Working with you to make Sheffield HEALTHIER

NHS
Sheffield
Clinical Commissioning Group

'Hard Truths'
Final Government Response to the Mid Staffordshire Public Inquiry

Governing Body meeting

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9 January 2014

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Key messages	
The paper details the key actions required from the full government response to the Mid Staffordshire public Inquiry, highlighting those relating to Clinical Commissioning Groups.	
Assurance Framework (AF)	
Assurance Framework Number: AF 2.1 Providers delivering poor quality care and not meeting quality targets ***How does this paper provide assurance to the Governing Body that the risk is being addressed?*** The report provides details of actions required for the CCG by the Department of Health. ***Is this an existing Control:*** Existing	
Equality/Diversity Impact	
Has an equality impact assessment been undertaken? No, not required. ***Which of the 9 Protected Characteristics does it have an impact on?*** *None*	
Public and Patient Engagement	
Not required	
Recommendations	
The Governing Body is asked to note the key actions and implications from the response.	

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1. Introduction

This paper summarises the recommendations of the above report and highlights key actions and timeframes, with specific reference to commissioning responsibilities.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259648/34658_Cm_8754_Vol_1_accessible.pdf

2. History

The history and timelines behind this report are as follows:

- **2005-2008:** reports of failings at Mid Staffordshire NHS Foundation Trust emerge
- **March 2009:** Healthcare Commission publishes report of its investigation
- **24 February 2010:** Robert Francis QC publishes report of independent inquiry
- **9 June 2010:** Andrew Lansley announces a full public inquiry into the failings at Mid-Staffordshire NHS Foundation Trust
- **February 2013:** Report on the Public Inquiry – Francis 2
- **March 2013:** First and Foremost – Government initial response

3. National Independent Reviews Since February 2013

Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, NHS Medical Director

The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish.

A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick.

A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart.

Challenging Bureaucracy, led by the NHS Confederation.

The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

4. Conclusion of the Report 'Hard Truths'

- This was a **system failure** as well as failure of an individual organisation
- **No single recommendation** should be regarded as the solution to the many concerns identified

- A **fundamental change in culture** is required across the NHS
- We need the **engagement** of every single person serving patients in the change that needs to happen

5. Summary of actions

(Highlighting denotes the actions or implications involve CCGs / Primary care)

5.1 Chapter 1 Preventing Problems

RIGHTS AND RESPONSIBILITIES
NHS England, CCGs and Health Education England (HEE) working with NHS staff and patients on embedding the NHS Constitution
December 2014 Friends and Family Test to be extended to Mental Health settings

PATIENT SAFETY
NHS England is developing a new Patient Safety Collaborative Network to spread best practice
October 2013 Monitor introduced new Risk Assessment Framework
Named Consultant and Nurse on every patient's Bed
Named Accountable Clinician for people receiving care outside hospital
April 2014 *every person with a long term condition will be offered a personalised care plan*
End March 2014 – re launch of Patient Safety Alerts System
New criminal offence of 'wilful or reckless neglect' to be introduced
Within 5 years 5000 patient safety 'Fellows' will be trained and appointed by NHS England to be champions in patient safety.

TRANSPARENCY AND MEASUREMENT
Statutory duty of candour on organisations and professional duty of candour on individuals via professional regulators
April 2014 Monthly Never Event data published
June 2014 Publish Patient Safety Thermometer data
Spring 2015 *every patient will be able to see their own records, test results and appointments and order repeat prescriptions on-line*
June 2014 the CQC and NHSE to develop a Hospital Safety website
NHSE publishing clinical outcome by Consultant for 10 medical specialties

STAFF RECRUITMENT AND WELLBEING
HEE will introduce values based recruitment of qualified health care and public health students
Point of Care Foundation to work on spreading Schwartz Rounds (monthly staff support forums)
Summer 2014 NICE to produce guidance on safe staffing levels in acute hospitals (interim guidance from the NQB to be used)
April 2014 publication of ward level staffing information

PATIENT EXPERIENCE AND COMPLAINTS
Chief executives and Boards to take greater personal responsibility for complaints - including complaints discussed at every board meeting, quarterly data on lessons learned,

Healthwatch scrutinising Trust complaints data

December 2013 – *80% of CCG's to be commissioning support for patients participation and decisions in relation to their own care* (Guidance already published for Commissioners – '*Transforming Participation in Health and Care')*.

