Mid-Staffordshire NHS Foundation Trust Public Inquiry 2013

1.0 INTRODUCTION

This paper is in three parts and presents an initial briefing to the NHS Central London, West London, Hammersmith and Fulham and Hounslow Governing Bodies on the Robert Francis QC Inquiry into the failings at Mid Staffordshire NHS Foundation Trust.

Part 1 is in preparation for considering the publication of the findings of the 2nd inquiry by Robert Francis QC (DoH 2013) published on 6th February 2013. It presents an overview of the background and key findings of the initial Francis Inquiry (DoH 2010) and the subsequent publications and recommendations.

Part 2 of this paper is a review of the Mid Staffordshire Public Inquiry (DoH 2013) published findings and its recommendations, identifying key areas relevant to the NHS CWHH Clinical Commissioning Groups (CCGs) – it is important to note that Appendix A is work in progress which will develop as CCGs develop their own action plans.

Part 3 of this paper provides an overview of the Government's initial response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry 'Patients First and Foremost' which was published in March 2013.

Note: On 6 February, in response to a request from the Prime Minister, Sir Bruce Keogh (the Medical Director) announced an investigation into hospitals that are persistent outliers on mortality indicators. Sir Bruce identified an initial list of five organisations that had been outliers for two years on the Summary Hospital-level Mortality Indicator (SHMI), with a further nine Trusts identified. None of these Trusts are within North West London.

Part 1

2.0 BACKGROUND

Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 resulted in an investigation by the Healthcare Commission (HCC) which published a highly critical report in March 2009. This was followed by two reviews commissioned by the Department of Health (DH). These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management.

1 http://www.midstaffspublicinquiry.com/

An inquiry was, led by Robert Francis QC, primarily to give those most affected by poor care an opportunity to tell their stories and to ensure that the lessons learned from those experiences were fully taken into account in the rebuilding of confidence in the Trust.

3.0 OVERVIEW OF THE FINDINGS FROM THE 1st INVESTIGATION INTO EVENTS AT MID STAFFORDSHIRE

Ensuring that NHS patients receive high quality care is an inherently complex and fragile operation. Robust systems and processes to monitor, performance manage and regulate the quality of care provided to patients is therefore essential.

The initial review into Mid Staffordshire (DoH 2010) confirmed that the success of these systems and processes is almost entirely dependent on the values and behaviours of the staff working throughout the system. Strong leadership at every level is needed to ensure that values and behaviours that put patients first can prevail.

In February 2010 Robert Francis QC published his finding and recommendations. Key background themes included:

- Mid Staffordshire NHS Trust was a Dr Foster outlier for mortality.
- Clinical governance was poor with an overreliance on data rather than outcomes.
- An ineffective complaints process that was not transparent.
- Soft intelligence did not matter and the views of frontline staff were ignored.
- Patients were neglected; the inquiry heard many accounts where privacy and dignity was ignored, nursing care was either poor or non-existent, this included essential care such as nutrition, hydration, pain relief, and toileting and falls prevention.
- Many of the wards were short staffed, staffing levels had been cut, sickness absence and vacancies were high and morale was very low.
- Further staffing reductions followed the reorganisation of the medical and surgical emergency admission wards.

Within the report eighteen recommendations were made, seven of which were relevant to commissioning organisations:

**Recommendation 5**: The board should institute a programme of improving the use of audit in which the Board should review audit processes and outcomes on a regular basis.

**Recommendation 6**: Robust processes should be in place to both respond to and scrutinise themes from complaints.
Recommendation 7: Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.

Recommendation 8: Staff feel able to raise concerns related to patient safety without reprisal.

Recommendation 10: The Board should review the management and leadership of the nursing staff to ensure that the principles described are complied with.

Recommendation 11: Ensuring that clinical staff and their views are represented at all levels in the Trust.

Recommendation 16: The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role with the objective of learning lessons about how failing hospitals are identified.

The result of this final recommendation being the public inquiry which published its findings on the 6th February 2013 and which will be presented in Part 2 of this briefing.

