Bexley Clinical Commissioning Group

ENCLOSURE: L
Agenda Item: 14/13

Governing Body (Public) Meeting

DATE: 28th February 2013

Title	**Francis Report**
Recommended action for the Governing Body	That the Governing Body: **Note** the report and the planned actions
Executive Summary	On 6 February 2013 Robert Francis QC Published the long awaited final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry The Inquiry has been examining the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care. It builds on Mr Francis's earlier report, published in 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The Inquiry identifies a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self-interest and cost control ahead of patients and their safety. The report makes 290 recommendations (for provider, regulators, and at about 50 directly affecting commissioners) designed to change this culture and make sure patients come first by creating a common patient centred culture across the NHS. The recommendations include: **A structure of fundamental standards and measures of compliance:** • A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue. • These standards should be defined in genuine partnership with patients, the public and healthcare

professionals and enshrined as duties, which healthcare providers must comply with.

- Non-compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk
- To cause death or serious harm to a patient by non-compliance without reasonable excuse of the fundamental standards, should be a criminal offence.
- Standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations.
- These fundamental standards should be policed by the Care Quality Commission (CQC)

Openness, transparency and candour throughout the system underpinned by statute. Without this a common culture of being open and honest with patients and regulators will not spread. Including:

- A statutory duty to be truthful to patients where harm has or may have been caused
- Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient
- Trusts have to be open and honest in their quality accounts describing their faults as well as their successes
- The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence
- It should be a criminal offence for the directors of Trusts to give deliberately misleading information to the public and the regulators
- The CQC should be responsible for policing these obligations

Improved support for compassionate, caring and committed nursing

- Entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients
- Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard

	- Nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level - Healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so. **Stronger healthcare leadership** - The establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct - It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts - A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations. The full report, and executive summary is not reproduced in these papers but is available at the following address: http://www.midstaffspublicinquiry.com/. It is recommended that every member of every NHS Governing Body or Board reads this report The first recommendation in the report states: 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

<table>
<tr><td></td><td colspan="3">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.

We there intend to bring a fuller report to the Governing (Public) Meeting on 28th March 2013 with the initial outline of the plan for the CCG to address the issues raised in the report.</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="4">Which objective does this paper support?</td><td>Patients:</td><td>Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders</td><td>✓</td></tr>
<tr><td>People:</td><td>Empower our staff to make BCCG the most successful CCG in (south) London</td><td>✓</td></tr>
<tr><td>Pounds:</td><td>Delivering on all of our statutory duties and become an effective, efficient and economical organisation</td><td></td></tr>
<tr><td>Process:</td><td>Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience</td><td>✓</td></tr>
<tr><td rowspan="6">Organisational implications</td><td>Key Risks
(corporate and/or clinical)</td><td colspan="2">To be considered as part of the CCG response to the Report</td></tr>
<tr><td>Equality and Diversity</td><td colspan="2">To be considered as part of the CCG response to the Report</td></tr>
<tr><td>Patient impact</td><td colspan="2">To be considered as part of the CCG response to the Report</td></tr>
<tr><td>Financial</td><td colspan="2">To be considered as part of the CCG response to the Report</td></tr>
<tr><td>Legal Issues</td><td colspan="2">To be considered as part of the CCG response to the Report</td></tr>
<tr><td>NHS constitution</td><td colspan="2">To be considered as part of the CCG response to the Report</td></tr>
<tr><td>Consultation (Public, member or other)</td><td colspan="3">None to date, but a theme of the report is public consultation and therefore this will be considered as part of the response</td></tr>
<tr><td>Audit (Considered / Approved by Other Committees / Groups)</td><td colspan="3">None</td></tr>
<tr><td>Communications Plan</td><td colspan="3">None to date, but this will be considered as part of the response</td></tr>
<tr><td>Author</td><td colspan="3">Simon Evans-Evans</td></tr>
<tr><td></td><td>Clinical Lead

Dr Varun Bhalla</td><td colspan="2">Executive Sponsor

Simon Evans-Evans</td></tr>
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		Director of Governance and Quality
Date	7th February 2013	

Preparing for the Francis Report

Introduction and Background

In 2007 the Healthcare Commission became aware of a number of apparently high mortality rates for specific conditions and emergency admissions at Mid Staffordshire NHS Foundation Trust. A comprehensive investigation was carried out between March and October 2008. The independent report from the Healthcare Commission *'Investigation into Mid Staffordshire NHS Foundation Trust'* was published on 18 March 2009, and identified lessons for other organisations and recommendations. This report was followed by reviews of lessons learnt & progress updates by Dr David Colin Thomé, and Professor Sir George Alberti in April 2009. On 9 June 2010, the Secretary of State for Health, announced a public inquiry into Mid Staffordshire NHS Foundation Trust, chaired by Robert Francis QC. The inquiry has focussed on the failure of commissioning, supervisory and regulatory bodies to spot problems at the Mid Staffordshire trust, where hundreds of people died as a result of poor care.

Findings from Mid Staffordshire Report - 2nd Enquiry 2013

On 6 February 2013 Robert Francis QC Published the long awaited final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, the report containing 1,782 pages and 290 recommendations.

The Inquiry has been examining the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care. It builds on Mr Francis's earlier report, published in 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

The Inquiry identifies a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self-interest and cost control ahead of patients and their safety.

The report makes 290 recommendations (for provider, regulators, and at about 50 directly affecting commissioners) designed to change this culture and make sure patients come first by creating a common patient centered culture across the NHS.

The recommendations include:

A structure of fundamental standards and measures of compliance:

A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue.
These standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, which healthcare providers must comply with.

Non-compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk
To cause death or serious harm to a patient by non-compliance without reasonable excuse of the fundamental standards, should be a criminal offence.
Standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations.
These fundamental standards should be policed by the Care Quality Commission (CQC)

Openness, transparency and candour throughout the system underpinned by statute.

Without this a common culture of being open and honest with patients and regulators will not spread. Including:

A statutory duty to be truthful to patients where harm has or may have been caused
Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient
Trusts have to be open and honest in their quality accounts describing their faults as well as their successes
The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence
It should be a criminal offence for the directors of Trusts to give deliberately misleading information to the public and the regulators
The CQC should be responsible for policing these obligations
Improved support for compassionate, caring and committed nursing
Entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients
Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard
Nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level
Healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so.

Stronger healthcare leadership

The establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct
It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts
A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations.

The full report, and executive summary is not reproduced in these papers but is available at the following address:

http://www.midstaffspublicinquiry.com/

The first recommendation in the report states:

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.

Actions for Bexley Clinical Commissioning Group

Whilst responsibility for such poor patient care rests primarily with the hospital staff and its board management, including the professional responsibility of clinicians for the care of individuals, a number of the findings of these investigations in respect of acute hospital care are potentially relevant to the whole NHS. The Clinical Commissioning Group must ensure that they have effective mechanisms to:

Assess and review the experience of patients, carers, relatives and staff
Encourage a culture of openness, transparency and collaboration
Focus on improving outcomes
Engage with clinicians
Foster relationship with regulators e.g. Monitor and CQC etc.
Develop robust systems for assessing the quality of care commissioned
Request and monitor improvement plans in order to tackle areas of concern or poor performance
Review the quality of care commissioned
Gather and triangulate evidence from stakeholders relating to provider quality

A detailed report will go to the Governing (Public) Meeting on 28th March 2013 with the initial outline of the plan covering the above points and addressing the issues raised in the report.