Notice of Meeting

Health Scrutiny Committee

SURREY COUNTY COUNCIL

Date & time	Place	Contact	Chief Executive
Thursday, 4 July 2013 at **10.00 am**	Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN	Leah O'Donovan or Victoria Lower Room 122, County Hall Tel 020 8541 7030 or 020 8213 2733 leah.odonovan@surreycc.gov.uk or victoria.lower@surreycc.gov.uk	David McNulty

If you would like a copy of this agenda or the attached papers in another format, eg large print or braille, or another language please either call 020 8541 9068, write to Democratic Services, Room 122, County Hall, Penrhyn Road, Kingston upon Thames, Surrey KT1 2DN, Minicom 020 8541 8914, fax 020 8541 9009, or email leah.odonovan@surreycc.gov.uk or victoria.lower@surreycc.gov.uk.

This meeting will be held in public. If you would like to attend and you have any special requirements, please contact Leah O'Donovan or Victoria Lower on 020 8541 7030 or 020 8213 2733.

Members

Mr Bill Chapman (Chairman), Mr Ben Carasco (Vice-Chairman), Mr W D Barker OBE, Mr Tim Evans, Mr Bob Gardner, Mr Tim Hall, Mr Peter Hickman, Mrs Tina Mountain, Mr Chris Pitt, Mrs Pauline Searle, Mr Richard Walsh and Mrs Helena Windsor

Co-opted Members

Dr Nicky Lee, Rachel Turner, Hugh Meares

Substitute Members

Graham Ellwood, Pat Frost, Marsha Moseley, Chris Norman, Keith Taylor, Alan Young, Victoria Young, Ian Beardsmore, Stephen Cooksey, Will Forster, David Goodwin, Stella Lallement, John Orrick, Nick Harrison, Daniel Jenkins, George Johnson.

Ex Officio Members:

Mr David Munro (Chairman of the County Council) and Mrs Sally Ann B Marks (Vice Chairman of the County Council)

TERMS OF REFERENCE

The Health Scrutiny Committee may review and scrutinise health services commissioned or delivered in the authority's area within the framework set out below:

- arrangements made by NHS bodies to secure hospital and community health services to the inhabitants of the authority's area;
- the provision of both private and NHS services to those inhabitants;
- the provision of family health services, personal medical services, personal dental services, pharmacy and NHS ophthalmic services;
- the public health arrangements in the area;
- the planning of health services by NHS bodies, including plans made in co-operation with local authorities, setting out a strategy for improving both the health of the local population, and the provision of health care to that population;
- the plans, strategies and decisions of the Health and Wellbeing Board;
- the arrangements made by NHS bodies for consulting and involving patients and the public under the duty placed on them by Sections 242 and 244 of the NHS Act 2006;
- any matter referred to the Committee by Healthwatch under the Health and Social Act 2012;
- social care services and other related services delivered by the authority.

PART 1

IN PUBLIC

1 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

2 MINUTES OF THE PREVIOUS MEETING: 14 MARCH 2013 (Pages 1 - 20)

To agree the minutes as a true record of the meeting.

3 DECLARATIONS OF INTEREST

To receive any declarations of disclosable pecuniary interests from Members in respect of any item to be considered at the meeting.

Notes:

- In line with the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, declarations may relate to the interest of the member, or the member's spouse or civil partner, or a person with whom the member is living as husband or wife, or a person with whom the member is living as if they were civil partners and the member is aware they have the interest.
- Members need only disclose interests not currently listed on the Register of Disclosable Pecuniary Interests.
- Members must notify the Monitoring Officer of any interests disclosed at the meeting so they may be added to the Register.
- Members are reminded that they must not participate in any item where they have a disclosable pecuniary interest.

4 QUESTIONS AND PETITIONS

To receive any questions or petitions.

Notes:

1. The deadline for Member's questions is 12.00pm four working days before the meeting (28 June 2013).
2. The deadline for public questions is seven days before the meeting (27 June 2013).
3. The deadline for petitions was 14 days before the meeting, and no petitions have been received.

5 CHAIRMAN'S ORAL REPORT

The Chairman will provide the Committee with an update on recent meetings he has attended and other matters affecting the Committee.

6 BETTER SERVICES BETTER VALUE (Pages 21 - 32)

Purpose of report: Scrutiny of Services

The Committee will scrutinise options arising from the Better Services Better Value review of south west London and north Surrey healthcare

7 SURREY NHS PROVIDERS' RESPONSE TO THE FRANCIS REPORT (Pages 33 - 138)

Purpose of report: Scrutiny of Services

The main NHS providers in Surrey will provide the Committee with an overview of how their organisation has responded to the recommendations of the Francis Report.

8 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME (Pages 139 - 154)

The Committee is asked to monitor progress on the implementation of recommendations from previous meetings, and to review its Forward Work Programme.

9 DATE OF NEXT MEETING

The next meeting of the Committee will be held at 10 am on 18 September 2013.

David McNulty
Chief Executive
Published: Wednesday, 26 June 2013

MOBILE TECHNOLOGY – ACCEPTABLE USE

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- Interfere with the PA and Induction Loop systems
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Thank you for your co-operation

MINUTES of the meeting of the **HEALTH SCRUTINY COMMITTEE** held at 10.00 am on 14 March 2013 at Ashcombe Suite, County Hall, Kingston upon Thames, Surrey KT1 2DN.

These minutes are subject to confirmation by the Committee at its meeting.

Elected Members:

Mr Nick Skellett CBE (Chairman)
Dr Zully Grant-Duff (Vice-Chairman)
John V C Butcher
Bill Chapman
Dr Lynne Hack
Mr Peter Hickman
Mr Richard Walsh
Mr Alan Young

Independent Members

Borough Councillor Nicky Lee
Borough Councillor Mrs Rachel Turner

Apologies:

Mrs Caroline Nichols
Mr Colin Taylor
Borough Councillor Hugh Meares

In Attendance

10/13 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS [Item 1]

Apologies for absences were received from Hugh Meares, Caroline Nichols and Colin Taylor.

11/13 MINUTES OF THE PREVIOUS MEETING: 24 JANUARY 2013 [Item 2]

The minutes were agreed as an accurate record of the meeting.

12/13 DECLARATIONS OF INTEREST [Item 3]

No declarations

13/13 QUESTIONS AND PETITIONS [Item 4]

A question was tabled from County Councillor Will Forster.

> "I understand that about 16% of over 75s need emergency readmission to hospital within 28 days of being discharged. This number has doubled in the last 10 years.
>
> "Is the Health Scrutiny Committee aware of this? What discussion has it had with the local NHS on this issue?
>
> "Please could the Chairman tell this Council about work that is planned to lower the numbers of patients, especially elderly patients, being readmitted in Surrey?"

Comprehensive responses were received from all but two of the CCGs by the time of the meeting. These responses were tabled and are attached to these minutes as an annexe. Members were advised to read these at their leisure and any further responses would be circulated upon receipt.

14/13 CHAIRMAN'S ORAL REPORT [Item 5]

Epsom Hospital Meeting
On Friday 1 March I attended a Hospital Summit organised by Epsom & Ewell MP Chris Grayling. We discussed the future of Epsom Hospital in relation to the BSBV programme. The outcome was for a working group to be put together under the Health & Wellbeing Board to look at options for Epsom Hospital going forward.

BSBV decision delayed
You are likely to have seen the news that the BSBV board has delayed the decision on its preferred options for consultation. This is due in part to lobbying by the County Council, local MPs and councillors along with GPs and consultants in Epsom. I am glad that the BSBV team is taking time to look again at all options, avoiding a rush to a decision before the 1 April NHS restructure.

CCG Meetings
Members of the Committee and I have been meeting with the CCGs in readiness for the new NHS structures going live on 1 April. These meetings have been extremely useful to gain understanding of their priorities for the

next year and getting to know them informally. We look forward to welcoming them to our meetings next year.

Healthwatch Tender Outcome
The outcome of the Healthwatch tender has been announced. Surrey Independent Living Council, Citizens Advice Surrey and Help & Care will together be Surrey Healthwatch. The group will take on its role on 1 April and will be able to influence policy, planning and delivery of health and social care services. They will also provide information and advice to help people access and make choices about services.

The Committee thanked LINk officers and volunteers for all their hard work.

Alan Young spoke about the announcement that morning from the Health Secretary regarding the abolition of gagging clauses in NHS severance packages. The Committee agreed this was a welcome change that would bring additional transparency.

He also spoke about a report published that morning regarding the number of CCG board members that were likely to have a conflict of interest in organisations with whom the CCG would be contracting. He indicated that it would be beneficial for the Committee to look into this in future. The Chairman indicated that there would be continuing informal meetings with the CCGs and this could be monitored through these meetings.

15/13 SOUTH EAST COAST AMBULANCE (SECAMB) PERFORMANCE DEEP DIVE [Item 6]

Declarations of Interest:

None.

Witnesses:

Geraint Davies, Director of Corporate Services, SECAmb

Rob Bell, Head of Commercial Services

Lorna Stuart, Senior Operations Manager

Marion Heron, Associate Director supporting Transition, NHS Surrey

Cliff Bush, LINk Chair

Carol Pearson, Chief Executive, Surrey Coalition of Disabled People

Key Points Raised During the Discussion:

1. The Director of Corporate Services provided an overview of the service. The plan is to have three Make Ready Centres (MRCs) at Chertsey, Tongham and Merstham. There are 18 old ambulance stations being replaced by 29 patient led Ambulance Community Response Posts (ACRPs). Across the south east coast , SECAmb performance year to date is 76% of Red 1 calls responded to within eight minutes; however Surrey is just under at 74%. The target is 75%. The service faces several challenges, one of which is reducing emergency hospital admissions. SECAmb uses ‘Hear & Treat’ to try to

deal with patients over the phone when an ambulance may not be necessary. The aim is to reduce pressure on the acute hospitals.

2. Calls to the ambulance service are categorised into Red 1 and Red 2. Red 1 calls are the most critically ill patients and should have an ambulance response within eight minutes. SECAmb receives about 18 Red 1 calls a day.

3. Members queried patient satisfaction with the service. The Director of Corporate Services indicated that a patient satisfaction survey is carried out by the service and that this would be shared with the Committee. Overall, patients indicated they are satisfied with the ambulance service. Where a patient is dissatisfied, a sample of these is followed up with a telephone call. The Director of Corporate Services also indicated that, often, the primary complaint is not receiving an ambulance; however, when the rationale for not sending an ambulance was explained, patients tended to understand better and were then satisfied with the service received.

4. Members queried how the calls were categorised: for example, if a patient is having a stroke that is not severe, a road accident victim or an elderly person collapsing. Witnesses responded that this can be a grey area; however there are keywords that, if heard during the phone call, will inform the call responder to appropriately assess whether the call is a Red 1 or Red 2. Members queried the use of 'Hear & Treat' on patients: for example, someone in severe pain but it is not life threatening. Witnesses responded that, again, it is very dependent on the responses given to the key questions the responder is asking.

5. There was concern amongst Members that calls were being downgraded in rural areas in order to meet performance targets. Witnesses responded that, across Surrey the service is managed on a daily basis to serve the community, be it directly with the patient or through a healthcare professional. SECAmb are transparent on their data and recognise that rural areas do not always receive the same service as urban areas. All calls are assessed clinically, in line with the appropriate pathway, and all calls are categorised accordingly. There are strict criteria for the categorisation and the service is fully audited. SECAmb does not downgrade calls to affect performance as this would be considered fraud. There are clinical pathways that set out specific outcomes for the patient depending on the responses to key questions during the call. Each call is dealt with appropriately and can either be escalated if the situation is life-threatening or downgraded if the responses indicate the need is not life-threatening.

6. The Director of Corporate Services stressed to the Committee the effectiveness of the system. From the second a call comes in, an ambulance is despatched while the call is still ongoing. This can lead to an instance where the vehicle arrives at the address before the call has been completed. If, during the course of the phone conversation, the severity of need is deemed to be less and can either be responded to via 'Hear & Treat' or by directing the patient to other services, the ambulance may be diverted elsewhere. The system is in place to ensure that the call is triaged appropriately according to the responses being given by the patient or caller.

7. Members questioned what the demands are on the service within Surrey. Witnesses responded that it varies greatly, including seasonal demands, and that it is a challenge to ensure the best service is provided regardless of where the patient resides.

8. Members continued to query rural response times, specifically the ability to meet the eight-minute response target. Witnesses responded that vehicles are placed in strategic areas according to the predicted demand on the service. They admitted that travel distance to rural parts can be longer, possibly nine to 12 minutes. The service is keen to develop links and partnerships with other organisations and look at other ways to ensure that there is medical support sooner. The service recognises that this is a challenge and seeks the support of the community to enhance the Community First Responder Scheme. There are also new initiatives, such as public-use de-fibrillator machines in supermarkets and at train stations. The ambulance service must work within its limited resources. An exercise was carried out with its commissioners and it would take an additional £15m per year to fully resource and cover the entire 3000sqm of SECAmb's coverage area. These local schemes must therefore be improved if access for rural areas is to improve.

9. Members then asked if different response targets could be considered for rural versus urban areas. Witnesses responded that, while they agree there is room for improvement, the most important aspect is ensuring the right clinical outcomes are achieved, not simply the quickest response time. The Director of Corporate Services indicated that it would be good to see more debate around clinical outcomes for the service, such as how, by getting a cardiac patient to hospital quickly, it helped him/her to be treated and discharged, that it helped to ensure the longevity of that patient's life.

10. The Chairman indicated that it might be beneficial to consider setting different targets with commissioners, aligned to achieving the clinical outcomes. SECAmb may well be meeting their performance targets across the patch, but ensuring clinical outcomes are appropriate is vitally important and might offer a better way of measuring performance.

11. Members queried how coherent responses could be from frantic patients or family members or those for whom English is a second language. Witnesses responded that there are resources that can be called upon to assist with people who do not speak English and that the call responders are trained to treat each call with caution to ensure that it has been triaged accordingly to ensure patient safety.

12. Members queried how well-equipped ambulance teams were to lift heavier patients. Witnesses responded that all units have access to various equipment that can be used as required to ensure that a patient is lifted safely. If additional assistance is required, they can also call upon additional crew or support.

13. Members asked about the use of volunteer ambulances and whether they had the same equipment as SECAmb ambulances. Witnesses

responded that all volunteer ambulance crews are staffed and equipped to the same standard as SECAmb. They receive the same training and have the same medical knowledge and competence to enable them to respond to the patient's needs appropriately.

14. The Director of Corporate Services then provided an update on the new NHS 111 service, which went live the previous day, 13 March. He indicated that things were going well, that there had been peaks and troughs during the time he'd spent observing. The service is supporting out of hours GP cover as well. Members queried the link-up between NHS 111 and the NHS Direct service. Witnesses indicated that NHS Direct would be ceasing, that NHS 111 replaces NHS Direct. Further information on this would be provided at a future meeting. A wider advertising campaign for the new service will be coming out soon.

Recommendations:

1. SECAmb is thanked for their attendance today;

2. The Committee would welcome further information and cooperation on developing the Community First Responders Scheme and placement of de-fibrillators in rural areas, particularly on where there are areas of joint working with the local authority; and

3. The Committee would also welcome working with SECAmb on how to use clinical outcomes to continue to work to improve performance across the County.

16/13 PATIENT TRANSPORT SERVICES [Item 7]

Declarations of Interest:

None.

Witnesses:

John Furey, Cabinet Member for Environment & Transport

Geraint Davies, Director of Corporate Services, SECAmb

Rob Bell, Head of Commercial Services, SECAmb

Tracey Coventry, Transport Co-ordination Team Manager

Marion Heron, Associate Director supporting Transition, NHS Surrey

Carol Pearson, CEO, Surrey Coalition of Disabled People

Cliff Bush, Chair, LINk

Key Points Raised During the Discussion:

1. The Cabinet Member attended the meeting and gave an update on the contract. He recognised that there had been several issues with the delivery, since the contract had gone live in October 2012. One of these key issues was the transfer of G4S staff into SECAmb, assessing their skills and competence. Many had to be retrained to

ensure that they were in line with PTS and SECAmb requirements. The second issue was the age of some of the vehicles. He advised that the new vehicles had not been delivered in time but that they had begun to be rolled out in mid-February 2013. The service is now delivering 18,000 transports a month within Surrey. It was reported that 85% of journeys were on time and that 91% of patients were on the vehicle for less than one hour. There is work currently being done to ensure that the eligibility criteria are clear for all groups and there are plans to roll out the booking solution.

2. The Committee was advised that the contract had still not been signed but that it should be done within the next week, before the end of the financial year. There had been concerns regarding the Director appointed by NHS Surrey but this has now been resolved. The Cabinet Member indicated that Surrey County Council was fortunate to have such a good working relationship with SECAmb that ensured the service was delivered effectively without a contract. He indicated that SECAmb had worked closely with the Transport Coordination Centre to ensure a smooth PTS transition. He continued by saying that it was due to good will on all sides that ensured patients had not suffered and it should be acknowledged and applauded that these groups had worked together well.

3. LINk, providing a patient perspective, stated that the patient experience had not been good; however the various groups have worked together to resolve and take forward a better service for the patient.

4. SECAmb's Head of Commercial Services informed the Committee that they were seeking feedback regarding the patient experience and this will be reported back in due course.

5. Surrey's Transport Co-ordination Team Manager reported that there is a centralised booking service that had initial problems, but these have now been resolved. Patients will soon be able to access one telephone number, which will then have options for the centralised booking service or for SECAmb.

6. The Chief Executive of Surrey Coalition of Disabled People stated that the problems had arisen due to lack of clear direction and this had been disappointing. She indicated that the Cabinet Member and his team have tried to resolve the problems along the way. The Coalition is aware that there is still quite a lot to be sorted; however it looks forward to the future improvements.

7. The LINk Chair stated that it had been frustrating to all concerned. He had wished for it to be noted that some patients were missing their hospital appointments due to late arrival of transport. Obtaining these appointments is difficult and when they are missed, there is often a long wait for a new appointment.

8. NHS Surrey have recognised that there was a lot of learning for the lead individual and were hoping for improved commissioning of services in the future. She personally offered her apologies on behalf of NHS Surrey.

9. The Vice-Chairman queried assurances that there was reliable digital technology in place to ensure that all patients could access the service (i.e. deaf or hard of hearing and visually impaired patients). Witnesses responded that various media, such as SMS text, had been put in place but this can be inappropriate when attempting to answer eligibility criteria questions so other alternatives are being looked at.

10. Members queried the eligibility criteria being finalised. Witnesses responded that these were being looked at and claimed that the eligibility criteria had not changed but the questions being asked had. The service would also assist those that were ineligible by giving out details for alternative transport organisations. Many people wrongly believe they are entitled to patient transport, thinking it is an open service. It is only available to those who have a genuine medical need. The Chair of LINk indicated that there is an outstanding issue about the eligibility of an advocate or chaperone riding with the patient.

11. Members queried whether the databases were sharing information between organisations. Witnesses indicated that information is transferrable and can be easily accessed. They also said that the booking system has been designed to ensure that any additional information on specific patient needs is in place to inform PTS staff for appropriate action.

12. Members queried when the Committee Chairman or Scrutiny Officer became aware of this issue, concerned about the ability of the Committee to recognise when problems are occurring and act appropriately. The Scrutiny Officer responded that she became aware in October and November 2012 of issues around the age of the vehicles and, with the support of the Chairman, had raised this informally with SECAmb. The Vice-Chairman also indicated that she was aware of issues with the SMS number in October 2012 and, with the help of the Scrutiny Officer, had raised this with the Transport Coordination Centre and SECAmb.

Recommendations:

1. Officers from Surrey County Council, SECAmb and the Surrey Coalition of the Disabled are thanked and commended on the joint working to improve the delivery of this contract;

2. The Committee was concerned that the new PTS contract has not offered the best patient experience to date but welcomes assurances that most problems have now been dealt with and looks forward to a report back in six months by SECAmb, Surrey County Council and the Surrey Coalition of Disabled People.

17/13 LINK STROKE REHABILITATION PROJECT FINAL REPORT [Item 8]

Declarations of Interest:

None.

Witnesses:

Jane Shipp, Development Officer, LINk

James Stewart, Patient Carer, LINk

Cliff Bush, Chair, LINk

Marion Heron, Associated Director supporting Transition, NHS Surrey (representing Maggie Ioannou, Director of Nursing and Quality, NHS Surrey)

Key Points Raised During the Discussion:

1. The Chair of LINk indicated that the report had been produced by volunteers who had worked many hours to gather and compile evidence. The Development Officer indicated that they had collected many patient stories that were unfortunately similar to the carer's story.

2. Witnesses highlighted three of the recommendations in the report to be addressed. First, for the struggling carers what is offered or available is not always clear. Sometimes there is no written no care plan nor any indication of what is happening and a genuine lack of available support. The second is to work with commissioners on engaging with patients and carers to deliver the best service after leaving acute care. Finally, therapy for stroke patients after leaving hospital. When patients are in a rehab hospital, they often receive daily therapy, seven days a week, but this then drops to sometimes less than five days a week. The report also highlighted inequity of provision in the east of the County. The report recommends a review of services county-wide, ensuring that patients are receiving rehabilitation and focusing on gathering evidential stories to back up what patients' needs are.

3. The Carer thanked the Committee for allowing him to share his story and raise the systematic issues that he and his wife had faced post-stroke. He stated that their concerns had been highlighted in many of the stories. He praised the work of the volunteers and thanked the Stroke Association for their support. He also encouraged organisations to work together to ensure that the patient is the central focus. He stated that strong leadership would ensure these improvements.

4. The LINk Chair was grateful for the Carer bringing the story to his attention. There is pressure on hospitals to discharge quickly but there needs to be quantifiable investment to ensure that stroke patients are provided with relevant therapy. He mentioned that the cost of early discharge may be not cost effective in the long run due to other impositions on the patient, such as cost of long-term therapy.

5. Members questioned impartial assessments of the person undertaking the Milford Hospital visits given the volunteer's involvement with the hospital pressure group some years earlier. Witnesses advised that the individual was a volunteer and that the group had used all of the resources that were available to them at the time. The enter and view reports were shared with the providers prior to inclusion in the report, giving them an opportunity to address any issues.

6. Members queried if there was additional information regarding how post-stroke rehabilitation impacts children. Witnesses responded that there was no specific data within Surrey around post-stroke rehabilitation for children. They also advised that there are now stroke patient registers and, going forward, this information may become available. Further work is being done with the local GPs and other providers to ensure that duplication is avoided when collecting and collating stroke patient data.

7. The Development Officer stressed that the work of the volunteers was vitally important to the success of the project and report. She thanked them for their support and commitment to the project and recommended that such groups be used in future. She also thanked the Committee for providing a voice for patients.

8. The Vice-Chairman thanked LINk for the report and indicated that this was the right time to share this report with Jeremy Hunt, the Secretary of State for Health, for action to be taken going forward.

9. Members queried whether Clinical Commissioning Groups (CCGs) had been involved yet and what their response had been. Witnesses responded that the CCGs had not yet been involved but would be in future. The NHS Surrey witness assured the Committee that Stroke Services had been discussed with all Surrey CCG Directors of Nursing (DONs) as part of the Quality Assurance Process. The DONs meet monthly so NHS Surrey would ensure that the Development Officer would be invited to a future meeting to discuss the report .

10. The Chairman thanked LINk and the volunteer network and the Committee endorsed the report unanimously.

Recommendations:

1. LINk and its volunteers are thanked for bringing this issue to the attention of the Committee and for their dedication and work on this project and the production of a comprehensive report;

2. The Committee endorses the report and the development of an action plan to be passed to Healthwatch to be taken forward; and

3. The Committee will monitor Healthwatch's progress on the plan and request a report in around six month's time on this.

