NHS Darlington Clinical Commissioning Group

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NHS DARLINGTON
CLINICAL COMMISSIONING GROUP
GOVERNING BODY

1. The Francis Inquiry Report into Mid Staffordshire Hospital Trust

Introduction

The report of the Francis inquiry, tells first and foremost of the appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board.
It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.
This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.
The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all
of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care.
Francis states that PCTs were not as effective as might have been expected in commissioning or monitoring delivery of quality.
This paper focuses on the implications of the Francis Report for CCGs and makes recommendations for implementation

2. Implications and risks

The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;

- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

What this means for Clinical Commissioning Groups

Commissioners of services, as the paying party for services they contract from providers, must ensure that those services are well provided and are provided safely. The fundamental standards to be policed by the CQC form the minimum level of service that should be provided, but the commissioner in its contracting arrangements will wish to set standards over and above that minimum standard for the services that it wishes to contract, and will set out redress for non-compliance with those contracted standards.

These contractual standards – enhanced quality standards – give commissioners the opportunity to promote improvement in the areas of service they wish to purchase.
Commissioners could also set out longer term goals for, or in conjunction with, providers by way of developmental standards and focus on improvements in effectiveness.

The NHS Commissioning Board should be responsible for devising and designing the enhanced standards to be incorporated into commissioning contracts or assisting local commissioners to do so.
The NHS Commissioning Board and the local commissioners of services must be adequately resourced to enable a proper scrutiny that providers are delivering the standard of service required under their contracts. The resource available to the commissioners to monitor the provision of contractual services should extend as necessary to the capacity to undertake audits, inspections and investigations, of individual cases and of groups of cases. The commissioners must have access to quality accounts and all QRPs available to the CQC.

Responsibility for driving improvement in the quality of service should therefore rest with the commissioners through their commissioning arrangements.

Commissioners should promote improvement by requiring compliance with enhanced standards that demand more of the provider than the fundamental standards.

Commissioners should have powers of intervention where services are being provided which do not accord with their contracts. If fundamental standards are not being provided, the CQC, as regulator, should also be informed, and the commissioner and the CQC should in such cases be able to act jointly or alone.

The commissioner should be able to stop the provision of a service being supplied in breach of the fundamental and/or enhanced standards and/or require the provision of the service to be done in a different way, or by different personnel, to protect patients. The CQC and commissioners should have contingency plans in place in the event of needing to exercise these powers.

In contracting providers, commissioners – not the provider – should decide what needs to be provided, but they should consider the views of clinicians, including those from providers and elsewhere, on commissioning needs as they consider it appropriate.

Commissioners should also consult others, as they deem necessary, including GPs and procurement expertise, to improve their commissioning arrangements.

Commissioners should also consult and liaise with other commissioning bodies, as they deem necessary, to achieve the necessary expertise or commissioning power to secure effective arrangements.

Commissioners should, in their contracts, require the boards of providers to seek and record the views and advice of its clinical and nursing directors of the impact on the fundamental standards of any proposed major change to clinical or nurse staffing arrangements or the provision of facilities.

Commissioners need to recognise their accountability to the public they serve by measures designed to involve the public in commissioning and enable their views to be taken into account. For this purpose, commissioners need to raise their public profile.

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.
Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.

3. Recommendations (completed)

The CCG Executive Team has appointed lead officer to oversee the response to the findings and recommendations and seek agreement on how to apply them to the work of the CCG.
The lead officers are
Liz Graham, Chief Nurse and Head of Quality and Lisa Tempest Chief Finance Officer

The CCG has consulted with the Darlington Patients Community Council on its response to Francis and for improving patient experience

The CCG Governing Body has met and discussed the priorities from Francis for the short-mid and long term

The CCG will announce at the earliest practicable time their decision on the extent to which they accept 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;

4. Author and sponsor director

Author: Liz Graham
Title: Chief Nurse and Head of Quality

Director: Martin Phillips
Title: Chief Officer
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