4.0 OVERVIEW OF PUBLICATIONS IN RESPONSE TO FINDINGS

4.1 Review of Early Warning Systems in the NHS


This describes the systems and processes, and values and behaviours which make up a system for the early detection and prevention of serious failures in the NHS. It emphasises that everyone has a role to play.

4.2 Assuring the quality of senior NHS managers


This report of a working group recognised that while the overwhelming majority of NHS managers meet high professional standards every day, a very small number sometimes demonstrate performance or conduct that lets down the patients they serve as well as their staff and organisations. The group’s recommendations include replacing the Code of Conduct for NHS managers with a new statement of professional ethics, and consultation on a system of professional accreditation for senior NHS managers.

4.3 The Healthy NHS Board

http://www.nhsleadership.org.uk/boarddevelopment/principles/
The document sets out the guiding principles to ensure NHS board members understand the collective role of the board, governance within the wider NHS, approaches that are most likely to improve board effectiveness, and the contribution expected of individual board members.

PART 2

5.1 TERMS OF REFERENCE OF THE SECOND INQUIRY

The Terms of Reference for this further inquiry were:

- To examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner; and appropriate action taken. This includes, but is not limited to, examining, the actions of the Department of Health, the local Strategic Health Authority, the local Primary Care Trust(s) the Independent Regulator of NHS Foundation Trusts (Monitor), the Care Quality Commission, the Health and Safety Executive, local scrutiny and public engagement bodies and the local Coroner.

- Where appropriate to build on the evidence given to the first inquiry and its conclusions, without duplicating the investigation already carried out, and to conduct the inquiry in a manner which minimises interference with the Mid-Staffordshire NHS Foundation Trust's work in improving its service to patients.

- To identify the lessons to be drawn from that examination as to how in the future the NHS and the bodies which regulate it can ensure that failing and potentially failing hospitals or their services are identified as soon as is practicable;

- In identifying the relevant lessons to have regard to the fact that the commissioning, supervisory and regulatory systems differ significantly from those in place previously and the need to consider the situation both then and now; and

- To make recommendations to the Secretary of State for Health based on the lessons learned from the events at Mid Staffordshire; and to use best endeavors to issue a Report to him by March 2011

6.0 OVERVIEW OF THE FINDINGS

Both inquiries identified a story of terrible and unnecessary suffering affecting 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 Public inquiry looked at each and every organisation which had commissioning, regulatory and or supervisory responsibility for monitoring Mid-Staffordshire NHS Foundation Trust between 2005 – 2009. It found failure of the NHS system at every level to detect and take action that patients and the public were entitled to expect.

The inquiry identified the following:

• There were poor or ill used mechanisms of communication between organisations to share intelligence and communicate concerns.

• Assumptions were continually made that important functions were being performed satisfactorily by others.

• The dangers of the loss of corporate memory from major reorganisations were inadequately addressed during the reorganisations which pervaded during the period under review.

Robert Francis QC emphasised the need to move away from a blame culture and stated that to focus on blame with a whole systems failure on the scale uncovered by the inquiry would perpetuate the cycle of defensiveness, concealment, lessons not being learnt and further harm.

7.0 OVERVIEW OF THE RECOMMENDATIONS

For the second inquiry, in total Robert Francis QC makes 290 recommendations. The 290 recommendations are far reaching and all need to be considered in relation to the commissioning role of Clinical Commissioning Groups (CCGs) and it is advisable that the Executive Summary is read as a minimum including all the recommendations in their entirety.

For the purposes of this paper the key recommendations directly attributed to the CCGs, or where there is a significant requirement for CCGs to work with or facilitate other agencies’ responsibilities, are presented in a high level initial summary (Appendix 1). This high level initial summary includes a local status update and outlines the next steps to be further developed at CCG level.

