NHS
Merton
Clinical Commissioning Group

REPORT TO MERTON CLINICAL COMMISSIONING GROUP CLINICAL QUALITY COMMITTEE

Date of Meeting: 23rd January 2014

Agenda No: 7.6 **Attachment:** 19

Title of Document: Francis Report Update	**Purpose of Report:** To Receive and Note
Report Author: Jenny Kay, Director of Quality	**Lead Director:** Jenny Kay, Director of Quality

Executive Summary:

The Government published its full, final response to the second Francis report *'Hard Truths, the journey to putting patients first'* on the 11th November 2013.

This paper provides an updated summary of the Merton CCG's overall approach to the Francis report, as follows:

- The Governing Body received and discussed a presentation by the Director of Quality in early spring 2013.
- This discussion resulted in the formulation of the CCG's quality strategy, which was first discussed and approved at the Quality Committee and Governing Body in May 2013, and then reviewed in September 2013, in light of emerging developments, notably the Berwick and Keogh reports.
- The workplan which accompanies the quality strategy specifies the action taken by the CCG to respond to the relevant recommendations of the Francis report, and this has also been updated and reviewed regularly, and is next due to be received by the Quality Committee in April.

Please also see:

Annex 1 - The Executive summary of the Government full and final response to the Francis report, including hyperlinks to all the recommendations which are relevant to commissioners

Annex 2 – the updated quality strategy workplan, which includes MCCG actions and recommendations to the Government's full and final response to the Francis report

Key sections for particular note (paragraph/page), areas of concern etc:

As above

Recommendation(s):

The quality committee / Governing Body is requested to receive and note the report and approve direction of travel

Committees which have previously discussed/agreed the report: Several presentations and papers to Quality Committee and the Governing Body during 2014: March 2013, Governing Body presentation on the Francis report, April 2013, Clinical Quality Committee – First draft of the CCG quality strategy May 2013, Governing Body approval of CCG quality strategy July 2013 Clinical Quality Committee –quality strategy workplan progress update August 2013 – Clinical Quality Committee – quality strategy updated in light of Berwick and Keogh reports August 2013, Governing Body presentation on the Keogh report September 2013 – Governing Body, update on quality strategy and workplan November 2013 – Clinical Quality Committee – quality strategy workplan updated**.**
Financial Implications: None specifically, albeit emphasis on improved staffing levels within providers may have resource implications, (while improving quality and efficiency)
Implications for CCG Board: Supports CCG strategic direction and quality strategy.
Other Implications: The implications of the report are relevant to many key areas of CCG responsibilities, including patient and public involvement/Legal/Governance/Risk/Diversity/ Staffing)
Equality Impact Assessment: No specific issues identified.
Information Privacy Issues: None
Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) May be published.
Next Steps: as per workplan attached.

Merton Clinical Commissioning Group

Quality Committee and Governing Body meetings, January 2014

Introduction.

The Government published its full, final response to the second Francis report *'Hard Truths, the journey to putting patients first'* on the 11th November 2013.

This paper provides an updated summary of the Merton CCG's overall approach to the Francis report and the action it has taken to respond to the recommendations.

Please also see:

Annex 1 - The Executive summary of the Government full and final response to the Francis report, including hyperlinks to all the recommendations which are relevant to commissioners

Annex 2 – the updated quality strategy workplan

2. Background

In June 2010 the Government asked Robert Francis QC to undertake a public inquiry into the role that commissioning, supervisory and regulatory bodies played in monitoring the work of Mid Staffordshire Foundation Trust between January 2005 and March 2009. This was the second stage of a review which had previously explored the internal workings of the Trust itself.

The final report of the public inquiry was published on the 6th February 2013. The report was presented in three volumes and made a total of 290 recommendations, related to the identification of early warning signs, culture, governance, the roles and responsibilities of organisations and agencies; providers, commissioners and regulators.

On 3rd April 2013, the Government published an interim response to the report, *'Patients First and Foremost'* reiterating the findings of the report and stating that "a culture of compassion" will be a key marker of success.

'*Patients First and Foremost'* set out a statement of common purpose, signed by the chairs of key organisations across the health and social care system. It reaffirmed the commitment to the values of the NHS as set out in its constitution, and included pledges to work together for patients, always treat patients and their families with compassion, dignity and respect, to listen to patients and to act on their feedback.

Subsequently, there have been the following publications, in response to themes from the Francis review:

CQC have published their new model of inspection, including hospitals, mental health and community care, social care and primary care
http://www.cqc.org.uk/public/about-us/our-inspections/our-new-acute-hospital-inspection-model

NHS England, 'Review into the quality of care and treatment provided by 14 hospital trusts in England', Professor Sir Bruce Keogh, (July, 2013)
http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/Overview.aspx
Berwick Report into Patient Safety, Department of Health, (August 2013)
https://www.gov.uk/government/publications/berwick-review-into-patient-safety

We now also have the Government's full and final response, 'Hard Truths, the journey to putting patients first' http://francisresponse.dh.gov.uk/ (Nov 13)

3. Action taken by Merton CCG.

The CCG has had several opportunities to consider the implications of the Francis report:

- The Governing Body received and discussed a presentation by the Director of Quality in March 2013.

- This discussion resulted in the formulation of the CCG's quality strategy, which was first discussed and approved at the Quality Committee and Governing Body in May 2013, and then reviewed in September 2013, in light of emerging developments, notably the Berwick and Keogh reports.

