Meeting	Health and Well-Being Board
Date	25 April 2013
Subject	**Quality and Safety – A response to Francis**
Report of	Chief Officer, Barnet Clinical Commissioning Group (CCG)
Summary of item and decision being sought	This report provides a summary of the main issues raised from the public inquiry into the events at Mid Staffordshire hospital carried out by Robert Francis QC. It also includes the main recommendations from that report which have significance for the CCG, and sets out Barnet CCG's progress to assess its current priorities; and it advises of next steps.

Officer Contributors	Vivienne Stimpson Director of Quality and Governance John Morton, Chief Officer, Barnet CCG
Reason for Report	To provide assurance that the CCG has begun to consider and reflect on the implications of the second Francis Report and the most recent publication released by the National Quality Board and has identified the next steps.
Partnership flexibility being exercised	None
Wards Affected	All

Contact for further information

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1. RECOMMENDATION

1.1 The Health and Wellbeing Board is asked to note and support the steps CCG Barnet is taking to address the findings of the Francis Report. This report details plans the CCG has in place to ensure that all the recommendations from the second inquiry by Robert Francis QC are fully considered and responded to at a Board level and highlights key areas for further action.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Barnet CCG Board meeting held on 4 April 2013.

2.2 Barnet Clinical Quality and Risk Committee March 2013.

3. LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS (SUSTAINABLE COMMUNITY STRATEGY; HEALTH AND WELL-BEING STRATEGY STRATEGY; COMMISSIONING STRATEGIES)

3.1 The specific issues outlined in this report will assist the Health and Well Being Board to deliver all key priorities in the Health and Well-Being Strategy. They will inform more specific commissioning plans developed both by the Council and Barnet Clinical Commissioning Group.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Barnet Joint Strategic Needs Assessment includes information on health outcomes for the local population. These will be addressed through implementing the Francis report and add context to Francis recommendations

5. RISK MANAGEMENT

5.1 The CCG needs to ensure the recommendations from this inquiry are fully considered in its role as a commissioning organisation.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

7. USE OF RESOURCES IMPLICATIONS- FINANCE, STAFFING, IT ETC

7.1 Additional resources may be needed to implement some of the recommendations in this report: these will need to be prioritised against CCG/LBB commissioning intentions and where appropriate funded from within existing NHS and local authority budgets.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A report was presented to the CCG Board in March 2013 to begin to engage with stakeholders.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 All providers are required to prepare a response to the Francis Report. Senior representatives from Barnet and Chase Farm Hospitals NHS Trust and Royal Free Hospital NHS Trust are in attendance at this meeting.

10. DETAILS

Background

10.1 This second and final report of the public inquiry into Mid Staffordshire NHS Foundation Trust published on the 6th of February 2013 provides detailed and systematic analysis of what contributed to the failings in care at the trust. It identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the trust's problems for so long, even when the extent of the problems were known. Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area, Mid-Staffordshire NHS Foundation Trust. During this period of time the Trust had come under close scrutiny in relation to its application for Foundation Trust status by the Department of Health, the Strategic Health Authority, Monitor, the Healthcare Commission, and the NHS Litigation Authority alongside local scrutiny groups and public involvement groups all of which had found that the Trust met the applicable standards and found no systematic failings. The truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them.

10.2 A focus on Patients

The Report recognises that what happened in Mid Staffs was a system failure, as well as a failure of the organisation itself. Rather than proposing a significant reorganisation of the system, the report concludes that a fundamental change in culture is required to prevent this system failure from happening again, and that many of the changes can be implemented within the current system. It stresses the importance of avoiding a blame culture, and proposes that the NHS – collectively and individually –adopt a learning culture aligned first and foremost with the needs and care of patients.

10.3 The report makes 290 recommendations, which focus primarily on securing a greater cohesion and culture across the system, which 'will not be brought about by further "top down" pronouncements, but by the engagement of every single person serving patients'. However, no single recommendation should be regarded as the solution to patient safety.

