Francis update June 2014 BHH

Context

The final Francis Report into Mid Staffordshire Hospitals Foundation Trust was published in February 2013, there were 41 out of 290 recommendations relating to commissioners of NHS services. The Department of Health reviewed the recommendations and published their response – *Hard Truths; The journey to putting patients first* in November 2013. This builds on the *Patients First and Foremost* - the Government's initial response published in March 2013.

All of the recommendations presented in the report either specifically relate to the role and the function of CCGs to support or facilitate others to implement. The BHH Quality team have worked with the Head of Quality and Safety at the CSU to facilitate the approach taken in BHH in response to the Francis recommendations.

During this time the Keogh, Cavendish and Berwick reports were also published;

- The Keogh report was published in July 2013 and addresses the key fundamentals for the NHS of Patient experience, safety, workforce, leadership and governance as well as capacity for improvement and learning.
- In July 2013 the Cavendish Review was published, this focussed on staff – healthcare assistants and support workers in the NHS and social care settings – quality assurance, recruitment, training and education, leadership supervision and support alongside time to care were the key tenets of this review.
- The Berwick Report – A promise to Learn; a Commitment to Act was then published in August 2013 highlighting leadership, patient and public involvement, staff training and capacity, measurement and transparency, structures, regulation and enforcement.

The reports and reviews supported the recommendations of the Francis Report and refocused attention on key areas for providers of health care. Responsibilities and accountabilities have been re-iterated with the Berwick report going as far as citing 'Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

The Francis action plan has been reviewed against the Government's response and RAG rated for progress to date across BHH CCGs Federation.

Appendix 1 detail reports received from providers

Government response categories

The government responses were divided into four areas – accepted, accepted in principle, accepted in part and not accepted. Of the 41 recommendations 30 were accepted; 7 were agreed in principle; 3 accepted in part and 1 not accepted.

BHH CCGs position

Work within BHH commenced in March 2013 with a paper submitted to the NWL Cluster Board and to which both BHH and CWHEE contributed and an initial action plan was shared with the BHH CCGs for approval. The Francis report contained 290 recommendations from the second enquiry, 42 recommendations were highlighted by NHS NW London for the CCGs consideration. The sections on Commissioning for standards and scrutiny and oversight of performance are specific to CCGs and it was suggested that BHH take an approach to concentrate on these. Subsequent work streams were then developed throughout the course of the year to look at how the key work streams contained within Francis could be facilitated and assurance sought from providers.

The revised action plan takes into consideration the systems and processes in place within BHH federation, links with the Commissioning Support Unit and considers implementation and progress alongside the government's response.

Recommendations rated red are:

- Recommendations 7, 8 and 191 – these relate to Human Resources
- Recommendation 208 – commissioners ensuring that providers have systems in place to distinguish between healthcare support workers and registered nurses.
- Recommendation 197 – Leadership training for nurses at all levels

Quality Improvement and Assurance

The Quality Team within BHH CCG Federation work closely with the Commissioning Support Unit and with provider organisations to facilitate quality improvement and ensure that learning from Francis, Cavendish, Keogh and Winterbourne View (December 2012) is embedded within commissioned services. During the financial year 2013/2014 the Quality Teams in BHH and the CSU have established the following:

- Quality Schedule developed from 75 indicators in 2013/2014 to 145 in 2014/2015
- Development of a Quality Strategy
- Development of a Patient Experience Strategy
- A new style integrated performance and quality report demonstrating trends and early warning signs
- Grade 2 incident panel review meetings to facilitate learning in the network
- Processes for conducting deep dive specialty reviews in providers
- Standardisation across Clinical Quality Groups terms of Reference 2013 to ensure alignment and consistency and that standing agenda items include - Performance

(Quality Indicators); Patient Experience (encompassing thematic analysis of themes and trends) e.g. Complaints & PALS, Friends and Family; Safeguarding (Children and Adults) and Francis Inquiry plan/ update. Each CQG is autonomous and able to undertake further in-depth review as indicated.

Monitoring of Provider Action plans

Provider responses on Action Plans have been monitored through the Provider Clinical Quality Groups for challenge on a quarterly basis. These will also be reviewed as part of the 2014-15 Quality Schedule requirements.

Appendix 1 details a summary of these plans and any further action required from providers. Action Plans and updated reports have been received from all BHH providers.

Purpose of paper

The CCG Clinical Quality, Patient Safety and Risk Committees are asked to consider the RAG rating within the action plan, giving consideration to whether it is felt that the current position is reflected and to take action against identified points.

CCG Francis Stock take with Government Response
April 2014

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review Date
1	All commissioning organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;	Accepted	Francis Report stock take and recommendations to be reported to: -April 2014 CCG Q&S Committees – Complete - Initial action plan and position statement discussed at CCG Q&S March/April 2013	Part of on-going monitoring	BHH CCGs BHH Quality Team		Quarterly – June/Sept/ Dec/ Mar
	Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to 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	Accepted	'Francis report 'quarterly report presented and discussed at CQG meetings with providers in line with Quality Schedule requirement s		NWL CSU Contract team, Quality Team to validate		Quarterly – June/Sept/ Dec/ Mar
	In addition to taking such steps for itself, the	Accepted	CCGs to submit relevant information to DH as required.				Quarterly

	Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;		Providers bringing Quarterly updates to CQG meetings – Complete				

Putting the patient first

The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
7	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the constitution, both of which should be incorporated into the contracts of employment	Accepted in principle	Commitment to be included in BHH contracts of employment. CSU HR Team to lead. HR to amend employment policy to reflect NHS Values and Constitution. Recruitment process needs to include assessment of these values.	How to gain assurance from providers that they have made a commitment to the values. How to consistently assess values on appointment? Consider including in Quality Schedule and future Contracting rounds the need to include NHS values and the Macmillan Values	NWL CSU HR Team for CCG Appointments NWL CSU / PCE review for providers – Contract Managers to ensure on CQG agenda for discussion.		

				Based Standard®			
8	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	Accepted	Relevant additions to be included in provider contracts to reflect requirements. Contracts Team to ensure contracts with providers / interim contracts contain NHS Values.	How to gain assurance from providers that they have made a commitment to the values. How to consistently assess values on appointment?	NWL CSU HR Team for CCG Appointments CQG review for providers – Contract Managers to ensure on CQG agenda for discussion.		Quarterly

Fundamental standards of behaviour

Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.

