REPORT TO:	HEALTH AND WELLBEING BOARD 10 June 2015
AGENDA ITEM:	13
SUBJECT:	Update on actions arising from the Francis Report
BOARD SPONSORS:	Paula Swann, Chief Officer, Croydon CCG John Goulston, Chief Executive, Croydon Health Services NHS Trust Steve Davidson, Director of Mental Health, South London & Maudsley NHS Foundation Trust

BOARD PRIORITY/POLICY CONTEXT:

The report of the full public inquiry into the failings at the Mid Staffordshire Foundation Trust was published on 6 February 2013. The inquiry, led by Robert Francis QC, looked at the role of commissioning, supervisory and regulatory bodies and why serious problems at the Trust were not identified and acted on sooner. The report referred to the checks and balances in the NHS system that should have prevented serious systemic failure of this sort but did not in this case.

The Report made 290 recommendations which were clustered into 5 key areas reflecting a common culture across the NHS that puts patients first. A culture which:

- supports compassionate care;
- is open and transparent;
- has accurate, useful and relevant information;
- is compliant with fundamental standards;
- has strong and patient centred leadership.

A number of initiatives have been introduced nationally as part of the response to the Francis Report, including the introduction of the **Duty of Candour**. It encompasses three concepts: 1) openness – enabling concerns and complaints to be raised freely and without fear; 2) transparency – sharing true information about performance and outcomes; 3) candour – informing any patient harmed by a healthcare provider and offering an appropriate remedy, regardless of whether they complain. Under the regulation the person harmed must be informed face to face as soon as reasonably practicable.

All NHS organisations, including Croydon CCG, Croydon Health Services NHS Trust and South London and the Maudsley NHS Foundation Trust, considered the findings and the 290 recommendations, and agreed an action plan against those recommendations during 2013.

The Francis Report recommended that each organisation should report on progress with its action plan, at least annually.

FINANCIAL IMPACT:

None

1. RECOMMENDATIONS

The health and wellbeing board is asked to:

- Note local work being taken forward by partners to implement recommendations arising from the Francis Report

2. EXECUTIVE SUMMARY

2.1 The February 2014 meeting received a report on the steps taken by Croydon CCG, Croydon Health Services NHS Trust and South London and the Maudsley NHS Foundation Trust to consider the implications of the Francis Report and to agree individual organisation actions plans.

2.2 This report provides an update on progress with the implementation of the Francis Report actions plans by Croydon CCG, Croydon Health Services NHS Trust and South London and the Maudsley NHS Foundation Trust, as at the end of the 2014/15 financial year.

3. DETAIL

3.1 The report of the public inquiry led by Robert Francis QC into Mid Staffordshire was published on 6 February 2013. It detailed the suffering of many patients at Stafford Hospital run by Mid Staffordshire NHS Foundation Trust. It concluded that this was primarily caused by a serious failure on the part of an NHS Trust Board that did not listen sufficiently to patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It failed to tackle a culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. The report referred to the checks and balances in the NHS system that should have prevented serious systemic failure of this sort but did not. The report set out 290 recommendations but its overarching theme was that a fundamental culture change is needed in the NHS to put patients first.

3.2 Whilst the Francis Review made no specific recommendations for health and wellbeing boards it did recommend that guidance should be given to promote coordination and cooperation between local Healthwatch, health and wellbeing boards, and council scrutiny committees (Recommendation 147).

3.3 The Department of Health published its interim response to the Francis Review, 'Patients First and Foremost' in March 2013 and indicated an expectation that local Francis Action Plans should be in place in health and care organisations across the country by the end of 2013. A further response, 'Hard Truths: the journey to putting patients first', was published in November 2013.

3.4 Croydon Clinical Commissioning Group has undertaken a full review of the Francis recommendations and has an action plan that has informed the development of a quality framework. Together they will further develop the CCG's assurance mechanisms to ensure quality is improving across all providers. The framework and action plan was agreed by the CCG governing body on 24 September 2014.