The recommendations from the Inquiry are wide reaching in their potential impact on future health care delivery and monitoring of those services and cover 22 themes for consideration and action:

• Accountability for implementation of recommendations
• Putting the patient first
• Fundamental standards of behaviour
• A common culture made real through the system
• Responsibility for, and effectiveness of, healthcare standards
• Responsibility for, and effectiveness of, regulating healthcare systems
governance – monitor’s healthcare system regulatory function
• Responsibility for, and effectiveness of, regulating healthcare systems
governance – Health and safety executive functions
Enhancement of the role of supportive agencies
Effective complaints handling
Commissioning for standards
Performance management and strategic oversight
Patient, public and local scrutiny
Medical training and education
Openness, transparency and candour
Nursing
Leadership
Professional regulation and fitness to practice
Nursing and Midwifery council
Caring for the elderly
Information
Coroners and inquests
Department of Health leadership

In summary numerous warning signs at Mid Staffordshire were not identified or acted upon, due to:

- A culture focused more on systems than patient care.
- More weight attributed to positive information than to information capable of implying cause for concern.
- Standards and methods of compliance that did not focus on the effect of a service on patients.
- Tolerance of poor standards and risk to patients
- Poor inter-agency communication
- Failure to take responsibility for monitoring, performance management and intervention.
- Inability to tackle challenges to the building of a positive culture.
- A failure to appreciate the risk of disruptive loss of corporate memory and locus resulting from repeated, multi-level reorganisation

The central theme of all the recommendations is the requirement for greater cohesion and unity of culture throughout the healthcare system, which Robert Francis QC states will not be brought about by yet further “top down” pronouncements, but by engagement of every single person serving patients in contributing to a safer, committed and compassionate and caring service.

8.0 LOCAL GOVERNANCE

To ensure the relevant inquiry recommendations are undertaken and completed within NHS CWHH the following governance mechanisms have been identified across the collaborative:

8.1 CENTRAL, WEST LONDON, HAMMERSMITH AND FULHAM AND HOUNSLOW (CWHH) CCGs GOVERNANCE PROCESS
• Francis Inquiry findings and reports shared with CWHH CCG Chairs and Quality leads (completed 6.2.13)

• CWHH Report on findings and recommendations and an initial status update to be reported at CWHH Collaborative Quality & Safety Committee in March 2013.

• CWHH Report on findings and recommendations and a status update reported at CWHH CCGs Quality & Safety Committees in March 2013 and due to be presented at Governing Bodies in May 2013.

• CCG action plans to be developed.

• Ongoing review of recommendations and CWHH status update, report by exception / highlight report to the CWHH Collaborative Quality & Patient Safety Committee detailed to the CCG Quality & Patient Safety Committees.

In addition to the above, all Clinical Quality Groups (CQGs) have been asked by CWHH to seek updates from provider organisations for the April 2013 CQG meetings on how each Trust is progressing the recommendations from the Inquiry. Trusts are being asked to report on the following:

• When they plan to publish their report regarding progress in relation to recommendations from the Robert Inquiry (rec. no.1)

• When they plan to enter into their contracts with staff a commitment to abide by the NHS values and the Constitution (rec.no.7)

• When they plan to review relevant risk management and HR policies to ensure the duty of candour is incorporated (rec.no. 173 & recs no. 181 & 183)

• When they plan to review their policies (ie Whistle Blowing Policy) to ensure that any bona fide disclosure in relation to public interest issues of patient safety and care are not prohibited (including gagging clauses) (rec.no. 179)

Part 3

The initial response from the Government ‘Patients First and Foremost’ which was published in March 2013, accepts the recommendations and states its intentions and actions following the inquiry.

The Governments response - Key Proposals:

1. Consult on a national barring list for unfit managers
2. A statutory duty of candour for providers not individuals
3. An elite fast track programme for talented leaders outside the NHS and an MBA-style programme for clinical leaders
4. CQC to develop an aggregated Ofsted-style ratings system for hospitals and to draw up simpler fundamental standards
5. CQC to delegate enforcement powers to Monitor and the NHS Trust Development Agency
6. NHS Employers to work on new model performance frameworks for staff
7. Pilot schemes that will require students seeking NHS funding for nursing degrees to first serve up to a year as a healthcare assistant
8. Criminally negligent practice will be referred to the Health and Safety Executive
9. Endorsement of the NHS Confederation's bureaucracy review
10. A new time-limited three stage failure regime covering quality and finance - which will be initiated by the Chief Inspector of Hospitals.