10.4 Patients must always come first if the NHS is to deliver the best and safest care possible. Patient care is everyone's responsibility. Implementing some of the recommendations in the report will be difficult, but the right thing to do.

10.5 While the inquiry was confined to Mid Staffs, there is evidence there are other places where unhealthy cultures, poor leadership and an acceptance of poor standards are too prevalent. Robert Francis' first recommendation is for everyone in the NHS to consider and review what happens in their own organisation in light of the inquiry's findings, and identify any actions they may need to take to ensure what happened in Stafford does not happen in their organisation. We propose an

NHS Barnet CCG with the CSU produces its own action plan over the next three months and report to the Board in June 2013. This work will be led by the Quality and Clinical Risk Committee

10.6 The report stated desire for more transparency and real-time information for both the public and providers will ensure the spread of accountability at all levels of the NHS. In addition, by providing clarity over who is responsible for improvements in quality we have a real mandate for change. Robert Francis' view is that the whole system must now revolve around quality and that top-down management is no longer viable. To achieve this will take real commitment from CCGs. It is clear that the levers for the transformation of services are already embedded in the system.

Francis does not lay the blame at any individual's door - and the report is clear that Mid- Staffs was a reflection of a system-wide failure.

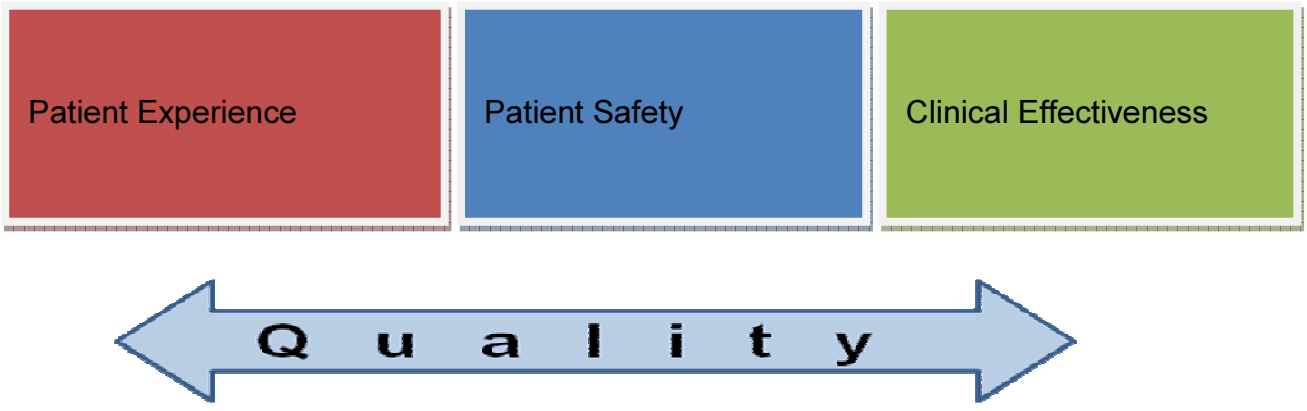
National Quality Board

10.7 The National Quality Board released a draft report in May 2012, which they finalised January 2013: Quality in the new health system; maintaining and improving quality. The report focuses on how the new health system should prevent, identify and respond to serious failures in quality and provides a collective statement from the NQB members as to:

- The nature and place of quality in the new health system.
- The distinct roles and responsibilities for quality in the different parts of the system.
- How the different parts of the system should work together to share information and intelligence on quality to ensure an aligned and co-ordinated system wide response in the event of a quality failure.
- The values and behaviours that all parts of the system will need to display in order to put the interests of the patient and public first and ahead of organisational interests.

10.8 The Health and Social Care Act 2012 is fundamentally changing the way the NHS, public health and care system in England is organised and run.