- The workplan which accompanies the quality strategy specifies the action taken by the CCG to respond to the relevant recommendations of the Francis report, and this has also been updated and reviewed regularly, and is next due to be received by the Quality Committee in April 2014.

These actions include:

- Review of Terms of Reference of the CCG quality committee, ensuring the forward agenda covers all 5 domains of quality, as well as a focus on provider performance, compliance and culture.

- Regular clinical (GP and Director of Quality) participation on all local NHS provider Clinical Quality Review Groups, which in turn have examined their own effectiveness in light of the Francis report (through a SW London workshop) and reviewed their provider's response to Francis.

- Continued improvement and development of the integrated quality and performance report, so that the CCG has 'insight and intelligence' into provider performance.

- Review of the progress against the Winterbourne View Report recommendations

- Current work to establish a quality framework across jointly commissioned services with the local authority, including nursing and residential homes

- Publication of the revised Communications and Engagement Strategy in January 2014, along with the establishment of a Patient Reference Group

- CCG participation in the Quality Surveillance Group across South London, to share information with other CCGs and agencies.

- Current internal audit of quality governance within the CCG (due to report April 2014)

- Review of safeguarding structure with new post for adult safeguarding to be embedded in the local authority team (by March 2014)

- Formulations of commissioning intentions for 2014/15, taking into account feedback from local clinicians and the public in relation to service development and improvement.

- Formulation of 2 and 5 year strategic plans, aimed at improving quality of care.

- Participation in CQC thematic review of transition into adult services for young people with complex health needs (resulting in a new children's commissioning group)

Conclusion and Recommendation

As a commissioner, Merton CCG is required to articulate the action we are taking in response to the full Government response to the Francis Inquiry.

The Quality Committee and Governing Body will continue to review the quality strategy, and through this strategy continue to:

- Monitor the quality of care received by residents of Merton, and be alert to any early warning signs
- Work continuously to improve the quality of care received by residents of Merton, through its commissioning intentions and service development work, as well as its work with primary care member practices.

Jenny Kay
Director of Quality
Merton Clinical Commissioning Group
December 2013

Annex 1

Government Response to the Francis Enquiry, published November 2103

Executive Summary

'The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed'
Robert Francis QC

1. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in February 2013, called for a 'fundamental culture change' across the health and social care system to put patients first at all times. Robert Francis QC, the Inquiry Chair, called for action across six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour.

2. The Government's initial response, *Patients First and Foremost*, set out a radical plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. This document and its accompanying volume build on this to provide a detailed response to the 290 recommendations the Inquiry made across every level of the system.

3. It also responds to six independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

••Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England.

••*The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, by Camilla Cavendish.

••*A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England*, by Professor Don Berwick.

••*A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart.

••*Challenging Bureaucracy*, led by the NHS Confederation.

••The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

4. Since the Inquiry reported, the Government has already instigated a number of significant changes which will improve inspection, increase transparency, put a clear emphasis on compassion, standards and safety, increase accountability for failure, and build capability.

The Care Quality Commission has appointed three Chief Inspectors of hospitals, adult social care and primary care.

••The Chief Inspector of Hospitals has begun a first wave of inspections of 18 Trusts.

••Expert inspections of hospitals with the highest mortality rates, led by the NHS Medical Director, revealed unacceptable standards of care. Eleven hospitals were placed into 'special measures' to put them back on a path to recovery and then to excellence.

••The Care Quality Commission has consulted on a new system of ratings with patient care and safety at its heart.

••Legislation to introduce a responsive and effective failure regime which looks at quality as well as finance is progressing through Parliament.

••The Government is legislating to give greater independence to the Care Quality Commission

••The Care Quality Commission has conducted a major consultation on a new set of fundamental standards: the inviolable principles of safe, effective and compassionate care that must underpin all care in the future. The fundamental standards will enable prosecutions of providers to occur in serious cases where patients have been harmed because of unsafe or poor care, without the need for an advance warning notice.

••NHS England has published guidance to commissioners, *Transforming Participation in Health and Care*, on involving patients and the public in decisions about their care and their services.

••For the first time, NHS England has published clinical outcomes by consultant for ten medical specialties and has also begun to publish data on the friends and family test.

••New nurse and midwifery leadership programmes have been developed from which 10,000 nurses and midwives will have benefitted by April 2015. *Compassion in Practice* has an action area dedicated to building and strengthening leadership.

••A new fast-track leadership programme to recruit clinicians and external talent to the top jobs in the NHS in England has been launched, including time spent at a world-leading academic institution.

•• By the end of the year, 96% of senior leaders and all Ministers at the Department of Health will have gained frontline experience in health and care settings

5. This document sets out how the whole health and care system will prioritise and build on this, including major new action on the following vital areas:

- Transparent monthly reporting of ward-by-ward staffing levels and other safety measures.
- All hospitals will clearly set out how patients and their families can raise concerns or complain, with independent support available from local Healthwatch or alternative organisations.
- Trusts will report quarterly on complaints data and lessons learned, and the Ombudsman will significantly increase the number of cases she considers.
- A statutory duty of candour on providers, and a professional duty of candour on individuals through changes to professional guidance and codes.
- The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident.
- Legislate at the earliest available opportunity on Wilful Neglect – so that those responsible for the worst failures in care are held accountable.
- A new fit and proper person's test which will act as a barring scheme.
- All arm's length bodies and the Department of Health have signed a protocol in order to minimise bureaucratic burdens on Trusts.
- A new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.
- The Care Bill will introduce a new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation.

