# HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

# 28 JANUARY 2014

# FRANCIS INQUIRY – UPDATE FROM NHS

Report from: Barbara Peacock, Director of Children and Adults

Author: Rosie Gunstone, Democratic Services Officer

**Summary**

This report sets out details of a powerpoint presentation from the Chief Nurse, NHS Medway Clinical Commissioning Group (CCG), on the update from the NHS following the Francis Inquiry into Mid Staffordshire NHS Foundation Trust last year.

## 1. Budget and Policy Framework

1.1 Under the Council's Constitution, Chapter 4 – Rules, Part 5, paragraph 22.2 (c) there are terms of reference for Health and Adult Social Care Overview and Scrutiny Committee to review and scrutinise matters relating to the health service in the area including NHS Scrutiny.

## 2. Background

2.1. At the Committee meeting on 9 April 2013 Members received a presentation from the NHS and from Medway Council into the public inquiry into the serious failings at Mid Staffordshire NHS Foundation Trust which identified failures in the systems, set up to identify and remedy non-compliance with acceptable standards of care.

2.2. The Chief Nurse and Deputy Chief Nurse, NHS Medway CCG will attend this meeting to present a powerpoint (as per Appendix 1) updating on local progress.

## 3. Risk management

3.1. There are no specific risk implications for Medway Council arising directly from this report.

## 4. Legal and Financial Implications

4.1. There are no legal or financial implications for the Council.

## 5. Recommendations

5.1. Members are asked to consider the update on the Francis Inquiry from the perspective of the NHS and to put forward any questions as appropriate.

**Background papers:**

None.

**Lead officer:**

Rosie Gunstone, Democratic Services Officer
Tel: (01634) 332715 Email: rosie.gunstone@medway.gov.uk

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# Francis Update
# Medway Clinical Commissioning Group

Geoffrey Wheat – Chief Nurse
Jane Shepherd – Deputy Chief Nurse

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# Findings of Inquiry - Key Themes

- Standards and methods of compliance
- Openness, transparency and candour
- Improved need for compassionate nursing
- Stronger patient centred leadership
- Accurate, useful and relevant information

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# Aims and Recommendations from Public Inquiry

- Shared Culture of putting patient at heart of care
- Evidenced based practice – compliancy with standards – measurable
- Transparency and accountability at all levels
- Enhanced recruitment, staff well being, leadership training and education.
- Systems to ensure all services are measurable and offer quality assurance

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# Independent Reviews

- Keogh Review – mortality review
- Cavendish Review – Health care assistants and support workers
- Berwick Review – Patient Safety
- Clywd / Hart Review – Complaints system
- NHS Confederation Review – NHS Bureaucracy
- Children's & Young Peoples health outcomes forum report

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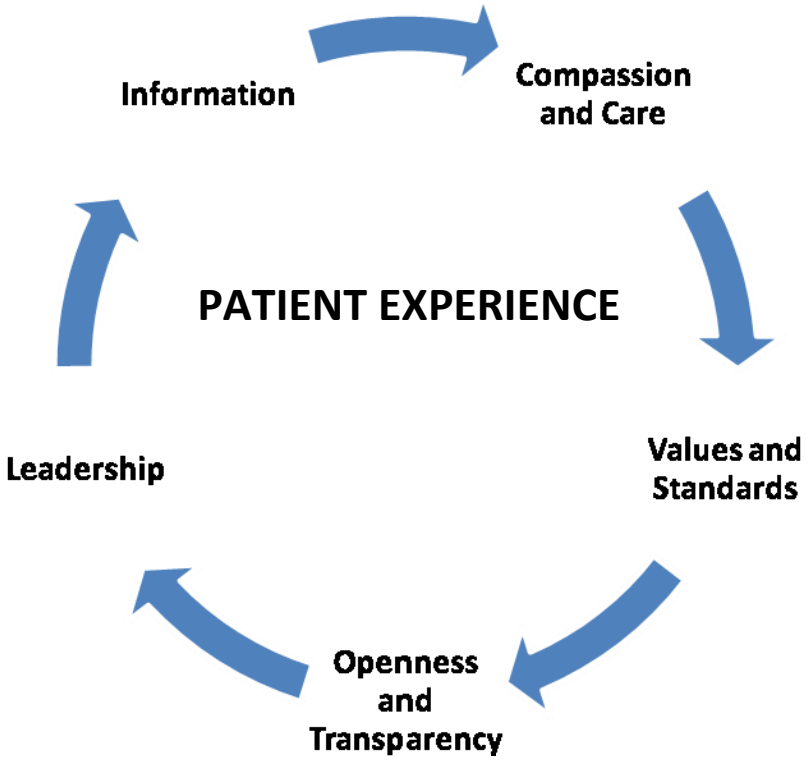
# Hard Truths - Everyone's Responsibility