FIGURE 1: Definition of quality
High quality care requires all three dimensions to be present Clinical Effectiveness Patient Experience and Patient Experience
This definition of quality has now been enshrined in legislation through the Health and Social Care Act 2012.[10]



The NHS is organising itself around a single definition of quality: care that is effective, safe and provides as positive an experience as possible. This simple, yet powerful definition that arose out of the NHS Next Stage Review has now been enshrined in legislation. It lies at the heart of the first ever NHS Outcomes Framework and continues to help unite the ambitions and motivations of staff with the hopes of patients and the expectations of the public. It is also inherent in the related Outcomes Frameworks for public health and adult social care. The appalling failures at Mid Staffordshire NHS Foundation Trust and at the independent hospital, Winterbourne View, provide stark reminders that when we fall short on our responsibilities in respect of quality, the consequences for patients, service users and their families can be catastrophic.
At the same time, we must also recognise that the provision of high quality care is an inherently complex and fragile operation. Quality is systemic -the patient journey cuts across primary and secondary care, health and social care, links with public health services and involves multiple professionals.

11.0 Our Commitment to Quality

As Leaders of the local system of commissioning, regulation and performance monitoring we are, nevertheless, clear about our individual and collective responsibility for creating the conditions and the environment which allows quality to prevail and ensures that the interests of patients always come first. Overall, the health economy must:

- Reaffirm our commitment to the primacy of quality in the new system;
- emphasises the critical importance of values and behaviours in creating a system that is truly focussed on quality and always places the interests of patients ahead of individual or organisational ambition;
- sets out the central role that patients and service users must play in the oversight and scrutiny, design and measurement of high quality services; provides clarity around the distinct roles and responsibilities for quality of individuals and organisations across the new system architecture;
- presents a new approach for supporting collaboration across the system and facilitating the sharing of information and intelligence on quality through a new network of Quality Surveillance Groups; and ensures that there is a clear and agreed approach to taking swift and coordinated system-wide action in the event of a serious quality failure being identified, in order to rapidly protect patients and service users.

12.0 Summary of the recommendations

Ensuring implementation of the inquiry's recommendations

At the heart of the report is a determination that the inquiry's recommendations and findings be implemented. Its first recommendation sets out requirements for oversight and accountability to ensure implementation of its proposals including:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should reflect on the report and its recommendations and decide how to apply them to their own work.
- Each organisation should announce at the earliest opportunity its decision on the extent to which it accepts the recommendations and what it intends to do to implement them.
- Each organisation should publish, at least annually, a report on its progress in achieving its planned actions.
- The Department of Health should publish a report, at least annually, collating information about the decisions, actions and progress reported by other organisations.
- The House of Commons Select Committee on Health should incorporate progress on implementation as part of their reviews of organisations in their normal business.

12.1 Creating the right culture and putting the patient first

The report highlights the importance of establishing a shared positive safety culture that permeates all levels of the healthcare system, which aspires to prevent harm to patients and provide where possible, excellent care and a common culture of caring, commitment and compassion. This requires:

- Shared values in which the patient is the priority of everything done
- Zero-tolerance of substandard care
- empowering frontline staff with the responsibility and freedom to deliver safe care
- strong and stable cultural leadership and organisational stability
- comparable data on outcomes
- expectations of openness, candour and honesty.

Leaders of organisations are expected to adopt the shared culture themselves, and be seen to do so. This should be supported by measures such as open board meetings, personally listening to complaints and an open and honest admission where there is an inability to offer a service. At a system level, this should be demonstrated by constantly considering how the wellbeing of patients is protected or improved by proposed measures.

12.2 Putting the patient first

The report underlines the importance of making patients the main priority in all that the healthcare system does. Within available resources, patients must be expected to receive effective services from caring, compassionate and committed staff, working to a common culture. They must also be protected from avoidable harm and any deprivation of their basic rights.