8. Following Don Berwick's recommendation, NHS England will establish a new Patient Safety Collaborative Programme across England to spread best practice, build skills and capabilities in patient safety and improvement science, and to focus on actions that can make the biggest difference to patients in every part of the country. The Safety Collaboratives will be supported systematically to tackle the leading causes of harm to patients. The programme will include establishing a Patient Safety Improvement Fellowship scheme to develop 5,000 Fellows within a national faculty within five years.

9. The Department of Health has agreed with the nursing and medical Royal Colleges and clinical leaders that every hospital patient should have the name of the consultant and nurse responsible for their care above their beds. The Government also intends to introduce a named accountable clinician for people receiving care outside hospitals, starting with vulnerable older people.

10. Patients and the public need easy access to reliable and accurate information about the safety of their hospital. The Care Quality Commission and NHS England will work with Monitor, Trust Development Authority, the Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean. This includes issuing a joint statement from the Care Quality Commission and NHS England on their commitment to complete alignment of patient safety measurement and developing a dedicated hospital safety website for the public which will draw together up to date information on patient safety factors, for which robust data is available. This will include information on staffing, pressure ulcers, healthcare

associated infections and other key indicators, where appropriate at ward level. The website will aim to begin publication from June 2014. It will, over time, become a key source of public information, putting the truth about care at the fingertips of patients and updated monthly.

11. Trusts will continue to be encouraged to use NHS Safety Thermometer data collection to help inform improvements in some key patient safety areas: pressure ulcers, falls resulting from harm, catheter-associated infections and venous thromboembolism. NHS England will work with the Care Quality Commission, Monitor, Trust Development Authority, the Health and Social Care Information Centre and others to make patient safety data more accessible to all and provide clear guidance on what it means – and does not mean.

12. NHS England will begin to publish 'never events' data quarterly before the end of 2013, and then monthly from April 2014 to help Trusts, patients and the public drive improvement of services.

13. NHS England will re-launch the patient safety alerts system by the end of 2013 in a clearer framework that will support organisations to understand and take rapid action in relation to patient safety risks. This new system will include greater clarity about how organisations can assess their compliance with alerts and other notifications and ensure they are appropriately implemented.

Openness and candour

14. The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident. Subject to Parliamentary approval, from 2014 every organisation registered with the Care Quality Commission will be expected to meet a new duty of candour. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients. Trusts who were not open with their patients could be required to reimburse the NHS Litigation Authority for a proportion or all of the payment.

15. In addition to the statutory duty of candour on providers, there is also a professional duty of candour on individuals that will be strengthened through changes to professional guidance and codes. The professional values of individual clinicians are critical in ensuring an open culture in which mistakes are reported, whether or not they cause actual harm. The General Medical Council, the Nursing and Midwifery Council and the other professional regulators will be working to agree consistent approaches to candour and reporting of errors, including a common responsibility across doctors and nurses, and other health professions to be candid with patients when mistakes occur whether serious or not, and clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities. We will ask the Professional Standards Authority to advise and report on progress with this work. The professional regulators will develop new guidance to make it clear professionals' responsibility to report 'near misses' for errors that could have led to death or serious injury, as well as actual harm, at the earliest available opportunity and will review their professional codes of conduct to bring them into line with this guidance. The professional regulators will also review their guidance to panels taking decisions on

professional misconduct to ensure they take proper account of whether or not professionals have raised concerns promptly.

Listening to patients

16. Listening to patients and the public and responding to what they say is at the heart of a compassionate healthcare system. Patients must be involved and given their say at every level of the system.

17. The NHS Constitution sets out in one place the rights that all patients should expect when they receive care, and which govern how NHS organisations must behave. NHS England, Clinical Commissioning Groups, Health Education England and the Department of Health are working together with others, including NHS staff and patients, to develop a joint strategy to embed the NHS Constitution in everything that the NHS does.

18. Following successful implementation in acute hospitals, the use of the friends and family test will be extended to mental health settings by the end of December 2014. This will allow patients and staff the chance to raise concerns about standards of care in their hospitals, quickly and effectively.

19. By December of this year 80% of clinical commissioning groups will be commissioning support for patients' participation and decisions in relation to their own care.

20. It is important that local Healthwatch, as the patient and public champion for health and care services, should be as strong and effective as possible so that it can speak up for patients and provide independent support on complaints. Healthwatch England and the Local Government Association have recently launched a tool to help local areas identify what outcomes and impacts a good local Healthwatch could achieve.

21. At a national level, the Care Quality Commission is now involving patients in its inspections to inform its ratings of hospitals. The three Chief Inspectors will use the insights of people who use services to guide, inform and influence the inspection process and the judgements that come out of it.

22. Improving that the way in which the NHS manages and responds to complaints will be critical in shaping a culture that listens to and learns from patients, and ending a culture of defensiveness, or at worst, denial about poor care and harm to patients. The Government welcomes the review of the NHS Hospitals Complaints System by Rt Hon Ann Clwyd MP and Professor Tricia Hart, and accepts the principles behind the recommendations.

23. The Government wants every hospital to promote a culture of openness and encourage feedback, making it clear to patients, their families and carers – for example through a sign on every ward and clinical setting – how they can complain, how to get independent local support and informing them of their right to complain to the Ombudsman if they remain dissatisfied. Trust Chief Executives and Boards will be expected to take personal responsibility for complaints, for example by signing off letters and through an update at each board meeting. Detailed information on complaints and the lessons learned will be published quarterly. This will include the number of complaints received as a percentage of patient interventions, the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman and

the lessons learned and improvements made as a result of complaints. The Care Quality Commission will look closely at how well a Trust deals with complaints and the Government welcomes the commitment of the Ombudsman to significantly expand the number of cases she considers.

