



Croydon Clinical Commissioning Group Response to Francis Report

Health and Well Being Board - 5th December 2013

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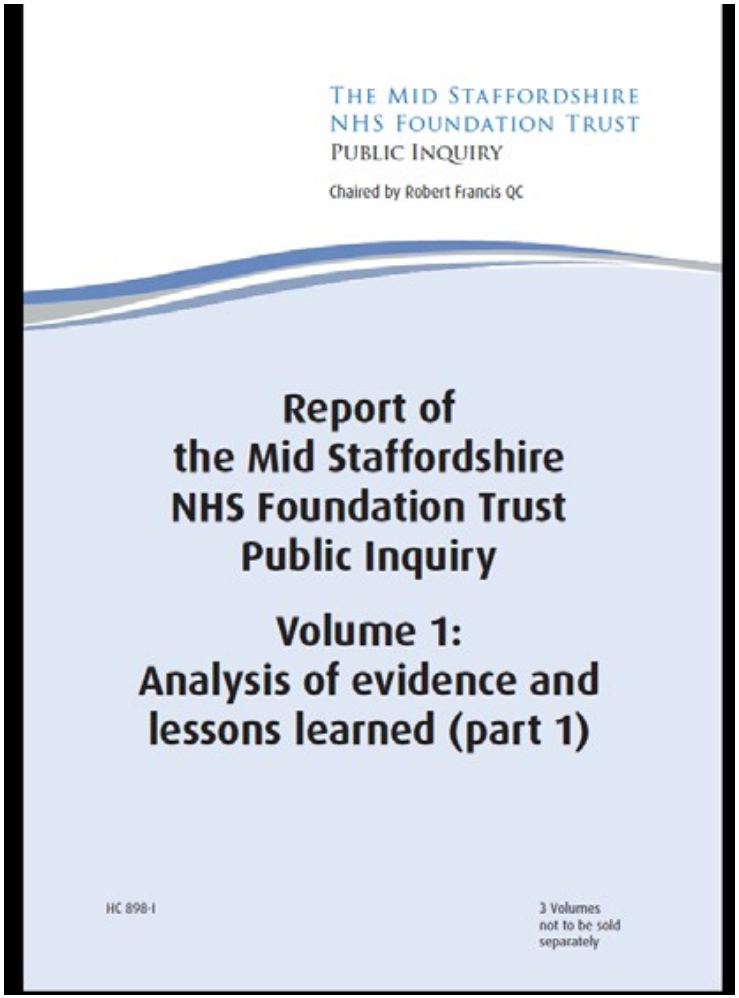
The ‘Mid Staffordshire Timeline’

- 2008
  - Healthcare Commission alerted of "apparently high mortality rates in patients admitted as emergencies".
  - Mid Staffordshire NHS Foundation Trust failed to provide an adequate explanation
  - A Healthcare Commission investigation was carried out between March and October 2008.
- 2009
  - Healthcare Commission published report in March 2009
  - Severely criticised the Trusts management and detailed the poor conditions and inadequacies at the hospital.
- 2010
  - Number of inquiries by June 2010, the new government announced that a full public inquiry would be held, chaired by Robert Francis QC
- 2013
  - The final report was published on 6 February 2013

The Francis Inquiry: What it was about

'To examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner, and appropriate action taken.'

The Francis Inquiry: What it was about



- > 1 million pages of documentary material
- > 250 witnesses
- 139 days of oral hearings
- Report handed to Sec of State 5 February 2013
- 1781 pages
- 290 recommendations

The Francis Inquiry: What it found (1)

- Patient stories
- Mortality
- Complaints
- Staff concerns
- Whistleblowers
- Governance issues
- Finance
- Staff reductions

The Francis Inquiry: A Patient Story

The daughter of a patient in ward 11

In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, "Nurse, nurse", and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet...

