Agenda Item No. 9

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

29 July 2015

Report title	**Update from the Wolverhampton Clinical Commissioning Group in response to the recommendations made by Francis Inquiry**
Cabinet member with lead responsibility	Councillor Sandra Samuels Chair Health and Wellbeing Board
Wards affected	All
Accountable director	Linda Sanders - People
Originating service	Wolverhampton City Clinical Commissioning Group
Accountable employee(s)	Manjeet Garcha Tel: 01902 442476 Email:manjeet.garcha@nhs.net
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:
Note and support the steps Wolverhampton CCG (WCCG) is taking to address the findings of the Mid Staffordshire Inquiry. This report covers the wider system changes which have been implemented to address the recommendations.

1. Purpose

1.1 To provide a further assurance report to the Health and Wellbeing Board that the CCG continues to consider and reflect on the implications of the Mid Staffordshire NHS Trust reports and system wide change necessary to improve patient safety, clinical effectiveness and patient experience. The Health and Wellbeing Board requested this at the January meeting.

2.0 Background

2.1 Sir Robert Francis was commissioned in July 2009 to chair a non-statutory inquiry into the happenings at Mid Staffordshire. The primary purpose of this being to give a voice to those who had suffered and to consider what went wrong. This initial report was published in February 2010 and subsequent reports in 2013 and Governments Response in 2014.

3. Introduction

The Francis Report highlighted that despite monitoring systems being in place, there was still a failure to provide safe care over a sustained period of time, which, had sadly resulted in the avoidable demise of many patients. The immediate priority across the health and social care system was to identify if there were any similar quality and patient safety failures in other areas of patient care, and this was guided by several reports and responses following 2013.

4. Key Reports and Inquiries

Since 2001 there have been several reports and inquiries (Appendix 1) which have all highlighted a deficit in quality of care. They all made recommendations which have common themes;

- Preventing problems
- Detecting problems quickly
- Taking prompt action
- Robust accountability
- Staff training and motivation
- Safety and openness

5. CCG and Provider Work streams – Update

5.1 **Transparency of quality data and improved availability** – this includes

- Publishing data on mortality, per consultant for 10 medical specialties
- Publishing data on Friends & Family Test (FFT), which now includes A&E, inpatient, maternity and primary care. There is now also a Staff FFT. Further roll out to include community and mental health.

Assurance: Wolverhampton CCG agreed Commissioning for Quality and Innovation (CQUIN) incentive with RWT for 2014/15, this is now embedded practice and monitored monthly at the Clinical Quality Review Meetings (CQRM). Results are published nationally on NHS Choices and ongoing assurance is sought. This is also supported by the Care Quality Commission (CQC) appointment of three Chief Inspectors hospitals, adult social care and primary care.

CQC inspections are ongoing and RWT have recently (June 2015) received a 3 day inspection, (awaiting report) and BCPFTs inspection is planned for the autumn. There have also been several inspections across primary and health and social care. All ratings and reports are published on CQC and Trust website, including reports to Trust Boards and Governing Bodies. RWT, as an aspiring Foundation Trust, has to achieve 'outstanding' or 'good' to be authorised by Monitor.

5.2 Addressing 'Failing' Providers

The Government has extended greater powers of intervention to the CQC. Providers are put into 'special measures' and action plans are monitored jointly by CQC, CCG, NHSE and Trust Development Authority (TDA) as appropriate. All measures stated in this report serve as an 'alert' for the commissioner that services are of concern, whilst the commissioner or provider can take one serious issue on its own, best practice shows that triangulation with several other key areas will give a clearer picture and then a level of appropraite escalation and management can be agreed.

Quality failures are given the same importance as financial failures.