Following this publication provider Trusts will now be in a better position to move forward with their own action plans and the implementation of these.

9.0 CONCLUSION

Parts 1 and 2 of this paper were reviewed by the NW London Cluster Quality and Clinical Risk Committee in February 2013 and CWHH CCGs Collaborative Quality and Patient Safety Committee and individual CCG Quality and Patient Safety Committees in March 2013.

All four CCG Quality and Patient Safety Committees identified that this paper should be taken to their respective Governing Body Meetings.

This paper presents the implications for commissioning organisations at a crucial point in time when the NHS is undergoing radical transformation. The findings and recommendations of both inquiries have been the impetus for recent developments in commissioning behaviours and practice and the bedrock upon which the guidance and frameworks pertaining to the present reconfiguration within the NHS are founded. Both Parts 1 and 2 of this paper are intended to foster reflection and Robert Francis QC has explicitly stated that when considering his second report, the previous findings of the initial inquiry should be seen as a part of the whole story.

As the CCGs have now taken on statutory accountability for commissioning acute, community and mental health services, it is vital that the outcomes from the Francis Inquiry are embedded in how assurance is sought from commissioned providers. Over the next twelve months CCGs will need to review their progress in relation to implementing the relevant recommendations whilst ensuring that robust systems to detect and address signs of system failure are in place and that the quality and safety of services for patients are kept at the forefront of both commissioning and service delivery.

The report makes clear what is required as a first step:
‘All commissioning, service provision and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their work’

It is recommended that:

1. The Governing Body note this paper and accept the recommendations of Robert Francis Inquiry report that are relevant to the CCG and to commissioning.

2. CCGs work with relevant stakeholders and partner organisations (NHS England, LA, Commissioned Providers, PPI Groups) to consider this report and recommendations.

3. Through local governance processes action plans are developed which are monitored through Quality Committees with ownership sitting with the Governing Body.

4. Assurance is sought from all commissioned providers that there are clear plans in place in response to the Robert Francis Inquiry.

Appendix 1 – High level initial Summary

The recommendations presented below either specifically relate to the role and function of CCGs or require CCGs to support or facilitate others to implement. The division of the recommendations into themes explicitly reflects section 2 Table of Recommendations in the Executive Summary to the Mid-Staffordshire NHS Foundation Trust Public Inquiry.

To seek assurance that the recommendation of this inquiry are enacted and that the public are clear as to what changes they can expect, Robert Francis QC’s first set of recommendations addresses the potential oversight of and accountability for implementation of its recommendations:

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.

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<tr>
<th>Rec No</th>
<th>Recommendation</th>
<th>CWHH status and next steps</th>
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| 1      | All commissioning organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; | Francis Inquiry Paper and recommendations to be reported to:  
-March 2013 CWHH Quality & Safety Cttee  
-March 2013 CCG Q&S Cttees  
-April 2013 CCG GBs |
|        | 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 | CCG decisions to be announced following April CCG GBs  
6 monthly update reports to be reviewed by CCG GBs |
|        | 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; | CCGs to submit relevant information to DH as required |

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.

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<th>Rec No</th>
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<th>CWHH status and next steps</th>
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<tr>
<td>7</td>
<td>All NHS staff should be required to enter into an express commitment to abide by the NHS values and the constitution, both of which should be incorporated into the contracts of employment</td>
<td>Commitment to be included in CWHH contracts of employment.</td>
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<td>8</td>
<td>Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.</td>
<td>Relevant additions to be included in provider contracts.</td>
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**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.