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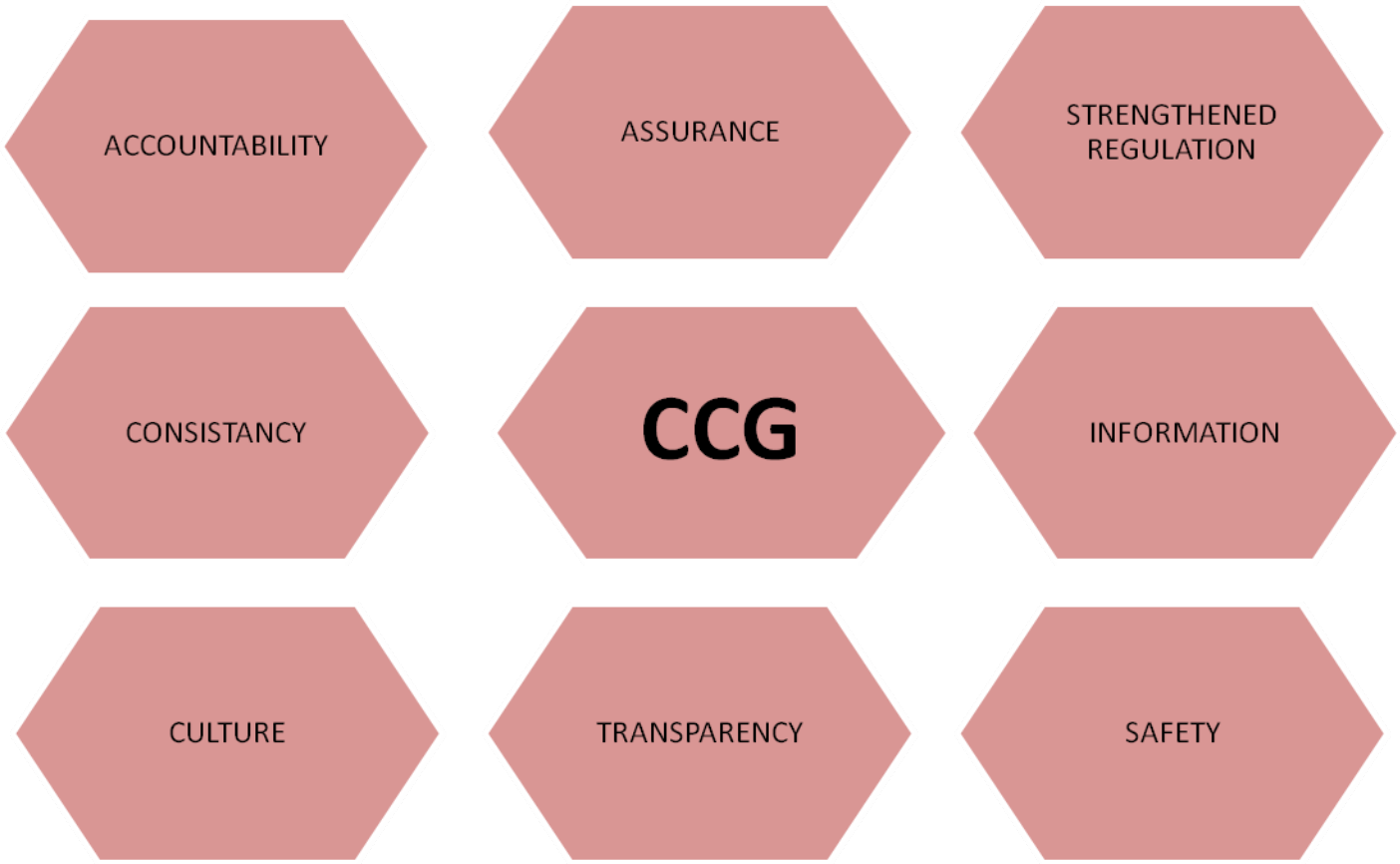
# Medway CCG Responsibility



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# Medway CCG Internal corporate assurance

## Local action plan key elements

- Absolute need for duty of Candour
- Fundamental need for cohesive working across health and social care
- Ensure responsibility and accountability
- Address local issues with clarity and conviction to improve quality standards

