

HEALTH AND WELLBEING BOARD

11 FEBRUARY 2014

Title:	The Francis Report
Report of the Barking and Dagenham Clinical Commissioning Group	
Open Report	For Discussion
Wards Affected: ALL	Key Decision: NO
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Summary: Further to an update report on the implementation of the Francis recommendations and the establishment of a designated task and finish group presented at the December meeting of the Health and Wellbeing Board, this report aims to appraise members of progress made to date.	
Recommendation(s) The Health and Wellbeing Board is asked to: <ul style="list-style-type: none">i. Consider the report noting the progress made to date and the commitment of the task and finish group members to ensure recommendations are implemented and embeddedii. Discuss the implications for Barking and Dagenham and propose any further actions the Board agrees are required.	
Reason(s): Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to review and comment on public inquiries into health and social care and make recommendations to improve the quality of care. The NHS Constitution should be the first reference point for all NHS patients and staff as it outlines the systems common values as well as patient rights, legitimate expectations and obligations of patients.	

1. Introduction

- 1.1 The purpose of this update report is to provide the Health and Wellbeing Board with a summary of the main issues and key recommendations raised in the second report from the public inquiry into the events at Mid Staffordshire Hospital carried out by Robert Francis QC
- 1.2 The report provides the Francis recommendation and action plan as developed by the task and finish group and details progress made to date with implementation of the actions across the Barking and Dagenham, Havering and Redbridge social care and health economy. The plan is attached at appendix 1.
- 1.3 The group is now established and this report details the preliminary progress made since the last update.

2. Background

- 2.1 The report of the Francis inquiry, tells first and foremost of the appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies were brought to the regulators attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus in reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.
- 2.2 The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. Francis states that Primary Care Trusts were not as effective as might have been expected in commissioning or monitoring delivery of care. The task and finish group considered the failings detailed above and in doing so agreed the actions in the implementation plan.
- 2.3 The task and finish group have been further influenced by the Keogh and Berwick reports, which both make explicit that service users and patients must be at the heart of all we do as system leaders, commissioners and providers of health and care services.
- 2.4 The Chairs of all safeguarding boards, Healthwatch representatives and the Lay members of the Clinical Commissioning Groups (CCGs) have provided input to the development of the Francis Implementation BHR System Wide Plan.
- 2.5 All three Local Authorities and CCGs report significant progress of actions in the plan. Progress against actions is detailed in Appendix 1.

3. Next steps

- 3.1 To hold a multi-agency commissioner and provider workshop in mid February to undertake a system wide quality gap analysis, and then building on what is in place

and working well develop a Quality Improvement Group that supports and enhances system wide quality improvement.

- 3.2 To continue to drive forward and implement the actions agreed in the plan. The task and finish group have now taken on a monitoring role and will meet monthly going forward.

4. Mandatory Implications

4.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall mortality analysis as well as a detailed safeguarding element within it. Integration and addressing issues presented by Francis are key themes of the JSNA 2013 and this paper is well aligned to address and follow up these priorities and the strategic recommendations of the JSNA. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA.

4.2. Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The strategy is based on four priority themes that cover the breadth of the frameworks and in which a large number of Francis's recommendations can be picked up within. These are: Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

4.3 Integration

One of the outcomes we want to achieve for our joint Health and Wellbeing Strategy is to improve health and social care outcomes through integrated services. Implementing the recommendations from the Francis Report will need to take account of integration and many of the actions will further support and strengthen integration, such as developing a joint mechanism for capturing service user/patient experience feedback to inform further integration.

4.4 Risk Management

Patient/service user care may be compromised if there is a failure to consider or implement relevant recommendations, which is in addition to organisational reputational risks. Agreement to establish the task and finish group and the consideration the Health and Wellbeing Board has already given to implementing the recommendations will mitigate this risk.

5. Non-mandatory Implications

5.1 Safeguarding

By its very nature the Francis Report has significant safeguarding implications and the overall report is aimed at making both the health and care system and the individual services within this more safe and driving continuous quality improvement. The CCGs are actively collaborating with the Children's and Adults Safeguarding Boards to lead and progress the implementation of the recommendations.