12	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	Accepted	BHH Incident & Serious Incident policy reflects this requirement – completed June 2013 NWL CSU Incident Process includes requirement to feedback to staff BHH have an assurance toolkit sign off process with NHSE to manage the Serious Incident function, currently managed by NWLCSU, performance is measured monthly internally within the CSU and reporting to NHSE Quarterly.	Business as usual Annual review of assurance process with NHS England	BHH/ NWL CSU Quality Team		Monthly Annual

A common culture made real throughout the system – an integrated hierarchy of standards of service

No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service.

Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.

17	The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.	Accepted in principle	Performance of providers currently monitored and failings in standards addressed at CQGs. Exception reports prepared as required /escalated to the Board. CCGs to work with NCB to develop quality standards as identified. Commissioning intentions led by CCGs Revised 2014-15 quality schedule – led by the NWL CSU Quality Team. Revised integrated performance and quality reports under review by CCG/Performance team CSU	On-going monitoring How to increase the public engagement of quality indicators / standards.	NWL CSU Contract Managers / NWLCSU Quality Team		September 14

Responsibility for, and effectiveness of, healthcare standards

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
42	Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.	Accepted	NWL CSU SI reports to be shared with CQC as required MOU agreements progressed where applicable Quality Surveillance Groups Current gaps in primary care reporting	On-going monitoring How to improve triangulation and increased working between CCG / CSU / TDA / CQC / LA NHSE (Primary care)	NWL CSU Quality Team		June 14
43	Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organizations for which they have responsibility.	Accepted	Performance of providers currently monitored and failings in standards addressed at CQGs Weekly CQC inspection alerts circulated. Ensure robust media screening to capture all articles and press about NWL NHS. Collaborative working with 3rd party provider's e.g. Macmillan. Trusts to agree to alert Commissioners if media interest at the Trust. Face to face meetings with	Collation of information from Communications Team.			Weekly

			providers as necessary Quality Surveillance groups				

Enhancement of the role of supportive agencies

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
107	If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS commissioning Board, the Care Quality Commission	Accepted	CCGs to work with PHE to share information around infection control as identified The DIPC for the 3 CCGs will ensure that procedures are clarified to ensure clarity of responsibility regarding IP&C and the management of HCAI. Some challenges identified with the triangulation of HCAI and other infection control information with the HPA database. Quality Schedule in provider contracts strengthened in relation to indicators and compliance frameworks This will include improving reporting of infections and outbreaks. PIRs now in place which are led by	Consider if the current provision of infection control support is sufficient within BHH due to the volume of reviews undertaken	NWL CSU Performance Team / BHH CCG Federation		June 14

	and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.		the BHH Quality team, there is no SLA in place for a commissioned service in relation to these Collaboration with NHS England / CQC / Monitor / TDA				

Commissioning for standards

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
123 Responsibility for monitoring delivery of standards and quality	GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of	Accepted	Performance of providers currently monitored and failings in standards addressed at CQGs. CCGs to distribute reports as required. CCGs, by their constitution, are led by GPs who are key in the performance monitoring of all service providers and who regularly scrutinise quality monitoring data. GPs are encouraged to use the Service Alert system for	Consider a permanent database or single mechanism for collecting GP intelligence from across the Federation Contract in place for Ulysses incident reporting system to be rolled out in BHH Federation	CCG locality teams		July 14

	concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners		reporting services that fall short on the quality of patient care for their patients. The CCG's Clinical Quality Committee, chaired by / attended by Clinical Directors, has overall responsibility for and oversight of clinical quality issues; it also has a role to report areas of serious risk or concern to the CCG Executive Committee, and both bodies report directly to the CCG Board. Local Intelligence monitoring and escalation processes in place for each CCG. Further work to enhance the feedback mechanisms.				
124 Duty to require and monitor delivery of	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and	Accepted in principle	Performance of providers currently monitored and failings in standards addressed at CQGs 2014/15 Standard	Business as usual Consider alternatives to	NWL CSU Contract Managers		Monthly

fundamental standards	quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received substandard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.		Contracts identify financial penalties for failures in quality. Quality Schedule led by the NWLCSU Quality team	financial penalties for quality breaches which aid improvements to quality.			
125 Responsibility for requiring and monitoring delivery of enhanced standards	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced	Accepted	CQUIN program currently rewards providers for Quality of care. Contract negations Quality Accounts	On-going monitoring Consider alternatives to financial penalties for quality breaches which aid improvements	NWL CSU Contract Team		Quarterly

	standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work			to quality.			
126 Preserve corporate memory	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to	Accepted	BHH followed NQB guidance on Handover & transition. BHH will engage with the NCB on the development of a code of practice as required Local information sharing agreements in place with other CCGs	Business as usual Consider any action the CCG may want to take in light of potential future expansion or restructure. Consider how to expand information sharing agreements between CCGs. Development of a policy to	BHH Federation		Annual

	see in any organisational transitions amongst their providers			manage handover when personnel leave the organization.			
127 Resource for scrutiny	The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide	Accepted	Performance of providers currently monitored and failings in standards addressed at CQGs. Robust Performance measures in place and Provider Performance scrutinized through due process within the committee structure of the CCG which involves key clinicians and managers and appropriate action taken as indicated. The CSU acts as an expert resource for the CCG- ensuring the implementation of the strategic vision for quality and are working to ensure that the contracts for 2014-2015 are sound and robust..	On-going monitoring	NWL CSU Performance monitoring NWL CSU Contract Managers		Monthly

			2014/15 Standard Contracts identify financial penalties for failures in quality NWL CSU manage contracts CQG / PCE Committees				
128 Expert support	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.	Accepted	NWL CSU commissioned to undertake relevant commissioning functions on BHH behalf	Business as usual Consider any gaps in expert advice and support that may need addressing.	NWL CSU contract and procurement		As required
129 Ensuring assessment and enforcement of fundamental standards through	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least	Accepted	Patient safety & Patient experience are included in the 3 domains of quality via which performance of providers is monitored and failings in standards addressed at CQGs.	Business as usual	BHH CCGs Safeguarding Team		Quarterly

contract	fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed		Appropriate policies and procedures and lead clinicians are in place to support vulnerable groups in line with agreed safeguarding arrangements. Safeguarding indicators are included in quality monitoring and regular updates reports on safeguarding are presented to QSCRCs. Lay involvement in EDEN project and PPE / PPGs. The CCG has processes in place currently using traditional methods alongside modern media to engage with and gain feedback and input from patients and the public. Patient and public engagement is well established within the CCG. PPE and patient engagement strategy in place.				