18/13 PERFORMANCE AND QIPP UPDATE [Item 9]

Declarations of Interest:

None.

Witnesses:

Marion Heron, Associate Director supporting Transition, NHS Surrey

Key Points Raised During the Discussion:

1. Members noted the mixed sex accommodation breaches and asked if there were any further details, specifically those at Epsom & St Helier Hospitals. The witness did not have any specific information but would be able to find out and report back via the Scrutiny Officer. The Scrutiny Officer also responded that, in the past, Epsom & St Helier had been affected by mixed sex accommodation breaches primarily at Epsom Hospital and mainly when the patient had been moved from the High Dependency Unit onto a regular ward. Nonetheless, further clarification would be sought from NHS Surrey.

2. Members also sought clarification regarding Healthcare Acquired Infection breaches within the limit and whether Epsom & St Helier hospitals had now been fined for this. The witness stated that the target had been met, meaning there had been a fine. It was noted that, from a previous conversation, this would be a £5.7m fine.

3. Members queried why Ashford & St Peter's A&E were not meeting their waiting times targets. The witness responded that Ashford & St Peter's is reviewing its A&E pathways as well as the services outside of the hospital. The CCG will be setting quality targets and reviewing the overall performance of the hospital.

4. Members queried why Frimley Park Hospital and Royal Surrey County Hospital were on amber for their A&E waiting times. Were recent events the cause for the drop in performance? The witness stated that she didn't have specific data but that there has been pressure on all acute hospitals in the last few weeks.

5. Members questioned if the provision of Health Checks had stopped. The witness indicated that, previously, targeted groups of individuals received invitations for a health check, but that this would be opened up further going forward.

6. Members questioned what the current situation was with the Jarvis Centre and other providers taking its breast cancer work. The witness indicated that Virgin Healthcare and Royal Surrey County Hospital will be managing the additional demand for the time being. The mobile units will be used for assessing and the Royal Surrey County Hospital will be used for further investigation.

7. Members sought clarification on the Improving Access to Psychological Therapies (IAPT) target of 15% but only showing as 2.4%. The witness advised that the aim of 15% is for March 2015 and that procurement is currently being reviewed by CCGs.

Recommendations:

1. The officer from NHS Surrey is thanked for attending and providing the performance information.

19/13 REVISED HEALTH SCRUTINY REGULATIONS [Item 10]

Declarations of Interest:

None.

Witnesses:

Leah O'Donovan, Scrutiny Officer

Key Points Raised During the Discussion:

1. The Scrutiny Officer updated the Committee on the key changes to regulations governing health scrutiny that had been amended and recently published.

2. Members questioned the requirement for a 20 working day response to a Healthwatch formal referral and the involvement of full Council in referring matters to the Secretary of State for Health. The Scrutiny Officer responded that the Committee would not have to consult the full Council before responding to Healthwatch and that a 'holding letter' would suffice as a response, prior to further investigations about the matter referred. Full Council will not have to endorse referrals to the Secretary of State but it may be useful for the Committee to ensure it is aware of what the Committee intends to do.

20/13 RECOMMENDATION TRACKER AND FORWARD WORK PROGRAMME [Item 11]

Declarations of Interest:

None.

Witnesses:

Leah O'Donovan, Scrutiny Officer, Democratic Services

Key Points Raised During the Discussion:

1. The Scrutiny Officer indicated that the draft work programme was suggestions for the next year and was available for members to review at their leisure and comment on outside of the meeting.

2. Member thanked the Chairman for all of his hard work and showing excellent leadership for the group. Members also thanked the Scrutiny Officer for her support for the Committee.

21/13 DATE OF NEXT MEETING [Item 12]

Noted that the next meeting of the Committee would be held on 4 July 2013.

Meeting ended at: 12.55 pm

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Chairman

Health Scrutiny Committee
Members Questions
14 March 2013

Q. I understand that about 16% of over 75s need emergency readmission to hospital within 28 days of being discharged. This number has doubled in the last 10 years.

Is the Health Scrutiny Committee aware of this? What discussion has it had with the local NHS on this issue?

Please could the Chairman tell this Council about work that is planned to lower the numbers of patients, especially elderly patients, being readmitted in Surrey?

Will Forster, County Councillor

A. The Health Scrutiny Committee is keenly aware of the issue of hospital readmissions for the frail/elderly. The issue of readmissions stems from a national issue of frail/elderly hospital admissions that are often unnecessary. Care for frail/elderly is often much better delivered in the community, rather than in an acute hospital setting.

In the last year, the Committee has had several formal committee items related to the prevention of unnecessary hospital admissions, particularly in the frail/elderly. The most relevant of these was on the development of what is known as Virtual Wards. A Virtual Ward involves the identification of patients at each GP surgery that are most at risk of a hospital admission. These individuals are placed in a 'virtual ward' and have their care managed by a Community Matron while they remain at home. This care can involve visits from community nurses, social care and GPs. It is very much a multi-disciplinary care management pathway, to enable the person to remain in his/her home while being cared for in a way that would have required hospital admission in the past.

Across Surrey there are Local Transformation Boards aligned to the acute hospitals and the local health economy which have multi-stakeholder membership. The Boards consist of Chief Officers and Directors responsible for the delivery of care, working alongside commissioners to ensure that the right services are developed for the patients in each area.

The Member may be aware of the restructure of the NHS and the plans for new Clinical Commissioning Groups to take over commissioning responsibilities from 1 April. Each CCG is developing its own plans for the next year and many include priorities to reduce the number of hospital admissions, and therefore readmissions, in the frail/elderly population. Each CCG has been contacted regarding their plans in this area and the following responses have so far been received. Northeast Hampshire & Farnham CCG has indicated they will be sending information through but were unable to meet the deadline for the 14 March meeting. This information, along with that from any other CCGs not able to respond at this point in time will be passed on to the Member upon receipt. The Committee will continue to work with all CCGs on their plans to address this issue.

East Surrey CCG

East Surrey has provided investment in their community provider to ensure it has the resources in place to support the care of patients. In October 2011 First Community Health and Care (FCH&C) received further investment of £900k. This was to provide increased staffing for a rapid assessment clinic at Caterham Dene Community Hospital, ward staffing and community nurses. The services have been set up to respond to patients with complex needs, caring for them effectively in the community rather than resulting in a secondary care admission. The pathways were designed in conjunction with the acute provider to ensure they were supportive of the pathways.

The CCG uses Docobo, which is a Risk Stratification Tool. The CCG have invested in a software tool that compares both primary and secondary care data to highlight those patients requiring a higher level of care. The tool has been installed at all the GP practices.

Finally, the CCG has a Proactive Care Team (Virtual Ward). Following further investment in FCH&C in October 2012, it is working with the GP Practices and community provider to implement proactive case management of patients. This will allow the health and social care system to provide care to patients before a crisis occurs, working with a multi-disciplinary approach to deliver to the patients needs. This work will also include improved support to nursing/care homes.

North West Surrey

The CCG has a unplanned care programme designed to reduce emergency admissions in the over 75's. The CCG is working with partner organisations to develop a frail elderly pathway to improve the care of the older person. The aim of the pathway is to proactively support people in their own homes and when a hospital admission is required to rapidly assess and treat the older person and discharge them back to their own home with the required health and social care support. We know that the longer an older person stays in hospital the more likely they are to decompensate hence rapid assessment, treatment and supported discharge.

The CCG is also focusing on providing support to care homes (Nursing and residential homes) to ensure the older person is cared for as long as possible in their usual place of residence.

The virtual ward has successfully reduced admissions for the older person particularly those living with one or more long term conditions the virtual wards will continue and will be developed further over the next year with the introduction of tele-health to support more people at home.

The CCG is also working with primary and community services to improve identifying those patients who are approaching the end of their life to ensure that a care plan is put in place to support the older person die in their preferred place of death with a supportive package to meet their needs and that of their carers. We know that a person approaching the end of their life have on average 3.5 hospital admissions in their last year of life if those who are approaching their end of life not identified and care plans and packages of support are not put in place.

Clinical commissioners and secondary care clinicians are developing other clinical pathways to avoid a hospital admission where this is clinically safe and appropriate.

Surrey Downs

Surrey Downs CCG has provided a comprehensive briefing on its plans, which is attached to this as an annexe.

Surrey Heath

Surrey Heath has the following projects aimed at reducing hospital admissions

- Virtual wards
- Carer support
- Nursing home projects
- Risk stratification and proactive care
- Dementia diagnosis and early intervention
- 111 Directory of Service
- End of life registers

The Committee thanks the member for raising this issue. It will remain a priority scrutiny area for the Committee's work programme going forward.

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Briefing for: Surrey Health Scrutiny Committee

Subject: Preventing avoidable emergency readmissions for over-75s

Date: 13 March 2013

Request

The Committee has requested information on Surrey Downs CCG's plans to reduce the number of emergency readmissions for people over the age of 75 years living in the local area. This follows a question the Committee has received from one of its members who has enquiried about the plans in place to address this across all Surrey CCGs.

Background

From 1 April 2013 Surrey Downs Clinical Commissioning Group will become the statutory organisation responsible for commissioning healthcare for the patients living in the Surrey Downs area. This includes the boroughs of Epsom and Ewell, Mole Valley, the eastern part of Elmbridge, as well as Banstead and surrounding areas.

Over the past few months local clinicians have engaged with key stakeholders and local people to lead the development of the CCG's commissioning intentions for 2013/14.

Improving care for the frail and elderly, which includes reducing unnecessary hospital admissions, is one of seven key priorities for Surrey Downs.

Work is already underway on a range of initiatives to reduce unplanned admission and readmission rates among older people. These include the introduction of a new community contract and the expansion of virtual wards, collaborative working to support frail and elderly patients in the local area, an initiative to enhance dementia care and plans to deliver improved end of life care.

These initiatives, and the work already underway to reduce unnecessary hospital admissions in the Surrey Downs area is summarised below.

New community contract and the introduction of virtual wards

As an emerging CCG, one of our first areas of work was the re-procurement of the community services contract for the area as the current contract had run its course. Clinicians in Surrey Downs CCG led this process and welcomed the opportunity to develop a new service specification that would improve care and ensure local health needs are being met, including those of older people.

The new community contract, which commenced on 1 February 2013 with Central Surrey Health included the introduction of a new integrated model of care which will help ensure frail and older people get the care they need, when they need it. The contract includes the expansion of virtual wards in the Surrey Downs area. It also places a greater emphasis on identifying those who need help earlier and supporting older patients to manage their health conditions in the community, with the right help.

Virtual wards are managed by GP practices and supported by Central Surrey Health who provide case management support to patients with long-term conditions or other co-morbidities. Many of the patients referred into this service are over the age of 75 years.

The virtual wards are supported by Integrated Community Teams, which operate in each area and have a single point of access for elective referrals, rehabilitation services and urgent care rapid response services. Further support is provided through an integrated mental health service provided by Surrey and Borders Partnership NHS Trust.

Through virtual wards GPs are able to manage more patients in the community by making sure they have the right level of support to help manage their conditions at home and in the community.

As a result of virtual wards we are already seeing a reduction in preventable unplanned admissions. In view of this, plans are already in place to extend this service and increase its capacity so that from 2013/14 1,000 local patients can benefit. This will enable us to further reduce unplanned admission and readmission rates for these patients.

Supporting older people and the frail and elderly

With an ageing population, and more people living with long-term health conditions, ensuring the right care is available in the community is a key priority for Surrey Downs CCG.

Working with Kingston Hospital Trust, social care colleagues from both Surrey and London, and other local commissioners, local clinicians have already put plans in place that will improve care for patients in the East Elmbridge area.

Working together, clinicians have developed a shared vision that focuses on delivering the right care in the right place at the right time through a fully integrated and patient-centred care pathway. The organisations are also working differently to reduce duplication of services and ensure closer working between all agencies, including better sharing of information.

Following a successful grant from the King’s Fund, and with the support of Surrey Council Council, clinicians have mapped the range of services available for frail and older patients that are referred into Kingston Hospital and have already starting working on a number of joint initiatives. This includes opportunities for jointly commissioning older patient psychiatric liaison services and agreeing joint processes and standards of care across health, social care, the voluntary sector and in

residential homes.

Clinicians have also established a Whole Systems Transformation Group involving providers and commssioners in the Kingston and East Elmbridge area that will focus on the frail elderly and access to urgent care. As a result of this group, a joint commissioning quality target has been established with community services, Kingston Hospital and social services to incentivise providers to work together to deliver a reduction in re-admissions in the frail elderly group over the next year.

Furthermore, following on from this work a co-operative working arrangement is now in place between A&E consultants/therapy staff and community nursing staff that enables patients in the Elmbridge area to be discharged directly into the virtual ward or community hospitals if there is a risk of readmission.

Following the success of this initiative, these principles are being applied across other areas of the CCG, where similar improvements are being made for the benefit of local patients.

Improving care for people living with dementia

In Surrey Downs clinicians are leading a major programme of work to improve early diagnosis and support for people living with dementia.

Using funding secured through the national Dementia Challenge Fund, Surrey Downs Clinical Commissioning Group is working with NHS and community partners on two projects that focus on making sure dementia patients get the care they need.

With a focus on early detection and diagnosis of dementia, the first project aims to help reduce unplanned hospital admissions and improve dementia care by making sure patients have the support they need at home or in the community.

Based on similar initiatives that have delivered improved dementia care in other parts of the country, we are introducing a team of new community-based specialist nurses. Working closely with mental health and community colleagues, their role will focus on diagnosing dementia earlier and closer integration of services to make sure services are joined up and patients get the level of support they need.

Partnership working will be key and we are working closely with Surrey and Borders Partnership NHS Foundation Trust, Central Surrey Health, Princess Alice Hospice, Alzheimer’s Society and Carers Support so that together we can improve dementia care for local patients.

Enhancing end of life care

Working with local care homes, we want to ensure patients receive the best possible care at the end of their life. We also want to make sure their wishes are respected. To achieve this we will be recruiting an End of Life Care Facilitator who will be a single point of contact for care homes, offering education, support and advice to homes to help them reach the highest standards of care (known as the Gold

Standards Framework).

Recognising the crucial role of carers at this sad time, we will also be supporting carers to make sure they are looking after their own health and well-being and receiving the advice and support they need.

Through more co-ordinated care and better support in the community, this area of work will enable us to further reduce the number of older patients who are admitted or readmitted to hospital as part of an unplanned attendance for people who are in the last stages of their life.

SURREY
COUNTY COUNCIL

Health Scrutiny Committee
4 July 2013

Better Services Better Value

Purpose of the report: Scrutiny of Services

The Committee will scrutinise options arising from the Better Services Better Value review of south west London and north Surrey healthcare.

Summary:

1. The Better Services Better Value (BSBV) programme is a large-scale review of the healthcare service provision in south west London and north Surrey. Those areas involved include the London boroughs of Richmond, Kingston, Merton, Sutton, Wandsworth and Croydon and Surrey.

2. This review encompasses Epsom Hospital, as it forms the Epsom & St Helier Hospitals NHS Trust. Epsom & St Helier Hospitals is a London trust, despite Epsom Hospital being physically located within Surrey boundaries.

3. The programme has been ongoing for some time and has recently published options for hospital reconfiguration that will be taken for consultation. The consultation is expected to begin in autumn 2013.

4. Each of the proposed options for reconfiguration will represent major change for Epsom Hospital and its current catchment area. It is therefore vitally important that the Health Scrutiny Committee comment on these proposals at the earliest opportunity and make its own response to the consultation when it begins.

5. It should be noted that the programme is also subject to a Joint Health Overview & Scrutiny Committee made up of representatives from the six London boroughs and Surrey County Council. This joint committee has a remit for scrutinising the programme in full, including the power to refer decisions to the Secretary of State under health scrutiny regulations.

6. Representatives from BSBV and the relevant Surrey Clinical Commissioning Group, Surrey Downs CCG, will be in attendance at the meeting to present the proposed options and answer questions.

Recommendations:

7. The Committee is recommended to scrutinise the proposed options for consultation.

Next steps:

The consultation on the proposed options is expected to begin in autumn 2013.

Report contact: Leah O'Donovan, Scrutiny Officer, Democratic Services

Contact details: 020 8541 7030; leah.odonovan@surreycc.gov.uk

Sources/background papers: None

Report to Surrey Health Scrutiny Committee on the *Better Services, Better Value* (BSBV) Programme

4th July 2013

1. Introduction and Programme Update

Drivers for Surreys' inclusion in Better Services, Better Value have previously been discussed with the Overview and Scrutiny Committee and related to the halting of the transaction with Ashford and St Peters NHS Foundation Trust and the knowledge that the majority of Surrey Downs patients' hospital activity flowed into services in designated London lead providers including Epsom. Following the widening of the scope of the review to include Epsom Hospital, there has been extensive involvement of Surrey Downs and Epsom Hospital clinicians. There has also been considerable engagement activity in the area to explore the case for change in health service provision with the general public and stakeholders. The programme clinical working groups were reconvened and include membership from Epsom Hospital and GPs from Surrey Downs Clinical Commissioning Group. This report is provided following the full and necessary inclusion of Surrey Downs and Epsom in the BSBV process.

A full list of the engagement events is attached as Appendix A. The aim of these meetings was to set out the clinical and financial drivers for making such large-scale changes to health services, describe the vision of the seven CCG's leading BSBV, explain what the impact on local patients would be if the proposals were to go ahead and listened to views and concerns raised in relation them. More recently a number of meetings have been held to discuss and develop the proposed consultation plan and to seek advice about how this should best be tailored to meet local needs.

This report provides a summary of the case for change and of the clinical recommendations that have been developed in response to the problems identified, an outline of the options appraisal process and a description of the options proposed for consultation. It describes what these proposals mean for local people, including the impact in terms of additional travel times and sets out the next steps for decision making.

2. Why are these changes being proposed?

The NHS cannot stay the way it is – we need to change

- Our communities, the way we live and the type of healthcare we all want are constantly changing, yet the way we provide health services has largely stayed the same for 30-40 years
- The safety and clinical quality of services at your local hospital depends on what day of the week it is, what time of day or night it is, and which hospital you go to
- When we are very sick or need emergency care, it is important that the most senior, experienced and specialist staff are on hand at the hospital. We need access to some essential clinicians and diagnostics 24 hours a day, seven days a week
- To achieve this we need to concentrate teams of highly trained professionals at fewer hospitals to make services safer and better

- We need to provide more services in the community. In particular, provide preventative and supportive care to people with long term conditions so they are healthier and less likely to be admitted to hospital

We want to save more lives and deliver better services

- We are failing to meet London Quality Standards (which apply to Epsom Hospital as it is part of a London trust) and Royal College guidelines. London Quality Standards are clear that the most senior, experienced and specialist doctors and nurses should be available at weekends as well as during the week. This is not the case in all our hospitals at the moment
- Maternity units should have the most senior, experienced and specialist staff available on labour wards 24 hours a day, during the week and at weekends, in case mothers or babies get into difficulties during the birth and need emergency medical help
- We can provide better quality care by carrying out routine inpatient operations in separate dedicated facilities. We want to do this for all, except the most complex, inpatient surgery and plan to establish a state of the art facility in south west London and Surrey for inpatient planned surgery
- We need to change the way we provide health services to respond to this and improve the quality and safety of care. We do not believe we can guarantee the highest quality of care with the way our services are currently organised.

There are opportunities to respond to continuing improvements in healthcare to save people's lives

- Advances in technology and treatments continue to revolutionise healthcare. A knock-on effect of these advances is the increasing need for specialist staff
- It is becoming difficult for every hospital to have every type of specialist staff, and even if they did, there would not be enough patients at each hospital to treat to maintain their expertise
- To ensure specialist staff treat enough patients to maintain their skills, we need to centralise services
- To offer access to essential diagnostic support 24 hours a day
- We have already done this in London for the treatment of heart attacks, stroke, cancer and major trauma with designated centres for each of these. Survival rates are now much higher as a result

Better financial outcomes can be delivered by reorganising healthcare services

- Value for money plays a part in Better Services, Better Value, but firstly it is about saving lives and raising standards of care
- Funding has not been cut, we just need to spend it differently to cope with rising demand. The demand for services is rising because the population is growing and many people are living longer, often with long-term conditions
- 50% of people who use our A&E departments could be treated more appropriately , more quickly and at lower cost to the NHS in an urgent care centre
- People with long-term conditions could be treated in the community and in their own homes.
- This should stop them from becoming sicker and needing to be admitted to hospital. This is good for patients who are more likely to be kept well and at home, and it saves the NHS the cost of emergency hospital admissions and long stays in hospital wards

No change is not an option

- There are not enough qualified, senior people in training, so we would not be able to recruit additional senior staff required across the five sites to meet the recommended clinical standards
- If these trainees did exist, we could not afford the extra staff required
- We would not be able to meet the standards of care and safety that are being introduced in other London hospitals (London Quality Standards), meaning our patients would receive a service that was not as good as those being developed elsewhere in London hospitals

- We would overspend our budget to the point where our services would reach crisis point in the next few years as we would not be able to deliver services cost-effectively
- We would not be able to invest as much money in services outside hospital to support people with long term conditions and deliver better care in GP surgeries, community settings and in people's homes

The benefits of reconfiguration

- For patients travelling to London providers more patients would receive improved quality of care and get the best health outcomes first time around, therefore reducing the need for further treatment or hospital readmission.
- Discussions with Surrey hospital providers will work to drive up quality standards. Surrey patients will either receive equivalent or higher standards than they currently achieve from Epsom Hospital.
- There would be more investment in GP and community services to deliver out of hospital care
- We would have the required number of experienced and specialist staff on hand at the hospitals and provide the necessary training to ensure skills are maintained – the financial savings from reconfiguration would help us to meet quality Standards for best practice clinical care
- The reconfiguration would improve the finances of local hospitals, making them financially viable for the future, this would include additional funding for activity expected to transfer to Surrey hospitals alongside local agreements on raising quality standards.
- The four London hospital trusts as a whole, and the all NHS community service providers, would be able to afford to provide the necessary health services for the population within the available NHS budget
- Reconfiguration would improve hospital infrastructure, with between £200-£300 million being invested in existing hospital facilities plus up to a further £51m investment in Surrey Hospitals
- These proposals would be better value primarily because they would ensure the best possible NHS services for all local people.

Patients and clinicians have developed and shaped these proposals

- The review has been clinically led by over 100 doctors, nurses, midwives and other clinicians from south west London and Epsom and surrounding areas, organised into six clinical working groups
- A Patient and Public Advisory Group was set up with members from all geographical areas impacted by BSBV. Patient representatives and the group have met throughout the review, helping us to steer the programme in the right direction and ensuring we engaged properly with local people
- We have talked to local people, communities, staff and others with an interest, including local authorities and the voluntary sector. We have attended over 100 meetings with local people
- Patients and clinicians have been involved in influencing and developing the proposals through clinical working groups, the Patient and Public Advisory Group and meetings with local people and online surveys

3. The clinical recommendations

These cover the services in the BSBV area, Surrey impacts are further explored in section 6

- Services remain at all five hospital sites in the BSBV review namely St George's, Kingston, Croydon, Epsom and St HelierMore and better services outside hospital, including in GP surgeries, community health settings and at home Three expanded emergency departments. Two hospitals would no longer provide emergency care. All five hospitals to continue to provide urgent care
- Three expanded maternity units led by consultant obstetricians with co-located midwifery led units. Two hospitals would no longer provide obstetric-led maternity units

- A separate, stand-alone, midwife-led birthing unit for women with low risk pregnancies, at a hospital that no longer provides obstetric-led maternity services, if public support and affordable for the local NHS
- A network of children's services with St George's Hospital at its centre. This would include inpatient beds, children's A&E and children's short stay units at the three hospitals with emergency services. Two hospitals would no longer have an A&E or inpatient beds for children
- A planned care centre for all inpatient surgery, except the most complex, on a separate site from emergency care, meaning that planned operations are not disrupted or delayed by emergencies

4. Process for agreeing options for consultation

By March of this year, the list of all potential options for configuring services had been generated using recommendations from our Clinical Strategy Group. We had a carefully structured, five-stage process for undertaking the option appraisal

- **Development of non-financial criteria and options**

Online survey and three large events held in January 2012 to get public input. Clinicians and patient representatives were brought together to decide how each factor should be weighted. When Epsom Hospital was included, a large-scale event was organised at Epsom racecourse.