24. The Government will explore with NHS England and other key partners the introduction of a regular and standard way of asking people who have made a complaint about whether they were satisfied with the way it was handled- to enable comparison across hospitals.

Safe staffing

25. Building on the Compassion in Practice action area dedicated to ensuring the right staff, at the right time and with the right skills, the National Quality Board and the Chief Nursing Officer are publishing a guidance document that sets out the current evidence on safe staffing. This clarifies the expectations on all NHS bodies to ensure that every ward and every shift has the staff needed to ensure that patients receive safe care.

26. By Summer 2014, the National Institute of Health and Care Excellence will produce independent and authoritative evidence based guidance on safe staffing, and will review and endorse associated tools for setting safe staffing levels in acute settings. The National Institute for Health and Care Excellence will then start work to develop similar guidance and endorsement for staffing in non-acute settings, including mental health, community and learning disability services.

27. From April 2014, and by June 2014 at the latest, NHS Trusts will publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools. The first of these will take place by June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools. A review every six months will allow for the collection of several data points to inform appropriate staffing. Commissioners will use staffing data as a basis for further questions and discussions with providers.

28. The Care Quality Commission through its Chief Inspector of Hospitals will monitor this performance and take action where non-compliance puts patient at risk of harm and appropriate staffing levels will be a core element of the Care Quality Commission’s registration regime.

29. Health Education England has been working with NHS trusts to develop the overall workforce plan for England for 2014-15, reflecting strategic commissioning intentions. This work indicates that a number of trusts have already increased their nurse staffing levels during 2013-14 and others are planning to do so. Initial plans indicate that Trusts intend to employ an increase of over 3,700 nurses in 2013-14.

30. The Department of Health has commissioned a programme of work from NHS Employers that will provide tools and training for employers to support the engagement, health and well-being of their staff.

31. A culture that prevents poor care before it occurs depends critically on the values of the people who work in the healthcare system. As set out in its mandate, Health Education England is committed to introducing values-based recruitment for all students entering NHS-funded clinical education programmes.

DETECTING PROBLEMS QUICKLY

32. The new Chief Inspector of Hospitals, Professor Sir Mike Richards has issued a 'call to action' to draw patients and doctors, nurses and other health professionals into expert inspection teams. In July 2013, 5,025 clinicians and 2,446 patients offered to take part in inspections. Inspectors will spend more time listening to patients, service users and the staff who care for them. Inspection will include a closer examination of records, and crucially, inspections visits will also take place at night and at weekends, with more unannounced inspections.

33. From January 2014, the Care Quality Commission will rate hospitals' quality of care in bands ranging from outstanding to inadequate. The three Chief Inspectors will use the insights of people who use services to guide, inform and influence the inspection process and the judgements that come out of it.

34. To give patients and the public confidence that problems are being sought out and dealt with, by the end of 2015 the Care Quality Commission will have conducted inspections of all acute trusts. Two waves of inspections have been announced. The first wave of 18

Trusts is under way and will be completed by Christmas 2013, with a second wave of 19 Trusts starting in January 2014. This will include re-inspecting the 14 hospitals investigated by the Keogh Review of mortality outliers, to assure itself that good progress is being made in improving the standard of care for patients.

35. In mental health, inspection will begin with wave one pilots in January to March 2014; followed by a second wave in April to June 2014. Ratings will be published from October 2014 for the NHS and January 2015 for the independent sector.

36. In adult social care, inspection will begin with wave one pilots in Spring 2014 followed by a second wave in Summer 2014. All social care services will have been rated by March 2016.

37. The Department of Health and the Care Quality Commission are developing for consultation the fundamental standards recommended by the Inquiry. They will be described in clear, unambiguous language, expressed in terms of what it means to patients and service users.

38. The Care Quality Commission has reviewed how it uses information to identify potential failures in the quality of care in hospitals. It will ask five key questions – is a service safe, effective, caring, responsive and well led? The fundamental standards, below which care should never fall, will be complemented by more stretching enhanced and developmental standards which commissioners will use to require providers to deliver services to patients and service users that are of a higher quality, and the Care Quality Commission will use to inform their ratings.

39. The Government is legislating to enhance the independence of the Care Quality Commission to ensure there can be no political interference in its vital work to protect patients.

40. The Secretary of State has made clear that so-called 'gagging orders' are unacceptable. NHS staff will be able to raise concerns about patient care in the knowledge that they will be listened to and their views will be welcomed. The new Chief Inspector of Hospitals will be judging whether the culture of the organisation actively promotes the benefits of openness and transparency; and staff can now blow the whistle to their health and care professional regulatory bodies. All healthcare professionals will be protected by the provisions of the Public Interest Disclosure Act 1998. Compromise agreements must include an explicit clause making clear that nothing within the agreement prevents disclosure under the Act. NHS England will develop a friends and family test for staff and the 'Cultural Barometer' is being piloted and evaluated prior to a potential further roll out.

41. Robert Francis found that there was a lack of communication and understanding between the different organisations that held responsibility for providing oversight, support and challenge to Mid Staffordshire NHS Foundation Trust. New arrangements for regulators and commissioners will ensure that the distinct roles and responsibilities, as well as the issues and areas they need to co-operate on, are clear and unambiguous. This includes structures for sharing information and joint decision-making where they are needed. The Care Quality Commission will focus on assessing quality and publishing its findings rather than intervening to drive improvement – which falls to the NHS Trust Development Authority and Monitor.

