Item Number: 10

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP **GOVERNING BODY MEETING**	Vale of York Clinical Commissioning Group

Meeting Date: 7 March 2013

Report Sponsor:	**Report Author:**
Caroline Wollerton	Caroline Wollerton (based on NHS Commissioning Board Area Team paper**)**

1. Title of Paper: Robert Francis QC, Public Enquiry Overview, Mid Staffordshire: Briefing Report

2. Strategic Objectives supported by this paper

The CCG has a statutory duty to act with a view to securing continuous improvement in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience and to promote the involvement of individual patients, and their carers and representatives where relevant, in decisions relating to the prevention or diagnosis of illness in them or their care and treatment.

3. Executive Summary

This paper provides Governing Body members with an overview of the key findings and recommendations arising from the Robert Francis QC, Inquiry into the failings of the Mid Staffordshire Trust. The report sets out the main recommendations under 5 key headings:

- A structure of clearly understood fundamental standards and measures of compliance, accepted and embraced by the public and professionals, with rigorous and clear means of enforcement
- Openness, transparency and candour throughout the system
- Improved Support for Compassionate Caring and Committed Nursing
- Strong and Patient Centred Healthcare Leadership
- Accurate, useful and relevant information

4. Evidence Base

N/A

5. Risks relating to proposals in this paper

N/A

6. Summary of any finance / resource implications

N/A

7. Any statutory / regulatory / legal / NHS Constitution implications

Many of the recommendations in the report link directly to the NHS Outcomes Framework and to the NHS Constitution and reinforce the role of the commissioner in terms of securing high quality, safe and effective services.

8. Equality Impact Assessment

N/A

9. Any related work with stakeholders or communications plan

N/A

10. Recommendations / Action Required

The Governing Body is asked to:

- Note and accept the contents of the report
- Endorse the recommendations contained in the report and support the development of a work plan to ensure the CCG is working towards implementation of the relevant recommendations with stakeholder and patient involvement.

11. Assurance

Matters relating to the development of a work plan will be discussed within the Quality and Performance Committee and will be escalated the Governing body as necessary.

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NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

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Robert Francis QC, Public Enquiry Overview, Mid Staffordshire

Briefing Report

1. Introduction

1.1 The report of the inquiry into the failings of the Mid Staffordshire Trust was published on 5th February 2013.

1.2 The report tells a story of appalling and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs and put corporate self interest and cost control ahead of patients and their safety.

1.3 The system as a whole appeared to pay lip service to the need not to compromise services and quality, but it was 'remarkable' how little attention was paid to the impact of proposed savings.

2. Findings and Recommendations

2.1 Culture

- Lack of openness to criticism
- Lack of consideration for patients
- Defensiveness
- Looking inwards not outwards
- Secrecy
- Misplaced assumptions about the judgement and actions of others
- An acceptance of poor standards
- A failure to put the patient first in everything that is done.

2.2 There are 290 Recommendations designed to change the culture and make sure patients are put first, grouped into 5 main themes.

3. A structure of clearly understood fundamental standards and measures of compliance, accepted and embraced by the public and professionals, with rigorous and clear means of enforcement

- Standards to be developed on patient safety, effectiveness and basic care
- To cause death or serious harm through non compliance will be a criminal offence
- NICE to develop guidance on staffing levels
- CQC to regulate clinical and corporate governance and financial control

4. Openness, transparency and candour throughout the system

- There should be a statutory duty to be truthful to patients where harm has or may have been caused
- Staff should have a statutory duty to make their employers aware of such incidents
- Trusts should be open and honest in their quality accounts, describing faults as well as successes. Deliberate obstruction of meeting these duties or deliberate deception of patients should be a criminal offence
- It should be a criminal offence for trust directors to deliberately give misleading information to the public and regulators
- The CQC should be responsible for policing these duties

5. Improved Support for Compassionate Caring and Committed Nursing

- Entrants to nursing should be assessed for their aptitude to deliver and lead proper care and their commitment to patient welfare
- Training standards must be developed to ensure qualified nurses can deliver compassionate care to a consistent level
- Nurses should be given a stronger voice in leadership at organisation and ward level
- All healthcare support workers should be regulated by a registration scheme

6. Strong and Patient Centred Healthcare Leadership

- An NHS leadership college should be established to ensure there is a common culture, code of ethics and conduct among all current and potential future leaders. A leadership college accreditation scheme should be considered
- A code of ethics for all senior staff should be produced, but apply to all NHS staff
- There should be a fit and proper person test for NHS directors. Being guilty of a serious breach of the code of conduct should lead to disqualification from holding senior positions in the NHS
- While registration could be performed by an existing regulator, the need for a separate entity should be kept under review. The need for such a management regulator would be informed by experience of the fit and proper persons test

7. Accurate, useful and relevant information

- The public should be able to compare relative performance in providers' compliance with standards
- All healthcare providers should develop and publish real time information on the performance of consultants and specialist teams in relation to mortality, morbidity, outcomes and patient satisfaction
- Every provider should have a designated board member as chief information officer

8. What Next?

- Further development of recommendations
- Lessons to be learned on on-going basis
- Every Organisation to report publicly on acceptance of the recommendations and what they are doing to implement them
- Bruce Keogh (NHS Commissioning Board) reviews for specified Trusts

9. Recommendation

The Governing Body is asked to:

9.1 Note and accept the contents of the report.

9.2 Endorse the recommendations contained in the report and support the development of a work plan to ensure the CCG is working towards implementation of the relevant recommendations with stakeholder and patient involvement.