Agenda Item No: **7**

Health Scrutiny Panel

15 January 2015

Report title	Update from the Wolverhampton Clinical Commissioning Group in response to the Francis Inquiry
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being
Wards affected	All
Accountable director	
Originating service	Wolverhampton Clinical Commissioning Group
Accountable employee(s)	Manjeet Garcha — Executive Director of Nursing and Quality Tel — 01902 442476 Email — manjeet.garcha@nhs.net
Report to be/has been considered by	N/A

Recommendation(s) for action or decision:

The Panel is recommended to note and comment on the work undertaken so far.

1.0 Purpose

1.1 Sir Robert Francis was commissioned in July 2009, to chair a non-statutory inquiry into the happenings at mid Staffordshire. A recommendation was made that there needed to be an investigation into the wider system to consider why issues had not been detected earlier and to ensure that the necessary lessons were learned. The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry made 291 recommendations, grouped into themes. It was recommended that all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations and decides how to apply them to their own work. The first update of progress was presented to the Health Overview and Scrutiny Committee in September 2013. This is the second update report from the Wolverhampton Clinical Commissioning Group.

2.0 Background and overview of proposed model

2.1 Sir Robert Francis was commissioned in July 2009 to chair a non-statutory inquiry into the happenings at Mid Staffordshire. The primary purpose of this being to give a voice to those who had suffered and to consider what went wrong. This initial report was published in February 2010.

2.2 Key themes of the report included:

- Lack of basic care
- A culture not conducive to providing good care
- Management focus was on financial pressures and achieving Foundation Trust status
- Management failed to remedy deficiencies in staff and governance
- Lack of urgency in response to problems and complaints
- Focus on systems and not outcomes
- Lack of internal and external transparency

2.3 A key issue raised was the role played by external organisations which had oversight of the trust. A recommendation was made that there needed to be an investigation into the wider system to consider why issues had not been detected earlier and to ensure that the necessary lessons were learned. As such, another inquiry was commissioned and the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was finally published in February 2013 with 291 recommendations, grouped into themes. Where possible, recommendations identified the organisation which it suggested should take them forward. It was recommended that all commissioning, service providers, regulatory and ancillary organisations in healthcare consider the findings and have an action plan to apply and monitor in own areas of work.

2.4 The Government's initial response, Patients First and Foremost, set out plans to prioritise care, improve transparency and ensure that where poor care is detected, there is a clear action and clear accountability. 'Hard truths – the journey to putting patients first, the government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry' builds on this to provide a detailed response to the 291 recommendations the Inquiry made across every level of the system.

3.0 Key Drivers

3.1 National Reports published since 2001 have resulted in a minimum of 911 recommendations.

Year	Key Report	No of Recommendations
2001	The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995	198
2002-5	The Shipman Inquiry	190
2009	Mid Staffs Review- Dr David Colin Thome	24
2009	Mid Staffs Review- Professor Alberti	23
2010	Colin Norris Inquiry 2010	32
2010	RF 1 March 2009 (Robert Francis QC)	18
2010	The Airedale Inquiry (Kate Thirwell QC)	6
2012	Winterbourne Review	56
2012	Morecambe Bay	35
2013	RF2 Feb 2013 (Robert Francis QC)	290
2013	Don Berwick- a promise to learn	10
2013	Bruce Keogh- Review of 14 NHS Trusts	8
2013	Ann Clwyd MP & Professor Tricia Hart- Review of NHS Hospitals Complaints Systems	4
2013	Cavendish Review- Healthcare assistants and support workers in NHS settings	2
2014	Hard Truths- Government Response to RF2	5
2014	Kennedy Breast Care Review	10
2015	Awaited Robert Francis review of Whistleblowing	TBC
Total		911

4.0 Current Position

4.1 Amongst the plethora of reports and hundreds of recommendations, there is a consistent theme for all commissioners, service providers and regulators in Wolverhampton. These are:

Theme	Monitoring Already	Further/on-going work planned
Preventing Problems	Patient Safety, openness & candour, listening to patients.	Culture & Safe Staffing
Detecting Problems Quickly	Expert inspection teams, mortality outliers & Quality Surveillance Group. Cross triangulating softer intelligence with local authority safeguarding teams and making a timely decision to suspend further admissions into care/nursing homes if there are concerns.	CCG/CQC visits taking place at night & weekends, embedding the new CQC inspection standards and framework
Taking Action Promptly	Timely and appropriate challenge to the person/persons	Aspiring FTs will be required to achieve good or outstanding to be

	with authority to respond accurately	authorized.
Ensure Robust Accountability	CCGs focus on Quality & Outcomes. Clinical Quality Review Meetings Contract meetings, escalation and governance processes. NHS England assurance.	Recognising the new criminal offence(s) wilful or reckless neglect or mistreatment of patients.
Ensuring Staff are Trained & Motivated	Staff engagement/feedback. Right staff with the right skills in the right place. Recruitment and workforce development strategies	Implementation of new Staff Engagement Guidance – essential for creating positive cultures of safe & compassionate care.
Safety and openness	Transparent, monthly reporting of ward by ward staffing levels and other safety measures. Quarterly reporting of complaints data and lessons learned by provider along with better reporting of safety incidents Statutory duty of candour on all providers and professional duty of candour on all individuals. Providers are liable if they have not been open with patients.	On-going monitoring to ensure changes are sustained. Changes to professional codes of practice awaited. Plan for 5000 safety fellows to be trained and appointed in next 5 years. Dedicated provider safety websites awaiting to be developed for the public.

4.0 National Drivers

4.1 National movement since RFII includes:

- A new Chief Executive for the NHS.
- On-going Sir Bruce Keogh and Sir Mike Richards Mortality Reviews.
- CQC Chief Inspector of Hospitals recruited.
- A new criminal offence for willful neglect, with a government intention to legislate so that those responsible for the worst failures in care are held accountable.
- A new fit and proper person test, to act as a barring scheme for senior managers.
- Every hospital patient to have the names of a responsible consultant and nurse above their bed.
- A named accountable clinician for out-of-hospital care for all vulnerable older people.
- More time to care as all arm's length bodies and the Department of Health have signed a protocol in order to minimize bureaucratic burdens on trusts.
- A new care certificate to ensure that healthcare assistants and social care support workers have the right fundamental training and skills.
- A new fast-track leadership programme to recruit clinicians and external talent to the top jobs in the NHS in England.
- Safer staffing levels declared monthly with evidence of board updates.
- A new patient safety alert system.
- Overhaul planned for the current serious incident system.

- Establishment of Quality Surveillance Groups.

4.2 **Summary**

In summary, there has been a plethora of reports and recommendations and the CCCG have been working with the providers to nurture a culture of change of behaviour which is not only sustainable but becomes the new way or working. There is robust monitoring of all plans and all exceptions are managed via the agreed governance avenues. The CCG continues to work with all providers of NHS services to improve outcomes for all service users.

5.0 Financial implications

5.1 There are no financial implications arising from this report.

6.0 Legal implications

6.1 There are no legal implications arising from this report.

7.0 Equalities implications

7.1 There are no equalities implications arising from this report.

8.0 Environmental implications

8.1 There are no environmental implications arising from this report.