- **Financial 'hurdle' to rule out options that would not work financially**

Financial assessment of all available options was carried out by a specialist team of financial experts and agreed by the directors of finance from each trust

- **Non-financial assessment**

Remaining options were assessed by an expert NHS panel, who worked with a data pack containing information relevant to the assessment of each of the options against the non-financial criteria

- **Financial assessment**

Remaining options were assessed financially by our specialist team of financial experts and accountants and agreed by the hospital directors of finance

- **Recommendation by the Better Services, Better Value Programme Board**

Our Clinical Strategy Group and Programme Board looked at the outcomes and held further discussions about the best way to shape services in the future

5. Options for Consultation

These five steps resulted in three options proposed for public consultation. These are as follows:

The preferred option

- St George's is a major acute teaching hospital
- Kingston and Croydon are major acute hospitals
- Epsom is a local hospital with a planned care centre
- St Helier is a local hospital

This option is preferred as it scored the highest on the financial and non-financial criteria. It also plays to the strengths of Epsom's existing estate and capability by locating an expanded elective centre there, and has a relatively low capital cost which is reflected in the high financial appraisal score.

The alternative option

- St George's is a major acute teaching hospital
- Kingston and Croydon are major acute hospitals

- St Helier is a local hospital with a planned care centre
- Epsom is a local hospital

This option scored lower than the preferred option in the overall financial and non-financial appraisal and slightly lower than the least preferred option. The main reason for this is the that it would require a significant additional capital investment of approximately £100m, as a consequence of building a new elective care centre at St Helier as opposed to expanding the existing one at Epsom. Despite this, it faces considerably fewer delivery challenges than the least preferred option and as a consequence, is assessed as the next preferred option.

The least-preferred option

- St George's is a major acute teaching hospital
- Kingston and St Helier are major acute hospitals
- Epsom is a local hospital with a planned care centre
- Croydon is a local hospital

This option scored lower than the preferred option but slightly higher than the alternative option in the overall financial and non-financial appraisal. However, this option would be the least preferred as it would have a high level of associated delivery risks. These risks are primarily associated with the loss of emergency and maternity services from Croydon resulting in a considerable flow of patients to Kings College Hospital, who have expressed concerns about their ability to accommodate the increase in activity. This option would also incur the highest estimated capital costs.

6. What does this mean for local people ?

For all options:

- It is expected that around 80% of the patient attendances would still be at Epsom Hospital
- Epsom Hospital would become a local hospital that ensured the majority of people could continue to access urgent care services, diagnostics, outpatients and day surgery. It would have an urgent care centre instead of its current A&E and it would no longer have a full maternity unitThe urgent care centre which would continue to treat patients (including children 0-19 years) with minor injuries or illnesses, such as broken bones, bites, infections, sprains and wounds
- Through our out of hospital strategy we will be proposing an expanded set of community services and considering more flexible access to beds in the community to prevent admission to hospital and enable earlier discharge.
- Under the preferred option, Epsom Hospital would have a planned care centre
- Investment in community services, and providing more healthcare closer to people's homes, has already started and this will continue
- We know from the extensive travel study work undertaken that a significant number of Surrey patients will transfer to Surrey Hospitals should these proposals be supported. Surrey Downs CCG will work with other Surrey commissioners and Surrey Hospitals to ensure that the quality standards are driven to give continuous improvement. The CCG plans to only commission services from hospitals evidencing the most essential standards and we will seek to agree a phased introduction of a shared quality approach across Surrey. The CCG will need to ensure that services to which patients transfer are either of equivalent or higher quality before any changes are implemented.

Investing in Surrey hospitals

- We are committed to raising standards of care for all our patients and our other Surrey hospitals are working to utilise the funding transferred with activity to achieve this
- The CCG is considering the appropriate approach to take in regard to Royal College and other standards with Surrey providers and commissioning colleagues

Expected impact on travel times

Although travel times to the nearest major acute hospital will increase for those affected, all residents in these areas should be able to reach a major acute hospital within:

- 25 minutes by car
- 100 minutes by public transport (99% of the population within 60 minutes)
- 20 minutes by blue-light ambulance

There will be no change in travel times for outpatients, primary care or day surgery and access to Urgent Care Centres will be the same as for A&Es currently.

The table below estimates the likely catchment populations affected by the travel time changes under the preferred option. The main affected areas are around Carshalton, Epsom, Ewell, Banstead and Leatherhead. Services are however only used by a proportion this population at any time.

Private transport – population catchments affected

Increase in travel time	Minutes				
	0-5	5-10	10-15	15-20	20-25
Private car peak times for the preferred option	176k	130k	145k	24k	6k
Private car at inter peak times for the preferred option	208k	198k	72k	11k	0

Public transport - population catchments affected

Increase in travel time	Minutes			
	n/a	0-20	20-40	40 - 60
Public transport for peak times for the preferred option	n/a	378k	131k	0
Public transport for inter peak times for the preferred option	n/a	384k	124k	4k

Using activity we can get closer to the actual number of patients affected. This will happen in the next iteration of the impact assessment.

There is extensive further information available on travel times and the full business available at http://www.bsbv.swlondon.nhs.uk/document-library/

We are undertaking further work on the equality impact assessment to understand these impacts on the nine protected groups and on any residents in the more deprived areas.

The Clinical Working Groups have reviewed the maximum travel times and deemed these reasonable for urgent care to be accessed and not compromising patient outcomes. The South East Ambulance NHS Trust has been involved in discussions on BSBV and we continue to work with them to use their extensive data sources to test our proposals and quantify impacts. It is understood that consideration would need to be given to any additional resources reconfiguration required of the Ambulance Trust and this would be covered in any final decision making Business case.

7. Development of out of hospital services in Surrey downs

Surrey Downs CCG is developing a wide range of initiatives to reduce dependence on hospital care and provide services closer to home. The priorities for Surrey Downs CCG's out of hospital programme which are currently under consideration include:

- Development of a Clinical Assessment Service (CAS) to reduce outpatient appointments
- Use of Virtual Wards, supported by risk stratification, to reduce non-elective admissions by targeting medium risk patients. These will be run by Central Surrey Health who will also provide rapid response, a clinical assessment unit (CAU) based at Leatherhead Hospital, and step-up beds at Leatherhead Hospital.
- Use of a Virtual Ward Plus model which will look after high-risk patients which will, in addition to the virtual ward, include End Of Life home care.
- Surrey Downs' Community Hospitals (Dorking, Leatherhead, New Epsom & Ewell, Molesey) will provide step-down beds for patients on the discharge pathway, reducing the need for excess bed days at acute hospitals and improving care for patients requiring rehab. This service will also be supported by an integrated rehab service (IRS).
- Surrey Downs will open an Urgent Care Centre at Epsom Hospital which should be able to provide care for more than half of the current A&E activity
- Continue to work with 'out-of-hospital' private providers such as EDICS, Epsomedical and Dorking Healthcare to provide outpatient appointments and procedures in settings closer to home.
- Primary care will support many of these initiatives and will also offer same day access appointments and out-of-hours services for patients to reduce the need for A&E attendances

8. What happens next?

The governing bodies of the seven CCG's leading BSBV have all met to review and discuss the proposals put forward by the programme Surrey Downs Governing Body met on the 17th May to consider the pre-consultation business case and agreed to nominate three members of the Governing Body to represent the CCG at a meeting, held in common with other CCG committees, to make a final decision on whether or not to progress to public consultation.

It was originally planned that this meeting would take place at the end of June. NHS England has asked us to look once more at the finances to give absolute assurance before the programme progresses to the next stage. We have also listened to the concerns of stakeholders and MPs that we should not consult with the public over the summer, when people are often away. We want to make sure that local people are able to take part in the consultation. Given the further work to be done, the Local Committee of CCGs is now expected to meet after the summer to plan the next steps.

9. Plans for Consultation

The BSBV communications team has developed the consultation plan with local Overview and Scrutiny Panels, Ipsos Mori, the Consultation Institute and the Patient and Public Advisory Group.

In Surrey Downs, in addition to continued engagement with programme stakeholders, there will be a series of public events to include:

- 5 x large-scale, deliberative public events
- 50+ local sessions with local community groups, including work on local estates
- Telephone interviews with residents living in areas of high deprivation
- 15 focus groups, with populations with protected characteristics
- 14 x road shows in Surrey (details may vary):
    - Epsom and Ewell: Ashley Shopping Centre; Epsom Hospital, Stoneleigh High St; Sainsbury's Kiln lane;
    - Reigate and Banstead: Burgh Heath ASDA; Horse Shoe Day Centre; Civic Centre
    - Mole Valley: Dorking Halls; Dorking Station; Leatherhead Town Centre
    - Elmbridge: Oxshott Station; Civic Centre; Sainbury's Cobham.
- 1 x health and equality forum

These plans have been already been discussed and supported by a number of Surrey Councillors. However, we would welcome any further comments and advice from members about how we can best ensure that we get feedback on the BSBV proposals from as many Sutton residents as possible.

Miles Freeman

Chief Operating Officer – Surrey Downs CCG

Appendix A – BSBV engagement meetings in Surrey

Name of meeting	Date	BSBV Attendees
Voluntary Action Mid-Surrey	19/03/2013	Jill Mulelly
Surrey Coalition of Disabled People	26/03/2013	Jill Mulelly Miles Freeman
Surrey Minority Ethnic Forum	08/04/2013	Jill Mulelly
Reigate and Banstead Council members	11/04/2013	Miles Freeman and Steve Loveless
Meeting with David McNutley (Surrey County Council)	22/04/2013	Miles Freeman & Charlotte Joll
Action for Carers (Surrey)	24/04/2013	Jill Mulelly
Epsom & Ewell Borough Council with Reigate & Banstead Borough Council (Joint)	08/05/2013	Rachel Tyndall
Mid Surrey Empowerment Board meeting	13/05/2013	Jill Mulelly Miles Freeman
Meeting with Surrey Councillors • Bill Chapman - Surrey Heath (member of HSC) • Nick Skellet - Tandridge (Chairman of HSC) • Bob Gardner - Regiate & Banstead	14/05/2013	Antonio Weiss/Toby Hyde/Stephen Hickey To discuss travel times
Ashtead Residents Association	14/05/2013	Dr Agatha Nortley-Meshe/ Dr Simon Williams
Meeting with Mole Valley County Council	29/05/2013	Miles Freeman/Rachel Tyndall

Meeting with Mole Valley County Council (Chris Townsend)	11/06/2013	Miles Freeman/Rachel Tyndall
Meeting with Surrey JHOSC Counsellors - Cllr Bill Chapman and Cllr Bob Gardner To discuss Surrey consultation plans	12/06/13	Alicia O'Donnell-Smith Jill Mulelly
Surrey Health & Wellbeing Board	13/06/2013	Sarah Tunkel and Dr Clare Fuller

Health Scrutiny Committee
4 July 2013

Surrey NHS Providers' Response to Francis Report

Purpose of the report: Scrutiny of Services

The main NHS providers in Surrey will provide the Committee with an overview of how their organisation has responded to the recommendations of the Francis Report.

Introduction

1. The Francis Report, published in February 2013, was the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Inquiry was chaired by Robert Francis QC. Attached at **Annexe 1** is a summary briefing of the report.

2. The Inquiry was set up to examine the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The purpose of the Inquiry was to look at why serious problems at the Trust were not identified and acted on sooner and to identify important lessons to be learned for the future.

Implications for NHS providers

3. The final report made 290 recommendations, the majority of which relate to patient care. The concern is that, with many other inquiry reports, the recommendations will initially be welcomed but then implementation will be slow or non-existent. The report makes it clear that this should not happen. The report therefore recommends that:

   - All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
   - 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

4. It is important for the Health Scrutiny Committee to be aware of the responses and plans of the NHS providers and commissioners in Surrey.

5. This will be a two-stage process. The first invited responses are from the major NHS providers: acute hospitals, mental health trust and ambulance trust. Each organisation has been requested to send through their response and any action plan in relation to the recommendations in the Francis Report. Their papers are attached as **Annexes 2-8**.

6. Later in the year, it is recommended that the Committee invite the new Clinical Commissioning Groups to send their responses and plans as commissioners.

Implications for the Health Scrutiny Committee

7. The report looked across the entire spectrum of those involved with Mid Staffordshire Hospital, including the local scrutiny bodies: Stafford Borough Overview & Scrutiny Committee and the Staffordshire County Council Health Scrutiny Committee.

8. Robert Francis was no less critical of the role that local scrutiny committees play in monitoring quality of care from the providers they have a remit for scrutinising.

9. Attached at **Annexe 9** is a summary of the involvement of the local scrutiny bodies in Staffordshire and the arising implications for Surrey's Health Scrutiny Committee going forward. The Committee should not rely solely on providers to monitor quality; it too has a role and it will need to ensure that it uses this going forward.

Recommendations:

10. The Committee is recommended to scrutinise the responses and plans related to the Francis Report of NHS providers in Surrey.

11. The Committee is recommended to put on its Work Programme a future item on commissioners' responses to the Francis Report.

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Sources/background papers:
Francis Report: www.midstaffspublicinquiry.com

Francis Report

Fault lies with Trust Board that didn't listen to patients or staff but also the whole of the NHS system. There is a system of "checks and balances...a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies" that should have worked together to identify poor care but for years this just did not happen.

Reasons include:

- Culture of focus on business not patients
- More weight on positive information about the service rather than to information that shows something wrong
- Measuring compliance didn't focus on the effect on patients
- High tolerance of poor care and risk
- Failure of communication between agencies
- Assuming monitoring was someone else's job
- Failure to tackle challenge of building a positive culture
- Failure to appreciate loss of experience through repeated reorganisations

Essential recommendations:

- Foster a culture where the patient is put first
- Develop standards that everyone – even the public – can understand and which a breach of will not be tolerated
- Provide compliance standards that are evidence-based and able to be understood and adopted by all staff
- Ensure openness, transparency and candour throughout the system
- Ensure the healthcare regulator focuses on ensuring compliance with the standards
- Make providers accountable and protect the public from those not fit to provide
- Make senior managers and leaders accountable
- Enhance recruitment, education, training and support to all those that provide healthcare, but especially nurses and those in leadership positions
- Develop and share standards that are always being improved with everyone – patients, public, professionals, providers, etc.

Background

The first inquiry heard personal stories about poor care, such as:

- Patients left in soiled bed clothes
- No assistance for patients needing help to eat

- Water out of reach
- Patients not helped with toileting despite requests to do so
- Wards and toilets extremely dirty
- Privacy and dignity denied – even in death
- Triage in A&E done by untrained staff
- Staff treated patients and fellow staff with “callous indifference”

Another key issue was the role of external organisations, including the local HOSC, in failing to recognise that the Trust was having problems. The Terms of Reference for the second review included examining the involvement of the numerous agencies.

Recommendations

There are 290 recommendations. The concern is that, with many other inquiry reports, the recommendations will initially be welcomed but then implementation will be slow or non-existent. The report makes it clear that this should not happen with these recommendations.

The report recommends that:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
- 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;
- In addition to taking such steps for itself, the 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;
- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

Summary of Findings

1. Warning signs
During both inquiries there was a constant argument from managers, leaders, regulators, etc that nothing of concern had ever been drawn to their attention. The inquiry found that, on the contrary, the following events could easily have been taken as a sign that all was not well at the Trust:

- Lost of star rating – from three stars to zero. Causes included failure to meet

targets for elective surgery, outpatient waiting times, cancer waiting times and financial performance, of which the SHA was aware. A recovery plan was agreed but the SHA was not overly concerned, thinking the main problem was poor record-keeping.

- Peer reviews – several reviews during 2005 and 2006 identified a number of concerns, some serious, with the Trust's ability to deliver safe care and raised questions about management capability. The issue is that it would appear no one was responsible for following up on peer review reports.
- Healthcare Commission (HCC) – an October 2006 HCC national review of children's service stated the Trust did not meet requirements or reasonable expectations of the public or patients. The Trust responded that this was probably due to a lack of data submitted and that an action plan was developed.
- Auditors' reports – reports identified and reported to the Board serious concerns about the Trust's risk management and assurance systems. The accuracy and reliability of the Trust's compliance with standards was also called into question. These reports should have raised flags about the competency of management at the Trust.
- Surveys – patient and staff surveys conducted on behalf of the HCC rated the Trust as being in the worst performing 20% in the country.
- Whistleblowing – a staff nurse made a serious and substantial allegation about A&E leadership in 2007. This was not resolved by the Trust nor did it make any external agency aware, apart from the Royal College of Nursing, owning solely to its involvement with the nurse.
- Royal College of Surgeons report January 2007 – the report described the Trust's surgical department as "dysfunctional." Again, the report was only known to the Trust and the Royal College: no external agency. Had it been known, it would have showed clear concern to the public or any regulator.
- Trust's financial recovery plan and associated staff cuts – savings in staff costs made when it was already identified as struggling to meet minimum standards. No evidence that any thought was given to the potential effect on patient safety and quality and no questioning of the plans. The SHA also did not question or scrutinise any of the changes.
- Application for FT status – the concerns made apparent by the application had implications about the standard of care being delivered. Senior leadership at the SHA were aware of critical findings but did not consider that a trust with such problems might not be able to deliver safe care. Furthermore, even though Trust management changed there was no sense of urgency from the SHA to make improvements. The HCC remained unaware of the FT status application despite looking into concerns that lead to the first investigation. Monitor was unaware of the HCC's concerns until after the FT application was approved. The HCC regional team was aware of the application but did not communicate this to the Head Office.
- HCC investigation – a formal investigation by the HCC was rare. Other bodies responsible for oversight and regulation awaited the outcome of the investigation, rather than considering for themselves if something needed to

be done.

2. Analysis of Evidence

The Trust and Trust Board

- There was a negative culture at the Trust. The Board and other leaders at the Trust failed to appreciate the enormity of what was happening. There was an ingrained culture of poor standards with a focus on finance and targets.

  "The Trust's culture was one of self-promotion rather than critical analysis and openness... It took false assurance from good news, and yet tolerated or sought to explain away bad news."

- Consultants "kept their heads down" and did not pursue concerns with management.
- There was no culture of listening to patients: there were "inadequate processes for dealing with complaints and serious untoward incidents (SUIs)." Staff and patient surveys showed dissatisfaction but no action was taken.
- There was poor governance and accountability despite this being apparent to the new Chair and Chief Executive in 2004 and 2005.
- Leadership focused on financial issues but not on how this affected service delivery quality.
- There was a shortage of skilled nursing staff but there was not enough done quickly enough to address it. Priority was on ensuring the Trust's books were in order for the FT application.
- "Completely inadequate standard of nursing:" staffing levels, poor leadership, recruitment and training. Incidents went unreported.
- The Trust prioritised finances and the FT application over quality of care.

Voice of the local community

- Patients and relatives felt excluded from participation in patients' care. Patient surveys showed something wrong long before the HCC got involved.
- Community Health Councils (CHCs) provided a good structure for patient and public involvement. The two new replacements over the last 10 years (Patient and Public Involvement Forums (PPIFs) and Local Involvement Networks (LINk)) "failed to produce an improved voice for patients and the public, but achieved the opposite."

  "The relatively representative and professional nature of CHCs was replaced by a system of small, virtually self-selected volunteer groups which were free to represent their own views without having to harvest and communicate the views of others. Neither of the systems which followed was likely to develop the means or the authority to provide an effective channel of communication through which the healthcare system could benefit from the enormous resource of patient and public experience waiting to be exploited."

- The Trust's PPIF achieved nothing "but mutual acrimony between members and between members and the host."

- LINks were “an even greater failure.” Each local authority devised its own working arrangements after the demise of the Commission for Patient and Public Involvement in Health (CPPIH). Squabbling from the previous system was continued under the LINk regime.
- All of this left the public with no effective voice throughout the crisis.
- The report makes clear that with the new Healthwatch there is an inherent risk that it continues the ineffectiveness of some LINks due to the DH not prescribing an operational model, leaving it to local authorities.
- The report also singles out the local authority scrutiny committees. They “did not detect or appreciate the significance of any signs suggesting serious deficiencies of the Trust.” Furthermore, the Inquiry found that there were “a number of weaknesses in the concept of scrutiny, which may mean it will be an unreliable detector of concerns, however capable and conscientious committee members may be.”
- Local MPs received complaints about the Trust but largely passed these on to others without any follow-up or consideration of the implications. While the Inquiry recognises they are not experts in health, it suggests that they may wish to look at how they can increase their ability to recognise problems in local healthcare.

GPs

- Local GPs only expressed concern once the HCC investigation was underway.
- The Inquiry does not blame GPs for failing to spot bad care but nonetheless states that it will be important that they monitor quality in future. They need to be able to recognise patterns of concern and have a responsibility to patients to keep informed on the standards of service available from providers.

PCTs

- PCTs were large organisations with large budgets and staff. They were not initially given the best tools in which to monitor quality and safety standards; rather, as elsewhere, the focus was on financial controls and targets.
- Reorganisations throughout the period meant previous changes had not yet been embedded and meant PCTs were focused on these rather than monitoring performance and quality. While the Inquiry does not blame PCTs for the reorganisations, it no less states that it failed to put in place systems and processes to manage risks as the systems changed.
- There was a continuous assumption that others had responsibility in terms of monitoring quality. Little to no attempt was made to collect quality information systematically.
- Going forward, with the new National Commissioning Board, its regional offices and CCGs, there is a need to ensure commissioning is focused on ensuring standards of service for patients and to identify of the nature of the service to be provided. In order to do this, commissioners must be “recognisable public bodies, visibly acting on behalf of the public they serve.”

SHAs

- SHAs were expected to perform a challenging role through a time of reorganisation, financial challenge and reduction in staff and organisational resources, coupled with a lack of clarity on how they were expected to address concerns about quality and safety.
- The reorganisation in 2005/06 appeared to be conducted without thought to risks to patient safety or quality in doing so. There was also no system of transferring information from one form of SHA to the next.
- The West Midlands SHA had a culture of placing too much trust in provider boards, ready to defend providers rather than consider criticisms and concerns. They also assumed others would share information about concerns without being asked. The SHA was “far too remote from the patients it was there to serve.”
- Going forward, the faults of the SHA are still relevant even though they are being abolished. The report indicates that a performance management and strategic oversight function will still reside in the new system somewhere.

Monitor

- The Inquiry points out that even if the FT application had been refused, it would not have necessary stopped patient suffering before January 2008. But, the regulatory assessment process required by the NHS Act 2006 “ought to have brought those deficiencies to light.”
- The Inquiry has raised strong concerns about the effectiveness of the FT system as a whole. It was warned to be careful of damning the whole system from one extreme case but no less questions how the system could effectively detect patient safety concerns of any significant nature if it could not detect them as severe as they were in this case.
- The report indicates that the “erroneous authorisation” of FT status happened because Monitor and the HCC were separate organisations. They went about their business without coordination. It was not just lack of communication but different, unaligned methods of assessment. The HCC was not tasked to look at finances while Monitor had little clinical resource.