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<tr>
<td>12</td>
<td>Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.</td>
<td>CWHH Incident &amp; Serious Incident policy will reflect this requirement.</td>
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<td>CSU Incident Process to include feedback to staff.</td>
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**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.
### Responsibility for, and effectiveness of, healthcare standards

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<th>Rec No</th>
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<th>CWHH status and next steps</th>
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<tr>
<td>42</td>
<td>Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.</td>
<td>CSU SI reports to be shared with CQC.</td>
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<tr>
<td>43</td>
<td>Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility</td>
<td>Performance of providers currently monitored and failings in standards addressed at CQGs.</td>
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### Enhancement of the role of supportive agencies

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<th>Rec No</th>
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<th>CWHH status and next steps</th>
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<tr>
<td>107</td>
<td>If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider’s management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS commissioning Board, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.</td>
<td>CCGs to work with HPA or successor bodies to share information around infection control as identified</td>
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### Commissioning for standards

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<th>Rec No</th>
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<th>CWHH status and next steps</th>
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<td></td>
<td>GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in</td>
<td>Performance of providers currently monitored and failings in standards addressed at CQGs. CCGs to distribute reports as</td>
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<td>123</td>
<td>Responsibility for monitoring delivery of standards and quality</td>
<td>particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients’ choice reality. A GP’s duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.</td>
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<td>124</td>
<td>Duty to require and monitor delivery of fundamental standards</td>
<td>The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received substandard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.</td>
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<td>125</td>
<td>Responsibility for requiring and monitoring delivery of enhanced standards</td>
<td>In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.</td>
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<td>126</td>
<td>Preserve corporate memory</td>
<td>The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.</td>
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<td>127</td>
<td>Resource for</td>
<td>The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers’ services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.</td>
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<td>Number</td>
<td>Expert support</td>
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<td>128</td>
<td>Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.</td>
<td>CWHH Collaborative established. CSU commissioned to undertake relevant commissioning functions on CWHH behalf</td>
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<td>129</td>
<td>In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed</td>
<td>Patient safety &amp; Patient experience are included in the 3 domains of quality via which performance of providers is monitored and failings in standards addressed at CQGs. Additional safeguarding indicators are also reviewed in performance reports. Quarterly Adult &amp; Child Safeguarding reports to be submitted to CCG Q&amp;S Cttees.</td>
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<td>130</td>
<td>Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail</td>
<td>CCGs clinically led. Secondary Care Consultant included in CCG GBs</td>
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<tr>
<td>131</td>
<td>Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.</td>
<td>CWHH Collaborative established. Where commissioning intentions coincide commissioning undertaken on a collaborative basis. CSU commissioned to undertake relevant commissioning functions on CWHH behalf.</td>
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| 132 | Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period:  
- Such monitoring may include requiring quality information generated by the provider.  
- Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases.  
- The possession of accurate, relevant, and useable information from | Performance of providers currently monitored and failings in standards addressed at CQGs. This includes information generated by provider. This is checked against other information streams.  
Commissioners undertake visits and inspections as required to provider services  
Various performance and quality information streams |
which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards. triangulated at CQGs and CCG Q&S Ctees CWHH to identify other enhanced standards for quality.

<table>
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<tr>
<th>133</th>
<th>Role of commissioners in complaints</th>
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<tr>
<td>Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.</td>
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CWHH Complaints Policy to be amended accordingly and processes identified for implementation.

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<th>134</th>
<th>Role of commissioners in provision of support for complainants</th>
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<tr>
<td>Consideration should be given to whether commissioners should be given responsibility for commissioning patients’ advocates and support services for complaints against providers.</td>
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Relevant recommendations for development to CWHH Complaints policy to be drawn up.

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<th>135</th>
<th>Public accountability of commissioners and public engagement</th>
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<td>Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement:</td>
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<tr>
<td>- There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners.</td>
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<td>- There should be lay members of the commissioner’s board.</td>
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<td>- Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account.</td>
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<td>- There should be regular surveys of patients and the public more generally.</td>
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<td>- Decision-making processes should be transparent: decision-making bodies should hold public meetings.</td>
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<td>Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community</td>
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CCGs have public engagement programs of work including links with relevant local groups. CCG GBs have 2 lay members

CCG PPE leads to identify recommendations for development of PPE Strategy to ensure these recommendations are implemented. Leads- CCG PPE leads
Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.