42. Quality Surveillance Groups have been in place since April 2013. Their role is to bring together all key organisations at a local level to share information to make judgements based on soft information and intelligence about the quality of care at hospitals where there are concerns about care standards. Once concerns are identified, action can be taken swiftly by the relevant organisation.

TAKING ACTION PROMPTLY

43. For more significant concerns where providers are unable to improve without further support, regulatory oversight will be required. Clear, meaningful ratings will be accompanied by clear, risk-based intervention. For the first time, the NHS will have an effective failure regime that addresses quality as well as financial distress and failure. This will give patients and the public confidence that action can be taken quickly when services are not performing well enough.

44. Expert inspection against standards, informed by hard data and soft intelligence, will enable the Care Quality Commission through its Chief Inspectors to make judgements about whether providers are:

••Outstanding: sustained high quality care over time across most services, together with good evidence of innovation and shared learning.

••Good: the majority of services meet high quality standards and deliver care which is person centred and meet the needs of vulnerable users.

••Requires Improvement: significant action is required by the provider to address concerns.

••Inadequate: serious and/or systematic failings in relation to quality.

45. Trusts aspiring to Foundation Trust status will have to achieve 'good' or 'outstanding' under the Care Quality Commission's new inspection regime to be authorised. Monitor and the Care Quality Commission will also implement a joint registration and licensing system in April 2014.

46. The regulatory regime will be based around a 'single version of the truth' grounded in standards and ratings through inspection. Under the single failure regime, clinical unsustainability will be grounds for failure procedures, including placing organisations in special measures, just as financial unsustainability is at present. Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority will publish further guidance on how they will work together to address quality issues after April 2014. Where a Foundation Trust is placed in special measures, it will have its freedom to operate as an autonomous body suspended. This will provide a basis for tailored and proportionate intervention that puts patients first and puts things right promptly.

47. In October 2013, Monitor introduced a Risk Assessment Framework for NHS Foundation Trusts which will allow Monitor to track risk and trigger enforcement action. In April 2013, the NHS Trust Development Authority published *Delivering high quality care for patients: The accountability framework for NHS Trust Boards* which sets out its approach to the oversight of and intervention in NHS Trusts.

48. Monitor published enforcement guidance in March 2013 on how it plans to obtain compliance in Foundation Trusts where there are breaches of health care standards specified by the Care Quality Commission, NHS England and statutory regulators of health care professions.

49. Where an NHS Trust or Foundation Trust has been placed into special measures by the NHS Trust Development Authority or by Monitor, the Board of the Trust will need to demonstrate to the relevant body that it is credibly and effectively addressing the issues that have been raised.

50. Where cases of failure cannot be resolved at local level, either by the Trust Board or local commissioners supported by NHS England, the use of special administration provides a mechanism for ensuring that issues are addressed as a last resort. Under special administration, the Secretary of State (in the case of an NHS Trust) or Monitor (in the case of a Foundation Trust) replaces the Trust's Board with a special administrator. Proposals in the Care Bill are designed to ensure that this action can be taken in cases of clinical as well as financial unsustainability.

ENSURING ROBUST ACCOUNTABILITY

51. Putting in place a clear and well-functioning system of accountability in the NHS is a critical condition for creating a culture of safe, compassionate care. In addition to the ratings and inspections led by the Care Quality Commission through its Chief Inspector of Hospitals, the Boards of Trusts are responsible for both holding their own organisation

to account and accounting to the public about its performance. NHS organisations and all parts of the health and care system will be more accountable than ever before.

52. NHS England will hold clinical commissioning groups to account for quality and outcomes and for their financial performance, and will have the power to intervene where there is evidence that they are failing, or are likely to fail, in their functions. Local commissioners of health, care, and other services have a new opportunity, through health and wellbeing boards, to work in partnership together to improve outcomes for the whole population.

53. There will be a new stronger fit and proper persons test for Board level appointments which will enable the Care Quality Commission to bar directors who are unfit from individual posts at the point of registration. This will apply to providers from the public, private and voluntary sectors. The Government believes that the barring mechanism will be a robust method of ensuring that directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact.

54. There must also, on occasion, be direct consequences for senior managers for failures in their organisations. NHS Employers will therefore be commissioned to work with the Care Quality Commission, the NHS Trust Development Authority and Monitor to develop hospitals through appraisal and other means, including linking the Chief Inspector's ratings to individual contracts.

55. The Government agrees with Professor Don Berwick's recommendation that there should be a new criminal offence 'in the very rare cases where individuals or organisations are unequivocally guilty of wilful or reckless neglect or mistreatment of patients'. This will help to ensure that there is ultimate accountability for those guilty of the most extreme types of poor care. The Government will seek to legislate on this, will work with stakeholders beforehand to determine the details of this measure, and will consult on proposals for legislation as soon as possible.

56. Subject to Parliament, the Care Bill proposes a new criminal offence applicable to care providers who supply, publish or otherwise make available certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation. The Bill also proposes that this offence will apply to the 'controlling minds' of the organisation, where they have consented or connived in an offence committed by a care provider.

57. In April 2013, Monitor published a guide for Boards on how to ensure organisations are working effectively to improve patient care. Monitor will also be publishing an updated Code of Governance for Foundation Trusts in early 2014 which will make recommendations to strengthen corporate governance in light of the Inquiry report. There are also plans for regular governance reviews of foundation trusts which will include quality governance

58. The professional regulatory bodies are currently hampered by a cumbersome and complex inheritance of legislation. The Government will seek an early opportunity to legislate, enabling all the professional regulators to move rapidly to a maximum 12 month period for concerns raised about professionals to be resolved or brought to a hearing, in all but a small minority of cases.