The Healthcare Commission

- The Inquiry indicates that the main failure to detect or prevent the events sooner was the concept of the core standards and the means of assessing compliance: the annual health check (AHC). It claims this suffers from a number of deficiencies.
- The standards were not created by the regulator but by the Government. This meant those looking at the standards interpreted them as Government-controlled and disengaged frontline clinicians from the process.
- Standards included a mixture of general and specific.
- The process was also not good in that it relied on self-assessment and self-declaration. Regulation was on looking at providers’ performance in relation to standards, most of which focused on theoretical systems rather than actual achievements or patient outcomes. The HCC would readily accept

assurances of action from the Trust. The HCC was too passive.

- The boards of regulators are still hired and fired by the Secretary of State despite previous calls for them to be more independent.

Care Quality Commission

- The CQC has had many challenges since its inception: need to merge three organisations, creation and administration of an entirely new system of registration and the monitoring of compliance with a new set of standards. They have also had to take on the regulation of other healthcare sectors and to do it all in a short timescale.
- There is evidence, the report says, that, in setting it up, the strategy has been to fit the activity of the organisation to the resources available.
- The Inquiry has received evidence that the CQC is not “a happy environment to work in.” There is a “defensive institutional instinct” to attack critics. The report says that a regulator needs to be open and welcome criticism.
- The Inquiry believes the new standards are better than what has gone before but still requires improvement; however, it also says that “the current outcomes are over-bureaucratic and fail to separate clearly what is absolutely essential from that which is merely desirable.”
- The Inquiry commends the CQC for its efforts but still has the impression that patient information and feedback are not priorities when looking at an organisation’s performance. It suggests that inspectors ought to be able to look at local complaints and even meet with the complainants.

The General Medical Council and the Nursing and Midwifery Council

- Both are not seen as high profile by the public, therefore no referrals were made about care at the Trust. Professionals as well may have been deterred from making referrals because of the complexity of the process.
- The report states that both organisations should be able to investigate matters of concern even when there isn’t a named individual, but does not believe either is capable of doing so at the moment.

Other external agencies

- The Health Protection Agency was involved with the Trust regarding infection control. It did not escalate any concerns about this area to the HCC or SHA. It also did not volunteer any information to the HCC during its investigation.
- There was a lack of consideration of how important it is for agencies and organisations to share information. “Organisational boundaries and cultures should not prevent the use by all of information and advice designed to enhance patient safety.”
- There is a regulatory gap between the Health & Safety Executive not getting involved in healthcare cases and the CQC refusal to investigate individual cases.
- Gathering patient safety information nationally, as done by the now-abolished National Patient Safety Agency, is welcomed by the Inquiry and further

development insisted upon.

- The Royal College of Nursing was an ineffective professional organisation and trade union at the Trust. The Inquiry found that there may be a conflict of interest between the RCN representing nurses and promoting best practice and standards of care and negotiating terms and conditions of pay and defending members' interests as a trade union.

Department of Health

- While the Inquiry recognises that senior DH officials accept responsibility for and sincere regret for the poor care at the Trust, it also states that the DH "lacks a sufficient unifying theme and direction, with regard to patient safety" even with recent reforms.
- Contributing to the problems at the Trust were the many policy changes occurring during the time. Despite their overall goal of improvement, they were not given time to succeed before a new policy was proposed and implemented. The former Secretary of State admitted that there was often a disconnect between policy decisions being made and practical implementation.
- Structural reorganisations have the potential to destabilise and remove from focus the priority of patient safety and quality.
- The NHS is large and complex, which presents a challenge in focusing on patients. The report indicates that this is only likely to continue as organisations become more autonomous. The DH has the role of ensuring consistency across the NHS.

Why things weren't discovered sooner

One of the main aims of the inquiry was to identify why problems weren't discovered and acted upon sooner. Some of the reasons were:

- The Trust lacked insight and awareness of the reality of what was going on. It was defensive against criticism and not open with patients, the public or external agencies.
- External agency remits were not clearly defined. There were regulatory gaps and a failure to follow up warning signs. Organisations worked in silos and even guarded territories.
- Lack of communication and information sharing across the healthcare system. Lack of openness, transparency and candour.
- Constant reorganisations lead to a loss of corporate memory and confusion about each organisation's function or responsibilities.
- All of this lead to a culture where too much weight was placed on the Trust's assurances or action taken by other regulatory bodies. There was insufficient scrutiny of assurances.
- Performance was all about identifying systems and processes and meeting targets.
- Quality of care and patients were not at the heart of the system for most of the organisations involved: finances and targets were. There was a lack of

engagement with patients and the public. Clinicians were not at the heart of decision-making.

3. Lessons Learned

A common culture

- There must be a "relentless focus" on patients in terms of safety and protection from poor care. There must be no tolerance of poor care. There must be leadership in place to ensure staff are motivated to not accept poor care.
- There must be accessible standards and means of compliance and no tolerance of non- compliance.
- There must be openness, transparency and candour across the system.
- There must be strong leadership in nursing and strong support for leadership roles. There must be a level playing field for accountability.
- There must be accessible information showing performance by individuals, services and organisations.

NHS Constitution

- The NHS Constitution should be the first point of reference for patients and the public and should have included all standards and codes of conduct staff should be expected to follow. It should enshrine patients as the priority.

Simplifying regulation

- The report recommends that the Secretary of State should consider transferring the functions of regulating governance of healthcare providers and fitness of persons to be directors or governors from Monitor to the CQC. It cautions against doing this too quickly or without appropriate planning, to avoid losing expertise at Monitor. It should also not be used a means of saving costs, leading to an under-resourced organisation.

Monitoring of compliance with fundamental standards

- The standards should be policed one regulator: the CQC. It should monitor both compliance with standards and governance and financial sustainability. The CQC shouldn't ensure improvement by the provider but ensure it complies with standards to protect patient safety and quality of care.
- Standards should be set out clearly so that they are understood and accepted by providers, patients and the public. They should not be 'top-down' from Government but should have been consulted on widely, especially to ensure nurses, doctors and patients buy into them.
- Procedures and metrics for policing compliance should be developed by NICE where possible, based on evidence. Help should be sought from the Royal College or third-party organisations if necessary.

Enforcement of compliance with fundamental standards

- The report states that CQC ought to be able to take immediate protective steps to stop a service continuing if there are concerns about its safety.

- Death or serious harm to a patient should enable the provider to be prosecuted under a criminal offence unless the provider can show there was no way of avoiding it.
- Information needs to be shared and complaints should be able to make up this information.
- Inspection should remain the central monitoring tool. There should be a specialist pool of hospital inspectors and consideration given to working with other agencies to inspect and using peer review techniques.

Applying for FT status

- Any application must be preceded by a physical inspection by the CQC. Any organisation found in non-compliance will not be supported in its application.
- Applicants must disclose all relevant information to Monitor in their application, whether it's good or bad. Failure to do so will be subject to criminal sanctions.
- The DH, the NHS Trust Development Authority and Monitor should review the consultation process, to ensure local opinion is captured and provided as evidence of the application.
- The focus of the authorisation process must be on fitness for purpose in delivering quality care and to do so sustainably.

Accountability of board directors and enhancement of governors' role

- Directors should have to comply with a code of conduct. The regulator should be able to make a determination that a person is not fit to be a director, preventing him/her from becoming one at any healthcare organisation.
- The role of FT governors needs to be enhanced, improved and made accountable. The Regulator should publish guidance on what is a proper governor role and what is required to fulfil it. Governors should also be able to be removed if found unfit. They should be provided with training.

Other agencies

- The former National Patient Safety Agency (NPSA) functions regarding incident reporting and analysis need to be continued.
- The HPA information regarding infection control needs to be passed on to the NHS Information Centre. Infection control officials should share concerns with commissioners and regulators when there is cause for concern.

Complaints

- Every trust should have an effective complaints process in place and should take all complaints seriously and respond accordingly.
- The process should be as simple as possible and complaints about potential standards breaches or very serious complaints should be accessible to the CQC, relevant commissioners, health scrutiny committees, communities and local Healthwatch**.**

Commissioning

- Commissioners, as the paying body, need to ensure services are well

provided and provided safely. The commissioner will want to set standards above the CQC bare minimum along with levers for non-compliance.

- Commissioners should set standards for improvement over the longer term. Commissioners should promote improvement.
- The NHS CB should design standards to be incorporated into contracts or assisted local commissioners to design their own.
- All commissioners should be adequately resourced to monitor providers. Commissioners should have access to quality accounts and reports available to the CQC.
- Commissioners should be able to intervene where services are falling down on standards and the CQC should be notified if basic standards are not being met. Contingency plans for providing the service elsewhere or in another way should be drawn up before having to do this.
- Commissioners should decide what needs to be provided, not the provider. They should also consider clinician views, including from providers, GP and procurement expertise to improve their arrangements.
- Commissioners need to raise their public profile so that they can be held accountable and take public views into account.

Local public and patient engagement and partnership

- The report recommends that local authorities pass funds for local Healthwatch to it so that it becomes accountable for the use of the funds. The local authority should then step in if it becomes incapable of performing its functions. There should be a consistent national structure for Healthwatch, along with training and advice.
- Scrutiny committees should have the power to inspect providers, using information from local patient involvement to do so.

Real patient involvement

- The CQC also needs to show that it is an open, honest and transparent organisation. They should look to involve patients in their consultative structure.
- Commissioners should seek public involvement.

Openness, transparency and candour

- The whole system needs to reflect these three qualities in its dealings with patients and the public.
- Organisations need to be completely truthful to regulators.
- There should be no ‘gagging’ orders on staff. There should be no culture of fear.
- The CQC should be responsible for monitoring providers for these qualities.
- Peer review needs to play a key role in delivering and monitoring services.

Caring nurses

- Nursing recruitment, training and education needs to have a focus on compassion and caring. This should be a national standard.
- Nurses should be required to have practical hands-on training and experience. They should never stop learning and being trained.
- Ward managers should be able to supervise and not be bound up in paperwork.
- The NMC should introduce a validation process similar to the GMC.
- Each organisation should have a responsible officer for nursing and he/she should be accountable to the NMC.
- There should be a new status of registered older person's nurse, to reflect the requirements of caring for the elderly.
- There should be at least one nurse on the executive boards of healthcare organisations, including commissioners.

Healthcare support workers

- Healthcare support workers should be subject to a new registration system so that no unregistered person is able to provide direct physical care to patients.
- There should also be a code of conduct for healthcare support workers and the public should be able to easily distinguish between them and nurses.

Leadership

- There should be professional management and leadership training to potential senior staff.
- There should be a code of ethics, standards and conduct for board-level healthcare leaders and managers. Non-compliance can lead to not being a fit director.
- As part of the annual appraisal process, feedback should be sought from patients and families on how well clinicians and nurses show care and compassion.

Proactive professional bodies

- Both the GMC and NMC should have clear policies for when they should be notified of complaints. Both should be more proactive in monitoring fitness to practice.
- Both should work together with the CQC.

Continuing care

- Hospitals should consider nominating one consultant or senior clinician and nurse to be in charge of each patient's care. This ensures families and patients know who is in charge.
- Patients should never be discharged without knowledge that they will be receiving care when they arrive at home. This could include a follow-up visit after discharge.
- GPs should also check on patients after hospital discharge. They should also

monitor patterns of concern which can then be made know to the CQC and commissioner if necessary.

- GPs should feel obliged to ensure their patients know what is the standard of service from providers.

Information

- Information must be available about the performance and outcomes of a service. The public should be able to compare providers.
- Information should be in real time as much as possible. Healthcare professionals should be duty-bound to work together to provide the information.
- Organisations should have a designated board member as a chief information officer.

Reorganisations

- Before any proposal for structural change, an impact and risk assessment should be undertaken by the DH and debated publicly.
- The NHS CB should develop a code of practice to ensure future transitions are planned and managed appropriately.

DH Leadership

- DH should involve senior clinicians in all decisions that may impact on patient safety.
- DH needs to connect more to the NHS and its patients, especially those that have had a poor experience of care. DH should consider a patient consultative forum.

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Ashford and St Peters NHS Foundation Trust (ASPH)

Responding to Francis June 2013 – Report to HOSC

Introduction

The final report of **The Mid Staffordshire NHS Foundation Trust** Public Inquiry - Chaired by Robert Francis QC, was published on Wednesday 6 February 2013.

The report is critical of multiple external healthcare organisations whose scrutiny failed to detect systemic deficiencies at Mid Staffordshire Hospital but concludes that the primary responsibility for the unacceptable standards of care lay with the Trust Board and professional staff. The report also concludes that the Trust Board did not sufficiently listen to its patients and staff and failed to tackle a negative culture involving tolerance of poor standards and disengagement from managerial and leadership responsibilities.

The Public Inquiry makes 290 recommendations of which 107 apply to acute hospital settings and can be loosely grouped for implementation according to:

- Patient Complaints
- Information and Data
- Human Resources
- Training and Development
- Medicine and Nursing
- Trust Board.

Patients First and Foremost

The Government made its initial response to the Inquiry on the 26 March 2013 in a document entitled, *Patients First and Foremost* which sets out a plan around 5 domains to revolutionise the care that people receive from the NHS. The Secretary of State (SoS) for Health requires all healthcare organisations to respond in the first instance in 2 ways by the 31 December 2013:

1. Organisations should hold listening events with their staff to hear about how the NHS can remain true to its core values of compassion and care. Feedback from these events is to be shared with the Centre.

2. NHS hospitals must set out publicly how they intend to respond to the Inquiry's conclusions.

The 5 *Patients First and Foremost* domains are:

- Preventing Problems
- Detecting Problems Quickly
- Taking Action Promptly
- Ensuring Robust Accountability
- Ensuring Staff are Trained and Motivated.
- Healthcare Support Worker experience prior to access to nursing degrees
- Code of Conduct for Healthcare Support Workers

ASPH Position

The ASPH Trust Board commitment to the creation and sustainment of an honest and open culture at ASPH that recognises and reports poor care and that enables a swift and effective response is unequivocal, as is the commitment to a culture without fear of retribution or failure to respond.

A high level analysis of the ASPH position against the Patients First and Foremost 5 domains and key areas for focus has been undertaken and found that ASPH is well positioned since much of the required work has already taken place or is in train. A more detailed analysis to triangulate the relevant Francis recommendations with the position against Patients First and Foremost is underway and aims to develop 2 key workstreams; firstly in relation to process improvement and secondly in relation to organisational culture.

Anticipated Areas for Improvement Work

- Complaints Handling Process
- Further work to embed the Duty of Candour
- Implementation of Schwartz Rounds planned for September 2013
- Appointment of ASPH Chief of Patient Safety effective September 2013

- Improved process to enable scrutiny and review of data by clinicians
- Implementation of Nursing and Midwifery Strategy "Together we Care" to include a focus on the development of Healthcare Assistants and supported by a visit to the Trust by the Royal College of Nursing Chief Executive, Peter Carter in July 2013
- Approval by Trust Board (June 2013) and implementation of a Safe Staffing Framework, embedding the use of an evidence based and validated tool
- Implementation of a Model of Care for Older People during the Autumn 2013
- Implementation of "Enhancing Staff Experience – Creating a Positive and Respectful Culture" as detailed below.

The ASPH Challenge

Recognising the results of the recently published ASPH Staff Survey, which quite rightly has caused great concern to the Trust Board and to stakeholders, the greatest challenge facing the Trust is the need to improve the experience and engagement of all staff. The first Listening Event, where staff contributed freely and thoughtfully to the discussion is a heartening and positive sign and has been followed up by additional team discussions the content of which will form part of the Trust's response to the SoS Health.

A discussion has also been held with the Council of Governors (CoG), in May, where their role was debated and considered. It was agreed to arrange a meeting between the Trust's CQC Liaison Team and the CoG to facilitate closer working and communication.

Getting the Culture Right

One of Sir Robert Francis's key conclusions was that the culture at Mid Staffordshire NHS Foundation Trust and across the wider NHS system was not "right". Clearly setting and sustaining the right culture will be critical to success.

The Chief Executive is personally leading and implementing a work programme entitled, Enhancing Staff Experience – Creating a Positive and Respectful Culture, The Programme aims to bring together the Trust's response to both the 2012 Staff Survey results and to the Inquiry by:

- setting a refreshed cultural tone for the organisation
- prompting the concept and feel of citizenship such that staff should expect to be involved in decision making and be enabled to do so
- using the Appreciative Inquiry methodology to focus on increasing what we do well.

Central to the Programme will be a number of key interventions:

- staff conversations with the Chief Executive via the CEOs “Sounding Board”
- an integrated leadership programme for the Trust Board, Divisional Teams, Specialty Leads and new consultants
- the continuation of Team ASPH. Team ASPH now has 27 teams participating in a programme that delivers expert external coaching and facilitation in order to build and strengthen the Team and to support them in developmental work.

Trust Board

The setting of organisational vision, strategy and culture is the role of the Trust Board. On the 27th March 2013 the Trust Board held a Board development session with a focus on culture. The development session resulted in the description of the Trust Board’s vision for the ASPH culture and the formulation of an action plan to get the Trust to where it wishes to be. Further work is now underway to articulate a refresh to the Trust vision and review of a detailed draft is to take place at this month’s Trust Board.

The Trust Board is committed to the relentless pursuit of excellence and the elimination of variability in the knowledge that this will take sustained commitment from all combined with a continued high level of vigilance and openness to understand and learn from poor experience or care. Work to review, understand and implement the learning from Francis is iterative and will continue over the coming months with a high degree of pace and focus.

Report prepared by

Suzanne Rankin

Chief Nurse and Executive Lead for ASPH Francis Response

Epsom and St. Helier NHS
University Hospitals
NHS Trust

EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

TRUST RESPONSE TO ADDRESS THE MID STAFFORDSHIRE NHS FOUNDATION TRUST - ROBERT FRANCIS PUBLIC INQUIRY

SURREY COUNTY COUNCIL HEALTH SCRUTINY COMMITTEE 4TH JULY 2013

INTRODUCTION

1. On February 6th 2013 the Robert Francis Public Inquiry report was published. This report criticised Mid Staffordshire NHS Foundation Trust, many regulators and scrutiny groups for significant failings in healthcare, leadership and management.

2. The government published a formal response on March 26th 2013 reaffirming the common principles of the NHS Constitution, stating that patients must be listened to, and that quality and compassion in care should be at the heart of all that we do, with a commitment to openness and candour.

STAFF BRIEFINGS

3. A large number of briefing events have been held across Epsom and St Helier University Hospitals NHS Trust involving various multi-disciplinary groups to highlight the key findings of the Francis Report and the Government Response.

4. Listening events have also been held in each clinical and non-clinical directorate to gain an understanding of views of members of staff across the Trust about the safety, quality of care and the patient experience. The organisation has a group of 150 top managers who have been facilitating these listening groups. A key question that is being asked of staff is:

   'If there was one thing that you could do to make a difference to improve care, what would it be'.

   In addition, staff have been asked if they would recommend their service to friends and family, and the reasons for that view. The feedback from listening groups will form the basis of a wider consultation within the Trust led by the Chief Executive. It is intended to launch this event in July.

GOVERNANCE STRUCTURES AND PROCESS

5. Each directorate has been asked to review their governance structures and procedures that are in place, and to gain an understanding of how the team and individual feedback from incidents and concerns occurs. They have been asked to provide a gap analysis to inform a wider steering group.

6. A Francis Steering Group has been set up, and is meeting monthly. It reports to the Trust Executive Committee (TEC), and is tasked to:
   - Assure the TEC that the Trust's Responsibilities in relation to the Francis Report recommendations are being met across the organization;
   - Provide a multi-disciplinary forum for discussion by senior members of the Trust's staff, of all issues relevant to the Trust's responsibilities regarding the report;
   - Monitor the actions required within the Trust-wide action plan;
   - Provide evidence that each recommendation has a plan and time-frame for completion.

7. The Steering Group has reviewed all 290 recommendations. Of these, 100 are directly applicable to Acute Trusts. Four working groups have been assigned to deliver an action plan to provide assurance that these recommendations are delivered. Each working group is chaired by an Executive Director:

• Organisational Development	Director of People and Organisational Development
• Complaints and Patient Experience	Director of Nursing and Quality Assurance
• Risk and Quality Assurance	Joint Medical Director (Epsom)
• Effective Ward Care	Joint Medical Director (St Helier)

   The Working Groups will encompass feedback from patients, visitors, staff and other stakeholders to reflect opinions about the findings of the Francis Report and their views about patient care and services within the Trust.

8. The Trust has committed additional resource in the order of £0.5million to enhance Quality Assurance and Governance. It is intended to:
   - restructure the Trust's governance structure, bringing staff together into a newly formed 'Quality Directorate' reporting to a team lead who, in turn, reports to a single Executive Director;
   - strengthen the Directorate management triumvirate introducing a senior manager who will lead and influence within the Directorate management team on quality, governance and patient safety matters; This support should also create a framework for learning across the organisation and to improve the patient experience
   - strengthen the link with the medical teams through the appointment of an Associate Clinical Director working alongside the quality team lead and, newly appointed, clinical leads assigned to Directorates.

SUMMARY AND CONCLUSIONS

9. NHS Trusts are required to set out how they intend to respond to the inquiry's conclusions before the end of 2013. This paper highlights the actions taken by the Trust to date.

10. Epsom and St Helier University Hospitals NHS Trust will work to ensure that a detailed set of actions are developed and implemented to enhance patient safety, outcomes and experience and to embed a culture of openness, honesty, candour and compassion when delivering health care.

ANNEXE 4

Themes Identified from Francis Report – June 2013

Introduction:

As part of the Organisational response to the findings and recommendations within the Francis report an initial high level review was undertaken and presented to the Board by Nicola Ranger – Director of Nursing. Following on from this the core themes have been identified and placed under headings found within the Governments Initial Response Paper "Patients First and Foremost." Frimley's initial actions are also shown.

A further board seminar on the Francis report recommendations will be held on the 5th July 2013 and subsequent further review will be undertaken.

