HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

Formal Board

7th May 2013

Subject:	The Mid Staffordshire NHS Foundation Trust Public Inquiry – next steps
Presented By:	David Farnsworth, Executive Nurse Quality & Safety

PURPOSE OF THE REPORT:

To inform the HCCG Board of steps taken in response to the publication of the second Francis report and how this is informing change.

KEY POINTS:

- Engagement – Staff and patients
- Common values
- Fundamental standards – establishment / enforcement
- Candour
- Transparency
- Implementation

RECOMMENDATION TO THE BOARD:

The Committee is asked to:

- Note the report, consider proposals and accept the recommendation

CONTEXT & IMPLICATIONS:

Financial	Contracting and incentivisation
Legal	Health and Social Care Act 2008
Risk and Assurance *(Risk Register/BAF)*	Includes updates on actions to mitigate risk
HR/Personnel	Contractual candour
Equality & Diversity	Promotes equality and diversity
Strategic Objectives	Meets the strategic objectives in relation to Governance and Quality
Healthcare/National Policy *(e.g. CQC/Annual Health Check)*	Meets the requirements of national policy in relation to quality
Partners/Other Directorates	West Mercia Cluster Local Authority Providers of commissioned services CQC
Carbon Impact/Sustainability	N/A
Other Significant Issues	

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	Quality & Patient Safety Committee April 2013

1. **Background:**

In February 2013, Robert Francis (QC) published the second report into the failings seen at Mid Staffordshire NHS Foundation Trust. This comprehensive report considered wider system failures which enabled such failings to have such a devastating impact on patients and families. With 290 recommendations, including many directed at commissioning bodies, it is clear that Herefordshire CCG has been impacted by this work, and in March 2013, the Executive Lead Nurse shared the findings with the Board. This was intended to inform discussion and challenge across the organisation, and further sharing has occurred within the governance structures of the CCG, across teams following briefings and within the CCG quality team.

2. Principles

Following significant level of discussion across the CCG structures and within governance driven environments, we have clearly heard that that there is a demand to ensure effective involvement from patients, public and indeed the staff in all areas of quality. This is widely supported from the recommendations within the report and has informed some fundamental standards which will need to be established including;

Common values

- To live up to our published values of being accountable to Herefordshire's patients and public, and placing them at the heart of everything we do.
- To aim to be a high reputation, high performance CCG
- To have strong, close links to front line clinical practice
- To enable patients and public to take responsibility for themselves
- To ensure equality and equity of services and outcomes
- To maintain continuous and meaningful staff engagement

We must demonstrate that not only ourselves, but our partners and contractors;

- Provide strong patient centred healthcare leadership
- Put patients before themselves
- Do everything in their power to protect patients from avoidable harm
- Demonstrate openness and honesty with patients regardless of consequences for themselves
- Direct patients to where assistance can be provided
- Commit to and apply NHS values in all their work
- Make NHS Constitution the shared reference point for values

It is noted that fundamental standards can be evidenced through our internal behaviours, organisational outputs and policies. This includes;

- Best practice across recruitment and employment
- Explicit and measurable policy standards
- Effective governance
- Creating opportunity to hear patient voices
- Acting in response to concerns

As an accountable organisation, the CCG must also demonstrate we commission and contract with agencies on this basis to ensure;

- Care and treatment is safe and effective
- Consent is informed and demonstrated
- Nutrition and hydration are key priorities
- Compassion and assistance are provided
- Dignity & respect are demonstrated throughout care and treatment
- Excellence in cleanliness and infection control practice can be evidenced
- NICE evidence based guidance and procedures which will enable compliance with fundamental standards are brought to each clinical setting

- There is a named nurse [and doctor] responsible for each patient
- Standards of training, assessment, appraisal for core values and competence are assessed
- Recruitment and training are focussed on values
- Leadership by example is demonstrated
- We reward good practice and improvement in the care of vulnerable, frail and elderly patients