59. As the medical revalidation programme is making good progress and is working effectively in practice, we are now at the right point for transferring the programme to NHS England to take forward and lead the continued implementation across England.

60. Commissioners have a vital role to play in securing safe, compassionate care for the populations they serve. Clinically-led commissioning groups, by putting doctors, nurses and other health professionals at the heart of commissioning with an explicit focus on improving health outcomes for the whole population, will provide a robust basis for effective commissioning. They will be supported by strategic clinical networks and clinical senates.

61. Ultimate responsibility for the NHS rests with the Government, and the Department of Health is committed to implementing the specific recommendations that Robert Francis directed at Government. Through the 'connecting' programme, departmental civil servants and Ministers are gaining direct experience of the realities of care services at the point of care.

ENSURING STAFF ARE TRAINED AND MOTIVATED

62. Well-treated staff treat patients well. A wealth of academic evidence demonstrates that effective staff engagement is absolutely essential for creating positive cultures of safe, compassionate care. The Department of Health has asked the Social Partnership Forum, which brings together representatives of staff and employers in the NHS, to produce guidance on good staff engagement.

63. Education and training are critical to securing the culture change necessary for the best patient care now and in the future. Action led by Health Education England and other organisations will focus on ensuring improvements in continuous professional development and appraisal. This will support NHS staff to prioritise the quality of care, work effectively in multi-disciplinary teams, to be compassionate, safety-conscious, and to genuinely listen to their patients and service users.

64. Improving the quality of nursing and the support available to nurses in the difficult and challenging work that they do to look after patients is at the heart of the response to the Francis report. We will continue to implement Compassion in Practice and the 6 Cs, fostering nurse leadership and supporting the implementation of nurse revalidation.

65. A key test of whether we have got safe, compassionate care right is the care we provide for older people, who can often be the most vulnerable patients, and those most in need of care that is properly joined up and well managed. Health Education England, working with the Chief Nursing Officer, the Director of Nursing at the Department of Health and Public Health England and the nursing profession, will develop a bespoke older persons' nurse post-graduate qualification training programme.

66. Health Education England has established the first set of pilots of up to one year of pre-degree care experience for aspiring student nurses. On completion the pilot will be evaluated to see how pre-degree care experience could be rolled out in an affordable and cost-neutral way, so that everybody who wants to train to be a nurse is able to gain caring experience before they start their studies.

67. The Nursing and Midwifery Council has committed to introduce an affordable, appropriate and effective model of revalidation for the nursing and midwifery professions to enhance public protection and continue to improve the quality of nursing for patients.

68. The review undertaken by Camilla Cavendish raised the need to improve recruitment, training, development and supervision of health and social care support workers, building on the work of Health Education England around the work on Agenda for Change Bands 1-4 and the publication by Skills for Care and Skills for Health of the National Minimum Training Standards in March 2013 to develop minimum standards for health care assistants and support workers. The Government has asked Health Education England to lead the work with the Skills Councils, and other delivery partners to develop a new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users.

69. One of the most powerful ways we can support staff to improve outcomes for patients and to enjoy more fulfilling work is to find ways of cutting back on burdensome bureaucracy in order to release 'time to care'. The bureaucracy review led by the NHS Confederation, recommends three main ways to reduce unnecessary burden by understanding, reducing and actively policing the volume of requests from national bodies; by reducing the amount of effort it takes providers to respond to information requests; and by increasing the value derived from information that is collected.

70. NHS England has introduced a Clinical Bureaucracy Index and Audit of Digital Maturity in Health and Care to support trusts in tracking how well they are using digital technology to reduce the burden of information collection on front line staff compared to their peers. Additionally, the Department of Health and every arm's length body signed a Concordat for reducing the administrative burden arising from national requests for information. The concordat aims at ensuring that national requests for information are undertaken using a single transparent process and that there are significant year on year reductions in the cost and burden caused by requests for information to the front line.

71. Excellent leadership is critical to the delivery of quality care. Patients need the NHS to have appropriately skilled leaders, with the right values, behaviours and competencies, at every level of the system. The development programmes of the NHS Leadership Academy will support a range of NHS staff (including clinical staff) to lead their teams and organisations to achieve more compassionate care for patients. A new fast-track leadership programme will attract senior clinicians as well as fresh talent from outside the NHS to manage NHS hospitals following an intensive programme of direct experience and time spent in a leading academic institution.

CONCLUSION

72. Improving care is the responsibility of all organisations and all individuals in the NHS. When we published *Patients First and Foremost*, we asked Trusts to hold listening events and set out for their local communities what they are doing to improve services for patients. It is encouraging that many Trusts have considered the Inquiry report in public Board meetings, and have held listening events. We have asked for feedback on these events by the end of 2013 but would urge organisations to continue such conversations to understand the concerns of their patients and staff and identify areas for improvement.