130 Relative position of commissioners and providers	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail	Accepted	CCGs clinically led and the CCG holds the accountability and makes the final decisions on all commissioning decisions but a BHH approach will ensure that all decisions are clinically led and provide high quality and safe patient care. Secondary Care Consultant included in CCG GBs PPE and patient engagement strategy in place.	Business as usual How to further enhance the contribution the public can make in influencing commissioning decisions. Consider any gaps in expert advice and support that may need addressing. Consider how this fits in with the Health and Well Being board which is charged with improving the health of the resident population and does this Board have a shared vision for integration and quality.	BHH CCGs Federation NWL CSU		June 14
131 Development	Commissioners need, wherever possible, to	Accepted	CCG commissioners work together where required	Business as usual	BHH CCGs Federation		As required

of alternative sources of provision	identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.		on procurement of services across CCG areas or functions (e.g. across Brent and Harrow) and are supported on relevant commissioning of services through CSU. Policies in relation to procurements undertaken are in line with the requirements as set out by the Co-operation and Competition Panel.		NWL CSU		
132 Monitoring tools	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent)	Accepted	Performance of providers currently monitored and failings in standards addressed at CQGs. This includes information generated by provider. This is checked against other information streams. Commissioners undertake visits and inspections as required to provider services Various performance and quality information streams triangulated at CQGs and CCG Q&S Committees	Business as usual	NWL CSU BHH CCGs Federation		Monthly

	audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving		Quality Schedules developed and additional indicators added in 2014/2015 Development of lay member walk rounds CCG Quality Team undertaking Clinical Leadership visits at Trusts. Small contracts database in creation, requires further development and quality assurance. The CCGs QSCRCs have the delegated authority in relation to the oversight and scrutiny of quality. This committee reports any areas of risk or exception to the CCG Governance Committee and Board.				

	the healthcare regulator to focus on fundamental standards.						
137 Intervention and sanctions for substandard or unsafe services	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.	Not accepted	BEHH CCG Director of Quality and Safety will work with NCB and the relevant regulators to develop the process and infrastructure to implement this recommendation The CCG has levers described in contracts presently that give it certain powers of intervention; guidance and legislation in relation to safeguarding children and vulnerable adults also give CCGs such powers to intervene. Performance of providers currently monitored and failings in standards addressed at CQGs. This includes information generated by provider. This is checked against other information streams.				

133 Role of commissioners in complaints	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	Accepted in principle	BHH Complaints Policy to be amended accordingly and processes identified for implementation for this. Quality Schedule 2014-15 incorporates complaints process and thematic reviews and triangulation of data	Business as usual	BHH Complaints Team		June 2014
134 Role of commissioners in provision of support for complainants	Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	Accepted	Relevant recommendations for development to BHH complaints policy. Work with PPE committees Collaboration with Health watch	Business as usual	BHH CCGs Federation		July 14
135 Public accountability of commissioners and public engagement	Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full	Accept in part	Lay members attend CCG GB and QSCRC (one CCG QSCRC has Lay Chair). There is a nominated Lay member lead for Quality each CCG but all the Lay	Business as usual Scope for further developments.	BHH CCGs Federation		Annual

	involvement and engagement: • There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. • There should be lay members of the commissioner's board. • Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. • There should be regular surveys of patients and the public more		members will have a role in ensuring that Patient Experience and Patient/public measures of quality, forms part of the Quality Agenda. All CCGs have 3 lay members (2 in Brent); the capacity for lay members in any of the CCGs is greater than the Governing Body with more lay people actively involved in PPE Publicly accountable body from 01.04.13: • CCG GB meets in public • Healthwatch a member of QSCR and GB • CCG consults with public and patient forums on service reform and redesign activities • Surveys of patients and wider public to elicit feedback and views				

	generally. • Decision-making processes should be transparent: decision-making bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community						
136	Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	Accepted	The CSU has been commissioned to provide the right level of expertise and technical support to contract development and monitoring. CCG Board holds meetings in public and Healthatch currently have members in attendance at QSCRC and CCG GB. There is also a well-developed communications function to provide timely, relevant information to the Public.	Scope for further developments.	BHH CCGs Federation		Quarterly

Local Scrutiny

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
138	Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services	Accepted	Commissioners will be supported by the Quality and Safety / Governance department and relevant others to develop the necessary contingency plans.	Business as usual Scope for further developments.	BHH CCGs Federation		Annual

Performance management and strategic oversight

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
139 The need to put patients first at all times	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with	Accepted	Performance of providers currently monitored and failings in standards addressed at CQGs and supporting evidence is requested where necessary	Business as usual	Trust Response to CQG		Monthly

140 Performance managers work constructively with regulators	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgment as to the safety of patients of the healthcare provider.	Accepted	The development of Early Warning Systems and Information Sharing with partner agencies will be considered by the Director of Quality & Safety for BHH. The CCG works collaboratively across the health and social care system and links into the new architecture of quality monitoring that is emerging including the local Quality Surveillance Groups being established by the NCB which include representatives from Monitor and CQC within its membership.	Business as usual Scope for further developments.	Trust Response to CQG		September 14
141 Taking responsibility for quality	Any differences of judgment as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take	Accepted in principle	Quality & Safety Information sharing protocol identified above to include this element	Business as usual Scope for further developments.			June14

	whatever action within its power is necessary in the interests of patient safety						
142 Clear lines of responsibility supported by good information	For an organisation to be effective in performance management there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	Accepted	BHH believes that this is in place but will be reviewed to ensure congruence with this recommendation. The CCG is currently looking at what information it holds and has access to in relation to quality. It recognises its role both to assure itself of quality and safety in the services which it commissions, and also to work with member practices and the NCB Area Team to secure improvement in quality and safety in primary care	Business as usual			Bi-annual
143 Clear matrix on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can	Accepted	Performance of providers currently monitored and failings in standards addressed at CQGs. Common metrics applied in Quality & performance reports	Business as usual Scope for development			Monthly

	be identified and accepted as needing to be fixed		Quality Schedule to includes new metrics. Stretch targets and CQUIN applied BHH to consider incorporating the use of the National Quality Dashboard (including widespread relevant benchmarking) in the monitoring of provider services				
144 Need for ownership of quality matrix at a strategic level	The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.	Accepted	CCGs to work with NHS E to develop quality metrics as identified	Business as usual			Quarterly