Preventing Problems	
Core Themes	**Francis Recommendations**
Compassionate Care	• The Trust must make its visible priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in such an area where it cannot achieve such a standard • The Trust, together with the Primary Care Trust, should promote the development of links with other NHS and Foundation Trusts to enhance its ability to deliver up-to-date and high class standards of service provision and professional leadership • The trust should ensure that its nurses work to a published set of principles, focusing on safe patient care
	FPH Initial Actions taken Trust Values launch June 2013 / Strengthening Patient voice at core forums / Sharing patient experience / Participation in Family & Friends testing / Revised recruitment strategy to ensure recruiting to values / Organisational approach to Nursing and Midwifery 6 C's

Professional Leadership	• As above • The Board should review the management and leadership of the nursing staff to ensure that the principles described in the report are complied with. • The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients
	FPH Initial Actions taken Existing leadership and quality framework for personal development / Clinical leadership programmes / Ward Sister structure development / Strong Governance structure
Clinical Competence	• The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis. The Trust, in conjunction with the Royal Colleges, the Deanary and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high quality, professional training and development is provided at all levels and that high quality service is recognised and valued • All wards admitting elderly, acutely ill patients in significant numbers should have multi-disciplinary meetings with consultant medical input, on a weekly basis. The level of specialist elderly medical care input should also be reviewed, and nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion

	FPH Initial Actions taken Preceptorship and development programmes / Strong culture for development and training / Opportunities extended competence to address high impact interventions / Access to KSS leadership Deanary programme / Utilisation of Clinical supervision (Medical) / Mentoring - coaching
Organisational Culture	• The Board should give priority to ensuring that any staff who raises an honestly held concern about the standard or safety of the provision of services is supported and protected from any adverse consequences, and should foster a culture of openness and insight
	FPH Initial Actions taken Whistleblowing policy available to all staff / Planned external review / Feedback of all staff via staff survey and development of recently launched values
Documentation	• The Trust should review its record keeping procedures in consultation with the clinical staff and regularly audit the standards of performance.
	FPH Initial Actions taken Rolling documentation audits undertaken / Pilot of new Admissions/Risk assessment booklets/ On-going working group reviewing streamlining of all documentation

Detecting Problems Quickly	
Quality/Monitoring	• The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.
	FPH Initial Actions taken Performance and quality data reviewed by Board on rolling basis / Structured Ward to Board programme in place
Duty of Candour	• The Board should give priority to ensuring that any staff who raises an honestly held concern about the standard or safety of the provision of services is supported and protected from any adverse consequences, and should foster a culture of openness and insight • The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients

	FPH Initial Actions taken Organisational "open door policy" / Planned expert training to be delivered
Taking Action Promptly	
Complaints/Incident Management	• The Board should review the Trust's processes for the management of complaints and incident reporting in the light of the findings of this report and ensure that it: - Provides responses and resolutions to complaints which satisfy complainants - Ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons being learnt - Minimises the risk of deficiencies exposed by the problems recurring and makes available full information on the matters reported and the action to resolve deficiencies to the Board, the Governors and the public

	FPH Initial Actions taken Structured complaints forum currently review of terms of reference, membership and core objectives / Structured tracking for changes in practice / Work recently commenced for peer review of complaints management Incident reporting monitored through Governance support structure / Both complaints and incidents do undergo duty of candour review
Ensuring Robust Accountability	

Board Accountability/ Professional Accountability	• In light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS Trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction. • The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients. • GMC/NMC/AHP regulations and Codes of Conduct

	FPH Initial Actions taken Board to Ward – Ward to Board processes in place / Quality walk rounds undertaken inclusive of execs and none execs
Ensuring Staff are Trained and Motivated	
Training/Core Skills	• The Trust, in conjunction with the Royal Colleges, the Deanary and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high quality, professional training and development is provided at all levels and that high quality service is recognised and valued • All wards admitting elderly, acutely ill patients in significant numbers should have multi-disciplinary meetings with consultant medical input, on a weekly basis. The level of specialist elderly medical care

	input should also be reviewed, and nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion • <u>Right people / right place / right skills</u> • Fitness for the Future/Academic Clinical Creditability to Support graduate workforce
	<u>FPH Initial Actions taken</u> Preceptorship and development programmes / Strong culture for development and training / Onsite Post Graduate Education centre / Close working relationship with the Deanary and HEIs

ANNEXE 5

TRUST BOARD

JUNE 2013

FRANCIS REPORT

Purpose – This paper is presented to the Board for information

Author and Lead Director: Louise Stead, Director of Nursing and Patient Experience

EXECUTIVE SUMMARY

Following the presentation of the initial plan in response to the Francis report a quarterly review will be presented to Board to update on our progress.

1. MAIN CONSIDERATIONS

The key recommendations of the report which impact on the acute provider were pulled out of the report and formulated in a table. The attached rag rated table shows our progress over the last two months. Since the publication of the report, the Government's response has been published and ongoing review of this from a policy view may well lead to further elements being rolled into this action plan.

ACTIONS FROM FRANCIS REPORT

RAG Ratings

Month	No. Of Actions	No. Of Actions rated as Red	No.Of Actions rated as Amber	No.Of Actions Rated as Green
March	76	24	23	29
May	76	16	24	36

2. RECOMMENDATIONS – The Board is asked to note the report.

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status

TABLE OF RECOMMENDATIONS

Rec No.	Theme	Recommendation	Action Plan / Status	RAG Status
	Accountability for implementation of the recommendations. These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.			
1.	Implementing the recommendations.	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.	**May 2013 - Initial plan to February board. RAG rating added and taken to March Board. To be monitored internally through Clinical Quality Governance Committee.**	
	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.			
3.	Clarity of values and principles.	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	Mirrored in new RSCH strategy with 31 key priorities.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
5.		In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: ●Staff put patients before themselves; ●They will do everything in their power to protect patients from avoidable harm; ●They will be honest and open with patients regardless of the consequences for themselves; ●Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; ●They will apply the NHS values in all their work.	Key elements to be included in job descriptions – Patients Pledge. **Action April 2013.** **May 2013 - RAG changed to Green. Copy of letter to be filed in Francis file which is kept in Director of Nursing's office.**	
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	Job descriptions amendments required. **April 2013.** **May 2013 - RAG changed to Green. Copy of letter to be filed in Francis file which is kept in Director of Nursing's office.**	
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.	Trust Values and Behaviours expectations to be provided to all Bank / Agencies used. **April 2013.** **May 2013 - RAG changed to Green. Copy of letter to be filed in Francis file which is kept in Director of Nursing's office.**	
	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.			
11.		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their	SOP s ratified through practice development, therefore opinions sought of many professionals. Competency based assessments already in place for nurses.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.		
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.	Trust has good levels of incident reporting. Work needs to be done on closing the loop so staff are informed of outcomes. **Action: S. Ramtuhul - May 2013.**	
	Responsibility for, and effectiveness of, healthcare standards.			
36.	Use of information for effective regulation.	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must	Scorecard Board Reports already available and shared with PCT/CCG at monthly Contract and Quality meeting.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations		
37.	Use of information about compliance by regulator from: ●Quality accounts.	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	Quality Account audited by Deloitte with KMPG. Methodology for data not currently included but will be for 2013/14. **Action: S. Ramtuhul.**	
39.	●Complaints.	The Care Quality Commission should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.	Data already collected and incorporated in Quality Account with Annual Report.	
40.		It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers	Complaints Monitoring Group review trends and greater depth around these should be generated. **Action: L. Stead - May 2013.**	
41.	●Patient Safety Alerts.	The Care Quality Commission should have a	Timely information regarding compliance has	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		clear responsibility to review decisions not to comply with patient safety alerts and to oversee the effectiveness of any action required to implement them. Information-sharing with the Care Quality Commission regarding patient safety alerts should continue following the transfer of the National Patient Safety Agency's functions in June 2012 to the NHS Commissioning Board.	been sporadic –DMDs will now lead on this and discussion will be on agenda at portfolio governance . **Action: L. Stead - May 2013.**	
44.		Any example of a serious incident or avoidable harm should trigger an examination by the Care Quality Commission of how that was addressed by the provider and a requirement for the trust concerned to demonstrate that the learning to be derived has been successfully implemented	We already speak to Care Quality Commission about serious SI's and they receive the panel reports. All SI's are reported STEIS but will now be followed up in portfolios. **Action: L. Stead - April 2013.**	
45.	●Inquests.	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.	Awaiting guidance around central process but would make more sense coming from coroner. Medical Director has already had discussions with HMC for Surrey about developing a shared approach	
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions.			
75.		The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors	Joanne Green to liaise with Governors regarding this and submission to Monitor with CQC for review. **May 2013.**	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.		
86.	Requirement of training of directors.	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors	Training needs identified in some areas. **Full review to take place.**	
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings.			
88.	Information sharing.	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents	In the event of a RIDDOR incident, which is also a reportable SI one report would be prepared to cover both as only one learning panel would be required. **Action: S. Ramtuhul.**	
89.		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive	This is not done presently – check with the HSE which reports they would like to see. Clinical Governance to set up. **Action: S. Ramtuhul.**	
	Enhancement of the role of supportive agencies.			
93.	NHS Litigation Authority	The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to	At present no firm benchmarks have been mandated other than ITU and Paediatrics, with which we are compliant.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management, such as occurred at the Trust.		
98.	National Patient Safety Agency functions.	Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	Not yet set up, but processes are in place when this becomes a requirement.	
101.		While it may be impracticable for the National Patient Safety Agency or its successor to have its own team of inspectors, it should be possible to organise for mutual peer review inspections or the inclusion in Patient Environment Action Team representatives from outside the organisation. Consideration could also be given to involvement from time to time of a representative of the Care Quality Commission.	PEAT soon to be replaced with PLACE already has Governors on the panel, but not a peer review element. We already do this for Privacy and Dignity and would have no problem with incorporating this with our inspections. Awaiting national guidance. **Action: J. Embleton to review.**	
	Effective complaints handling. Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.			
111.		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users,	Patient pledge website set up. Patient opinion not promoted widely. Requires further promotion **Action May 2013.** Post response inpatient survey yet again poor response to public seeing ways to complain.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		individually and collectively, to share their comments and criticisms with the organisation.	Posters to be redone **Action May 2013.** Staff already attend Older Persons network and LINKs and feedback any complaints received.	
112.		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	These are already logged as informal complaints and treated in the same way.	
113.	Complaints handling.	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	LS has document and mapping of this against our complaints process is underway. **Any changes to be actioned by June 2013.** **May 2013 - RAG changed to Amber.** **Complaints Summit has been held and new process in place from May 2013.**	
114.		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation	Triangulation with incident form currently not done. Further required to ensure they are linked. **July 2013.** **Action: S. Ramtuhul.**	
115.	Investigation.	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: ●A complaint amounts to an allegation of a serious untoward incident; ●Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; ●A complaint raises substantive issues of professional misconduct or the performance of	All of these would have a review by a senior member of staff not involved in the complaint. Definition of ARMS LENGTH not clear.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		senior managers; ●A complaint involves issues about the nature and extent of the services commissioned.		
116.	Support for complainants.	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	Already embedded.	
117.		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	ICAS being disbanded. ?How this will be taken forward? **Action: L. Stead.**	
118.	Learning and information from complaints.	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	Will require a further complaints resource to achieve this **To be actioned July 2013.** **May 2013 RAG rating changed to Amber.** **Letter to patients changed to incorporate consent to share. Information available on website.** **Friends & Family.** **First date available August 2013.**	
119.		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	**Action** Governor involvement on Complaints Monitoring Group should be considered. Report to Healthwatch could be instigated although patient confidentiality is key here as yet no guidance on what level of detail is required.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
120.		Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so	This will require scoping and review of what specialist commissioners and CCG will require. **July 2013.**	
122.	Handling large scale complaints.	Large-scale failures of clinical service are likely to have in common a need for: ●Provision of prompt advice, counselling and support to very distressed and anxious members of the public; ●Swift identification of persons of independence, authority and expertise to lead investigations and reviews; ●A procedure for the recruitment of clinical and other experts to review cases; ●A communications strategy to inform and reassure the public of the processes being adopted; ●Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.	Previous experience in this area, re Paediatric Epilepsy. All points already embedded in our processes.	
	Performance Management and strategic oversight.			
139.	The need to put patients first at all times.	The first priority for any organisation charged with responsibility for performance management of a	Already embedded.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		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.		
143.	Clear metrics 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 be identified and accepted as needing to be fixed.	Already embedded.	
	Medical training and education.			
155.		The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles: ●The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions. ●The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. ●There should be lay or patient representation on visits to ensure that patient interests are maintained as the	Annual Meeting with Dean and regular LETBs. Good relationship essential as with Paediatric epilepsy investigation Deanery. DH Allowance in professional leave allocation for	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		priority. ●Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out. All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.	these tasks	
158.	Training and training establishments as a source of safety information.	The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.	GMC Survey. Small student numbers.	
160.		Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	Show Being Open Policy.	
163.	Safe staff numbers and skills.	The General Medical Council's system of	Significant numbers of consultants in leadership	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training	roles. Good feedback from trainees	
	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.			
174.	Candour about harm.	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	Being open policy. Learning panels and outcomes shared with patients / relatives.	
180.	Candour about incidents.	Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency	Compliant.	
181.	**Enforcement of the duty.** Statutory duties of candour in relation to harm to patients.	A statutory obligation should be imposed to observe a duty of candour: ●On healthcare providers who believe or suspect	To be embedded in contracts. **A Turner – July 2013.** Letter to be sent to all current staff.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request; ●On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy	**A Turner – April 2013.** **May 2013 – RAG rating changed to Green.**	
182.	Statutory duty of openness and transparency.	There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.		

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
183.	Criminal liability.	It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: ●Knowingly to obstruct another in the performance of these statutory duties; ●To provide information to a patient or nearest relative intending to mislead them about such an incident; ●Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties	No action at present time as legal change required for this to be embedded.	
	Nursing.			
185.	Focus on culture of caring.	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: ●Selection of recruits to the profession who evidence the: − Possession of the appropriate values, attitudes and behaviours; − Ability and motivation to enable them to put the welfare of others above their own interests; − Drive to maintain, develop and improve their own standards and abilities; − Intellectual achievements to enable them to acquire through training the necessary technical skills;	Conversations and assurances with our key providers around curriculum content and appropriate selection of candidates. **Action J Embleton July 2013.** **May 2013 – RAG rating changed to Amber. Letter received from University giving assurance regarding selection of recruits.**	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		●Training and experience in delivery of compassionate care; ●Leadership which constantly reinforces values and standards of compassionate care; ●Involvement in, and responsibility for, the planning and delivery of compassionate care; ●Constant support and incentivisation which values nurses and the work they do through: − Recognition of achievement; − Regular, comprehensive feedback on performance and concerns; − Encouraging them to report concerns and to give priority to patient well-being.	PDR compulsory for all nurses. **Action A Turner – MAY 2013.**	
191.	Recruitment for values and commitment.	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours 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	Mandated questions to be asked at all interviews. **Action HR MAY 2013.** **May 2013 – RAG rating changed to Green.** **New Assessment Centres now assess care and compassion.**	
192.	Strong nursing voice.	The Department of Health and Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to, the Nursing and Midwifery Council	Awaiting further guidance.	
193.	Standards for appraisal and support.	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the	Awaiting further guidance.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		Nursing and Midwifery Council on their performance on a regular basis.		
194.		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	Guidance re appraisal to be issued to comply with the regulations. **A Turner – MAY 2013.**	
195.	Nurse Leadership.	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans	Currently our Ward managers are supernumerary 50% of the time. Requirements as detailed in this recommendation will be led by Time to Lead Programme. **Action ONGOING Lead J Embleton.**	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.		
198.	Measuring cultural health.	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer".	To be developed. **A Turner / Patients 1st.**	
199.	Key nurses.	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient	Already embedded on some wards. Further work to ensure compliance across all wards. **JULY 2013.**	
204.		All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be	Achieved. No non-executive directors who are nurses at present time.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		encouraged to consider recruiting nurses as non-executive directors.		
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.	Example of recent staffing proposals show this practice is already embedded.	
210.	Code of conduct for healthcare support workers.	There should be a natural code of conduct for healthcare support workers.	To be centrally mandated.	
211.	Training standards for healthcare support workers.	There should be a common set of national standards for the education and training of healthcare support workers.	To be centrally mandated.	
	Caring for the elderly. Approaches applicable to all patients but requiring special attention for the elderly.			
236.	Identification of who is responsible for the patient.	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	Already achieved.	
237.	Teamwork.	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	MDT meetings already held in all elderly care settings. Interaction with cleaners already identified as area of development in a Peer Review. **Action J. Carr MAY 2013.**	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
238.	Communication with and about patients.	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: ●All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. ●Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. ●The NHS should develop a greater willingness to communicate by email with relatives. ●The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. ●Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled	Relatives' clinics already in place. Not in place. Day Rooms have gone but should bay be closed they could be reinstated. Issue around secure email to be explored. **Action R Drewett – JULY 2013.** . Already in place informally. Formal process to be decided. **Action CJT – Date?**	
239.	Continuing responsibility for care.	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will	Achieved.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient		
240.	Hygiene.	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	Already embedded in practice.	
242.	Medicines administration.	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment	Pharmacy already check charts daily. Review of drug practice set up to include Medical Director, Director of Nursing and Chief Pharmacist. To be scheduled monthly as a minimum. **Action M.Gray** **May 2013 – RAG rating changed to Green. Monthly reviews scheduled. Findings from each visit to be put on G Drive so all concerned can learn from visits.**	
243.	Recording of routine observations.	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	Vitalpac is being rolled out.	
	Information.			

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
245.	Board accountability.	Each provider organisation should have a board level member with responsibility for information.	SIRO. Paul Biddle.	
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	Achieved.	
249.		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	To be implemented for 2012/13 Quality Account. **All Directors**.	
250.		It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of	To be implemented for 2012/13 Quality Account. **All Directors**	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		making the declaration.		
255.	Using patient feedback.	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible, even if later adjustments have to be made	Available to staff via Report Manager, heat map, e-survey.	
260.	Information standards.	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility. It would, therefore, be desirable for the data to be supplied to, and processed by, the Information Centre and, through them, made publicly available in the same way as other quality related information	Awaiting centrally mandated process.	
262.	Enhancing the use, analysis and dissemination of healthcare information.	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: ●Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; ●Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of	Information provided by CHKS and forms part of revalidation. Regular monitoring of mortality and morbidity in most clinincal areas. Define parameters. Central guidance. Already auditing adherence to Royal College guidance.	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment		
263.		It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties	Poorly developed in Trust at present. Joint approach between informatics, clinicians and audit department as in the current review of mortality.	
264.		In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	Some data (eg cancer survival) available but not in many departments. Await national guidance.	
268.	Resources.	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry	Development of information collection systems.	
271.		To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards	Current mortality audit underway and will be monitored going forwards. **May 2013 – RAG rating changed to Green. Full review of mortality has taken place.**	

Rec. No.	Theme	Recommendation	Action Plan / Status	RAG status
		establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail.		
	Coroners and inquests. Making more of the coronial process in healthcare-related deaths.			
273.	Information to coroners.	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.	Coroners referral forms implemented and real time audit of deaths to be launched **March 2013**.	
274.		There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	Medical Director has already discussed with Coroner. Policy of openness in place.	
279.		So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment	To be implemented March 2013. **May 2013 – Review of form to be completed by doctor completing the death certificate has been implemented.**	

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Surrey and Borders Partnership NHS
NHS Foundation Trust

Surrey Health Scrutiny Committee: July 2013

Subject:	Our Response to the Francis Inquiry 2013 – draft v4
Author:	Jo Young Director of Quality (Nurse Director)
Purpose:	**Brief the Health Scrutiny Committee on our programme of work**
Key Issues:	• A précis of the Frances report and the relevant recommendations was presented to the Trust Board in March 2013 and a briefing paper was also provided to our Council of Governors • In April 2013, a further report detailing the government's response to the Francis Report "Patients first and foremost" was presented to the Trust Board in public. This included emerging themes for the Boards consideration • In May 2013 our Quality Committee received our draft response to the Francis report and amendments to this were offered prior to its recommendation to be presented at our Trust Board in public in July 2013 • The report attached remains in draft until the Board have discussed and approved these proposals
Health/Social Impact:	People who use services and carers should be first in all we do.
Financial Implications:	We should guard against finance and targets getting in the way of impact on good quality safe outcomes based care.
Diversity / Equality Impact assessment	The service needs to recognise and respond to difference and provide kind and respectful care and support to all people who use services and their families
Recommendation to the HSC	The Committee are asked to discuss the report and its recommendations

Hampshire County Council
SURREY COUNTY COUNCIL

Surrey and Borders Partnership NHS
NHS Foundation Trust

Our Response to the Francis Inquiry 2013- Draft v4

Jo Young. Director of Quality (Nurse Director)

Following the publication of the Francis Report (Feb 2013) and the Governments response "Patients first and foremost" (March 2013) this paper provides details of how we are already working and identifies new programmes that we believe contribute to the call to action.

For a better life

Philosophy, Principles and Values

Our Philosophy is:

To recognise and support equality and human rights, responsibly and with integrity.

We believe this to be a fundamental pre-requisite for all we do and together with all of our employees we are tasked to conduct business in this spirit.

Our Principles:

What are most important to us are the people we serve - **people** who use services, families and communities. We find our strength in doing all things in **partnership** with others and what we do well is **promotion and prevention, early detection and intervention, consultancy, diagnosis and treatment.**

Our Values:

We are a combination of people, ideas and assets which exist to benefit people who use services, families and other stakeholders. We strive to be the best at everything we set out to do, and only set out to do those things at which we could be the best.

Our relationship with people is essential to achieving these ambitions and can describe how we behave by our set of codes (values):

- Involve not ignore
- Creating respectful places
- Open, inclusive and accountable
- Treat people well

Membership:

We are a membership organisation, and with our Governors we are accountable to the public and listen and respond to the public.

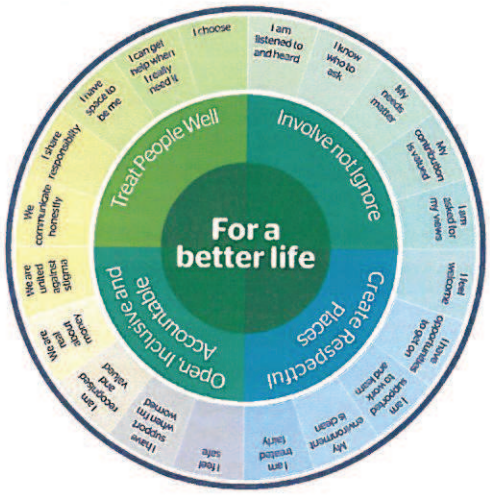
The Francis Inquiry (2013):

Is a call to action for all clinicians, everyone working in health and social care, organisations and Boards to put people who use services first and to protect them from harm.

In Mid Staffordshire Hospital during 2005 - 08 appalling care was able to flourish. The responsibility rested with their Trust Board who failed to tackle the negative culture found in teams and tolerated seriously poor standards of care and treatment. The key warning signs were missed indicated by mortality rates, poor care and complaints.

The Board put process before people and staff members lacked compassion. People who used the service were neglected and harmed.

This must never happen here.



The way we do things around here...

Culture

Our values are the code to which we behave. Implicit within this are the responsibilities to be open, transparent and candid.

We do difficult and complex work, challenging us emotionally and physically. Creating the right environment and support to enable our standards of behaviour to be consistently demonstrated is essential to the delivery of a culture of mutual respect.

Some of the programmes of work we are already doing to promote accountability for the way we do things around here from Board to the front line include:

Table 1
• Staff Conversations
• The Respect programme (tackling discrimination)
• Supervision and Appraisal
• Periodic Service Reviews
• Equality Objectives
• STARS Awards
• SIST (staff debriefing team)
• Employee assist programme
• Professional Registration / revalidation
• Leadership Forum
• Equality and Human Rights Strategy
• Health and Wellbeing programme
• Board Walk Arounds
• Property Strategy
• Role based Competencies
• Board Development Programme

Accountability

Our staff members are the first line of defence to prevent harm to people who use services. Together we should do everything in our power to protect people who use services from harm.

We will be honest, apply our values in our decision making and direct people to the care they need.

To help us with this we will:

Table 2		By When
A	Consider changing "open, inclusive and accountable" in our values to become "open, honest and accountable"	July 13
B	Re-issue the Nolan Principles to the Board	July 13
C	Re-issue the NHS managers code of conduct to all managers	July 13
D	Identify Chief Information Officer responsibility within the Board	July13
E	New marketing campaign promoting whistle-blowing	Sept 13
F	Define thresholds for reporting to professional bodies	Oct 13
G	Review membership of the Quality Committee to include Governors as members	Nov 13
H	Refresh job descriptions to carry our values and standards of behaviour	Mar 14

Kindness and Respect

People who use our hospital and community services should expect to receive a humane service that is sensitive, kind and respectful. A service that optimises people's strengths and promotes recovery and independence.

We provide a named professional or care coordinator to all people so that they know who the person responsible for their care is. People and their families expect to have regular and meaningful interaction with staff members.

We will show our respect for people who use services by ensuring that people are cared for in hygienic and clean environments and that nourishing food and drinks are available, and when needed people are supported to have their meals.

We are interested in people's onward journey after hospital and are responsible for ensuring people are being discharged to a safe and suitable destination.

Whilst the Francis report focus is hospitals, we apply these principles to all of our services.

What we are already doing includes:

Table 3

- Safe Wards Trial
- Staff training in Dementia Care
- Acute Care Partnership meetings
- Nurse Excellence Programme
- National In-patient survey
- National Community survey
- National Staff Survey
- Appreciative enquiry of people's experience of care planning
- Quality Assurance of the Crisis Line
- Safety Collaborative
- Clinical Audit
- Service Deep Dive Reviews and improvement actions

Improvement Programme 2013 -14

A new programme of work will be commenced to inspire our employees to achieve high quality performance.

