REPORT TO:	Health Policy & Performance Board
DATE:	6 November 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Francis Inquiry Update
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report provides an update to the Board in relation to the recommendations and actions from the Francis Inquiry. As the Board is aware this report was produced from the publicly held inquiry into the care provided by Mid Staffordshire NHS Hospitals Foundation Trust. The report provided 290 recommendations and was clear in its challenge to all of those involved (commissioners, regulators and other) that they had in many ways failed to protect the patients.

2.0 RECOMMENDATION: That the Board:

i) Note the progress being made in this area and the plans for on-going monitoring ; and

ii) Define if any further updates will be required by the Board and the frequency.

3.0 SUPPORTING INFORMATION

3.1 In the previous report the recommendations where outlined and in particular those which relate to the commissioners of care specifically the fundamental need for commissioners to commission safe and effective care through appropriate contract and performance monitoring, including setting and monitoring tightly quality standards and ensuring that processes are in place to identify any problems with local service quality at an early stage.

3.2 Since the publication of the inquiry the following actions have been completed with all local NHS providers

1. All providers locally agreed to delivery improvements in care via a Commissioning for Quality and Innovation (CQUIN)

2. All providers have presented for review and approval an internal assessment of their performance in relation to the Francis Inquiry recommendations. Within the assessment they were required to review Quality of care and

strategies, Nursing Strategies and staffing levels, training and competency of nursing staff, training and competency of Health Care Assistants, leadership, whistleblowing and duty of candour.

3. The initial assessments by providers have identified some good practice but also some areas of work to progress, to this end each provider will submit updates regularly through the contracting process on their performance.

4. The CCG has now in place excellent quality reporting across all providers and an Early Warning Dashboard (reviewed monthly) which includes patient complaints, incidents, safety issues, Health Care Acquired Infection rates, CQC reviews, performance on all national and local quality targets.

5. The local Quality Surveillance Group is now well established and this group has been effective in identifying issues with providers and enabling all Commissioners to work together with providers to improve their performance and keep patients and service users safe.

3.3 The CCG Quality Committee is reviewing quality across all providers and working closely with LA colleagues to enable us to be assured that quality is fundamental to service delivery in all areas.

3.4 It is clear that ensuring the people of Halton are safe and receive a quality services is a fundamental function for the CCG and the Local Authority we are responsible to the local people and we must be able to provide assurance to them. The process remains complex as there are many actions and processes which deliver quality but it is essential that this is delivered.

3.5 Currently the CCG is working to develop processes to ensure that we hear first-hand the views of patients bad are able to take action to improve as required. The CCG has developed an issues@haltonccg.nhs.uk email address which is currently available to GPs and all other clinicians to raise issues with service provision. The clinicians' are closest to patients and will receive early feedback of issues both negative and positive, we are encouraging them to provide this feedback to the CCG and sharing this with providers to understand issues early and find solutions. We will also use this process to identify key themes for providers. This process is not a replacement for formal complaints system which we advise continuous to be used as appropriate. To date the key themes reported through this process have related directly to discharge arrangements and to improve this across all providers as Safer Care Collaborative has been developed. This group will look to agree across all providers' good practice in communications, discharge and pathways of care.

3.6 The CCG at its recent Check point meeting with NHS England was able to evidence a good handle on provider performance in relation to quality, delivering on trajectory in most areas, one area which require further work locally is the Friends and Families Test (F&Ft) in acute care for which response rates have been low in some areas but this is true nationally. As this is a key strand of the listening to the patient voice, though not the most important, we are working closely to support providers to improve in this area. Maternity Services F&Ft commences in October 2013 and our local community and mantel health providers are pilot sites for the mental health and

community F&Ft programme.

3.7 As the Board will be aware since the publication of the Francis Review there has been the publication of the Kehoe Reviews and the Cavendish Inquiry both of which link directly to the issues identified in the Francis Inquiry and have major impacts on service providers and the quality of care. It is planned that a short overview of these reports will be presented at a later date if the Board would find this of interest.

4.0 POLICY IMPLICATIONS

4.1 Both the LA and CCG need to continue to work together to develop local safety and quality standards to ensure the safety of services to the people of Halton.

4.2 Failure to monitor, report and manage quality of services will have a major impact on the health of local people.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Poor quality health care costs more, for service users they are sick for longer, the outcomes of their illness are poorer and they are more likely to be unable to be financially independent

5.2 For the NHS poor quality care means patient spend longer in hospital and need more intervention, all of which costs

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Poor quality health care will affect detrimentally the wellbeing of local children and young people.

6.2 **Employment, Learning & Skills in Halton**
Healthy people are better able to develop skills and live an active and useful life.

6.3 **A Healthy Halton**
Poor quality care will affect the health of all people in Halton and prevent local people maintaining their health.

6.4 **A Safer Halton**
Safeguarding is an essential element and will be monitored via this process.

6.5 **Halton's Urban Renewal**
Local people who are not healthy cannot support Halton's urban renewal.

7.0 RISK ANALYSIS

7.1 The report outlines clearly some areas of risk for the LA and CGG.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified with this report.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act