Medical training and education

Rec No	Recommendation	National DoH response	Assurances	Future options	Primary Lead	RAG rating	Review
152	Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.	Accepted	BHH CCGs will agree the relevant metrics and supported by CSU will identify those providers about which there are concerns with the training provided and report as required Trusts to provide Training updates and staffing ratio at CQG Safe staffing a regular agenda item on CQG Committee	BHH to consider what actions to take if providers are not achieving sufficient training levels.	NWL CSU Contract Managers CCG Collaborative Trust Response to CQG		Monthly from June 2014

Openness, transparency and candour

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Rec No	Recommendation	Government response	CWHH Initial Response and Status March 2013	Future options	Primary Lead	RAG rating	Review
173	Every healthcare	Accepted	Duty of candor		Trust Response		Annual

Principals of openness transparency and candour	organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.		introduced into 2013/14 Standard Contracts. Implementation monitored via CQGs.		to CQG		
179 Restrictive contractual clauses	"Gagging clauses" or non-disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	Accepted	HR will ensure that any clauses within contracts of employment that may be construed as 'gagging clauses' are flagged to the CCG Governance Lead to ensure compliance with this recommendation CQG challenge when patients are not kept informed of an incident.	Review of HR policy to ensure actioned.	NWL CSU HR Team Trust Response to CQG		Annual

Nursing

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
191 Recruitment for values and	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess	Accepted	BHH contracting & HR leads to review and make recommendations about how this should	How to gain assurance from providers that they have made a	NWL CSU HR for CCG Appointments		Sept 14

commitment	candidates' values, attitudes and behaviors towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements		be fully implemented. NWL CSU HR Team to lead on behalf of CCGs. HR to amend employment policy to reflect NHS Values and Constitution. Recruitment process needs to include assessment of these values.	commitment to the values. How to assess values on appointment? Consider including in Quality Schedule and Contracting rounds the need to include NHS values and the Macmillan Values Based Standard®	CQG review for providers – Contract Managers to ensure on CQG agenda for discussion. Trust Response to CQG		
197	Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff	Accepted in part	BHH Director of Nursing and Quality is a Registered Nurse	BHH Director of Nursing to consider how this should be implemented.	Demonstrated at CQG Trust Response to CQG		Dec 14
204	All healthcare providers and	Accepted in	BHH Director of Nursing	Consideration to	CCG Discussion		Complete

	commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	part	and Quality is a Registered Nurse and is to advise the CCG Boards on the recruitment of nurses as non-executive directors	be given to recruitment of Nurse NED.			
205	Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	Accepted in principle	Process in place to review provider CIP process and policy and to ensure that Quality Impact assessments have been undertaken consistently within the Trust. Includes ensuring if the DoN has signed off QIA.	Business as usual	BHH Quality Team CCG Chairs		6 monthly
208	Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse	Accepted in principle	Trusts present their achievements against the recommendations at CQGs. Regular updates to CQG on Trusts implementation of action plans.	CCGs to consider what action to take if Trust reject recommendation.	CQG demonstration through Trust Action Plan Trust Response to CQG		Dec 14

Information

Rec No	Recommendation	Government response	Assurances	Future options	Primary Lead	RAG rating	Review
246 Comparable quality accounts	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	Accepted	DoH has recently published guidance to providers around the development of Quality Accounts to include relevant benchmarking. Quality accounts are currently submitted to commissioners for comments. CSU lead on the Quality Account process Trusts have presented their draft accounts and their intentions to the lead commissioning CCG Quality Committee	Business as usual	NWL CSU CCG lead commissioner for Trust		6 monthly
247 Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local	Accepted	Quality accounts are currently submitted to commissioners for comments.	Business as usual			Annual

	Healthwatch, and all systems regulators.		NWL CSU lead on the Quality Account process Trusts have presented their draft accounts and their intentions to the lead commissioning CCG Quality Committee				
269 Improving and assuring accuracy	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	Accepted	Performance of providers currently monitored and data challenged at CQGs and supporting evidence is requested where necessary	BHH to develop and provide assurance around the quality of data reviewed. Consider the development of an audit committee.			Sept 14

APPENDIX 1

PROVIDER UPDATES IN RESPONSE TO FRANCIS

NORTH WEST LONDON HOSPITALS AND EALING HOSPITALS TRUST

The Trust Board received an initial gap analysis of the Francis report recommendations for provider organisations in July 2013. It was agreed by the Trust Board that there should be a review of the Francis report recommendations in conjunction with the outcomes of the Keogh and Berwick reports and from this a number of high level objectives proposed. A template was provided by NWLCSU to facilitate this process which was completed by both organisations.

A gap analysis was undertaken against the recommendations proposed for provider organisations; this report was presented to the Trust Board in July 2013 for both Trusts. The gap analysis was further updated in November 2013 and formed the basis for the attached implementation plan.

The North West London Hospital NHS Trust and Ealing NHST Trust declared that it supports in principle the recommendations outlined in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: February 2013

The paper submitted to the July Trust Board outlined the outcome of a joint Trust Board workshop with Ealing NHS Trust to explore and agree the works teams under each of the five previously agreed high level objectives. The five objectives are:

- To ensure a patient centred approach to care and service delivery
- Developing a patient safety culture
- Engaging and empowering the workforce
- Clinical and Operational effectiveness
- Governance and leadership: creating a safety and learning culture

Many of the work stream actions will be taken in conjunction with preparing for merger of the two organisations; this will provide alignment of systems and processes and also support increased assurance to the existing and new Trust Board.

The plan will be a live document changing as the work streams progress to capture actions, achievements and measurable outcomes.