Developing the SABP way (Safer and Better Practice Programme), using a *simple rules based* and lean approach that facilitate employees to research and improve on best practice and strive to be the safest and best health and social care enterprise in England.

Every individual will be stimulated to continuously learn, problem solve in teams and understand the value of collaborative working across our organisation.

The Safer and Better Practice programme will be blended with the introduction of Customer Journey Mapping, to truly explore and understand the experience of people who use services and families.

Experience

We have introduced this year a programme of real time people's experience tracking (PETs). The aim is to reach more people, hear what they have experienced now and inspire staff and teams to initiate service improvements in response to what people are saying.

Our real time PETs will reach people who use services, family carers and staff and will include the 'friends and family' test as well as local questions.

Complaints are another way people can tell us about their experience. Many people we support need assistance to raise a concern or complaint. What we are doing already is:

Table 4
• Root Cause Analysis investigations
• PALs visits to in-patient services
• Document management to ensure timely responses
• Numbers, services and theme reporting
• Accessible options for complaints information
• Learning events

To help us further we will:

Table 5		By When
I	NED Chair of the Quality Committee to review sample of upheld complaints	August 13
J	Review our processes and reporting of complaints	December 13
K	Annual peer review of complaints	March 14
L	Create easy ways to register a complaint	March 14

Effectiveness

One of our biggest challenges has been the introduction of electronic record systems and the quality of the data.

Getting data quality right whilst reducing the amount of recording and paperwork would release more time for staff to care and support people.

In addition to the SABP way and the Customer Journey Mapping, commitment is made to analysis using process mapping of the standard operating procedures for RiO (electronic care record).

Safety

Standards of safety are essential in our business. We are already focused on:

Table 6
• Safety Collaborative
• Acute Care Pathway Task and Finish Project
• Performance KPIs
• Serious Incident management and learning
• Suicide Prevention

To help us further we will:

Table 7		By When
M	Enforcement of reporting management changes	July 13
N	Develop Early Warning System	July 13
O	Review safe staffing levels in hospital services	Sept 13
P	Develop escalation protocols as part of SABP way	March 14

Our Leadership...

Leadership Competencies

We aim to develop, train and inspire staff to be great leaders. The competencies we are looking for from all our leaders are:

- Personal Motivation
- Strategic leadership
- People Leadership
- Performance Leadership
- Experienced track record

We want all of our leaders to be proud and put people who use services first. They need to be open and truthful in all their dealings with people who use services, families and the public and organisational and personal interests must never be allowed to outweigh honestly.

We want our clinical leaders to be supervisory and not extra / surplus in their team. They should know all of the people who use their services well and be visible to people and their families.

One key person must be identified as leading the care of people who use services.

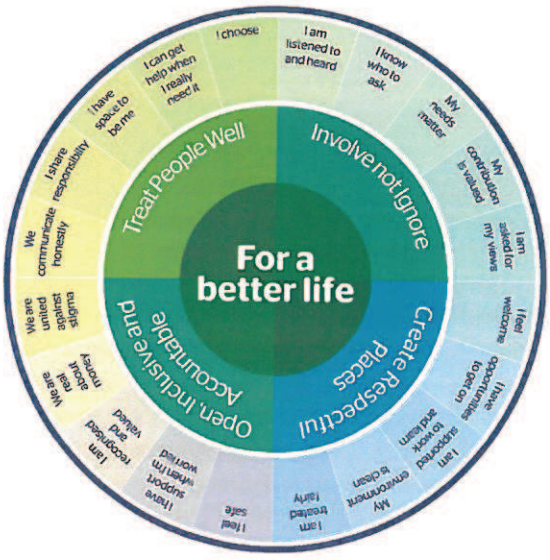
Leadership Faculty

Our work programme in the Faculty has already delivered:

- Leadership Competency Framework / Levels of leadership
- Assessment Centre for recruitment of senior staff
- Development Centre for current leaders
- Leadership programmes from ward manager to senior manager
- Talent management ideas
- Succession planning processes

To help us further we will:

Table 8		By When
Q	Cultural survey of staff to be included in staff survey	Aug 13
R	Equality Awareness for Governors	Oct 13
S	Review of Governors role and practice	Dec 13
T	Grow our Council and Board collaborative relationship	Mar 14



Appendix One: Summary of Actions

		Action	By When
Culture	A.	Consider changing "open, inclusive and accountable" in our values to become "open, honest and accountable"	July 13
	B.	Re-issue the Nolan Principles to the Board	July 13
	C.	Re-issue the NHS managers code of conduct to all managers	July 13
	D.	Identify Chief Information Officer responsibility within the Board	July13
	E.	New marketing campaign promoting whistle-blowing	Sept 13
	F.	Define thresholds for reporting to professional bodies	Oct 13
	G	Review membership of the Quality Committee to include Governors as members	Nov 13
	H.	Refresh Job descriptions to carry our values and standards of behaviour	Mar 14

		Action	By When
Complaints	I.	NED Chair of the Quality Committee to review sample of upheld complaints	August 13
	J.	Review our processes and reporting of complaints	December 13
	K.	Annual peer review of complaints	March 14
	L.	Create easy ways to register a complaint	March 14
Safety	M	Enforcement of reporting management changes	July 13
	N.	Develop Early Warning System	July 13
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Leadership	Q	Cultural survey of staff to be included in staff survey	Aug 13
	R.	Equality Awareness for Governors	Oct 13
	S.	Review of Governors role and practice	Dec 13
	T.	Grow our Council and Board collaborative relationship	Mar 14

Appendix Two: Service Improvement Programmes 2013-14

- **Real Time People Experience Trackers**
- **Safer and Better Practice Programme (the SABP way) using lean tools and techniques**
- **Customer Journey Mapping – improving care pathways through the eyes of our customers**
- **RiO – Process mapping to release more time back to care**

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Surrey and Sussex NHS Healthcare NHS Trust

Update on Trust Actions in Response to the Francis Report

1 Background

1.1 The first report into the care provided by Mid Staffordshire NHS Foundation Trust was published in February 2010. The Inquiry Chairman, Robert Francis QC, stated that 'patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care'.

1.2 Eighteen recommendations were made for both the Trust and central government. The report is based on evidence from over nine hundred patients and families who contacted the Inquiry with their views.

2 Final Report Published 6th February 2013

2.1 The final report published on the 6th February 2013, follows a request in June 2010 by the former Health Secretary Andrew Lansley to conduct the inquiry, after he had recommended in the previous report that there should be 'independent scrutiny of the actions and inactions of the various organisations to search for an explanation of why the appalling standards of care were not picked up'.

2.2 Terms of reference were 'to examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, and to examine why problems at the trust were not identified sooner and appropriate action taken'.

3 Priority Changes Recommended by Francis

3.1 Francis states that five changes are required now:

- That there should be clearly understood and implementation of fundamental standards – it should be a criminal offence to cause death or harm to a patient by non-compliance.

- There should be openness, transparency and candour throughout with a duty of candour being imposed, underpinned by statute and with the deliberate obstruction of this duty being a criminal offence.

- That no person is allowed to deliver hands-on care of a patient without being properly trained and registered; with an additional calling particularly for a new registered status for those working with older patients.

- That there is a strong patient-centred healthcare leadership with the public being entitled to see leaders held to account; and that there is a disqualification of those leaders seriously breaching the code of conduct.

- That there is accurate, useful and relevant information available with patients being able to have access to this.

4 Organisations responding to the Report Publicly

4.1 Francis also states that each organisation should report publicly on how it has enacted the recommendations. It is recommended that:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
- 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;
- In addition to taking such steps for itself, the 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;
- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

5 Initial Government Response

5.1 On publication of the Report, David Cameron, the Prime Minister has apologised for the ‘appalling treatment’ suffered by patients at Mid-Staffordshire NHS Foundation Trust. He thanked Robert Francis QC for his report, which, he said ‘shows how the system as a whole failed’, then specifically highlighted three themes from the report:

- The focus on financial targets at the expense of patient care
- The attitude of patient care being ‘someone else’s problem’
- The defensiveness and complacency instead of facing up to and acting on data which should have implied a cause for concern.

5.2 The government will respond in the very near future to the report in detail; however the PM stated that the recommendations will include three core areas in which immediate attention and progress should be paid:

- Patient care,
- Accountability;
- Defeating complacency.

6 Initial Local Response to the Report

6.1 The report is a long and extremely concerning report, touching on all stages of the patient's journey as well as culture, competence and leadership. Although the next steps in relation to mandatory requirements are awaited; it has been strongly agreed by the Board that there are many areas of learning to consider without having to wait for that direction on those recommendations.

6.2 The report has been discussed and debated at several Trust and divisional committees such as the Quality and Safety Committee, the Management Board for Quality and Safety, and various staff meetings such as the Senior Leaders' meeting, the Chief Executive's monthly staff meeting and at meetings with nursing, medical and healthcare support staff.

6.3 The Board agreed that a specific briefing and highlighting of how the report actually translates into the 'everyday care of patients and their families/carers' would also be produced locally and sent to each individual Trust member of staff to ensure that everyone whatever their role and whether clinical or non-clinical, understood the significance of the report and importantly their own accountability to the delivery and influencing of safe and quality care. This action has been completed with ever staff member having a copy attached to their payslip.

6.4 The Surrey and Sussex Healthcare (SaSH) NHS Trust Nursing and Midwifery Strategy 2013-16 : Your Care First was launched on 10th May 2013 and articulates that learning in particular about demonstrating compassion and delivering optimal standards of care is implicit throughout the strategy. The strategy clear defines how these standards will be achieved, measured, monitored and sustained, with the patient always at the centre of all that we do.

6.5 The current work on developing the role of the ward manager by working with Bucks New University who are running a bespoke ward manager leadership course is considered to be key in improving our front-line nursing leadership and placing these leaders at the centre of the teams caring for patients. The report stated that the decline in standards was associated with inadequate staffing levels and skills, and a lack of effective leadership and support and our local aim to empower and enable the ward manager to lead and drive safety and quality right at the centre of that care is now going to be even more important considering the learning from the report.

6.5.1 The learning from the report has also helped further shape the course content and associated objectives. Coaches and/or mentors have been allocated to the ward managers in the form of senior multi-professional clinical and non-clinical colleagues during and importantly following the course and are aimed at continuing that support and advice when change management is being implemented and sustained.

6.6 Additionally the report highlights that Healthcare support workers (HCSWs) constitute a very large proportion of the healthcare workforce with often little if any voice that is being heard; it raises concerns that there is almost no protection available to patients or the public and no minimum standards of training or competence. Again this learning is helping shape the development and delivery of our bespoke SaSH

Healthcare Assistant Development Programme which commenced on 4th June with a plan to run three cycles of this course in 2013/14 to include content of:

- Teamwork, communication skills, empathy and compassion;
- Quality, patient safety and patient experience;
- The changing landscape of the NHS;
- Accountability, learning from the Francis Report and regulation.

6.6.1 The Trust Healthcare Assistants already undertake 'task based' training days but this development programme has a wider aim in relation to embedding the relevant critical thinking and compassionate behaviours.

6.7 Surrey and Sussex Healthcare NHS Trust has an updated Whistle Blowing Policy compliant with recent legislation where whistle blowers will suffer no discrimination and have their concerns fully investigated.

7 Challenges

7.1 We are however, in no way at all complacent, and have many challenges that we continue to strive to meet on a daily basis and the learning from the report strengthens our requirement to overcome these challenges such as:

7.1.1 Reducing our usage of agency nursing staff and recruiting to all of our nursing vacancies; with the additional objective of ensuring that those staff settle and remain in the Trust for several years to help form and consolidate strong quality local nursing teams.

7.1.2 Quickly embedding our new clinical governance structure and supporting our staff in undertaking the associated roles to ensure that the care provided across the Trust is always of a high quality, promotes the safety of patients and contributes to a positive patient experience.

7.1.3 Ensuring that our intelligence from all sources such as complaints, compliments and relevant reports is analysed effectively and learning always implemented quickly, efficiently and equitably across the Trust with transparency and as highlighted within the report – candour.

8 Summary

8.1 The report has been read and digested at many levels across the Trust; and to particularly ensure that our more junior or less experienced staff who may not see the report as having much bearing on their everyday working lives we have produced a pocket sized guide to help them understand the learning and the associated importance and accountability of every staff member that a patient comes in contact with – both for direct and indirect care.

8.2 We have considered much of our current work and mapped it positively against some of the report's learning, many in relation to failures of staff leadership and empowerment and looked at how we mitigate against these failures happening potentially at a local level.

8.3 However, again we must reiterate that we are by no means complacent as to the work that still is yet to be continually achieved, such as driving out inequity across the Trust in relation to every patient having an optimal experience twenty-four hours a day, seven days a week; and embedding the highest achievement of all quality indicators into a 'business as usual' culture.

8.4 We now need to ensure that safety, quality and compassion is always integrated into everyday systems and processes at every stage of the patient's journey, and continue to make this our priority on a daily basis, while awaiting the government's response to the recommendations and the associated mandatory requirements.

8.5 The Trust overarching action plan is attached for your information.

Des Holden **Sally Brittain**

Medical Director **Deputy Chief Nurse**

June 2013

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	FRANCIS INQUIRY INTO MID STAFFS - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS				
No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
1	**The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.**				
a	Trust vision and values agreed, consulted and launched widely focusing on achieving Trust vision of 'Putting people first - providing safe, high quality accessible care'	Chief Executive	Director of Comms	Completed	The work associated with continuously improving the quality of patient experience and improved staff engagement is now devolved to the Patient Experience and Staff Engagement Group (PESE). The work plan is reported to the Board of Directors Quality and Safety Committee as part of the quality governance arrangements in the Trust. Effectiveness will be measured through the key performance indicators in the dashboard. **October 2012** In addition the Trust is now rated as 'Performing ' overall on the DH Operational Performance Framework following it's work with Empathica which is on going **June 2013** The PESE has been reformatted as the Patient Experience Delivery Committee with an amended TOR that make explicit reference to the report within. The FFT has now been rolled out as per National Guidelines and this along with the Empathica reports and Patient Opinion/Choices feedback support development of services and allow for concerns to be raised. In addition Surgery are trialing "meet the matrons' for face to face feedback and medicine 'consultant clinic's

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
b	Improve the data capture for all patients and staff across to ensure that the voices of all service users are strengthened. Improve the focus on consistently improving services for specific patient groups.	Director of Information and Facilities / Chief Operating Officer	Equality and Diversity Lead	Completed	CERNER upgrade implementation is complete. The system ensures that the Trust can 'flag' a variety of E and D information. The Trust is engaged in whole health economy transformational work programmes to 'fit' the services to the population needs. There are specialty specific patient / service user groups / forums within the Divisions. All Divisions receive monthly real time monitoring information to inform local actions to improve services and patient experience. Ongoing improvement actions are devolved to the Divisional Management Boards. They are subject to Executive and Board of Director's scrutiny through the Deep Dive Governance and Quality and Safety Committee reporting arrangements. **June 2013** All Divisions now receive monthly Empathica feedback and are developing their action plans resultant to the National Inpatient and National Staff Surveys. The PLACE Assessment has been undertaken, the Trust await their final report and will action issues identified. Heathwatch will being their peer review of service having taken over from LiNKS. These reports are discussed at the Trust Board as part of the Joint Chief Nurse/Medical Director Report.
c	Move to a 'medical management model' placing clinicians at the heart of managerial decision making.	Chief Executive	Chief Operating Officer / Medical Director / Chief Nurse	Completed	Medical Management structure in place ensuring clinical leadership from ward to Board.

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
d	Increased use of external benchmarking sources to measure all aspects of safety, clinical effectiveness and patient experience by combining quality and performance dashboards at all levels from ward to board	Chief Nurse, Medical Director, Chief Operating Officer	Head of Performance / Head of Integrated Governance and Quality	Completed	Integrated Quality and Performance Dashboards are in place across the Trust. These are triangulated as they contain benchmarked safety, effectiveness and experience information. Scrutiny is provided through both the performance management and the quality governance route. External scrutiny is undertaken at ongoing Clinical Quality Review Meetings with CCG's and CSU. Synbiotix currently being rolled out across the Trust provides real time ward based performance feedback on clinical and quality indicators The Trust has approved a Quality Management and Governance Policy. This sets out the quality framework in place including roles, responsibilities, accountability, monitoring and reporting at all levels in the organisation. It further contains the Quality Strategy for 2011 – 2013 and implementation work plan and benchmarked Safety and Quality Dashboard. Dashboards will be rolled out at all levels in the organisation. Weekly clinical dashboards are in place for all inpatient wards – falls, pressure ulcers, MRSA BSI, CDI, ward acuity, drug errors, complaints received and quality standards framework scores. ED weekly quality dashboard in place. **June 2013** Monthly submission of data to the National Safety Thermometer.
e	Improve risk assessment throughout the Trust at all levels enabling management of risk in day to day decision making	All Executives for their portfolios	Risk Management Lead	Completed	The Risk Management Strategy work plan has delivered electronic risk assessment and registers which are owned in the corporate and clinical divisions/ directorates interrogated routinely and escalated where appropriate. The work plan to implement the strategy is monitored through

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
					the quality governance arrangements to the Board of Directors Quality and Safety Committee. There are key performance indicators in place at Division and Trust level to measure both process and outcomes.
f	Improve staff engagement in all aspects of the Trust's business, achieving improved results in the National Staff Survey in relation to - safety culture measures and quality of service measures	Director of HR	Equality and Diversity Lead	Completed	The Patient Experience and Staff Engagement Group work plan to deliver continuous improvement in these areas has been approved by the Board of Directors. The implementation of the work plan is reported and monitored through the quality governance arrangements by the Board of Directors Quality and Safety Committee. The Trust's Patient Safety Strategy has been led by a Lead Nurse for Patient Safety and a Consultant Lead for Patient Safety. National key performance indicators are monitored to assess the effectiveness of outcomes. Key performance indicators are in place to measure the effectiveness. Update: The Patient Experience and Staff engagement group is being revised to fit with the overall quality strategy to form a Patient Experience Steering Group. This group will meet as a business meeting (month 1) and an open stakeholder forum (month 2) and alternate. The implementation plan for Patient Experience and key performance indicators (from patient feedback) are agreed and being reported to the Safety and Quality Committee. **June 2013** The PESE has been reformatted as the Patient Experience Delivery Committee with an amended TOR. Staff at all levels were engaged in the development of the Nursing & Midwifery Strategy launched on 10th May. The Leadership Development Course for Ward Manager is currently underway alongside the HCA development course. Synbiotix the ward based real time safety and quality metric is being rolled out across the Trust ownership of the data is at ward level.

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
g	Actively seek and consider and acts on the views and experiences of patients who use the Trust's services	Chief Nurse	Deputy Chief Nurse	Completed	Feedback is actively investigated, reviewed, analysed with gaps being actioned as part of the Quality Governance arrangements. Divisional service review routinely includes experience information to measure quality in each service. **September 2011**: The Deep Dive executive scrutiny quality performance management process is being revised and aligned to the Quality Management framework. Patient Experience, focusing on change resulting from patient feedback will be a key focus at the meetings. **October 12** Each month the Divisional Chief Nurses present a report with regard to patient experience noting actions as a result of patient feedback obtained from the RTM. The Divisions have patient experience on their agenda's and regularly review trends and actions resultant to feedback. **June 2013** Patients Stories are utilised at the Trust Board, N&M Professional Practice Committee, Senior Leaders and All Staff meetings and within the Divisions. This is in addition to the Divisional Chief Nurses review of comments on Patient Opinion, FFT and Empathica feedback and the learning disseminated from complaints.
3	**The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership.**				
a	Actively participate in all clinical networks within the region relevant services provided at SASH.	Chief Operating Officer / Medical Director / Chief Nurse	General Managers / Lead Clinicians / Divisional Chief Nurses	Completed	SASH participates in relevant clinical networks for the services it provides. It responds to external advice / guidance at a national, regional and local level through the quality governance arrangements. Reporting to the Board Quality and Safety Committee.
b	Actively participate in the	Chief Nurse	Service	Completed	EQ programmes are monitored on an ongoing basis as a

	FRANCIS INQUIRY INTO MID STAFFS - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS				
No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
	Enhancing Quality Programme achieving all milestones		Managers for the four care pathways		CQUIN through the quality governance arrangements. External scrutiny by commissioners occurs at the Clinical Quality Review meeting with the PCT's. **September 2011** All four clinical pathways are exceeded the required improvement in the Composite Care Score. **October 12** The Trust is developing the pathways for Dementia and AKI as part of the network **June 2013** Funding has been agreed for a Consultant Dementia & Older People Nurse
c	Improve Trust performance in relation to mortality and achieve a culture where it is embedded in all clinical specialties as an indicator of the quality of service provided	Medical Director	Divisional Chiefs	Completed	The HSMR 2010/2011 has improved to 91 (prior to rebase). Mortality reviews are conducted routinely as part of the quality governance processes. Stroke and #NOF Mortality reviews have been presented and changes implemented. Mortality discussed at monthly Specialist Audit Days. **September 2011** Mortality and Morbidity arrangements from specialty to Board are reviewed and aligned to quality management framework. HSMR and Mortality review groups are being implemented and will report to the Clinical Effectiveness Steering Group. **October 12** The Trust achieved its lowest ever mortality rate this year and is proactively reviewing mortality as part of the newly formed Mortality Review Group chaired by the medical director. **June 2013** The SHIMI & HSMR are within the expected range a Trust such as this.

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
d	Implement Global trigger tool clinical audit of case notes in line with the IHI methodology to establish the rate of harm in the Trust. Draft and implement a patient safety strategy focused on aspects of clinical care which are known to be associated with avoidable harm and implement measuring outcomes and reporting to Board	Chief Nurse / Medical Director	Patient Safety Consultant Clinician, Divisional Chief Nurse Surgery / Head of Integrated Governance and Quality	Completed	The Patient Safety Strategy and improvement work plan outcomes are monitored through the GTT clinical audit and 6 monthly mortality reviews in line with the Patient Safety First Strategy. This is monitored as part of the quality governance arrangements. **September 2011** Global trigger tool assessments are evidencing no adverse events at present. **June 2013** The Safety Thermometer supports identification of harm free care and allows the Trust to identify wards where there are concerns. This will be supported by Synbiotix and the pressure damage board work.
e	Achieve all operational performance targets and commitments to ensure the Trust is performing as expected by service users	Chief Executive	All Executives for their portfolio	Completed	There are extensive remodelling and transformational whole health economy work programmes in place for all areas of adverse performance. Monitoring internally is through performance management arrangements and externally at the Clinical Quality Review Meetings by the CCG's & CSU **Feb 2012** Trust is continuing with remodelling plans including opening 2 new modular wards in Feb 12. Operational targets continue to be challenging to deliver. The Trust is aiming to meet 18 weeks and AE 4 hours by end of March 2012. **May 2012** The trust has achieved the performance milestones agreed with SHA and PCT for ED, RTT, reduction of backlog, 18 weeks and diagnostics and is on trajectory to sustain national targets from June 2012 **October 12** The Trust has surpassed the targets and is now considered to be performing, for the first time, using the national definition. This is a significant improvement.