5.3 Leadership and Accountability/Oversight

Includes:

- CQC inspection and CCG Assurance Framework Domain includes 'well led organisation'
- Performance Management Frameworks
- Nursing and Midwifery Revalidation to commence approx. April 2016
- Revalidation for doctors has been strengthened
- Senior leadership programmes
- Fast track leadership programmes for clinicians to recruit external talent into top jobs in the NHS
- Named GP for all elderly/vulnerable patients in primary care
- Monthly oversight reports from all providers (safety, effectiveness and experience)
- Mandatory reporting of agreed indicators as per quality schedules included in contracts i.e. staff training, absence, appraisal, complaints, FFTs, agency usage, safer staffing, infection management
- Primary Care Quality Monitoring
- Nursing and care home sector improving quality schemes

Assurance- provider assurance via monitoring key performance indicators and remedial action plans. E.g. compliance to training plans and targets for training achieved at different levels i.e. safeguarding training at levels 1, 2, 3 and 4 for all including clinician and non-clinicians. CCG provides and monitors mandatory and all other training via

individual staff appraisals on an annual basis. WCCG also provides training and update for primary care staff at bi monthly Team W events.

In addition, WCCG has worked with RWT to share learning on key patient safety issues which have seen a significant and sustained improvement as Never Events across the Birmingham, Black Country & Solihull NHSE foot print, which was evaluated very well and participants valued the opportunity to learn from other commissioners and providers as well as discuss learning from the incidents across various specialties.

The new measures as identified above and in response to the Francis Recommendations, go some way in identifying early failing services, measures to turn them around, accountability and when necessary, criminal sanctions. But it has to be recognised that these are only the beginning of the process to fundamentally change the culture to ensure safe and compassionate care across the whole of the NHS.

5.4 Commissioning for Quality

The CCG is committed to ensuring that there are appropriate processes in place to engage with the public and staff, gain views on services, use this information to inform service design or redesign, measure outcomes and inform our future commissioning intentions. We do this by several forums;

- Patient Participation Groups
- Locality Meetings
- 'pop up' shops
- Consultation/engagement events
- Children and Young People Forums
- Patient surveys
- Carers Support
- Complaint monitoring
- Staff surveys
- Joint engagement forums with key stakeholders
- Use of technology i.e. twitter, facebook, e-news letters etc

5.5 Performance management and standard setting

The policing of compliance with standards are very challenging and requires a robust policy and strategy which is supported by all stakeholders. In order to meet this standard there are robust performance management processes in place. In order to get a better understanding of the quality of care provided in various settings, WCCG has in place a series of scheduled and unscheduled quality visits to all providers of NHS commissioned care. These include acute, mental health, primary, local authority, third sector and independent sector. We work in collaboration with our stakeholders and regulatory partners i.e. CQC, TDA to conduct regular 'walk rounds' to ensure direct observation of care. Findings are shared with providers and regulators for transparency and over time this has fostered stronger working relationships. WCCG is working with Health watch to undertake some joint work. The visiting team is made up from clinicians, governing body members with specialist interest in Quality, lay members, expert patients and members from the quality team.

Assurance: is sought at monthly CQRM, performance and contract review meetings to monitor all agreed performance indicators. This is further supported by information from the quality visits and other softer data related to patient safety, experience and effectiveness.

NHSE chair a monthly Quality Surveillance Group for key issues to be discussed and escalated and the CCG has a quarterly Assurance Review meeting to monitor the system wide assurance.

5.6 Organisational Culture

Robert Francis recommended that all providers demonstrate commitment to reviewing organisational culture. Since 2013, all providers have had in place robust action plans to monitor their progress with the pertinent recommendations and evaluation to monitor effectiveness. As you can see from **appendix 1,** since Francis, there have been several other reports which all impact on safety and quality of services patients/carers receive.

Assurance - Each provider was tasked with providing assurance to its respective governing body/trust board on progress made with their action plans. Over time the action plans have matured and all actions completed. On ongoing basis principles of openness, transparency and candour are monitored, all action plans are sighted by WCCG and evidenced i.e. job descriptions have been reviewed and updated, provider and CCG Being Open policies are in place and human factors are considered for all significant event learning.