73. Across the health and care system, staff want to deliver safe, effective and compassionate care, to feel safe to raise any concerns, and to have confidence that these will be tackled. This response is of necessity detailed in order to do justice to the insightful findings of a major public inquiry. Within this complexity, however, it is important never to lose sight of the simple messages at the core

Annex 2: Relevant recommendations for Clinical Commissioning Groups:

The detail of each recommendation and the Government response can be found at these hypertext links:

- Recommendation 1 – Accountability for implementation of responses
- Recommendation 2 – Adopting and demonstrating a shared culture
- Recommendation 17 – Enhanced quality standards
- Recommendation 20 – Policing fundamental standards
- Recommendation 113 – Patients Association's peer review into complaints
- Recommendation 120 – Commissioners access to complaints information
- Recommendation 123 – General Practitioners undertaking a monitoring role
- Recommendation 124 – Commissioners applying fundamental safety and quality standard
- Recommendation 126 – Code of practice for managing organisational transitions
- Recommendation 127 – Commissioners scrutinising providers
- Recommendation 128 – Commissioner access to experience and resources
- Recommendation 129 – Commissioning focus on standards
- Recommendation 130 – Commissioners requirements of providers
- Recommendation 131 – Alternative sources of provision
- Recommendation 132 – Commissioners monitoring contract performance
- Recommendation 133 – Commissioners intervening in management of complaint
- Recommendation 134 – Commissioning patients' advocates and support services
- Recommendation 135 – Commissioner accountability to public
- Recommendation 136 – Commissioners acting for their public
- Recommendation 137 – Commissioners powers of intervention

- Recommendation 140 – Sharing information when concerns are raised
- Recommendation 141 – Individual responsibility of regulators and performance managers as well as co-ordination between them

- Recommendation 147 – Coordination between local Healthwatch and other scrutiny organisations
- Recommendation 149 – Support for scrutiny committees
- Recommendation 152 – Training standards concerns
- Recommendation 153 – Duty to cooperate with professional regulators
- Recommendation 173 – Organisations and staff must be honest, open and truthful
- Recommendation 176 – Statutory duty to disclose information
- Recommendation 179 – Gagging clauses to be prohibited
- Recommendation 180 – Guidance and policy on openness
- Recommendation 182 – Duty on individuals to provide truthful information
- Recommendation 183 – Criminal offence to obstruct statutory duties
- Recommendation 202 – The importance of nursing representation at provider level
- Recommendation 204 – Providers required to have registered nurse executive director
- Recommendation 205 – Recording advice from nursing directors on any major changes to nursing arrangements
- Recommendation 206 – The role of the Chief Nursing Officer
- Recommendation 215 – Standards for senior managers and leaders
- Recommendation 218 – Non-compliance with standards for leaders
- Recommendation 268 – Resource for comparative statistics

Merton Clinical Commissioning Group

Quality strategy – workplan

Update January 2014

This workplan is organised using the Monitor Quality Governance Framework headings. It captures the themes and issues raised in the quality strategy document.

Please note it does not track performance on each quality improvement initiative, (Chapter 9 of the quality strategy) as each is subject to its own monitoring process.

Action Plan

1.Strategy	Action	Lead	Desired Outcome	Timeline Plan and Progress
1.1	Quality strategy: consultation, development and sign off	DoQ	Agreed plan for action for 13/14	April 13 to CQC to May 13 to Governing Body Final sign off completed June 13 Review September 13 and January 14 at GB Bi-monthly updates agreed to MCQC
1.2	Ensure all annual corporate strategy reviews for 14/15 include (e.g. ISOP, CQUIN, commissioning intentions) quality advice	DoQ and CO	Quality embedded in strategy development	April 14 Ongoing, 2014 – 2016 Operating plan and Commissioning Intentions document contains quality section.
1.3	QIPP schemes – need to ensure CCG and provider QIPP schemes have quality impact assessment signed off by their Nursing and Medical Directors	DoQ	Assurance that any adverse impact is identified and mitigated	Dec 14 Quality impacts now explicit within QIPP workbook Process for EIAs agreed for 2014/15 QIPP round
1.4	Contribute actively to partnership	CO	Merton will	Now embedded in mainstream CCG activity, eg

	strategies (eg BSBV)	and Chair	evidence of influencing strategic direction of locality	Healthwatch launch July 17th – CO speaking DoQ attended maternity network – agreed future representation DoQ attended stroke network event – DoQ attended AHSN event CO and DPH attend all One Merton Group and Health and Well being Board meetings Merton Engage event October Comms and Engagement strategy to GB in January
1.5	Develop partnerships with LB Merton across adult and childrens' services	CO and DoQ, DoC	Evidence of joint commissioning / planning for children	Integration work with adult services commenced (ITF funds, Director of Integration appointment) Joint work to self assess care of patients with learning disabilities (completed November 2013) Joint work regarding health input to special schools and CQC review of young people with complex health needs in transition – leading to new Childrens Commissioning approach New quality board / dashboard for jointly commissioned services proposed and to be enacted early 2014

2.Capability and culture	Action	Lead	Desired Outcome	Timeline Plan and Progress
2.1	Assessment of leadership and culture of provider organisations via the national annual staff survey Identify staff survey measure for community Trust	DoQ	Assurance, or improvement plan / evidence of improvement	Staff survey results for all major providers discussed at all CQRGs and Merton CQC Providers presenting quality strategies to quality committee SMCS quality strategy reviewed at CQRG SWL and St George's quality summit focussed on Board and Exec leadership and culture CQRGs addressing issues of leadership, culture and staffing
2.2	CSU – plan a joint workshop between exec team and CSU directors to review CSU partnership working on quality	CFO	Better joint working on quality	October 3rd 2013 – workshop occurred, good discussion of issues in relation to need for CSU to improve quality assurance across host and associate contracts: agreed to: • Review service specs • Restructure of CSU will bring quality and contracting together • Organise SW London DoQ meetings • Refresh consortium agreement • CQRG workshop in November Further discussions ongoing re increasing the 'added value' in quality offer from CSU
2.3	CSU – regular meetings regarding quality requirements with identified lead within the CSU	DoQ	Improved reporting to MCQC and CGRGs	Regular formal operational contact now established re Sis and complaints, risk register, BAF, policies etc.
2.4	Local CCGs Directors of Quality to meet regularly to agree 'host' commissioning role and responsibilities	DoQ	Better joint working and reduced duplication	Meetings in the diary. Currently these are 'informal' meetings.
	Support development of South London Quality surveillance group	NHSE / DoQ	Improved information sharing and networking across	QSG meetings occur regularly, now beginning to see more effective info sharing.