12.3 Fundamental standards of behaviour

The report proposes that fundamental standards of behaviour which apply to all staff that work and serve in the healthcare system, be enshrined in the NHS Constitution. Recommendations to achieve this include:

- Incorporating explicit reference in the Constitution to all professional and managerial codes by which NHS staff are bound, and an expectation that staff will follow and comply with standards relevant to their work.
- Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work.
- Professional bodies should work to provide evidence-based standard procedures for as many interventions and pathways as possible.
- Managers need to ensure that their employees comply with these requirements.

- Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary.
- Employers must insist on the reporting of concerns relating to patient safety – employees should receive feedback on any action taken.

12.4 An integrated hierarchy of standards of service

The report proposes establishing an integrated hierarchy of service standards to promote the likelihood that a service will be delivered safely and effectively. Standards would range from mandatory fundamental service standards to discretionary developmental standards, with clear expectation of zero-tolerance towards any organisation providing services that do not comply the fundamental standards. The standards should be evidence-based and measurable, and be clear about what needs to be done to comply.
They should also be subject to regular review and modification.

12.5 Responsibility for and effectiveness of, healthcare standards

The report highlights the importance of simplifying the regulation regime for NHS trusts to eradicate overlap and minimise the gaps between the functions of the different regulators. It proposes significant changes to the current division of regulatory responsibilities between Monitor and the Care Quality Commission (CQC), with the creation of a single regulator for all trusts, including foundation trusts. Monitor would retain its residual role as a regulator of the health economy. It suggests that these changes be implemented incrementally after thorough planning, and should not be used to justify reducing resources allocated to regulatory activity. It also stresses the importance of retaining the corporate memory of both organisations. Recommendations are:-

- Creating a single regulator for all trusts
- Monitoring compliance with standards
- Setting standards and developing evidence-based compliance
- Effective assessment of compliance with standards
- Effective assessment of compliance and enforcement of compliance with standards
- CQC independence, strategy and culture

12.6 Responsibility for, and effectiveness of, regulating health systems Governance

The report recognises that, "much high-quality, committed and compassionate nursing is carried out day in and day out, often with inadequate recognition." However it states, "it is clear that the nursing issues found in Stafford are not confined to that hospital but are found throughout the country' and argues the NHS needs to give the highest priority to 'reversing the scandalous decline in standards." The report focuses on the culture of caring requiring more focus on delivering compassionate care at the point of recruitment, in training and through annual appraisal. The report also examines and makes recommendations in relation to the role of nursing leadership and that of healthcare support workers.

This area of recommendations covers the following issues:

- Consolidating Monitor's regulatory functions
- Authorisation of Foundation Trusts (FTs)
- Role of FT governors
- Accountability of directors

12.7 Effective assessment of compliance and enforcement of compliance with standards

- Any service that does not consistently meet the relevant fundamental standards should not be allowed to continue.

- Effective enforcement should be ensured by installing a low threshold for suspicion, and no tolerance of non-compliance with fundamental standards.
- It should be a criminal offence where death or serious injury is caused by breaching fundamental standards.
- Failure to disclose breaches of fundamental standards should also attract regulatory actions.
- Interim measures:
- The CQC should be able to take immediate steps to protect patients where it has reasonable cause for concern about an issue, even if it is still investigating non-compliance.
- A public interest test should decide whether there are reasonable grounds to make the interim requirement or recommendation.