The North West London Hospitals NHS Trust and Ealing NHS Trust
Francis, Keogh & Berwick Workshop Notes:
20th November 2013

The following section details the work streams proposed under the agreed five high level objectives. The work streams under each heading are listed in order of agreed priority. The five agreed high level objectives and related works teams are:

To ensure a patient centred approach:

1. There should be clear individual responsibility to ensure good patient experience built into staff job description and objectives. Performance in part monitored as part of family & fronds test. Non-Executive Directors should be linked with Divisions.
2. Review measurement of patient experience, focus on a small number of indicators at anyone time to drive improvement activity. Build into performance KPI reporting.
3. To continue to seek patient feedback to measure quality of services and inform changes. Embed feedback at all levels of the organisation. Increase frequency of patient storeys to the Trust Board and replicate within the divisions.
4. To review the complaints process to meet local and national standards and guidance. The process should meet the needs of the complaints in a timely manner and identify root cause so that continual improvements can be made. Involve the Non-Executives Director in the appeal process.
5. Cascade the 'St Mark' approach to 'owning the patient'. This will avoid the conveyor belt experience. Provide a named consultant; ensure good handover between specialties to ensure continuity of information and avoidance of mixed messages.

Engaging and empowering the workforce:

1. Clear expectations – (everyone's responsibility)

2. See it, sort it, report it or tell someone who can
3. Visibility & approachability
4. Listening , Acting and feedback – visibility and approachability
5. Continuous improvement mentality - staff support / Learning.

Governance & Leadership

1. Effective Leadership

- Conduct of Board important translates into organisation culture
- Capacity & capability of all Executives / Clinical Leadership
- Senior clinicians in leadership roles must maintain an active clinical role - Clinical leadership needs to be felt / heard / seen.
- Senior managers must maintain regular contact with "shop floor"

Governance & Leadership continued:

2. Feedback / information

- Need more soft information (new of GP's, patients, NEDs) to help manage organisation

3. Time
   - Need more time to explore multiple solutions to complex (wicked) problems rather than jumping most obvious (expedient) one immediately.
4. reports treat Board as a whole
   - what is the distinction in the role of Executives and NEDs?
   - what role do NEDs play in supporting and challenging Executives
5. Voice
   - Need to proactively help create a "community voice" in the most deprived parts of the community we serve e.g.: Harlesden.

Clinical & Operational Effectiveness

1. Training and Competencies

- leaders at all levels, especially front line staff.
- procedures and responsibilities
- clarity
- appropriateness and values of data and patient pathways
- accountability
- 'how it's done here' – culture too

2. Learning from mistakes

- themes from complaints
- incidents feedback and learning
- local ownership of challenges
- assurance we listen to patients
- ? focus on groups for more issues
- know progress made – continuous improvement.

3. Quality & Safety Report
    - less focussed on targets – more on remedial actions!
    - what are the key measures to have in a timely/accurately way?
    - how is this support by IT
    - break down & aggregate up to services / Trust level
    - promotes ownership at local level e.g. LOS / SHIMI
    - benchmarking with the best
    - networking

Clinical & Operational Effectiveness continued:

4. Communications
   - with front line staff
   - discussion on topic
   - local forums / focus groups
   - could be focussed on something went wrong in the own department
   - links with learning and listening

5. Looking after all sites
   - big organisation
   - culture in all sites
   - 'openness'
   - risk

Patient Safety Culture

1. Board Visibility and Setting examples
   - behaviour within board
   - how the board supports executive/management in dealing with problems and risks
2. Patient safety at the heart of investment strategy
   - empower staff to build vision
   - training in business planning
3. People at the bottom of the organisation
   - need to understand the Board attitude / focus and beliefs

4. Monitoring quality & Safety at ward level.
    - sharing trends & defining actions locally (ward level/ team)
5. Get what you measure
    - measure attitude and behaviours
6. Risk Register focus
    - ward to Board and visible
    - simpler and more effective incident reporting

Francis, Keogh and Berwick Reports Recommendations
Implementation plan – 2013/14

This implementation plan has been informed by a workshop held between **The North West London Hospital NHS Trust and Ealing NHS Trust** where the outcomes and recommendations from the three reports were discussed. The recommendations were, discussed and benchmarked with current knowledge of the two organisations culture, system and processes. The outcome of this workshop was framed around five high levels objectives that had previously been agreed.
This plan will be reviewed regularly and reported to the relevant Trust subcommittees to update and provide assurance to the Trust Board on progress in meeting the recommendations. An annual report will be presented to the Trust Board.

NWL Hospitals NHS Trust

Recommendations	Action	Timeframe	Lead(s)	Outcome	Monitoring	Progress	RAG
To ensure a patient centred approach to care and service delivery. To continue to ensure that patient's views are used and acted upon to inform service developments and improve the overall patient's experience.	• Clear individual responsibility to ensure good patient experience built into staff job description and objectives. • Non-Executive Directors to be linked with Divisions. • Review measurement of patient experience; focus on a small number of indicators. • To continue to seek patient feedback to measure quality of services and inform changes. • Embed feedback at all levels of the organisation, including patient stories. • Increase frequency of patient storeys to	Review April 14 January 14 January 14 On-going April 14 January 14	DoHR DoN DoN DoN / DoO MD DoN / DoO DoN	Improved local and national patient experience survey results. Reduced complaints. Increased compliments. Compliance with	Performance monitored via: local survey and national results. Family & Friends Test. Patient stories, which inform local action plans. Quarterly complaints report.	Appraisal documentation is currently being updated. Non-Executive Directors have been linked to divisions and guidance produced for Quality & Safety visits. Draft Patient experience KPI's in	

	the Trust Board. • To review the complaints process to meet Trust, local and national standards and guidance. • Involve the Non-Executives Director in the complaints appeal process. • Provide a named consultant to all patients. • Ensure good handover between specialties to ensure continuity of information and avoidance of mixed messages.	March 14 April 14 March 14 March 14	DoN DoN MD MD / DoN	performance standards. Good complainants experience and evidence of learning and quality improvement.	Bi-monthly update report to the Clinical Performance and Patient Experience Committee (CP&PEC)	place. Complaints review group established. Patients have a named consultant but undertaking a review for those who require support from multiple specialities to ensure system effective. Handover process in place but will be reviewed.	
Recommendations	**Action**	**Timeframe**	**Lead(s)**	**Outcome**	**Monitoring**	**Progress**	**RAG**
Developing a patient safety culture Ensuring systems, process and training is in place to enable staff to fulfil their responsibilities as outlined in Trust policies and procedures to improve the organisation safety performance to protect both patients	• Review Trust Board Code of conduct. • Review how the Trust Board supports executive/management in dealing with problems and risks • Patient safety at the heart of the investment strategy by empowering staff to build vision for their service / speciality and providing training in business planning • Promote the Trust Boards safety attitude, focus and belief to staff at all levels of the organisation.	March 14 Review March 14 Review March 14 Review March 2014	CM/ CE CM/ CE DoS DoO CM/ CE DoG	Improved patient safety culture: Revised and re-launched Trust Board code of conduct Clear safety & quality KPI framework from	Trust Board minutes and action log. Strategy annual plan. Through risk management and feedback systems and processes e.g. performance	Planning Trust Board Governance workshop. Performance management, safety / quality performance framework currently under review. Improved risk	

