changes
134 Role of commissioners in provision of support for complainants	CCG has been involved via the Joint Commissioning Unit (with BMBC) re commissioning advocacy services though no evidence as yet of efficacy	See 7 b)
135 Public accountability of commissioners and public engagement	CCG has membership system (OPEN) and two lay members on Governing Body with meetings of the latter held in public See 129 re consideration of how to engage meaningfully	See action 3
136	CCG set up to operate in the manner described	
137 Intervention and sanctions for substandard or unsafe services	Sanctions already considered – further national consideration re national powers of intervention required but CCG should consider how it conducts contract negotiation and monitoring to ensure auditable and escalating route of escalating actions if standards or safety not maintained. Recommend CCG seeks more meaningful relationship with regulators re this – LAT Quality Surveillance Group probably the best route	**8.** Utilisation of Quality Surveillance Group