5.2 Chapter 2 Detecting Problems Quickly

SETTING STANDARDS
During 2014 Fundamental standards to be developed by DH and CQC, complemented by discretionary enhanced quality standards and longer term developmental standards

INSPECTION AND REGULATION
End of 2015 CQC expert-led inspections all acute trusts
By June 2014 CQC Mental Health specific inspections
Regulators to share information that may indicate concerns about the quality of care via Quality Surveillance Groups
From October 2013 Intelligent Monitoring of Trusts published quarterly
Early 2014 Monitor to publish an updated Code of Governance for FT's
King's Fund and University of Lancaster to examine evidence-based solutions for evaluating leadership and culture within an organisation

REGISTRATION AND LICENSING
Joint registration and licensing system to be implemented by Monitor and CQC from April, with clearer delineation of their respective roles and FT process

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5.3 Chapter 3 Taking Action Promptly

COLLABORATION
April 2014 CQC, Monitor and TDA will publish further guidance on how they work together to address quality

RATINGS
Aspiring FT's will have to achieve a good or outstanding CQC rating prior to FT authorisation
Ratings will be published for individual services, as well as for the hospital overall

INTERVENTION
CQC will have powers to act immediately if patients are at immediate risk of harm.
DH to enable Monitor to impose additional licence conditions on trusts issued with a CQC warning notice
Where FTs are placed in special measures, they will have their autonomy suspended

SPECIAL ADMINISTRATION
Special Administration as a last resort and Trust Board will be replaced by a Special Administrator by the Secretary of State

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5.4 Chapter 4 Ensuring Robust Accountability

HEALTHY BOARDS
To implement the Healthy NHS Board (2013) and act as strong leaders
Fit and proper persons test to be developed by DH and imposed by CQC to bar individual Directors who are unfit at the point of registration
It will be a Criminal Offence via a new Care Bill, if providers publish false or misleading information and this will apply to individual Directors and Senior Managers

PROFESSIONAL REGULATION
Law Commission will streamline and modernise professional regulation law, enabling concerns to be resolved within a year

COMMISSIONING FOR QUALITY
CCGs to be held to account for commissioning quality services via the Commissioning Framework (Nov 2013)
NHS England is reviewing standard NHS contract in order to facilitate commissioner intervention when concerns are identified
Quality Surveillance Groups in place to share intelligence

CORONERS
Regulations to be published strengthening medical examiners independence from the deceased

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5.5 Chapter 5 Ensuring Staff are Trained and Motivated

STAFF ENGAGEMENT AND RECRUITMENT
Social Partnership Forum will develop staff engagement guidance for employers
HEE to develop tests for caring during nursing recruitment
Improved training for Healthcare Assistants with new ‘Care Certificates’
Proportionate revalidation process to be introduced for nurses

OLDER PEOPLE
Specific post graduate training for ‘nursing older people’
Taskforce led by Age UK to reduce malnutrition among older people in a range of settings

BUREAUCRACY
October 2013 Concordat signed by regulators to reduce the administrative burden on providers
The HSC Information Centre will become a ‘gateway’ for information requests
NHSE has now introduced a Clinical Bureaucracy Index to track how well trusts are using digital technology in data collection

LEADERSHIP
NHS Leadership Academy to initiate a new leadership programme to fast-track NHS clinicians

6. Implications for Commissioners

There are a wide number of recommendations, and some specific for commissioners to take forward. From these action and related guidance the CCG will develop a strategy for quality commissioning before March 2014, to take these forward during the next two years.

All providers in Sheffield will be expected to review the recommendations, developing specific action plans to deliver key objectives to the DH timescales. These will be managed via the engagement and contracting process with providers.

7. Recommendations

The Governing Body is asked to note the key actions and implications from the response.

Paper prepared by Jane Harriman, Deputy Chief Nurse

On behalf of Kevin Clifford, Chief Nurse

December 2013