and staff from avoidable harm.	• Review patient safety and quality KPI's at ward / department level. • SUI training for consultants to support charing of panels and improved clinical ownership • Revised Datix system procured and installed. • Datix upgrade will be supported by training. • Full RCA training to support staff with lower risk incidents. • Share patient safety and quality trends & defining actions locally (ward - Department level/ team) via staff training to access data from Datix systems. • Measure staff attitude and behaviours • Risk Register focus, ward to Board, visible, simpler and more effective incident reporting	Review March 14 December 13 February 14 February 14 March 14 Review March 14 April 14 Review March 14	DoN / MD/DoO DoG DoG DoG DoG DoG DoHR DoG	'ward to board' Increased reporting. Reduction in SUI. Evidence of learning and service improvements to reduce risk. Staff reported positive safety culture.	management framework and incidents & complaints reports. Quarterly staff survey results. Bi-monthly update report to relevant Trust Board Subcommittee	management system will be in place February 2014 as part of upgrade to Datix system. This will facilitate feedback to reporters on incident outcome and learning.	

Recommendation	Action	Timeframe	Leads(s)	Outcome	Monitoring	Progress	RAG
Recommendation	**Action**	**Timeframe**	**Lead(s)**	**Outcome**	**Monitoring**	**Progress**	**RAG**
Clinical and Operational effectiveness Understanding clinical and operational performance to identify risks and inform improvements quality of care.	• Review staff training and competencies of leaders at all levels, especially front line staff. • Ensure clarity of relevant policy & procedures and staff responsibilities – promote current risk management strategy • Review appropriateness and values of data and patient pathways to monitor compliance with standards e.g. KPI's and ensure staff accountability • Set and promote standard and lead the culture of 'how it's done here'. • Ensure Learning from safety events e.g. incidents & complaints by listening to and involving patients where appropriate. • Quality & Safety Report to focus on core benchmarked KPI's, be available at all levels e.g. ward / division & Trust and demonstrate learning • Improve communication with front line staff using local forums / focus groups to raise safety issues and promote listening, learning / change in practice. • Ensure effective leadership on all hospital sites to support an open safety culture.	Review March 14 January 14 March 14 April 14 Review March 14 Review March 14 Review March 14 Review March 14	DoHR / DOG DoG MD / DoN DoG DoN/ MD DoG / MD / DoN DoG DoG / MD / DoN DoO / DoN / MD	Improved patient safety culture: Increased reporting. Evidence of learning and service improvements to reduce risk. Reduction in SUI.	Core competencies for all staff Implementation of Trust Risk Management Strategy Performance management dashboards. Bi-monthly update report to relevant Trust Board Subcommittee Local and Trust wide risk registers. Safety log of issues raised and action taken.	The Trust has a Risk Management Strategy. Performance framework review in progress. Evidence of actions taken following an incident or a complaint is available. KPI data is available but 'new' Datix system will make report generation easier.	

Recommendation	**Action**	**Timeframe**	**Lead(s)**	**Outcome**	**Monitoring**	**Progress**	**RAG**
Governance and leadership: creating a safety and learning culture Ensure governance systems that provide the right level of assurance to the Trust Board and escalation of appropriate clinical risks.	• Review Trust Board code of conduct. • Continued review of executive and senior leader's capacity & capability. • Senior clinicians in leadership roles must maintain an active clinical role. • Senior managers must maintain regular contact with "shop floor" • Increase feedback from stakeholders e.g. GP's, patients, NEDs to help ensure effective management of the organisation. • Review process for enabling more time to explore multiple solutions to complex (wicked) problems rather than jumping most obvious (expedient) one immediately. • Clarify the distinction between the roles of executives and non – executives. • Proactively create a "community voice" in the most deprived parts of the community we serve e.g.: Harlesden.	March 14 Ongoing. Ongoing Ongoing Review March 14 Review March 14 March 14 Review March 14	CM / CE Exec Team MD / DoN DoO DoS / DoN Exec Team DoG DoN	Revised Trust Board Code of Conduct. Visible clinical and managerial leadership. Increased feedback from stakeholders to inform service improvements. Improved patient safety culture: Evidence of learning and service improvements to reduce risk.	Bi-annual report to relevant Trust Board Subcommittee	There is a Trust Board Code of Conduct. Arrange a facilitated Trust Board leadership and effectiveness workshop early in 2014.	

CE	Chief Executive	**CM**	Chairman	**DoN**	Director of Nursing	**DoE&F**	Director of Estates and Facilities.	**DOHR**	Director of Human Resources	**DOT**	Director of Transformation
Exec Team	Executive Team	**MD**	Medical Director	**DOG**	Director of Governance	**HoP**	Head of Performance.	**DoO**	Director of Operations	**DoS**	Director of Strategy.

KEY:		**Completed**		**On Target**		**Partially Completed**		**Not Started**	**December 2013.**

CENTRAL NORTH WEST LONDON FOUNDATION TRUST

The following report was presented to the February Clinical Quality Group as an update on Francis and actions taken which relate to issues raised in the Francis report. It also outlines the key issues for the trust from the Government's response to the Francis report. An action plan has previously been provided.

The Government has reaffirmed its commitment to the current regulatory regime and its determination to drive standards. It maintains that commissioning will assist in this drive and it looks likely that it will introduce more sanctions against individuals when problems arise. There is an acknowledgment that the quality of frontline staff is a key determinant of the quality of the patient experience and therefore an emphasis on staffing and training. Transparency is a key theme from the need to address patient concerns through to increased requirements to provide information on a local and national level.

There has been progress against each of the 5 work streams identified by CNWL's Board in July 2013: complaints, patient safety, governance, staffing and informatics and information sharing but they all remain priorities for the Trust .

