NHS
Tower Hamlets
Clinical Commissioning Group

Francis Report Key Recommendations for Commissioners

Key Themes and recommendations	Government Response	Current Position	Actions
Complaints			
120. Commissioners access to complaints information. 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.	DoH response: Agree in part but consider that requiring trusts to provide all complaints information will place a significant burden on both provider and commissioner. Work in progress as a result of Francis. 2015 every hospital to publish quarterly DoH will be reporting on provider complaints	Complaints report received monthly from CSU based on complaints that have come in directly to CCG Poor access to complaints information from main provider Patient experience part is a CQUIN in 2014-15 contract	Monitor performance on CQUIN 14-15. Review complaints for common themes Triangulate complaints information with other information on incidents, patient surveys, Sis, Healthwatch reports. Need to put in place system for obtaining information on complaints from nursing and residential care homes. Primary care.
133. Role of commissioners in complaints. Commissioners should be entitled to intervene in the management of an individual	DoH response: Accepted in principle. Concerned that it risks creating uncertainty over roles and responsibilities in the	THCCG receive information from providers on number of complaints and trends by CAG via CQRM	

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complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	management of complaints. Enabling commissioning bodies to intervene in the management of an individual complaint would undermine the fundamental principle that local organisations themselves are, in the first instance, responsible for seeking to resolve a complaint. A commissioner could intervene if it considers an organisation's general handling of complaints cases needs to be improved – but their intervention would not be about the specifics of an individual case.		
134. Commissioning patients' advocates and support services. Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	DoH response: Accepted. The DoH will begin an evaluation of the current arrangements for commissioning NHS advocacy services in 2014.	Currently providers investigate their own complaints. If a complaint comes directly to the CCG it is passed on to complaints in commissioning support who then ask providers to investigate. The final report is then signed off by CSU	
Commissioning for Standards			

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123. Responsibility for monitoring delivery of standards and quality. GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality.	DoH response: Accepted.	Service alerts system in place GP quality lead Locality infrastructure Clinical commissioning forum Clinical lead roles GP involvement in quality assurance visits Information sharing with Healthwatch	Strengthen internal processes for dealing with soft intelligence and triangulate with hard data
124. Duty to require and monitor delivery of fundamental standards. The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree	DoH response: Accepted in principle. View was that incentivising compliance through redress for individual patients would not be practicable.	Currently monitoring standards via contract. There is an agreed method in place for measuring compliance CQRMs in place Quality assurance visits in	Need to ensure future service specifications have clear quality standards embedded

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a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received substandard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.		place Themed visits in place that relate to safeguarding and DoLs Participation in peer review days	
125. Compliance with enhanced standards. In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise higher standards either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.	DoH response: Accepted. DoH undertaking a piece of work on enhanced standards	New quality standards negotiated for 14-15 contracts CQUINs 14-15 Basics need to be right first!	
126. Preserving Corporate Memory. The NHS Commissioning Board and local commissioners should develop	DoH response: Accepted.		?Need internal CCG discussion on succession planning and how we preserve corporate memory

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and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.			Code of practice for managing transitions – share with providers
127. Commissioners scrutinising providers. The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.	DoH response: Accepted.	CQRMs Bi weekly performance meetings SPR Urgent Care Working Group NHS contract and levers Quality assurance visits provide further scrutiny	
128. Commissioner access to experience and resources. Commissioners must have access to the wide range of experience and	DoH response: Accepted.	SLA in place with NELCSU Access to clinical advice through practices and	

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resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise.		governing body members NHSE patient safety team National Quality Board	
129. Ensuring assessment and enforcement of fundamental standards through contracts. In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	DoH response: Accepted.	Quality assurance visits in place Patient and user feedback surveys FFT Application of contract levers as necessary CQC inspections KPIs (quality and patient safety)	
Public Accountability			
135. Public accountability of commissioners and public engagement. Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the	DoH response: Accepted	Governing Body meetings held in public Developing patient council Patient leaders programme	CCG undertaking further work on branding in 2014-15

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public requires their full involvement and engagement: •There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. •There should be lay members of the commissioner's board. •Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. •There should be regular surveys of patients and the public more generally. •Decision-making processes should be transparent: decision-making bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.		being commissioned CCG annual public event Undertake surveys with commissioning plans CCG Annual Report CCG constitution Lay members on governing body Health and wellbeing board membership CCG website – communications, news, publications Patient surveys Health Conversations	
136. Commissioners acting for their public. Commissioners need to be recognisable public bodies, visibly	DoH response: Accepted	See above Assurance framework	

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acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.		Organisational Development for staff and governing body Performance and appraisal management	
Performance Management and Strategic Oversight			
139. Ensuring patient safety and quality standards are met. The first responsibility for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring 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.	DoH response: Accepted.	CQC registration of providers gives an assurance to commissioners. NHS contract provides a framework for on-going assurance on compliance with standards. Quality assurance visits Participation in peer reviews Board to board discussions Analysis of key trends – SIs and complaints	

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140. Sharing information when concerns are raised. Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	DoH response: Accepted.	Links established with CQC and TDA 'Duty of candour' in NHS contract Safeguarding policies and procedures Quality Surveillance Group	
141. Individual responsibility of regulators and performance managers as well as co-ordination between them. Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.	DoH response: Accepted in principle.	Immediate concerns re: safety are dealt with directly between commissioner and provider. Regulators would be informed but remedying the immediate patient safety issue would be the priority. CQRMs in place. Whistleblowing policies	
142. Unambiguous referral and information. For an organisation to be effective in performance management there must exist unambiguous lines of referral and information flows, so that	DoH response: Accepted	Information flows between provider and commissioners in place but needs developing.	

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the performance manager is not in ignorance of the reality		Contract monitoring in place. Challenges with data quality	
143. Metrics relevant to quality of care and patient safety. 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.	DoH response: Accepted	Local quality schedule developed and will be part of 14-15 contract	Need to ensure future service specification for smaller providers include any local quality indicators that are appropriate.