The Francis Inquiry: Fear of Trouble

- *There would have been a lot of little incidents that just made you feel uncomfortable and made us feel that we didn't want to approach the staff. I did feel intimidated a lot of the time just by certain ones.*

- *you have rushed the blood through, I said to the sister, and she said, ... I have had to come in and give the blood and don't moan... because I have had no break today. That's what she said, and she probably hadn't had a break. So I didn't mention the frusemide to her because she was obviously fraught.*

The Francis Inquiry: Recommendations (1)

- There were 290 recommendations
- The first recommendation of the report states:

'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 work***

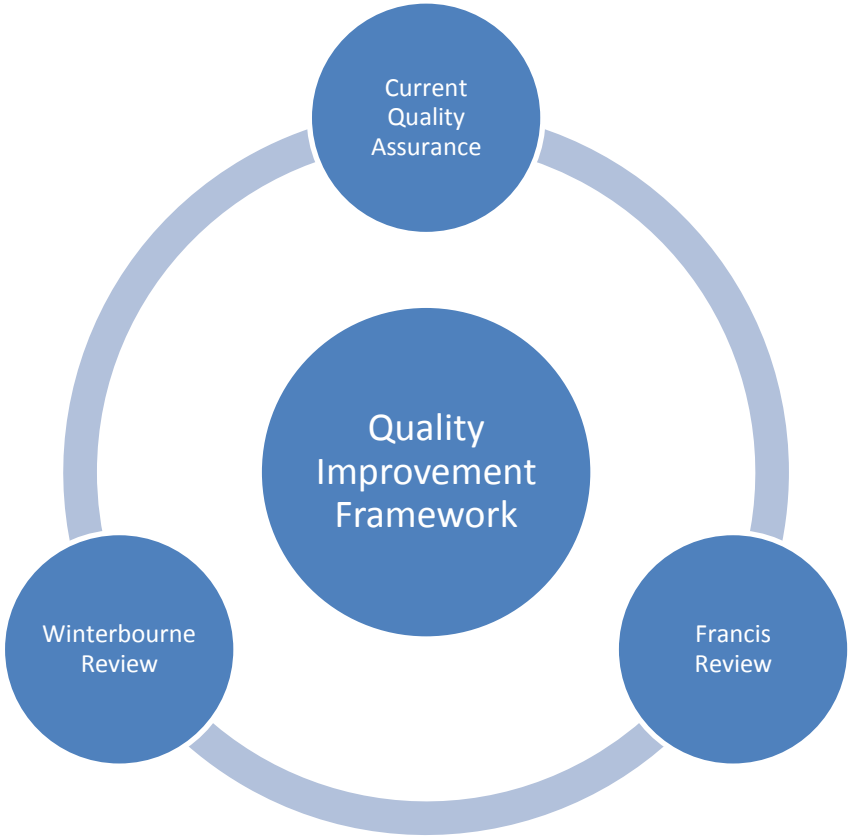
Each such organization ***should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do about implement those accepted****, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions.'*

The Francis Inquiry: Recommendations (2)

- Common values
- Fundamental standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong patient centred healthcare leadership
- Accurate, useful and relevant information
- Culture change not dependent on Government

The CCG's Response

- A review of all 290 recommendations
- Action plan progress to be reported every 6months
- Review of provider action plans



Key Themes for the CCG

The inquiry identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the trust's problem and it is structured around:

- Understanding and setting standards of quality
- Intervening and issuing sanctions if not meeting standards
- Early Warning Systems

All underpinned:

- Being able to collect feedback from patients, staff, health professionals
- Sharing intelligence across organisations
- Acting quickly on concerns and issues

Standards of quality

What do we already have in place?

- Good understanding of our main acute provider
- Announced visits
- Clinical Quality Review meetings
- Quality Monitoring and Learning Assurance Group
- Quality Surveillance Group / Risk Summits

What do we need to do more of?

- Share information across other agencies
- Understand community services, mental health services
- Programme of review, proportionate to the size of the contract
- Set out clearly CCG expectations of improvement metrics / dashboard

Intervening and Issuing Sanctions

What do we already have in place?

- Contract queries
- Financial penalties
- Recommissioning services for improvement

What do we need to do more of?

- Apply current levers consistently across providers

Early Warning Systems

What do we already have in place?

- Patient feedback system
- GP amber alert card
- Quality Monitoring and Learning Assurance Group
- Quality Surveillance Group / Risk Summits

What do we need to do more of?

- Better relationships with other agencies
- Better triangulation of information

Making a difference locally

Across all key providers

- Developing for 2014/15 key quality improving expectations
- Seeking assurance of mortality rates and staffing levels

Croydon Health Services NHS Trust

- Deep dives into specific service areas

South London and Maudsley NHS Foundation Trust

- Developing reporting and understanding of delivery

Intermediate Services

- Establishment of Clinical Quality Review meeting