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
f	Constantly improve referral pathways to tertiary / specialist centres through case review and incident reporting to identify system failures that have the potential to harm patients. Work collaboratively with other providers to understand system failures occurring across organisational boundaries to promote safety	Chief Operating Officer / Chief Nurse	Chiefs	Completed	The Trust follows National Guidance for investigating incidents, reviewing cases, complaints and concerns raised through its policies and procedures. Actions are identified and monitored to completion under the quality governance arrangements. External monitoring by CCG's & CSU is in place. Performance is measured through key performance indicators, clinical audit and measurement of improvement in patient safety programme and via patient feedback mechanisms.
4	**The Trust, in conjunction with the Royal Colleges, the Deanery and the School of Nursing should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels and that high-quality service is recognised and valued.**				
a	Approve and launch a new organisational development strategy focused on delivering the organisational objectives and Trust business plans.	Director of HR	Head of Education, Training and Development	Completed	Senior and Middle Managers Leadership programmes in place focused on the Trust's objectives. **June 2013** Ward Manager Leadership Courses and HCA Development Courses are in place
b	Launch leadership and management development programmes to meet identified training needs for middle and senior managers to enable delivery of objectives	Director of HR	Head of Education, Training and Development	Completed	As above

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
c	Improve compliance with appraisal and personal development plans and training attendance to achieve standards required by Trust Board and externally	Director of HR	Head of ETD , all line managers	Completed	Improved appraisal and PDP achieved in 2010/2011. Workforce governance arrangements are in place with reporting and monitoring to the Board of Directors Investment and Workforce Committee. External monitoring is undertaken by the CCG's & CSU at contractual meetings.
5	**The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.**				
a	Improve 'closing the loop' from clinical audits undertaken at clinical specialty level	Medical Director / Chief Nurse	Divisional Chiefs	Ongoing	The Trust Clinical audit programme is built from speciality and division audit programmes. All core audits are in all speciality programmes. Audit completion, action planning, monitoring and re-audit key performance indicators are being developed. They will be included in the Quality and Safety Dashboard which will be subject to performance and governance monitoring and reporting arrangements. The Board Quality and Safety Committee will receive reports quarterly. External scrutiny will be undertaken at the CQRM with the PCTs. September 2011 Update: The operational process for clinical audit activity has been reviewed in light of the increase in the national audit programme and internal audits. The clinical audit programme is being actively managed within the Divisions by the Chiefs of Service. Executive scrutiny and performance management occurs at the Divisional Deep Dive. The Trust Board's Safety and Quality Committee is overseeing the clinical audit programme as part of the Board's assurance framework. **February 2012** Key performance indicators are in place for the clinical audit programme at Trust and Divisional level. These are reported to Trust Board monthly via their Safety and Quality Committee. Compliance with progressing the programme and agreeing action plans from completed audits is increasing month on month.

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
					May2012 Enhanced monitoring of action plans arising from clinical audits is in being progressed and compliance with closing the actions to time is being implemented across all Divisions. **October 12** The Trust has made significant progress with ensuring audits have a resulting action plan which is then monitored within the Divisions **June 2013** Divisions continue to improve as detailed above with a report to S&Q Committee to provide assurance
b	Clinical Effectiveness Strategy to be launched to strengthen the use of clinical audit to support delivery of safe, high quality care	Medical Director / Chief Nurse	Quality and Standards Lead	Completed	Clinical Effectiveness strategy approved and being implemented through the work plan. Reporting through KPI as part of the quality dashboard is in place. **September 2011** The Quality Management and Governance Policy sets out a Clinical Effectiveness Steering Group and reporting groups. It will oversee implementation of the Clinical Effectiveness Strategy. Executive scrutiny will take place at the Divisional Deep Dive with monitoring and reporting at both Management Board and Safety and Quality Committee. **October 2012** The Clinical Effectiveness Group is being reviewed to ensure the model is fit for purpose. Its sub groups are still meeting and its objectives are being monitored by the MBQR and SQC. **June 2013** Strategy Written, TOR in draft , meetings to commence as soon as possible

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
c	Improve links between clinical audit and risk / improvement work streams within the Trust to enable effective change being made in response to audit outcomes.	Medical Director	Divisional Chiefs	Mar 2011ongoing monitoring via Management Board and Safety Committee	The Risk and Clinical Effectiveness policies and their associated work streams support delivery of the Trust's Quality Strategy. The inclusion of safety, effectiveness and experience information and benchmarks in all quality dashboards alongside the scrutiny and challenge undertaken in the integrated governance team identifies themes to optimise efforts to improve service quality. **September 2011**: Standardised process being implemented that cross references clinical audits with incidents, risk register, patient experience feedback. This will be used to decide the level of assurance that can be derived as well as to prioritise clinical audit resources. **February 2012** Improving linkage is in place. **May 2012** Process in place with KPI's for monitoring divisional action plans to encourage action following audit Specific topics audited following risk register review e.g. continuous radiology audit. More formal arrangement in place for 2012/3 with scrutiny from S&QC. **June 2013** Datix Web live for incident reporting since February 2013 Incident reporting and clinical audit no longer considered a significant control issue.
d	Review the current clinical audit arrangements across the Trust to ensure they can support the Trust's requirements	Medical Director	Internal Audit	Completed	The Internal Auditors are undertaking an independent review of the current arrangements and will be providing a report to the Audit and Assurance Committee. Following this there may be the need to review arrangements further. September 2011 Update Internal audit have reviewed the clinical audit function and are reporting to the Audit and Assurance Committee in

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
					September 2011. Actions identified from this audit are contained within the Quality Management Implementation plan. **June 2013** Following consultation clinical audit restructured to fit preferred model effective early 2013
6	**The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it: • provides responses and resolutions to complaints which satisfy complainants; • ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned;• minimizes the risk of deficiencies exposed by the problems recurring; and • makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public.**				
	Actively seek and consider and acts on the views and experiences of patients who use the Trust's services	Chief Nurse	Deputy Chief Nurse	Completed	As per action 1a.b.d.g.
	Sustain current performance levels in complaints management and seek to achieve further improvements	Chief Nurse	Head of Integrated Governance and Quality	Under review	Following consultation the complaints process is under review, performance is stable but not at the desired level , current process as being reviewed looking at new and reopened complaints however referrals to Ombudsman stay stable. Previous inspection from the CQC found no concerns, audit highlights the issues above
	Improve the use of all sources' of information to identify risks and deficiencies in systems used within the Trust / across organisational boundaries. Improve collaborative working with other agencies to ensure complete pathways are robust where deficiencies are identified	Chief Nurse / Medical Director / Chief Operating Officer	Risk Management Lead	Completed	Action undertaken as at 1d and 3f. Implemented into ongoing work streams within the quality governance framework.

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
	Review the reporting arrangements and communication of shared learning across the Trust to enable maximum opportunity to be a learning organisation.	Chief Nurse / Medical Director / Chief Operating Officer	Risk Management Lead	Initial action completed. Ongoing monitoring via Quality and Safety Committee	Specialty level forums being developed. Sharing at Divisional and Trust levels in place. **February 2012** Trust approved Quality and Safety strategy in place and work plan being progressed to implement specialty quality and risk forums. To date Trust Board, Management Board, internal governance framework review and revision has been progressed. **May 2012** External review of board meetings and communication and session with Trust staff to share mid Staffs learning with staff at SaSH. **June 2013** Final action still under review local shared learning in place and patient stories now discuss at Board, Divisional, N&MPPC which include lessons learnt
	Improve capability of frontline staff to conduct appropriate level investigations to bring swift resolution and answers to service users with concerns	Chief Nurse / Medical Director / Chief Operating Officer	Divisional Chiefs and Divisional Chief Nurses	Completed	Clinical Divisions have an infrastructure of trained Clinical Leads and Matrons within their specialties / departments trained in RCA.

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
7	**Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.**				
	Rolling review of all relevant Human Resources policies in line with the Trust's Organisation Wide Policy for the Management of Policies, Procedures and Guidelines.	Directors for Policies relating to their portfolio	Deputy Director of HR	August 2011	**February 2012** Rolling programme in place **May 2012** All HR policies on the intranet are in date apart from the TU recognition and facilities agreements which we are currently negotiating with the Trade Unions. This work is nearing completion and we anticipate launching them mid summer together with the Partnership Agreement. The Medical and Dental Disciplinary Policy and Procedure mirrors maintaining high professional standards and is being rolled over as it is and is with Chair of LNC for signing off. We have a rolling programme of policies for review. The following policies have been reviewed and are due to be launched at the beginning of June : Annual Leave Whistle blowing Special Leave The sickness absence policy is also under review and is due to be launched during June. We have established a Policy Review Group with the trade unions. **June 2013** Policies as above are all ratified and available for staff on the intranet

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No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
8	**The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.**				
	Ensure staff safety culture of openness and reporting improves as measured in the National Staff survey	Director of HR	Head of Employee relations	June 2010	Staff Safety Culture completed. Patient Safety Leads are progressing work plan associated with patient safety improvement priority work streams. Annual staff survey to measure progress will be reported to the Board's Quality and Safety Committee. **May 2012** Paper going to the Board which identifies the Trust as being in the best 20% and where there has been a statistical improvement since 2010 for Percentage of staff reporting errors, near misses or incidents witnessed in the last month (98%) The report does go on to say that the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (44%) is high and puts us in the worst 20% for acute Trust. W need to continue to focus on safety and quality and work to prevent the incidents from occurring in the first place **June 2013** Staff engagement score showed significant improvement in top 20% for staff motivation. Improvement in communication with senior managers also a significant improvement. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (90%) Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (37%) this is **not** in the worse 20% of Trust

	FRANCIS INQUIRY INTO MID STAFFS - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS				
No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
	Improve staff engagement in all aspects of the Trust's business achieving improved results in the National Staff Survey in relation to - safety culture measures and quality of service measures	Director of HR	Equality and Diversity Lead	Completed	Action as at 1a with ongoing implementation arrangements.
10	**The Board should review the management and leadership of the nursing staff to ensure that the principles described in the report are complied with.**				
	Review nursing professional and line management structures and reporting arrangements as part of the clinical services restructure.	Chief Executive	Chief Operating Officer	Complete	Clinical restructure completed.
	Design and launch a weekly programme of audit of clinical nursing standards based on Essence of Care Standards, High Impact actions and energising for excellence.	Chief Nurse	Deputy Chief Nurse	Complete	**September 11** The redesigned programme is nearing completion for implementation. The current arrangements; safety cross metrics, safer smarter nursing metrics remains in place until the new programme is launched. **February 2012** Revised programme in place and supplemented by a programme of daily Matron checks and daily ward reporting of key harms. March 2012 work in progress to implement nursing safety thermometer **May 2012** Process designed to collect safety thermometer data and input onto Quality Observatory. Initial data shows 95% harm free care for our patients

	FRANCIS INQUIRY INTO MID STAFFS - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS				
No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
					June 2013 Saving lives is within the Synbiotix data collection model The N&M Strategy clearly defines the standard of care and conduct required of all RN,RM in the Trust. The HCA Code of Conduct will be reviewed and rolled out to that group of staff
	Key performance indicators (Metrics) for nursing are in place throughout the Trust. These include falls, pressure ulcers, complaints, HCAI data, incidents and errors in relation to nursing activities	Chief Nurse	Deputy Chief Nurse	Complete	Dashboards will be rolled out at all levels in the organisation. Weekly clinical dashboards are in place for all inpatient wards – falls, pressure ulcers, MRSA BSI, CDI, ward acuity, drug errors, complaints received and quality standards framework scores. ED weekly quality dashboard in place. **May 2012** Decrease in falls and pressure ulcers and complaints noted in Q4 2111/2. Reprofiled the Infection Control meeting , now weekly and chaired by CEO. Action plan from external visit being implemented and contacting areas of excellence to learn from. **June 2013** There is a pressure damage board in place which has been supported by additional care bundles and seen a reduction in pressure damage There is a new falls team and falls strategy in place to support additional physical presence on the wards and scrutiny of available data Safety Thermometer is submitted monthly
11	**The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients.**				
	Move to a 'medical	Chief Executive	Chief Operating	Complete	Structure in place

	FRANCIS INQUIRY INTO MID STAFFS - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS				
No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
	management model' through organisational structure review which places clinicians at the heart of managerial decision making.		Officer / Medical Director / Chief Nurse		
12	**The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.**				
	Improve quality of healthcare record keeping standards to ensure they meet the professional standards required for each professional group	Chief Operating Officer / Chief Nurse / Medical Director	Divisional Chiefs and Divisional Chief Nurses	Pilot completing May 2011 Full roll out by August 2011- complete	Documentation/Cerner groups merged and meeting monthly. Nursing documentation redesigned and pilot underway and now rolled out through Trust Plan to include session on stat/mandatory days for nursing staff. **May 2012** Documentation session included in stat/mand days. Audit of heath care records in May report expected in July.
	Improve Information Governance toolkit performance to at least level 2 across all criteria in 2010/2011	Director of Information and Facilities	Information Governance & Security Manager	March 2012	Level 2 achieved in all but 5 areas of IG toolkit in 2011. **October 2012:** The process of reassessment is underway and the Trust anticipates maintaining the high standards of previous years. **June 2013** Toolkit compliance maintained
13	**All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.**				
	Improve frontline staff understanding of the causes, management and implications of confusion in	Chief Nurse / Medical director	Head of ETD	Initial actions complete. Pilot MCA and Consent survey	Staff survey currently being piloted in Medicine Division about Mental Capacity and Consent. Plans to roll out Trust wide and review current stat and mandatory training packages in place. Bespoke training being delivered to areas identified as

	FRANCIS INQUIRY INTO MID STAFFS - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS				
No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
	all patients.			completing May 2011. Sept 2011	requiring additional focus. **February 2012** Consent TNA completed and Policy revised. E learning package in place covering MCA / DOLS and consent – mandatory training for Consultants and Associate Specialists being rolled out across all relevant staff groups. **May 2012 update** Monthly/regular safeguarding for adults, children and learning disabilities provided in house.
	Improve understanding and management of patients with dementia	Medical Director	Director of Strategy	October 2010 onwards	As above in relation mental capacity and consent. Trust has a Consultant and Nursing Dementia Lead and is drafting the Dementia Strategy. The Trust is participating in the EQ programme. **September 2012** Established dementia steering group (met twice) Draft dementia strategy and action plan written for sign-off by steering group in October, then to management board for final sign off. Clinical and operational document in development (as part of action plan) Older Adults liaison team to be in place by 1 Nov 2011 Fixed term dementia specialist nurse / champion post currently in recruitment for 6 months to drive forward action plan, facilitate education and training and monitor quality and efficiency benefits On plan to record prescribing of anti-psychotics and benzodiazepines as part of EQ programme **February 2012** Strategy in place. Additional resources under recruitment. Implementation programme being progressed. **May 2012** Dementia nurse appointed. Dementia care improvement group with stakeholder membership established, patient experience measured by KPI's

	FRANCIS INQUIRY INTO MID STAFFS - ACTION PLAN IN RESPONSE TO RECOMMENDATIONS				
No	**Action**	**Executive Lead**	**Senior Manager**	**Date for Completion**	**Progress as at June 2013**
					June 2013 Consultant Nurse for Dementia and Older People at a senior post agreed Staff have completed Dementia Programme Identified Dementia leads in place
14	**The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.**				
	Trust nurses work to the professional standards set by their regulatory body and the Code of Conduct.	Chief Nurse	Divisional Chief Nurses	Completed	All professional nursing standards are subject to constant review and scrutiny and managed in line with HR and professional codes of conduct.

For more information

For more information about the Francis Report visit

www.midstaffspublicinquiry.com/reportour

or visit our intranet site

www.intranet.sash.nhs.uk.

If you would like to discuss any aspect of the Francis Report with Michael Wilson, Chief Executive, please talk to your line manager or contact Sacha Beeby on 01737 231817 or email: sacha.beeby@sash.nhs.uk

◆ Our Values

As an employee of Surrey and Sussex Healthcare NHS Trust, you have an individual responsibility to treat everyone with:

- ***Dignity & Respect:*** we value each person as an individual and will challenge disrespectful and inappropriate behaviour
- ***One Team:*** we work together and have a 'can do' approach to all that we do recognising that we all add value with equal worth
- ***Compassion:*** we respond with humanity and kindness and search for things we can do, however small; we do not wait to be asked, because we care
- ***Safety & Quality:*** we take responsibility for our actions, decisions and behaviours in delivering safe, high quality care

Our values set out the expectation that we should all take individual responsibility.

Surrey and Sussex NHS
Healthcare NHS Trust

The Francis Reports

A guide for staff

Putting people first
Delivering excellent, accessible healthcare

◆ The first Francis Report:

The first report into the care provided by Mid Staffordshire NHS Foundation Trust was published in February 2010. The Inquiry Chairman, Robert Francis QC, stated that 'patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care'.18 recommendations were made.

◆ The second Francis Report:

The final report published in February 2013, was to examine why problems at Mid Staffs were not identified sooner and appropriate action taken. It touches on all stages of the patients' journey as well as culture, competence and leadership. 290 recommendations are made.

◆ Francis-2 Recommends:

- It should be a criminal offence to cause death or harm to a patient by non-compliance
- Openness, transparency and candour throughout the system.
- No one allowed to deliver hands-on care of a patient without being properly trained and registered, and a new registered status for those working with older patients.
- Patient-centred healthcare leadership with the public being entitled to see leaders held to account.
- Accurate, useful and relevant information easily available to patients.

◆ Our response :

The Government still has to decide how it will respond to the recommendations in the most recent Francis report and it is unclear as to what NHS-wide changes will be made. The report says that each Healthcare Trust should look closely at the recommendations and decide how to apply them to their own work.

However, putting that to one side, we should all take some time to think about our own practice and make sure that safety, quality and compassion is the centre of our work day-in and day-out, and at every stage of our patients' journey.

◆ Our Trust:

Over the last two years our trust has moved from delivering very few of the national quality and safety standards, to delivering them all.

We have modernised East Surrey Hospital with improved facilities in the Emergency Department and Endoscopy and our new Main entrance.

We have doubled the number of consultants in the Emergency Department, and increased consultants in many other services across the Trust. We have also increased the number of midwives, nurses and middle grade doctors too.

Ward hygiene and cleaning scores, IV line and urinary catheter care and antibiotic prescribing audits have all contributed to improved high levels of quality and safety.

Although we have experienced two norovirus outbreaks, we have contained these more quickly than previously, with fewer patients either contracting norovirus, or affected by ward closures

Patient Opinion, an external online forum for patients to write about their experience, recently singled us out as one of their most improved trusts for patient experience.

South East Coast Ambulance Service NHS Foundation Trust

Taking forward the Francis report – an update for Surrey HSC

In February 2013 Robert Francis QC published his report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, along with 290 recommendations aimed at ensuring that the problems that afflicted the Trust, and the poor patient care and needless deaths that resulted, are never repeated.

While the main focus of the report is hospital services, many of the recommendations are equally applicable to the NHS as a whole. The words 'nursing staff 'could easily be substituted with the words 'ambulance staff', and SECAmb takes seriously its responsibility for ensuring that patients must always come first, and has already begun to consider and act on the Francis recommendations.

On publication of the report in February, a meeting was held with Trust governors, staff-side representatives and non-executive directors to discuss the findings and recommendations of the report and its impact on SECAmb. The presentation given at the meeting was developed with the involvement of SECAmb student paramedics and staff as part of their preceptorship programme. The outputs from this meeting were presented to the Trust Board in March, along with a report originally provided to the Trust's executive team which provided initial thoughts about the implications of the report for the Trust. A presentation was also provided to Band 8 managers in March as part of a regular series of 'talk to us' sessions.

Culture

Culture is a key focus of the Francis report, and cognisant of its importance, SECAmb began a programme of work around 18 months ago to explore the various cultures within the Trust and to put in place an action plan aimed at harmonising these cultures and aligning them with SECAmb's ethos and values. This has included a cultural audit, a series of meetings with Clinical Team Leaders, a programme of open sessions with band 8 managers, new mechanisms for communicating with staff, the renegotiation of terms of engagement with our staff-side colleagues, and the rejuvenation of the Trust's Foundation Council (the staff equivalent of the Trust's Council of Governors), and regular discussion and review at Board development days.

One of Francis's overarching recommendations is that the NHS must put patients first and make efforts to ensure that it recruits staff who are kind, caring and compassionate. Over the last two years SECAmb's emergency patient surveys have shown satisfaction levels of 92%-93%, which is testament to the sterling work and calibre of SECAmb staff. This excellent record notwithstanding, SECAmb has recently taken steps to promote values-based recruitment, providing information for prospective candidates and testing values at interview.

Further actions were proposed to the Trust Board in May, many of which are already underway and include: provision of NHS and Trust values sessions in all training programmes; an agreement with the Trust's Joint Partnership Forum (a group of SECAmb directors/managers and union representatives) to support improvement in

behaviours; the introduction of staff advisors to support staff in difficulty; development of a new Personal Appraisal and Development Review plan.

Engaging with patients and improving their experience
The Trust receives feedback about its services via complaints, concerns and compliments and also carries out patient surveys for both its emergency and patient transport (PTS) services to proactively seek patients' views, the results of which are always encouraging. However the nature of ambulance service work can present challenges in terms of obtaining patient feedback, so proposals for the development of a Patient Experience Strategy were presented to and approved by the Trust's Risk Management and Clinical Governance Committee in May. The strategy will be developed with the involvement of patients and staff, will reflect the Trust's values, vision and objectives and will shape our future efforts to obtain patient feedback spanning the whole range of SECAmb services and patients. This will enable us to determine what works well for patients and carers, as well as what doesn't, and to make improvements as a result in order to improve the public's experience of SECAmb's services.

Leadership
The NHS 'command and control' style of leadership is particularly prevalent in ambulance services. While the Trust Board undertakes a continuous programme of development, further specific actions were proposed at the Board's May meeting to try to move the Trust towards a 'shared leadership' model, including: 360 degree appraisals for directors and managers; a review of Trust management programmes; refocusing of Board information to reflect qualitative as well as quantitative measures; the introduction of an external and internal coaching and mentorship programme for first-line clinical managers.

Defining and measuring standards of care
There exists a plethora of official targets and measures against which NHS trusts are assessed by a host of regulators. However, SECAmb is keen to ensure that it captures and has metrics for assessing the quality of all aspects of the patient journey, and will be holding a workshop in June to begin to map out the journey and identify key interactions and interventions.

Openness, transparency and candour
SECAmb has always believed itself to be an open, honest and transparent organisation. Following the Francis report the Trust will reiterate and promote its ethos in this respect throughout the organisation, from classroom to Board room, promoting the new Duty of Candour and ensuring all staff are aware of their obligations in terms of honesty and transparency, and at the same time reiterating the Trust's pledge to them that should they wish to report concerns they will be listened to and respected.

Finally, the Trust has recently drafted an action plan showing proposed recommendations against each of the relevant 290 recommendations, and this will be reviewed by the Trust's Board Review Meeting in June.

Francis Report – Key messages for Health Overview & Scrutiny Committees

Local HOSCs have a role to play in monitoring quality by providers in their area.

1. Stafford Borough OSC

In Staffordshire, the majority of scrutiny of the Trust during the period under review was undertaken by the Borough Overview & Scrutiny Committee. There was no clear allocation of responsibility between Staffordshire County Council and Stafford Borough Council, with just a general working agreement that the County Council HSC would look at county-wide issues while the Borough OSC would look at local issues.

Committee records

Minutes at Stafford Borough Council were not overly informative as they merely summarised presentations and formal questions without summarising the debate. While the Inquiry does not feel that a Hansard-style verbatim record of meetings is necessary, it no less believes that minutes that do not effectively reflect the discussions at a meeting are unfair to councillors and obstruct public involvement and engagement by not providing a full record.

Information availability

Stafford Borough OSC received information primarily from the Trust itself. There was little to no information provided by members of the public or PALS in relation to complaints about the Trust. Additionally, the HCC did not provide the committee with any relevant information.

Public participation

Public were allowed to attend committee meetings but had to table questions seven days in advance. As public did not often attend meetings, there was concern that incidents were missed due to the lack of engagement and also the rigid questions policy. Additionally, it did not appear that there was an attempt at gathering information from the public.