12.8 CQC independence, strategy and culture

- Any attempts to abolish the CQC and create a new organisation should be avoided, and its role should develop on an evolutionary basis.
- The CQC needs to be seen as acting entirely independently of government, and the Government should only consider it necessary to intervene in the CQC in the most extreme circumstances.
- The relationship between the CQC and the Department of Health (DH) must be meticulously transparent and where issues relating to regulatory action are discussed, they must be properly recorded to allay any suggestion of inappropriate interference.
- Transferring power to define standards to NICE, or a similar body, may protect the regulator's autonomy while retaining powers for the Secretary of State to define outcomes.
- The structure under which the CQC is required to work is over-bureaucratic and does not separate clearly what is absolutely essential from what is merely desirable.
- The strategic direction of the new regulatory model being developed by the CQC is encouraging, but the leadership of the CQC should communicate this clearly to the public and its staff.
- CQC should review its processes to ensure that it is capable of delivering effective regulatory oversight and enforcement in accordance with the principles set out in the inquiry's report.
- The CQC should undertake a formal evaluation of how it would detect and act on the warning signs or other events causing concern similar to events that occurred at Mid Staffs, and open that evaluation to public scrutiny. .
- The culture within the CQC needs to change – there is a pattern consistent with a negative and closed culture of the sort they should be combating; it must be a model of openness, so that it can encourage employees in regulated organisations to come forward with concerns.
- The CQC board should have closer involvement with the healthcare professional community and patient representative groups.

12.9 Authorisation of FTs

- The processes of authorising FTs and monitoring compliance with FT standards should pass to the CQC, which should incorporate the relevant departments of Monitor
- The NHS Trust Development Authority (NTDA) must develop a clear policy requiring roof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a FT application
- No NHS trust should be supported to apply for FT status unless it meets the criteria for authorisation, including compliance with fundamental standards and a full physical inspection of its primary clinical areas and all wards.

- The stakeholder consultation process for assessing potential applicant NHS trusts for FT status should be jointly reviewed by DH, NTDA and Monitor.
- There should be a duty on applicants for FT status of utmost good faith to disclose any significant material information to the application, alongside ongoing obligations of transparency, openness and honesty.

13. Accountability of directors

All directors of all bodies registered by the CQC and Monitor should be, and remain a fit and proper person for the role.

Consideration should be given to including as criteria for fitness a minimum level of expertise and/or training.

Monitor and the CQC should produce guidance on procedures to be followed in the event of an executive or non-executive director being found guilty of serious failure in the performance of their office.

FTs should be required to have in place an adequate programme for the training and development of directors.

13.1 Commissioning for standards

The section on commissioning for standards pulls out the reflections and lessons learned by the primary care trust. The report suggests commissioning as a practice must be refocused to procure the necessary standards of a service as well as what it provides as a service (outcomes in quality as well as activity). Below are the recommendations for future commissioners:

- Commissioners should be closer to the public. The engagement of the public needs to be visible in the Commissioning process at Board level, through consultations, surveys and transparent decision making.
- Commissioners should set the commissioning agenda and make the final decision on what services are provided at a local level.
- Commissioners should be entitled to lay down a fundamental safety and quality standard/specification for services, as well as how the commissioner will measure compliance.
- In addition to fundamental standards, commissioners can promote improvement by requiring compliance with or development towards enhanced standards.
- Wherever possible, commissioners need to identify/make available alternative sources of provision so they are not constrained to one provider. To achieve this, commissioning may need to be undertaken collaboratively among commissioning groups to add collective weight to discussions with more dominant providers.
- Commissioners need specialist clinical expertise (not all of which can come from GPs), as well as procurement expertise to undertake their role effectively. Where commissioning groups are too small in themselves to acquire such support, they will need to collaborate with others.
- Commissioners must have the capacity and resources to monitor the performance of every commissioning contract on a continuing basis during the contract period, this may include:

1. quality information generated by the provider
2. commissioners undertaking their own (or independent) audits, inspections, and investigations
3. the possession of accurate, relevant, and useable information
4. monitoring compliance both with the fundamental standards and with any enhanced standards adopted.

- Commissioners must be entitled to intervene in the management of an individual complaint when they feel it is not dealt with satisfactorily (while the provider has primary responsibility). They must monitor complaints and their outcomes on as near a real time basis as possible.
- Commissioners should have contingency plans in place to mitigate risk from substandard or unsafe services.
- Commissioners should intervene where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from harm. These powers should align and compliment the role/action of regulators – acting jointly where needed. One method of action may be through the issuing of performance notices.
- 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.
- GPs in primary care should undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services, developing an ongoing relationship and recording this through a systematic shared process. This will enable them to be aware of patterns of concern at a population level and effectively influence commissioning decisions.