5.7 Workforce and Safer Staffing Levels

Since the last update, there has been much activity in this area, namely ward level data being published by each trust and whether they are meeting their staffing requirements, every six months trust boards receive assurance that a detailed review of staffing levels has been undertaken using evidence based tools. National Institute for Health and Care Excellence (NICE) also undertook a staffing review and made some recommendations for using key accredited tools. It was anticipated that NICE would endorse safe staffing levels**,** however, it did not.

Key changes in recruitment of student nurses, it is proposed that before entering NHS funded nurse training courses, each student nurse will have to demonstrate and evidence a yearlong placement in a health care setting as a health care assistant.

Training for Health Care Workers and Social Care Support Workers will be required to be certificated to assure the fundamental training and skills to give personal care to patients and service users. There is ongoing work with Health Education England and Skills Council to progress this.

Assurance – providers share their board reports at CQRMs, on an ongoing basis all soft or hard data related to patient safety incidents is correlated with staffing levels to get a better understanding of the whole picture i.e. information on pressure ulcers, falls and other harms is triangulated with ward dashboards to identify key issues with staffing and

skills mixes. Wards that are a concern are supported through staffing, education, training and leadership. Further work is ongoing to extend this to other services i.e. maternity and community settings.

Workforce training, skills, absence management, bank/agency usage are all monitored.

5.8 Supporting staff to share concerns

Francis highlighted that one of the key areas which needed to be addressed immediately was the issue related to staff feeling supported and free from reprisal in the event they wished to 'whistle blow'. In his 2015 report, *Freedom to Speak Up,* Robert Francis identified 5 key overarching themes for which he made 20 recommended principles to put into practice. The five key themes were;

- Culture change
- Improve handling of cases
- Measures to support good practice
- Particular measures for vulnerable groups
- Extending legal protection

Assurance – whilst formal assurance is gained via policies and procedures being in place, WCCG place a greater emphasis on learning from staff on how things have changed/improved or not. This is obtained via several forums including: surveys, response rates, staff FFT, complaints, whistleblowing cases, engagement with vulnerable groups, walk around and sickness rates. All providers provide ongoing monthly assurance via the CQRM's.

6.0 Next Steps/Conclusion

It can be recognised that the CCG has taken a number of steps in meeting their responsibilities to address recommendations initially set out by Francis, but as demonstrated in appendix 1, maintained by several other reports which followed, which may have specific function but key themes remain consistent over safety, safeguarding, experience and effectiveness.

There are early discussions across the wider health and social care economy to lead on a provider led workshop what will bring together all WCCG providers and local commissioners to harness the learning and share good practice to further drive up standards of care across the whole of the health economy in the City.

WCCG remains committed to this important agenda; I would very much welcome the opportunity to return to Health and Well Being Board in six months to report on further progress and updates including the findings of the recent and pending CQC Inspections.

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Appendix 1

Year	Key Report	No of Recommendations
2001	The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995	198
2002-5	The Shipman Inquiry	190
2009	Mid Staffs Review- Dr David Colin Thome	24
2009	Mid Staffs Review- Professor Alberti	23
2010	Colin Norris Inquiry 2010	32
2010	RF 1 March 2009 (Robert Francis QC)	18
2010	The Airedale Inquiry (Kate Thirwell QC)	6
2012	Winterbourne Review	56
2012	Morecambe Bay	35
2013	RF2 Feb 2013 (Robert Francis QC)	290
2013	Don Berwick- a promise to learn	10
2013	Bruce Keogh- Review of 14 NHS Trusts	8
2013	Ann Clwyd MP & Professor Tricia Hart- Review of NHS Hospitals Complaints Systems	4
2013	Cavendish Review- Healthcare assistants and support workers in NHS settings	2
2014	Hard Truths- Government Response to RF2	5
2014	Kennedy Breast Care Review	10
2014	Independent Enquiry into Child Sexual Exploitation in Rotherham	15
2015	NHS Saville Legacy Unit; Oversight Report	14
2015	Robert Francis review of Whistleblowing: Freedom to Speak	20
Total		960