Where fundamental standards are not upheld, the CCG will take action. There must be;

- Zero tolerance for harm or poor outcomes
- Investigation of every incident with learning demonstrated and change seen
- Response to every concern raised and zero tolerance of barriers to reporting
- Action taken to stop services where persistent failure is seen
- Cooperation and information sharing with regulatory bodies

In order to ensure failure is identified, it will be a statutory obligation that all organisations demonstrate candour. Once again, both the CCG and partners will be required to ensure;

- Individual professionals are provided with a framework to inform the organisation of relevant incidents
- Healthcare provider organisations are placed under a duty to inform patients of error
- There is no censorship of critical internal reports and full information is available to patients
- That all complaints and concerns are welcomed and accompanied by swift action / remedy
- There is independent investigation of serious failure
- Complainants and staff are involved in change
- Trust Boards are demonstrating total immersion in all organisational quality matters, including failings
- No barriers to whistleblowing

Finally, the CCG will be a champion for transparency which will require honesty about information for public including;

- Improved core information systems with clear performance measures
- Accurate, useful and relevant information
- Balanced information in quality accounts about failures as well as successes
- Independent audit of quality accounts
- Patient, public, commissioners and regulators access to effective comparative performance information for all clinical activity

3. Outputs

From the 290 actions in the Francis report, HCCG have identified these key principles where action is now required. This will require a matrix of actions directed at internal governance, operational processes, organisational development, commissioning activity, contractual changes, provider development, performance management, engagement with patients, carers and staff.

As a first response to this, the CCG has now undertaken a public engagement event on June 4th 2013, which saw representation from a wide range of patients, carers and third sector groups representing patient interests. Within this event, the CCG asked participants to inform quality standards and expectations across the health care provider environment, and which might be used to design standards for commissioning. As might be expected, much related to the requirement for professional care, diginity and respect. Most assumed that treatment would be safe and clinically effective, but were keen that compassion was evident throughout health care.

The CCG have placed a very high value on this feedback, and it is intended to use this as a key driver for the actions required to ensure the learning from Francis is embedded in all our work.

Such actions will be identified, assigned owners and timeframes for delivery will be established. Once fully populated, in line with the key principles identified in this report, the template included at appendix 1 (approved at the Quality & Patient Safety Committee), will form the action plan. This will be brought to the Quality & patient Safety committee in July 2013, and presented to Board in August, whereafter progress is monitored by the Board on 6 monthly basis, and managed through the Quality & Patient Safety Committee as a standing agenda item.

Francis Report Action Plan

Main Theme	Further Information	Actions	Rec. No.	Lead	Completion Date	Status	Comments/ Updates
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, 2				
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 to 8				
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.		9 to 12				

Main Theme	Further Information	Actions	Rec. No.	Lead	Completion Date	Status	Comments/ Updates
A common culture made real throughout the system – an integrated hierarchy of standards of service	No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.		13 to 18				
Responsibility for, and effectiveness of, healthcare standards			19 to 59				
Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions			60 to 86				
Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings			87 to 90				
Enhancement of the role of supportive agencies			91 to 108				

Main Theme	Further Information	Actions	Rec. No.	Lead	Completion Date	Status	Comments/ Updates
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.		109 to 122				
Commissioning for standards			123 to 137				
Local scrutiny			138				
Performance management and strategic oversight			139 to 144				
Patient, public and local scrutiny			145 to 151				
Medical training and education			152 to 172				

Main Theme	Further Information	Actions	Rec. No.	Lead	Completion Date	Status	Comments/ Updates
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.		173 to 184				
Nursing			185 to 213				
Leadership			214 to 221				
Professional regulation of fitness to practise			222 to 235				
Caring for the elderly	Approaches applicable to all patients but requiring special attention for the elderly		263 to 243				
Information			244 to 272				
Coroners and inquests	Making more of the coronial process in healthcare-related deaths		273 to 285				

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Department of Health leadership			286 to 290				