Some specific further action has been identified as follows

- Additional training/communication to front line staff in respect of their responsibilities to be open and transparent with patients and carers in the event of an incident or a near miss
- Continued vigilance to ensure that all Trust information is honest and truthful in line with the duty of candour.
- Further work to determine ward staffing levels and to use the electronic rostering system to monitor this.
- Provision of bi annual reports to the Board on staffing levels
- Publication of staffing levels on each ward
- Review of the format of the quality account in respect of guidance set to be released in the new year
- Review of the methodology used for the appraisal of the board and the training and development of directors in the light of this appraisal
- Review of the training and development needs of governors especially in relation to their role in engaging the public

- Provision of board reports on complaints
- Quarterly publication of complaints information
- Regular reviews of data quality and benchmarking analysis and presentation

1. Context

The Francis report was published on 24th February 2013. It looked at the events in Mid Staffordshire Foundation Trust in 2005/09.
The Board has reviewed the Trust's systems, practices and culture in the light of Mid staffs a number of times, May 2009, March 2010, March 2013 and July 2013.

The Trust has had a continuing focus on

- Culture
- Complaints/Incidents
- Clinical engagement/leadership
- Governance
- Care and treatment (including dignity)
- Staffing

which predates the first reports in 2009 and at each juncture the Trust has used the information revealed in investigations and the advice and guidance contained in responses from statutory bodies to inform its on-going work.
In July 2013 the Board agreed five workstreams

- Complaints
- Patient safety including incidents
- Governance
- Staffing
- Informatics and information sharing

These were underpinned by cross cutting themes of openness and transparency, communication and governance.

2. Government response to Francis

The government published a detailed response to Francis which we have reviewed in detail. The key theme is that the government continues to place great reliance on the inspection regime of the CQC and the regulatory system of Monitor working together to provide for a single regulatory system. Other statutory bodies and commissioners are also encouraged to review the services provided (particularly by NHS bodies) to continually drive up quality.

Some of the key issues arising from the response are set out below.

2.1. Regulation

The Government is clear in its commitment to the CQC regime. It is also clear that the CQC and Monitor will remain separate. There is likely to be further legislation which will strengthen CQC powers. Quality surveillance groups are seen as the mechanism for airing quality concerns and for commissioners and regulators conferring together.

2.2. Standards

There is an intention to further define standards which will add to the overall burden of regulation. There will be legislation to set the fundamental standards of care which will be a regulatory system in their own right alongside the CQC broader assessments of overall quality. NICE will in future also specify developmental standards and the Royal colleges to contribute to the development of outcome measures. The fundamental standards will have a clearer focus on governance arrangements for complying with them. The CQC will then issue guidance on all these elements of governance. There is also a renewed emphasis on the NHS constitution and national standards for cohorts of staff. The Trust will ensure that it makes these available to staff with sufficient emphasis.

2.3. Commissioning

The government supports commissioners in having an active role in inspecting providers in order to drive up quality. There is as yet no further guidance on how this will work in practice. Further considerations being given to strengthening the standard contract to give commissioners the right to intervene or to suspend a service or element of it where there are reasonable grounds for material concerns about patient safety or outcomes. The government confirms that one of NHS England's key functions is to develop the assurance process

which identifies how well clinical commissioning groups are performing against their plans to deliver better outcomes. There is as yet no timeframe for this.

2.4. Duty of candour

The government very strongly endorsed the duty of candour. We have already put in place actions to ensure that we comply with the duty of candour. It is clear that there is an intention to punish trusts and individuals who provide misleading information with an intention to put in place legal changes that place a statutory duty of candour on healthcare providers and create a new offence of providing false or misleading information. The Trust is involved in the government's consultation on how to fix the thresholds for the statutory duty of candour.

2.5. Staffing

The government supports the Francis theme that the quality of nursing needs to improve. There is likely to be further guidance issued on an appropriate and effective model of nurse revalidation. In the meantime trusts should continue to take account of guidance issued by the National Quality Board. Trust Boards will be required to receive reports twice a year on staffing levels and trust will be required to publish data at ward level. The Government agrees with the importance of nurse leadership on wards but doesn't preclude ward manager doing other duties or being counted as part of the nursing establishment. Further consideration is being given as to whether nurses are well trained enough in care of the elderly.

2.6. Information

There is likely to be revised guidance on the format of quality accounts and the Government is keen to standardise information allowing for better and easier comparison between providers. This is likely to place an even great burned on trusts to provide the Health and Social Care Information Centre with information and for them to explore options and make progress for using standard reporting formats with a view to improving consistency of analysis across the system.
There are also clear plans to use national benchmarking data to identify any outlier organisations in terms of quality of service provision. As a result there will be an increase in the number of mandatory indicators and datasets that the Trust will have to provide. There will also be an increase in the level of scrutiny across all these datasets and within the indicators related to safety and quality in particular. There

will be a requirement to undertake increased internal analysis and benchmarking to ensure that early warning systems are in place to identify under performance in all areas and to share this analysis across all services within the organisation.

2.7. Governance

There will be a fit and proper persons test and a disbarring scheme for directors. There is also emphasis on ensuring that directors and governors have adequate training. Government has stopped short of placing a requirement on trusts to have a programme of continual development for directors however Monitor suggests that boards have regular self-assessments to test capabilities and attend training on core elements of quality governance and continuous improvement. We may need to strengthen/tailor our training and development programmes. Trusts are required to ensure our compromise agreements contain an explicit clause relating to disclosure in the public interest. Francis very much pushed the role of governor in interacting with the public. Government has resisted prescribing this but good practice guidance will shortly be issued in respect of training for governors – again government has resisted being prescriptive but it does stress the importance of Govern well (FTN programme).

2.8. Safety

There is a particular focus on safeguards in the event of a death with an enhanced role for Public Health England in respect of infection control.

2.9. Complaints

The government supports many of the Francis recommendations. Trusts will be required to provide the board with monthly data on complaints, including actions taken and its effectiveness, and to publish data quarterly. The government may well prescribe a format for the publication of serious complaints to make for easier comparison and may change the NHS England Serious Incidents framework so that serious complaints would trigger an investigation. Other good practice recommendations will be built into a revised Complaints Policy and our systems will be flexible enough to accommodate any further requirements recommended by the Ombudsman. There is a clear requirement on trusts for them to make sure that all patients are aware of their right to complain which will require a concerted internal communications effort. Every patient must be told; How to complain; How they can get independent support; their right to go to the ombudsman; How to contact health watch. The effectiveness of our arrangements in light of the Government response will be reviewed and changes overseen by the quarterly Complaints Monitoring Group which meets in January.