3.5 Croydon CCG Governing Body received an annual update report at its 26 May 2015 meeting, which is appended. The report includes a summary of the key action taken under each of the 11 themes identified in the Francis Inquiry Report. Risks relating to patient safety and quality are specifically reviewed at the CCG's Quality Committee. The committee also periodically considers whether it is satisfied with the presentation of information on quality, so that the data, analysis and accompanying narrative are providing the insight required to give assurance to the Governing Body.

3.6 The key quality metrics are identified and reported to CQRGs and to every meeting of the Quality Committee and the Governing Body. Information from providers is compared with information from other sources, including patient feedback and soft intelligence from regulators. The CCG quality lead now has a regular programme of visits to clinical areas and the feedback from these is reported to the Quality Committee. Through adherence to this framework the CCG is assured about the quality of local services, and where performance concerns arise that they are identified and appropriate action is initiated

3.7 The CCG has continued to work with providers, regulators and stakeholders including patients and the local public to progressively improve the safety and quality of services commissioned for Croydon residents. To this end the changes in practice envisaged by the Francis Report have been embedded in the approach the CCG takes to commissioning, including through the clinically-led quality monitoring of local services (including through the Clinical Quality Review Groups) and its governance via the Quality Committee and the Governing Body.

3.6 In July 2013 an action plan was presented to the Croydon Health Services NHS Trust Board detailing the actions against existing programmes of work and new reviews to be undertaken in response to the Francis Report. A further update on the progress of this work was presented to the Quality & Clinical Governance Committee in April 2014.

3.7 Following the Care Quality Commission (CQC) Inspection in 2013 a Trust wide Quality Improvement Plan was developed to address all the recommendations from the CQC inspection. The Quality Improvement Plan (QIP) which is an overarching Trust wide document not only includes the recommendations and compliance actions from the CQC inspection in September 2013 but also includes outstanding actions from previous inspection reports, the Francis report into Mid Staffs, the Government's response to Francis and the Clwyd/Hart report into complaints handling.

3.8 The majority of QIP milestones have now been delivered or are on track within agreed timescales and the remit of the QIP has been expanded to become the Quality, Experience and Safety Programme (QESP).

3.9 QESP sets out to drive continued improvements in quality, safety and patient experience by embedding best practice throughout the Trust.

3.10 In reviewing the 28 Francis recommendations within the Quality Improvement Plan, the Trust has made significant progress in addressing actions, as described in the report appended.

3.11 The South London and Maudsley NHS Foundation Trust Board received a further update paper on the Francis Report at its 24 March 2015, which is appended.

3.12 In 2013 a working party was established which identified four essential work streams to:

1. Create the right culture for positive challenge and positive action (Francis themes of leadership, openness and transparency, values and standards)
2. Work with service users in a spirit of co-production and co-creation
3. Look after staff, each other and ourselves
4. Assure quality of care in every corner of the Trust (information)

3.13 An action plan followed progress against which was reviewed in September 2014 and a very large number of local initiatives were identified. A few of the main ones are described in the table below:

	Example of CAG work	Example of Corporate work
Culture for positive challenge and action	Scheduled patient safety Walk Rounds	Value based recruitment Revalidation of doctors and nurses 6 C’s Compassionate Nursing Practice
Working with service users in a spirit of co-production and co-creation.	PPI meetings are established Examples of excellent practice in co-production in areas around the Trust including winners of national awards	The Recovery College EPIC is established to develop governance around service user and carer involvement. Duty of Candour Policy implementation.
Looking after staff, each other and ourselves	Reflective Practice groups Individual coaching Staff invited to executive team meetings Senior managers visiting services on regular basis to listen to staff concerns	Coaching and workshops from SLaM partners. Schwartz Rounds® planned Arts Strategy Whistleblowing Policy Debriefing Policy review Staff Counselling service developments Well-being services initiatives
Assuring quality of care in every corner of the Trust	Work with teams to prepare for CQC visits to new standards Establishment of new quality governance structures	Trust Quality Strategy Care Delivery System implemented to address violent incidents.