Technical support for CWHH has been commissioned from CSU. CWHH Communications Plan to be developed to ensure these recommendations are implemented.

Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.

CWHH Director of Quality and Patient Safety to work with NHS ENGLAND and CQC as required to implement this recommendation.

### Local Scrutiny

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<tr>
<td>138</td>
<td>Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services</td>
<td>CWHH to develop Contingency Plan.</td>
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### Performance management and strategic oversight

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<tr>
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<th>CWHH status and next steps</th>
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<tbody>
<tr>
<td>139</td>
<td>The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with</td>
<td>Performance of providers currently monitored and failings in standards addressed at CQGs and supporting evidence is requested where necessary</td>
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<td>140</td>
<td>Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgment as to the safety of patients of the healthcare provider.</td>
<td>Quality &amp; Safety Information sharing protocol between CWHH &amp; CQC, Monitor, NTDA and NHS ENGLAND to be developed.</td>
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### Taking responsibility for quality

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<tr>
<td>141</td>
<td>Any differences of judgment as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.</td>
<td>Quality &amp; Safety Information sharing protocol identified above to include this element</td>
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<td>142</td>
<td>For an organisation to be effective in performance management there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.</td>
<td>Clear lines of Governance established for CWHH. These will be reviewed on an ongoing basis for effectiveness</td>
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<td>143</td>
<td>Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed</td>
<td>Performance of providers currently monitored and failings in standards addressed at CQGs. Common metrics applied in Quality &amp; performance reports. CWHH will incorporate use of the National Quality Dashboard (including widespread relevant benchmarking) in the monitoring of provider services</td>
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<td>144</td>
<td>The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.</td>
<td>CCGs to work with NHS ENGLAND to develop quality metrics as identified</td>
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### Medical training and education

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<td>152</td>
<td>Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.</td>
<td>CCGs to report training metrics as required</td>
</tr>
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</table>

### 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.

### Rec No | Recommendation | CWHH status and next steps
--- | --- | ---
173 | Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful | Duty of candor introduced into 2013/14 Standard Contracts. Implementation to be monitored via CQGs. |
179 | “Gagging clauses” or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care. | Review of CWHH HR Policies to be undertaken to ensure this recommendation is implemented. |

### Nursing

### Rec No | Recommendation | CWHH status and next steps
--- | --- | ---
191 | Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates’ values, attitudes and behaviors towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements | CWHH contracting & HR leads to review and make recommendations about how this should be implemented. |
197 | Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff | CWHH Director of Nursing to identify recommendations about how this should be implemented. |
204 | All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors. | CWHH Director of Nursing is a Registered Nurse. Consideration to be given to recruitment of Nurse NED. |
205 | Commissioning arrangements should require the boards of provider organisations to seek and record the advice of | CWHH Perorma to review provider CIP Quality Impact assessments developed. This identifies that DoN should sign off QIA. Monitoring of this process will identify |
its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.

levels of implementation at providers.

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<td>208</td>
<td>Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse</td>
<td>CWHH contracting &amp; DoN leads to review and make recommendations about how this should be implemented.</td>
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Information

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<td>246</td>
<td>Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.</td>
<td>DoH has recently published guidance to providers around the development of Quality Accounts to include relevant benchmarking. Quality accounts are currently submitted to commissioners for comments.</td>
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<td>247</td>
<td>Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.</td>
<td>Quality accounts are currently submitted to commissioners for comments. Quality accounts for other relevant London Trusts to be requested for submission to CWHH.</td>
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<td>269</td>
<td>The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.</td>
<td>Performance of providers currently monitored and data challenged at CQGs and supporting evidence is requested where necessary. CWHH Audit Committee to develop and provide assurance around the quality of data reviewed.</td>
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