13.2 Effective complaints handling

The report recognises that there should be a uniform process for managing complaints and that the "recommendations and standards suggested in the Patients Association's peer review into complaints at the trust should be reviewed and implemented nationally".

- Provider organisations must actively promote their desire to learn and act on comments and complaints. They must make it easy for those who wish to do so using a number of different methods.
- Overview and scrutiny committees, Local Healthwatch, commissioners and the CQC should all have access to complaints information. Where necessary, complaints should be investigated through an arms length independent investigation or where there are large scale clinical failures, the response should be coordinated through the National Quality Board.
- Commissioners should require access to complaints information at the time the complaints are made and should receive complaints and their outcomes "on as near real-time basis as possible"

13.3 Openness, transparency and candour

The report concludes that "insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding." The overall recommendations include:

- Full disclosure where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff – whether or not the patient asks.
- All organisations should review their contracts of employment, policies and guidance to ensure they reflect the need for openness, transparency and candour, as well as the National Patient Safety Agency's (NPSA) *Being open* guidance. At a national level, this would include reviewing the NHS Constitution and amending the Code of Conduct for NHS Managers.
- Conditions of registration or authorisation of healthcare organisations should be amended
  - to include a standard requirement that any information provided to the public about services, compliance with statutory standards and statistical results is truthful and not misleading. Compliance with the standard should be regulated by the CQC.
  - to oblige healthcare providers to provide all relevant information to enable the coroner

to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.

- Healthcare organisations, regulators and commissioners should be banned from policies and contracts which seek, or appear to seek, to limit genuine public interest disclosure on patient safety and care ('gagging clauses').
- A statutory obligation should be imposed to observe a duty of candour on healthcare providers, registered medical practitioners, registered nurses and other registered professionals who believe or suspect that treatment or care provided has caused death or serious injury to a patient.
- An additional statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation.
- It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation to:

  - knowingly to obstruct another in the performance of these statutory duties; provide information to a patient or nearest relative intending to mislead them about such an incident

  - dishonestly make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties. The duty should be policed by the CQC, which should have powers to prosecute.

13.4 Caring for older people

The report concludes that “the true measure of the NHS’s effectiveness in delivering hospital care can be found in how well the elderly are looked after” and makes the following recommendations:

- Hospitals should review whether to reintroduce identifying a senior clinician who is in charge of a patient’s case, to help ensure there is clarity over who is in overall charge of a patient’s care. Nominating a named nurse for each patient for each shift is also recommended to improve the coordination of care.
- Emphasis is placed on the importance of team working, including recognising and valuing the contribution of cleaners, maintenance staff and catering staff.
- Regular interaction between nurses and patients should be systematised through regular ward rounds:

  - All staff need to be enabled to have constructive and friendly interactions with patients

  - Where possible, wards should have areas where patients and relatives can meet in relative privacy and comfort

  - There should be a greater willingness to communicate by email with relatives

  - The current common practice of summary discharge letters followed up by more substantive ones should be reconsidered

  - Information about a patient’s condition, progress, care and discharge plans should be shared with that patient and where appropriate those close to them.
- The care offered by a hospital should not end “merely because the patient has surrendered a bed”, patients should never be discharged in the middle of the night or without assurance that a patient will receive the care they need when they arrive at a planned destination. Discharge areas in hospital need to provide continued care to the patient.
- All visitors and staff need to be reminded to comply with hygiene requirements, including junior staff being encouraged to remind anyone, including senior staff.
- Arrangements and best practice for providing food and drink require “constant review, monitoring and implementation”.