3. Update on progress

There has been progress on all the five work streams and it is clear that these work streams already largely accommodate the Government's response to Francis.

3.1. Complaints

There has been a review of complaints arrangements in the Trust which has been supported by a former deputy Ombudsman. A full report will be presented to the Board in March and it is anticipated that the revised arrangements will be implemented in June 2014.

3.2. Patient safety including incidents

Our continued focus on infection control has been rewarded by zero reported infection control incidents. We have appointed a new DIPC and are strengthening the infection control team to consolidate our systems and processes and ensure a coordinated approach across all CNWL services. The NHSLA has revised its approach and no longer sets risk management standards but will in future engage with trusts on the basis of their level of claims. We will however ensure that our on-going systems to manage risk are best practice. We are reviewing nutritional standards through the Physical Healthcare Steering Group.

One of the ways of ensuring the quality of services is to empower staff to raise concerns. The most recent staff survey results indicate that a very high percentage of staff are confident that they are safe to raise concerns and that they will be appropriately dealt with. We have also used the staff newsletter to promote the importance of all staff being confident to raise issues. The Whistle Blowing Policy has been revised and will be reissued in January. There have been two meetings of the staff governors with the Chief Executive looking at how to engage staff as members of the trust and how to ensure that staff really are confident in raising issues.

In respect of serious incidents we have strengthened the in house team including creating a post for an in house solicitor and a small team of investigators. This will not only boost capacity to investigate incidents but also the cross-Trust analytic capacity. We are continuing to develop our reporting of patient incidents to enable intelligent analysis at all levels in the organisation to ensure that themes and trends are spotted early and preventative action initiated wherever possible, ideally at a local level. The Trust has in place an Incidents and

Serious Incidents Group chaired by the Director of Nursing and Operations. This group was originally set up to monitor MH&AS but is being extended in January to incorporate all services including CPS, HCH, Sexual Health and MK services.

3.3. Governance

Our governance systems and process are kept under constant review. A full review is now underway to ensure that they fully support the new divisional structure. Notwithstanding this review we have continued with development sessions for Governors which has resulted in more constructive challenge at governor meetings. We have rigorous processes for the quality impact assessment of any service changes or reductions including the attendance of the Medial Director and the Director of Nursing at the Business and Finance Committee. We have developed clear and simple guidance on consultation requirements.

The Duty of Candour is contained within all 2013/14 contracts with CCGs and NHS England specialist commissioning. The Trust sub-contract pro forma has been updated (in consultation with our solicitors) to ensure the Trust are compliant with this service condition in all future sub contracts. Contract Variations will be issued where 3 year contracts or council contracts are in place and this clause is not within the original contract.

3.4. Workforce

The development of the nursing workforce will continue through 2014 building on our established training and development programs. The focus of the nursing directorate is being reviewed to ensure that it provides targeted support and challenge. The trust is engaged with the national development of a methodology to measure the health/strength of the nursing workforce but this is understandably going to be very complex to deliver. Much of the focus of the Francis report was on the appropriateness of staffing levels. The Trust is working with other mental health trusts to establish good benchmarking for mental health inpatient wards. In the meantime the Trust will continue to set its own standards for staff levels and skill mix and use its electronic rostering system to monitor against these standards.

3.5. Informatics and Information sharing

The major ICT programme is on target and is monitored both at an executive level and by the Informatics committee on behalf of the board. The Trust has improved its informatics capacity and front line staff now have access to timely performance data to enable them to better monitor and plan their services. The Trust has appointed a new Director of Communications who takes up the post in the spring and who will continue the drive to improve our internal and external communications capacity.

THE HILLINGDON HOSPITALS NHS TRUST

The Trust has provided a number of detailed updates to the Board on Francis which demonstrate how they can learn from and respond to Francis. The trust has reviewed the 290 recommendations and has provided an overview of the number that are relevant. In addition the Trust has utilised the five domains outlined in 'Patient's first and Foremast', the Government's initial response to the Inquiry and its five point plan, as a framework to support analysis. In relation to the Trust understanding of the Francis report, the Trust held two opening listening events and discussed the finding of Francis at divisional and team meetings. There were a number of engagement activities carried out over recent months, over and above Francis listening exercises, such as the staff survey, patient surveys, CARE Champions/Ambassador meetings. In addition the Board has discussed the Trust's approach to clinical quality at two board strategy sessions and agreement has been reached on a strengthened approach to quality governance and quality information in the Trust.

The full response from the Trust will be reported against annually, this is overseen by a dedicated group overseeing the key themes and identifying issues that need to be addressed. Leads from the key professions and management groups have been identified and agreed by the Executive team to drive forward this work.

The Trust have identified a number of key priorities and a work plan to include:

- Publication of a refreshed clinical quality strategy
- Review of quality data and a strengthened approach to clinical governance
- Further embedding of culture and values
- Launch of a new leadership strategy
- Enhancing the role of foundation Trust Governors
- Ensuring visible, sensible, supportive listening leaders
- Launch of a refreshed Nursing and Midwifery Strategy and investment in nurse leadership development
- Introduction of a Nursing Quality Assurance Framework
- Review of Education and training for Health Care Support Workers following on from the Cavendish review.

It is evident from on –going assurance meetings that the Trust is well positioned and that much work has already taken place in response to the report. The Trust has a detailed action plan which has been approved by the Board.

The Director of Nursing presented the updated action plan at the January Board TM said the report was centred around a ward to ward report and what actions have been taken since the publishing of the Francis Report last year. The report highlighted five key domains, the first being clinical leadership ensuring that there is a dynamic process in action to make sure that the Board is thoroughly engaged in what is happening at grass roots level and stated that particularly, the Chief Executive is out of his office in clinical areas on a frequent basis. This ensures that every clinical area has access to Board members to express views at every opportunity. TM went on to say that the Trust is never complacent in other areas such as complaints, mortality, infection control and the Trust is heading in the right direction with all these issues.