3.14 The review concluded that a more systematic approach was required across the whole organisation. The membership if the Trust Board changed significantly in early 2015 and the new Chair, Roger Pafford and CEO Matthew Patrick agreed that the Trust Board would listen to patient voices as the most important source of feedback on organisational performance. It was agreed that patient experiences would be presented at Trust Board meetings. Furthermore the Board leadership would be visible and available to listen to staff through visiting services. In January 2015 approval was given to implement Schwartz Rounds in the organisation beginning in Autumn 2015.

3.15 In March 2015 a further paper to the Trust Board proposed the establishment of a Speak up Guardian role. This individual will support a change of culture in the organisation to enable staff to speak up and raise concerns which impact on the organisation constructively and without fear of recrimination. The Guardian seeks to instil confidence in staff to report concerns and believe that something can be done about them. A further proposal outlining that role will be considered at the July Trust Board.

3.16 A commitment was made to a 'zero tolerance of bullying' campaign led by HR. This will begin by using focus group methodology to understand the Staff Survey 2014 results from SLaM which indicate that 'bullying, harassment and discrimination at work' are worse for BME staff.

4. CONSULTATION

4.1 The Croydon CCG action plan includes utilisation of patient and public feedback on service quality by both providers and commissioners as a core part of quality monitoring. The detailed reports from Croydon Health Services NHS Trust and South London and Maudsley NHS Foundation Trust describe how patient and carer feedback is a key part of their quality monitoring frameworks.

5. SERVICE INTEGRATION

5.1 As we develop the new approach to outcomes based commissioning of health and social care for people over the age of 65 the focus on quality monitoring will be rooted much more in the outcomes that older people have identified matter to them. The new type of contract will incentivise the provider alliance to deliver the outcomes specified through a different style of service specification.

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 There are no financial implications for the health and wellbeing board.

6.2 The implementation of quality improvements in part prompted by the Francis Report, such as with respect to establishing Safer Staffing levels for each inpatient ward, has resulted in additional expenditure across the NHS.

7. LEGAL CONSIDERATIONS

7.1 Legal advice has not been sought on the content of this report.

8. HUMAN RESOURCES IMPACT

8.1 There are no human resources impacts for the board, however partner organisations have experienced challenges in recruiting additional staff, which has been a significant implication across NHS providers.

9. EQUALITIES IMPACT

9.1 The health and wellbeing board, as a committee of the council, has a statutory duty to comply with the provisions set out in the Equality Act 2010. The board must, in the exercise of all its functions, have due regard to the need to comply with the three arms or aims of the general equality duty.

9.2 The equality analysis conducted by the Department of Health on *Hard Truths: the journey to putting patients first*, the government response to the Francis Report, states that:

> There is little evidence to show that the vulnerability faced by different groups actually leads to an increased risk of harm. However, there are particular groups who may be more vulnerable in a healthcare setting, and it is thought that vulnerability could well result in a less safe service being delivered to them. *(Hard Truths The Journey to Putting Patients First Equality Analysis p.4)*

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APPENDICES

The following papers from partner organisations are appended to this report.

1. Croydon Clinical Commissioning Group Francis Report Update. Sean Morgan, Interim Director of Quality Improvement and Governance, Croydon Clinical Commissioning Group
2. Croydon Health Services NHS Trust Francis Action Plan update. Michael Fanning, Director of Nursing, Croydon Health Services NHS Trust
3. South London and Maudsley NHS Foundation Trust: Francis Inquiry Report. Alison Beck, Head of Psychology and Psychotherapy; Neil Brimblecombe, Director of Nursing, South London and Maudsley NHS Foundation Trust

BACKGROUND DOCUMENTS

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC can be found at www.midstaffspublicinquiry.com/report