			agencies	
2.5	Fill Named GP and adult safeguarding roles	NHSE / DoQ	Improved engagement from GPs in safeguarding agenda, fewer SCRs involving GP care	NHSE to advertise Named GP posts Jan 14 Re adult safeguarding – restructure agreed, appointment to be made to new post by April 14.
2.6	DoQ to meet CQC and other key partners to establish working relationships	DoQ	Information sharing, early warning of any emerging issues	First meeting took place May 13 Dates in the diary for future meetings CQC to attend quality committee Jan 14
2.7	Plan workshop across SW London to share good practice in relation to CQRGs	DoQ	CQRGs which work effectively to assure quality and recognise themes from Francis, Berwick and Keogh	Event took place November 14 – DoQs will now drive forward suggested changes in their own CQRGs

3. Processes and structure	Action	Lead	Desired Outcome	Timeline Plan and Progress
3.1	Scope all contracts, including smaller providers, to ensure quality outcomes and KPIs are identified and monitored	DoC with DoQ	Governing Body Assurance that quality outcomes are identified and monitored	Initial meeting May 13, to agree plans. Continuing healthcare paper to MCQC in June and November 13 Winterbourne view review and self assessment of learning disability placements and arrangements concluded November 13. Intermediate and smaller contracts – scoped and timetable of reports to quality committee agreed. New quality board (and dashboard) with Local Authority to review jointly commissioned contracts agreed to commence early 2014
3.2	Feedback loop for quality info e.g. quality alerts, PALs etc to be developed	JK with CSU	GPs and others to feel confident that the information they share, is used appropriately to improve services and they hear the outcome	December 14 Quality alert system drafted and circulated, QAs reported through CQRGs, GPs getting feedback. Also need to develop a monthly QA report (early 2014). Awaiting Wandsworth MAD button – they want to road test it first before demonstration. (chased late 13) Care Connect system being trialled in RMH acute PALS and complaints systems in place, Friends and family systems in place PALS and Complaints reports received at CQRGs, though not yet amalgamated into one overarching report
3.3	Scope all CQRG agendas to ensure they cover all 5 quality domains / outcomes effectively		Governing Body Assurance that quality outcomes are identified and monitored	See above re CQRG workshop. Reviews of Mental Health Trust and SMCS CQRG has taken place
3.4	SI process to be established and		Assurance that	Assurance paper with NHS England – mostly green, on

	tested		the 'system' is picking up trends and themes and appropriate learning and improvement is occurring.	remaining amber item (responsibility of NHS England). SIs reported to all CQRGs SI report from CSU – need to integrate SIs from all contracts currently only host contract seen in their overall SI report.
3.5	Risk register for quality risks to be updated	CSU and exec team	'live' risk register which demonstrates understanding of main risk areas and demonstrates action taken regarding risks	Risk register in place and updated. Staff trained. Now need to complete operational grass roots 'team risks'
3.6	Patient participation groups to be 'activated' where appropriate and contribute to 'insights' regarding service issues (links to PPI strategy)	PPI mgr	Active groups which provide rich feedback	Agreed to present to HWB in September CG and CLK have audited practice take up of the PPG LES. GB workshop on involvement and engagement July 13 Comms and engagement strategy and workplan received by quality committee Nov 13, to GB in January 14 PRG to be set up first meeting Feb 14 Workplan for PPGs to be agreed
3.7	Locality leads for practices to review quality standards for practices (as discussed at membership meeting)	Locality leads	Consistent standards across all practices in Merton CCG	No practices with more than 5 outlier issues

4. Measurement for quality	Action	Lead	Desired Outcome	Timeline Plan and Progress
4.1	Integrated performance and quality report to be available	CSU / CCG (MT)	Board assurance	Improved version available, now in ongoing development,
4.2	Quality dashboards to be developed for all major providers and services (acute, community, safeguarding, children, mental health, maternity etc)	CSU, with DoQ	Dashboards and data that 'tell a story', show trends and comparative data between organisations	Quality workshop with CSU October 3rd Mental health dashboard presented at June 13 CQRG. Maternity dashboard agreed at June maternity network meeting, next step to populate this with April data as 'test' Safeguarding children performance metrics agreed with MSCB Nursing and residential home dashboard in development
4.3	Metrics to be in place for all major quality improvement initiatives	DoC	Be able to demonstrate evidence of improvement	Quality premiums data collection systems being developed QIPP quality impact assessment tool development, needs populating. Cquins for providers established and reported Primary care quality outcomes / standards available and show good performance
4.4	Primary care system (EMIS web) roll out and further developments to be agreed	Primary care support team	Easy access to audit and other quality data for GP practices	Finance confirmed by NHS England. EMIs roll out progressing to plan. Further developments to be agreed
4.5	Access to primary care information QOF / QP etc	Primary Care Support Team / MT	Easy access to relevant information	No access available as yet for CCG. Discussed with NHS England, data will be available from October. Medical and Nursing Directors presenting to quality committee in January 14.