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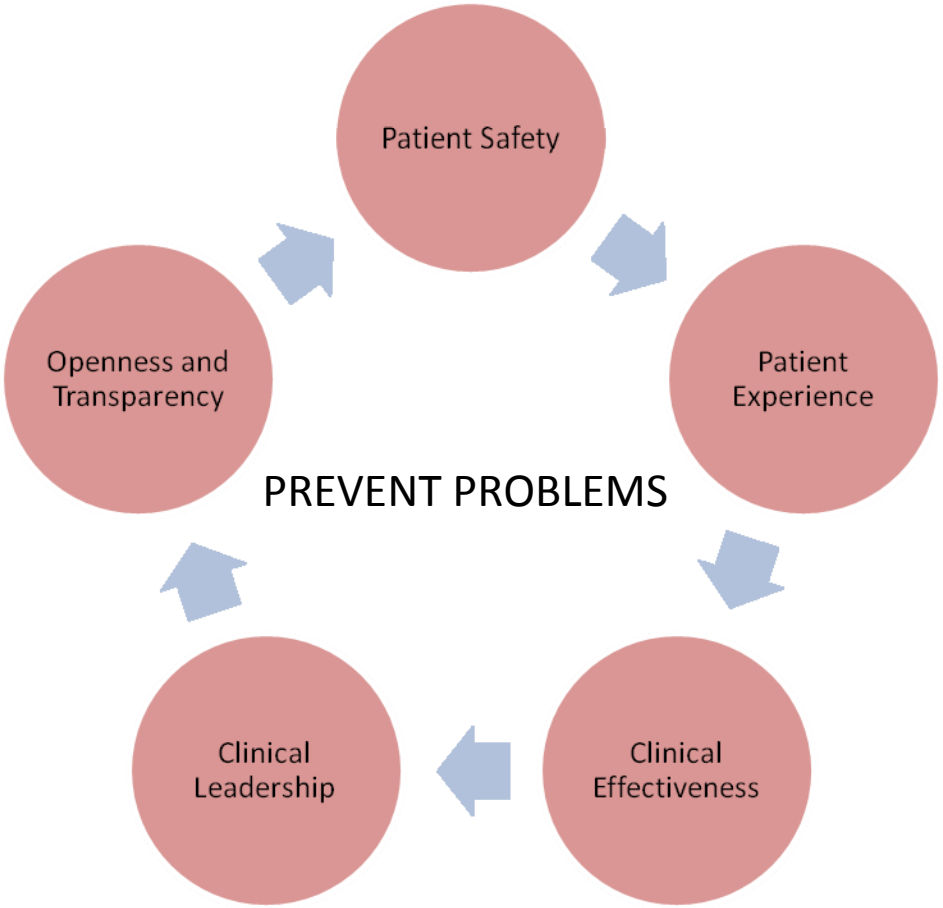
# Gaining assurance  of providers compliance



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# Detecting Problems Quickly – Governance processes'

- **Clinical Quality Review Group [CQRG]meetings with providers – Holding the provider to account through robust challenge**
- **Provider site visits – planned and unannounced**
- **Undertake ad-hoc and specific audits with providers**
- **Early implementation of validated 'cultural barometer' with evidence of learning**
- **Triangulation of data from early warning dashboards and internal reporting structure – finance, performance and quality meetings and Governing Bodies**
- **Local and National data for Serious Incidents Requiring Investigation and Health Care Associated Infections**
- **Quality Surveillance Group**
  - Sharing of quality, safety and safeguarding information between, commissioners, regulators, NHS England, Health Education England etc.
- **Regular CCG Chief Nurse to Provider Chief Nurse meetings and walkabouts**

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# Taking action promptly

- **Continuous quality improvements supported by penalties and incentives**
- **Key triggers and early warnings**
  - Culture and leadership
- **Raising issues as they arise immediately**
- **Follow up to full assurance at CQRG**
- **Appropriate escalation procedures, internal and external**
  - Quality Surveillance Group
- **Undertake a rapid responsive review**

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# Ensuring Robust Accountability

- CCGs at the heart of improving health outcomes

- CCGs are held to account by NHS England for quality, outcomes, financial performance – NHS England have the power to intervene when evidence of failure or likely to fail

- This accountability is demonstrated via the Board Assurance Framework and regular assurance meetings with NHS England

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# Collaboration

- **09/07/2013 –** CCG facilitated a Francis Event with key stakeholders across each of the three North Kent CCGS. The aim was to increase awareness of the Francis Recommendations and to promote thought around all of our responsibilities in delivering the recommendations across the whole organisation.

- **12/12/2013 –** Whole systems seminar, involving Acute, Community, Primary care Providers, Ambulance service, Mental Health providers, Independent sector, Local Authority, Universities, Kent and Medway Health Watch. The aim was to showcase best practice across various different settings, in the delivery of the Francis recommendations, so that learning could be shared.

- **I'd like to extend an invitation to you to undertake some of the walk rounds with me and the Chief Nurse for MFT**

- **Future whole systems seminar planned summer 2014**

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# Key Messages

- **It is essential that we all own the Francis recommendations across health and social care and that we are committed to providing safe, effective patient centred care.**

- **We have a duty to make sound commissioning decisions, provide a stable infrastructure, robust scrutiny mechanisms with detailed challenge that triangulates all data and above all have a duty of candour.**

- **We listen, we speak and we move forward.**