Recognition of problems

The main campaigner in the period of poor care under review was Julie Bailey. She got involved with the Borough OSC and asked questions at a meeting and wrote letters to members. As mentioned above, the poor standard of minute-taking meant the responses to her questions were never recorded. In response to one of her letters, she was somewhat dismissed with comment that the Health Scrutiny Committee could not get involved in individual cases. This followed the committee's support for the Trust's FT application.

While the committee probed into details of financial difficulties, including the reduction of staff, and the reasons for a poor rating from the Health Care Commission's Children's Services review, there was little in the way of deep, delving questions or scrutiny. In a presentation about an Ipsos Mori survey, in which the Trust appeared to 'spin' poor results, the committee did consider that they weren't being told the whole story and proceeded to seek further information. This was while the HCC investigation was going on. For the most part, the committee took the Trust's assurances at face value.

Conclusions
The committee did not have adequate resource or expertise to mount an effective scrutiny of the Trust, especially on their cost-cutting plans. They had to accept Trust assurances that quality of care would not be affected by staff reductions. There was no guidance or benchmarks to assist members.

The FT consultation process was “meaningless” as the committee did not appear to robustly question the Trust nor did it take any steps to verify what it was told. Again, it had to accept the Trust’s statements in good faith.

The committee was reliant upon the PPIF for information and to undertake visits to investigate claims of cleanliness. It did not respond to reports from the PPIF with any comment or further requests for action.

Julie Bailey and her concerns were essentially dismissed. The view was taken that it was not for the committee to take action but for her to approach others. The committee should have recognised these as serious concerns and, furthermore, should not be so dismissive, as this could lead less persistent campaigners to continue.

There was no definitive scrutiny of the Trust prior to finding out about serious concerns. The scope of scrutiny and terms of reference for the committee might have helped, as committees have many areas in which to scrutinise. They must balance these and there was evidence that there was uncertainty about how to scrutinise an acute hospital. There was also not enough weight placed on information from the public.

Councillors claimed there wasn’t more that could be done. They didn’t have the ability to enter and view the hospital nor did they have the expertise or background to effectively question or scrutinise. The Inquiry feels otherwise. The committee did have the ability to get information from PALS, the PCT, the PPIF and its residents. The allegation is that it waited for these bodies and individuals to approach it. It did not pay attention to the PPIF annual reports and was unaware at the ineffectiveness of the PPIF. The committee never thought to ask the County Council HSC to use its power to report the Trust to another NHS Body or the Secretary of State. Finally, the committee only really began to scrutinise the Trust after the HCC investigation began; however, the committee did not attempt to contact the HCC to offer its help. It expected the HCC to contact it, which it did not.

2. Staffordshire County Council HSC

Delegation to the OSC
There was a failure of communication between the County Council HSC and the Borough OSC as to the exact responsibilities of scrutiny. While the County Council did not forgo any scrutiny of the Trust, most of it was no less done by the Borough OSC instead.

Committee approach
The Chair of the HSC argued that members are elected to represent their

communities, not for their expertise in health matters. He also argued that the committee's role was not to "micro-manage the Trust." His view was to hold 'relationship-building meetings' with the Trusts.

There appears to have been a disagreement between the Chair and Vice-Chair on these meetings. While the Chair felt that the committee should build relationships and not be antagonistic, the Vice-Chair did not want to participate in relationship-building meetings, feeling that they did not pose the best opportunity to scrutinise.

The Inquiry believes the committee did not actively seek the views of the public, as per the Chair's policy. He disagreed with DH guidance on a HOSC seeking the views of others. There was, in fact, no policy for members of the public to ask questions at committee. The main source of information, as with the Borough OSC, was the trusts themselves.

Scrutiny of the Trust

The Trust was questioned in 2005 about a service reconfiguration that the committee felt it had not properly been consulted on, as set out in the regulations. There was consideration given to referring them to the Secretary of State but it was decided that the questioning was sufficient and they would be required to provide several items for the committee: improved lines of communication; reassurance about the development of patient, carer and public involvement systems; and details of current service provision.

The committee wrote to the Trust regarding the closure of a gynaecological ward and its potential effect on patients. At the next meeting, it was reported that the senior officer to whom they had written had accepted the points raised.

There was concern about cleanliness and the level of CDiff infections but, in comparison with other authorities, the committee did not feel it merited further in-depth scrutiny.

Little weight was given to the Annual Health Check that resulted in a lower score and evidence of non-compliance in some areas. The Chair took on face value the Trust's explanation that this was mainly due to not submitting information.

As part of the FT application process, the Trust was required to consult the HSC. The Chair did not feel it was the committee's place, as part of the consultation, to ask whether the Trust was performing at high standards. It relied on Monitor's assessment of how well the Trust was performing and did not seek views from elsewhere. The fact that it was granted FT status merely perpetuated the myth that the Trust was performing well and was clinically safe and sound.

During the HCC investigation, the Chair met with the Trust but did not raise the issue of the inquiry. He felt the HCC had more powers and resources than the committee and was reluctant to take any action on its own.

Clarification was sought in relation to higher mortality figures at the Trust but it was explained as being down to "coding information about patients." This was accepted by the committee and no further scrutiny done, in part because, again, the Chair felt

the HCC had better access to information and powers beyond that of the committee.

After publication of the damning HCC report, the committee questioned the Trust. There was concern expressed about lay members being able to understand information without expert assistance. The HSC set up joint accountability sessions with the Borough OSC at this stage. They also put together a joint code of working that made explicit that scrutiny of the Trust was the responsibility of the county HSC.

Conclusions
The idea of being a “critical friend” rather than robustly challenging the Trust meant the committee did not uncover deficiencies. Trust statements were taken at face value and little done to investigate further. There was a feeling of the committee wanting to support the hospital rather than challenge it.

There was a lack of clarity on the role of scrutiny. The Chair did not feel the guidance from the DH was good enough. The Inquiry, on the other hand, did not believe he had read it. The Inquiry believes the Guidance did place too much emphasis on building relationships and having constructive dialogue but, at the same time, it does not explicitly state that a committee cannot launch a scrutiny into a serious matter for concern regarding service safety and quality.

The Inquiry believes scrutiny has a clear role to play in monitoring provider trusts in its area. This must be more than simply accepting what a trust says unchallenged. Since the HCC report, Stafford HSC has held regular meetings and required reports, with members asking more challenging questions based on information from the public.

The Inquiry feels the scrutiny performed by the committee was deficient for a number of reasons:

- It failed to make clear where the responsibility lay for scrutinising the Trust, a major provider of healthcare in the county. In spite of claims to the contrary, it did not divest itself of its responsibility to involve itself in the scrutiny, either in theory or practice.
- Having maintained such a role, it confined itself to the passive receipt of reports.
- It made no attempt to solicit the views of the public. It had no procedure which would have encouraged members of the public to come forward with their concerns.
- It made little use of other sources of information to which it could have gained access, such as complaints data or even press reports.
- It showed a remarkable lack of concern or even interest in the HSMR data. Difficult though statistics can be to understand, it should have been possible to grasp that they could have meant there was an excess mortality that required at least monitoring by the committee, with challenge being offered to the coding explanation.
- It showed little reaction to the concerns expressed by CURE to the Borough Council OSC, even though they were at least in general terms brought to its

attention.

- It took no steps to consider the implications of the announcement of an investigation by the HCC or to follow its progress.

The Inquiry agrees that committees cannot be experts in healthcare, but the minimum expectation of elected members would be to make themselves aware of, and pursue, the concerns of the public that elected them. The ability to call Chief Executives of provider trusts is a powerful tool that could incentivise improvement and act as a key challenge to information the public may feel is inaccurate or superficial.

3. Report recommendations relating to HOSCs

47 The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.

119 Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.

147 Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

148 The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.

149 Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

150 Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.

246 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.

4. Conclusions for Surrey HSC

1. Surrey HSC should consider defining what the responsibilities/expectations are for our Borough and District Councils.

2. Surrey minutes are fairly descriptive in outlining member questions and witness answers; however, the quality of minutes is related to the person taking them. There may be scope to look at improving our minute-taking by: agreeing best practice on level of detail; inviting peer review; and/or all Democratic Services staff to undergo minute-taking training to refresh skills.

3. The Committee needs to work with Healthwatch going forward on utilising their power to undertake enter and view inspections. We should develop a relationship with Healthwatch whereby information can be shared freely and regularly.

4. The Committee ought to consider its public engagement tools. Either through the new Healthwatch or through setting up its own methods, the Committee could improve the amount of public engagement and involvement it has.

5. The new Quality Account MRGs will offer an excellent opportunity for Surrey HSC to more closely engage, and raise issues of public concern, with the provider trusts in the County.

6. Training will always be an issue for the Committee. While members should not be expected to be experts in healthcare, they should have a basic understanding of the health landscape in Surrey. This will be down to Democratic Services but also the capability of individual members. The HSMR should be one of the first training sessions, along with other provider performance information.

7. The Committee has moved from a very antagonistic approach to scrutiny in years past to a more constructive relationship with all NHS bodies. It will need to constantly monitor its questioning to ensure that it is challenging provider trusts and not simply accepting statements as the full story. Regular de-briefs between the Scrutiny Officer, Scrutiny Manager and Committee Assistant offer a good way of analysing the Committee's public meetings. These should include the Chairman and Vice-Chairman in future, where possible.

Health Scrutiny Committee
4 July 2013

Recommendations Tracker and Forward Work Programme

Purpose of the report: Scrutiny of Services and Budgets/Policy Development and Review

The Committee will review its Recommendation Tracker and draft Work Programme.

Summary:

1. A recommendations tracker recording actions and recommendations from previous meetings is attached as **Annex 1**, and the Committee is asked to review progress on the items listed.

2. The Work Programme for 2013/14 is attached at **Annex 2.** The Committee is asked to note its contents and make any relevant comments.

Recommendations:

3. The Committee is asked to monitor progress on the implementation of recommendations from previous meetings and to review the Work Programme.

Report contact: Leah O'Donovan, Scrutiny Officer, Democratic Services

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Sources/background papers: None

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ANNEX 1

HEALTH SCRUTINY COMMITTEE
ACTIONS AND RECOMMENDATIONS TRACKER – UPDATED 26 MARCH 2013

The recommendations tracker allows Committee Members to monitor responses, actions and outcomes against their recommendations or requests for further actions. The tracker is updated following each Select Committee. Once an action has been completed, it will be shaded out to indicate that it will be removed from the tracker at the next meeting. The next progress check will highlight to members where actions have not been dealt with.

Select Committee Actions & Recommendations

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC004	District and borough co-optee report [Item 10]	Protocol to be sent to HOSC Members.	Bryan Searle	Work is ongoing.	*None*
SC005	District and borough co-optee report [Item 10]	Protocol to be sent to all Leaders of Boroughs and Districts to determine their own local arrangements.	Bryan Searle	Work is ongoing.	*None*
SC020	Performance and QIPP Update [Item 7]	Members to be provided with a guide to the measures on infection control required by hospitals and noted that there is much agreement on best practice	Acting Director of Governance, Transition and Corporate Reporting, NHS Surrey	To be provided as soon as possible	*July 2013*
SC022	South East Coast Ambulance (SECAmb) Performance Deep Dive [Item 6]	Members to be provided with further information on the development of the Community First Responders Scheme and placement of de-fibrillators in rural areas.	Director of Corporate Services, SECAmb/Scrutiny Officer	This has been put on the Work Programme for July 2014	*July 2014*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC023	South East Coast Ambulance (SECAmb) Performance Deep Dive [Item 6]	The Committee would welcome working with SECAmb on how to use clinical outcomes to continue to improve performance across the County.	Director of Corporate Services, SECAmb/Scrutiny Officer	This should form part of the next performance update from SECAmb	*TBC*
SC024	Patient Transport Services [Item 7]	The Committee is concerned that the new PTS contract has not offered the best patient experience to date, but welcomes assurances that most problems have now been dealt with. The Committee requests a performance report in six month.	Scrutiny Officer, Director of Corporate Services, SECAmb CEO, Surrey Coalition of Disabled People	This has been added to the Work Programme for September 2013	*September 2013*
SC025	LINk Stroke Rehabilitation Project [Item 8]	The Committee endorses the report and the action plan, and requests Healthwatch takes it forward.	Healthwatch/Jane Shipp	This has been added to the Work Programme for January 2014.	*January 2014*
SC026	LINk Stroke Rehabilitation Project [Item 8]	The Committee to monitor Healthwatch's progress on the plan and requests an update report in future.	Scrutiny Officer	This has been added to the Work Programme for January 2014.	*January 2014*
COMPLETED ITEMS					
SC021	Recommendation Tracker and Forward Work Programme [Item 8]	The implications and issues arising from The Francis Report to be included in the Work programme for future consideration.	Scrutiny Officer	This has been put on the work programme	*COMPLETED*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC007	Surrey County Council Cabinet Members for Adult Social Care and Health priorities and performance update [Item 11]	The Public Health strategy comes to the next appropriate meeting, including financial aspects and outline spending plans.	Dr Akeem Ali	The Committee considered the Public Health budget at an information workshop following the 14 March 2013 meeting.	*COMPLETED*
SC017	Sexual health services [Item 9]	The Committee looks forward to receiving further information and clarification in due course on future commissioning arrangements for all sexual health services and the new JSNA chapter	Director of Public Health/Scrutiny Officer	Information was provided to the March 2013 Public Health budget workshop.	*COMPLETED*
SC018	Review of Epsom Hospital Merger [Item 6]	The Committee formally calls on Epsom Hospital and Ashford & St Peter's Hospitals and other health organisations in Surrey to re – open discussions on joint arrangements seeking improvements in care and organised efficiencies either through management steering or eventual merger	Epsom & St Helier Hospials/Ashford & St Peter's Hospitals	This has been passed to the hospitals for action.	*COMPLETED*
SC019	Review of Epsom Hospital Merger [Item 6]	The Committee is concerned that boundary issues appear to have been a factor affecting the roll out of Better Services Better Value(BSBV) and calls for a wider and more independent review of acute provision in the sub-region.	NHS South West London/NHS Surrey/CCGs from 1 April	This has been passed to these bodies for action	*None*

Number	Item	Recommendations/ Actions	Responsible Member (officer)	Comments	Due completion date
SC006	Health Scrutiny Committee annual survey and report [Item 11]	That the HOSC consider producing an annual report to Council detailing performance.	Scrutiny Officer	The HSC contributed to the Scrutiny Annual Report.	*Complete*

Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
September 2013				
18 Sept	NHS 111 Service	Scrutiny of Services – The NHS 111 Service went live in Surrey in March. The aim of the service is to provide an alternative to 999 for non-emergency medical advice, improving on the historic NHS Direct service. It should help reduce demand on both the ambulance service and A&Es from non-emergency patients. The Committee will scrutinise outcomes in the first six months of the service being available, to identify whether it is having an impact on A&E attendances and ambulance conveyance rates. The Committee will also explore the patient experience of the service.	SECAmb CCG Representative Acute representative Patient representative	
18 Sept	Healthwatch Update Report	Scrutiny of Services – Healthwatch works with the Committee to identify areas of concern for investigation. Healthwatch will report on its work since April and the Committee can identify any future areas of work.	Healthwatch representative	
18 Sept	Patient Transport Update	Scrutiny of Services – The Committee scrutinised the first six months' delivery of the Patient Transport contract in March, following several complaints from and identified problems experienced by service users. The Committee will again scrutinise delivery of this contract to seek assurances that the problems have been fixed.	SECAmb PTS commissioner SCC Transport team Surrey Coalition of Disabled People	
18 Sept	NHS Finances	Scrutiny of Services – The Committee will scrutinise current CCG budget	CCG finance	

Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
		information.	representatives	
Workshop to be scheduled				
TBC	GP Out of hours service	Scrutiny of Services – Public confidence in local GP out of hours schemes is very low. This can lead to more A&E attendances as people struggle to access healthcare at nights and weekends. The Committee will scrutinise current plans for out-of-hours care across the county.	CCG representatives	
November 2013				
14 Nov	Development of Services for the Frail and Elderly	Scrutiny of Services/Policy Development – The Frail/Elderly pathway has been identified as a key priority County-wide. Issues include the unnecessary admission of care home residents into hospital. Hospitals and CCGs have been developing key workstreams around improving the pathway. It is important for the Committee to scrutinise current services and contribute to the development and commissioning of new services and pathways.	SASH East Surrey CCG & other CCGs Sarah Mitchell, Strategic Director for Adult Social Care	To be joint with ASC Select
14 Nov	Virtual Wards	Scrutiny of Services – The Committee will scrutinise outcomes from this project, one year from implementation.	North West Surrey CCG East Surrey CCG Jean Boddy, Adult Social	

Health Scrutiny Committee Work Programme 2013-2014

Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
			Care	
14 Nov	Health & Wellbeing Board Update	Scrutiny of Services – The Health & Wellbeing Board will be invited to present a report identifying progress since April and any potential changes in service provision or commissioning for the next year.	Chair(s) Health & Wellbeing Board Simon Laker, Assistant Director, Health & Wellbeing	
14 Nov	Report of Quality Account Member Reference Groups	Scrutiny of Services – The Committee will receive mid-year update reports from each of the NHS Trust Quality Account Member Reference Groups (QA MRGs).	MRG Chairmen	
		January 2014		
9 Jan	Sexual Health Services for Children and Young People	Scrutiny of Services – The Committee will scrutinise prevention work with children and young people in schools, colleges and the youth service.	Akeem Ali, Director of Public Health Caroline Budden, Children, Schools & Families	To be joint with C&F Select
9 Jan	Childhood Obesity	Scrutiny of Services – There is a growing national problem of obesity in children and young people. The JSNA identifies that Surrey does not have an agreed weight management care pathway and services vary across the County, not meeting the needs of those at high risk. The Committee will scrutinise efforts of Public Health and the CCGs in addressing this	Akeem Ali, Director of Public Health Guildford &	To be joint with C&F Select

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Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
		issue.	Waverley CCG Children, Schools & Families representative	
9 Jan	Post-stroke Rehabilitation Update	Scrutiny of Services/Policy Development – In 2012, the Committee commissioned Healthwatch's predecessor, LINk, to undertake a project on the accessibility and quality of post-stroke rehabilitative care in the county. They made their report in March 2013 and developed an action plan that passed to Healthwatch for their continued work. The Committee will scrutinise progress so far in implementing the improvements suggested in the action plan.	Healthwatch representative Jane Shipp	
9 Jan	Surrey & Sussex Local Area Team	Scrutiny of Services – The Surrey & Sussex Local Area Team of the National Commissioning Board will be invited to report on their commission intentions for primary care and prisoner and offender health for the next year.	Amanda Fadero, Surrey & Sussex LAT	
9 Jan	NHS Finances	Scrutiny of Services – The Committee will scrutinise current CCG budget information.	CCG finance representatives	
March 2014				
19 Mar	Mental Health Crisis Line Review	Scrutiny of Services – The Committee will scrutinise further work to improve the mental health crisis line provided by Surrey & Borders Partnership NHS Foundation Trust. The report will include outcomes of the carers meetings once they are complete; a review of the acute care pathway; and any further user surveys.	Mandy Stevens/ Rachel Hennessy, SABP NE Hants &	

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Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
			Farnham CCG	
19 Mar	End of Life Care	Scrutiny of Services – People approaching the end of their lives may have complex care needs. Their family also needs to be supported to cope with the relative's eventual death. The Committee will scrutinise current service provision in responding to a person's choices in end of life care.	CCGs Acute hospital representative Social care representative	
19 Mar	Review of Quality Account Priorities	Policy Development – The Committee will receive progress reports from the QA MRGs for each NHS Trust and review the MRG's comments on priorities for the next year's QA for those Trusts that have submitted draft priorities.	MRG Chairmen/Leah O'Donovan, Scrutiny Officer	
May 2014				
22 May	Diabetes management	Scrutiny of Services – The prevention and management of diabetes was identified as a priority for the County in the Joint Health and Wellbeing Strategy. The Joint Strategic Needs Assessment has identified that not everyone who needs weight management and exercise programmes is accessing them. The Committee will scrutinise current service provision and identify any gaps.	CCGs Primary Care representative Community Health representative	
22 May	Review of Quality Account Priorities	Policy Development – The Committee will review the MRG's comments on priorities for the next year's QA for those Trusts submitting priorities since the last meeting.	MRG Chairmen/Leah O'Donovan, Scrutiny Officer	
22 May	NHS Finances	Scrutiny of Services – The Committee will scrutinise current CCG budget	CCG finance representatives	

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Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
		information.		
July 2014				
3 July	Prisoner and Offender Health	Scrutiny of Services – There are five prisons in Surrey with approximately 2,700 prisoners. Prisoners have high health needs, often coupled with backgrounds characterised by inequalities. The Surrey Joint Strategic Needs Assessment (JSNA) sets out a number of gaps and areas of unmet need for the prisoner population in Surrey and it is therefore important that the Committee investigates options for addressing this issue.	Surrey & Sussex LAT Surrey & Borders Partnership NHS Foundation Trust	
3 July	Meeting rural area emergencies	Scrutiny of Services – The Community First Responder Scheme (CFRS) and the location of public-use de-fibrillators in rural areas is part of the way in which these residents receive medical emergency services as there is not always the ability to get an ambulance within the eight-minute target window. The Committee has expressed a desire to learn more about this area and to identify ways of expanding the CFRS scheme in order to reach more people in rural areas.	SECAmb SCC representative	
To be scheduled				
	Renal Services	Scrutiny of Services/Policy Development – St Helier Hospital, which is based in the London Borough of Sutton, provides renal services to most Surrey residents. Following the outcome of the Better Services Better Value review that X should become a planned care centre, there is a need to review access to these services for residents of Surrey. The Committee will scrutinise current availability of renal services and the potential to move services back into Surrey.	Epsom & St Helier Hospitals CCG lead (TBC)	

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Date	Item	Why is this a Scrutiny Item?	Contact Officer	Additional Comments
	Cancer Services	Scrutiny of Services – The Committee will scrutinise current provision of cancer screening and treatment services across the County.	Acute hospital representatives Community health representatives	
	Community Health Services	Scrutiny of Services – The Committee will scrutinise current community health provision across the County from the three community providers.	Virgin Care Central Surrey Health First Community Health & Care ASC representation	
	Continuing Health Care (CHC)	Scrutiny of Services – Historically there was a backlog of CHC decisions to be made. The Committee will scrutinise the new lead CCG on arrangements for handling the backlog and moving forward.	Surrey Downs CCG Andy Butler, SCC ASC	
	Partnership working arrangements with Surrey & Borders Partnership NHS Foundation Trust (SABP)	Scrutiny of Services/Policy Development – The Mental Health Services Public Value Review of 2012 reviewed the partnership working arrangements of Surrey County Council and Surrey & Borders Partnership NHS Foundation Trust. The Committee will scrutinise the outcomes of this review.	Donal Hegarty/Jane Bremner, ASC	To be joint with ASC Select

Health Scrutiny Committee Work Programme 2013-2014

Task and Working Groups

Group	Membership	Purpose	Reporting dates
Unplanned Care	TBC	There is a national and regional issue whereby people attend A&E for non-emergency care. The various reasons include inability to secure an appointment with a local GP or general lack of knowledge about other more appropriate services. CCGs will attempt to reduce the number of A&E attendances and the aim of this Group will be to work with the CCGs to communicate the message of A&E alternatives to the general public.	TBC
Prevention for 50-plus	TBC – To be joint with Adult Social Care Select Committee	Preventing the need for social care or health care in the future is paramount to reducing costs across the health and social care landscape as well as contributing to a healthier Surrey population. The Group will investigate the availability and provision of preventative services across the County for both physical and mental wellbeing for	March 2014

		those over 50.	

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