- In the absence of automatic checking and prompting, the nurse in charge of the ward, or their nominated delegate, needs to over see the administration of medication, underpinned by a frequent check.
- Where possible, recording of observations on the ward should be done automatically as they are taken, with results immediately accessible to all staff electronically in a form.

13.5 Information

The report is clear about the positive role that information can play, encompassing issues such as: highlighting inadequate performance; accountability; informing the public; and supporting patient choice. Francis advocates an integrated system with common information practices, while acknowledging that the Government's information strategy "appears to contain most if not all" of his suggested elements.

- Any electronic patient information system should have the facility to collect performance management and audit data automatically; be designed in partnership between health professionals and patient groups; and have the capability to go "over and above nationally required minimum standards."
- All providers should appoint a board member that holds responsibility for information.
- Quality accounts should outline information in a standardised format to enable comparison. They should be subject to independent audit and all directors should sign a declaration to verify the contents. The CQC and/or Monitor "should keep the accuracy, fairness and balance of quality accounts under review", they should also have the ability to place a requirement on providers to make corrections where necessary.
- Information utilised for quality and risk profiles should be publicly available "as far as is consistent with maintaining any legitimate confidentiality."
- A consistent approach nationwide for gathering patient and public feedback about NHS services.
- The Health and Social Care Information Centre should have an enhanced role, with proposed tasks including, for example: independent collection, analysis, publication and oversight" of health information; the transferral of information functions from the NPSA to the Centre.
- All providers should implement information systems that can offer real-time performance data on services, specialist teams and consultants. The information should be published "to the extent practicable" and made fully available to both commissioners and regulators.
- It is stressed that "all healthcare professionals" should acknowledge their duty "to collaborate in the provision of information required" for treatment effectiveness data. Such information should be published and regularly.
- The DH, Information Centre and UK Statistics Authority should undertake a review of patient outcome statistics. The first two should collaborate on ensuring that summary hospital-level mortality indicators (SHMIs) "or any successor hospital mortality figures" are "recognised as national or official statistics."

13.6 Specific Recommendations for Commissioners

One of the key recommendations from the first enquiry was to review the operation of the commissioning, supervisory and regulatory bodies with respect to their monitoring function and ability to identify failure in the provision of safe care.

The report found that a critical gap in the system of oversight of quality and safety arose from the inability of the commissioners to collect information on provider quality and to understand and make use of the contractual mechanisms that were available to them. On the evidence available, the report found that this was endemic among commissioning organisations. Barnet Clinical Quality and Risk committee is refreshing the performance framework so that it collects more detailed and relevant information from providers.

13.7 Priorities and Next Steps

1. Patients must always come first. In the light of the Francis report the CCG will be refreshing the Quality Strategy to reflect the Francis report findings .

2. The CCG recognises that implementing some of the recommendations in this report may be difficult. This is why the CCG wants to take more time to consider some of Francis' recommendations, so they achieve the desired effect and improver care. To this effect over the forthcoming months the CCG will be holding a workshop with stakeholders to examine Francis further. An initial draft stock take is attached in Appendix A that examines our current position against the commissioning standard.

3. Robert Francis' first recommendation is for everyone in the NHS to urgently consider and review what happens in their own organisation in light of the inquiry's findings, and identify any actions they may need to take to ensure what happened in Stafford does not happen in their organisation or in the case of the CCG that this does not happen in any of the services that we commission. The CCG will be formally requesting a review from all commissioned services.

4. As a priority the CCG is ensuring that the quality standards going into all contracts for 2013/2014 are robust and reflective of the recommendations within the Francis report, this piece of work is currently underway.

5. The CCG is undertaking an assessment of all (CIP)Cost Improvement Plans in commissioned services to assure itself in relation to any impact on quality and safety for patients.

Together the aforementioned will inform a more detailed action plan to be presented at a future CCG/HWBB meetings.

14. BACKGROUND PAPERS

14.1 None