NHS
East Riding of Yorkshire
Clinical Commissioning Group

NHS
Hull Clinical Commissioning Group

# HULL AND EAST RIDING FRANCIS 2 STAKEHOLDER BOARD

## PUTTING PATIENTS FIRST SUMMARY REPORT

**Updated November 2014**

Hull City Council
Hull and East Yorkshire Hospitals NHS Trust
Humber NHS Foundation Trust
City Health Care Partnership CIC a co-owned business
Spire Hull and East Riding Hospital
healthwatch East Riding of Yorkshire
healthwatch Kingston upon Hull
EAST RIDING OF YORKSHIRE COUNCIL

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*"The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent.*

*It is respectfully suggested that the subject matter of this Inquiry is too important for it be allowed to suffer a similar fate.*

*What is required is a means by which it is clear not only which of the recommendations has been accepted, by whom, and what progress is being made with implementation, but above all how the spirit behind the recommendations is being applied.*

*All organisations that are or should be involved in implementation should account for their decisions and actions in this regard."*

- **Robert Francis Q.C.**
**Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry**

# Contents

## 1. Introduction - The Challenge

The second Francis report (Francis 2), published in 2013, into the deaths at Mid Staffordshire Hospitals NHS Foundation Trust found considerable failures of local NHS organisations and providers to work together when failures in the quality of care at the Trust were known in the local area. In total the report made 290 recommendations for improvement spanning commissioners, providers, regulatory and other organisations affiliated with NHS healthcare.

NHS commissioners and providers in Hull and the East Riding of Yorkshire recognised the challenge ahead and met to agree an approach that would focus on key recommendations where working together would add value in terms of developing a shared approach and leadership to create a cultural shift across the local health economy in line with the recommendations in the report.

A Francis 2 Stakeholder board was established to take the work forward. Chaired by the East Riding of Yorkshire Clinical Commissioning Group (CCG) Director of Quality & Governance/Executive Nurse, the Board comprises of executive directors, senior staff and lay members from:

- NHS Hull CCG
- Hull and East Yorkshire Hospitals NHS Trust
- Spire Hull and East Riding Hospital
- City Health Community Partnership Community Interest Company
- Humber NHS Foundation Trust
- Healthwatch Hull and East Riding

The University of Hull and East Riding of Yorkshire Council have also attended the Board for specific agenda items. Please refer to Appendix 1 for the Stakeholder Board membership.

The commitment and energy from partner organisations in the Stakeholder Board and its working groups has been considerable. Each organisation has contributed their time, skills and experiences to work together to meet the challenges posed by the Francis Report to focus on local patients' needs first and foremost. The contribution of each organisation to this programme of work and the spirit of co-operation that enabled this work are gratefully acknowledged by the Stakeholder Board.

## 2. The Work So Far

Prior to the setting up of the Francis 2 Stakeholder Board each partner organisation had undertaken an internal check in line with the recommendations of the first Francis Report to determine areas where further improvements could be made. They had produced detailed plans to highlight how learning from Francis could be further strengthened and embedded

in their own organisation to ensure that the needs of patients, carers and users of services were at the heart of their day to day business.
The Stakeholder Board initially undertook a scoping exercise which involved looking at progress so far against recommendations in the Francis 2 report to identify where each organisation was in terms of taking the recommendations forward. The Stakeholder Board did not look to duplicate or replace the work already being done to meet Francis 2 recommendations. Its aim was to identify where the partner organisations had common goals and develop a joint approach to making progress against these goals to lead to the best possible results for local people.

Through this work it is clear that there is already evidence of good practice across Hull and the East Riding and the Stakeholder Board has been a valuable opportunity to share and celebrate this and to learn from one another.

All partners shared a commitment to continuing and developing this approach because it was the right thing to do and not just as a result of the Francis Report and its recommendations.

From this exercise the areas where joint working was agreed were as follows:

- The Duty of Candour (Being open and honest when things go wrong)
- NHS Complaints
- The role of staff in patient experience

Work groups were established to take the work forward in the sub groups. The groups comprised members from key stakeholder organisations to provide their input and specialist perspective from across the care economy. The Terms of Reference for each group were agreed by the Stakeholder Board with clear aims and timescales being set to ensure a focus on the required outcome was maintained. Please refer to Appendix 1 for a list of sub group members.

## 3. Key Results of the Sub Groups

The first phase of work for the sub-groups has concluded and each sub group has produced a report detailing their key results. The information developed by the sub-groups has been agreed by the Senior Leaders across health and social care at a Leaders Summit meeting held in May 2014 as follows:

### 3.1 Duty of Candour

**Chair:** Alexandra Henderson, Lay Member, NHS East Riding of Yorkshire CCG

***Focus of the sub group***

To explore 'Duty of Candour'- How organisations ensure they are open and honest with patients/carers, the public and with each other when things go wrong with the aim of looking at how this could be applied within and between organisations.

***Actions taken by the sub group***

- Current practice around Duty of Candour from national publications and professional standards was reviewed to understand current requirements.
- Conflicts or contradictions in guidance were identified and a common approach was discussed.
- The group considered what a local Duty of Candour would look like.

***Key results***

- A Duty of Candour protocol between local providers of NHS services and commissioners has been developed. The protocol reflects best practice and builds in local practice that the organisations in Hull and East Riding determine to be in the best interest of patients.

- Detail as to where the Duty of Candour 'fits' in each organisation has also been produced to enable each organisation to embed a local Duty of Candour.

**Please refer to the Hull and East Riding of Yorkshire NHS Duty of Candour (appendix 2)**

### 3.2 NHS Complaints

**Chair:** Jason Stamp, Lay Member NHS Hull CCG

***Focus of the sub group***

To review current complaints handling both within and across organisations, share best practice and agree best practice principles for investigating and learning from complaints. The group incorporated identified best practice from the findings and recommendations of the *Review of the NHS Hospitals Complaints System – Putting Patients Back in the Picture* that was completed by Ann Clwyd MP and Professor Trish Hart on behalf of the Government in October 2013.

### *Actions taken by the group*

A review taking into account the recommendations within the Clwyd Hart report into patient complaints was conducted to inform the development of a set of patient-focused pledges for complaints across commissioners and providers.

### *Key results*

Pledges have been produced which aim to:

- Provide a framework for more joined-up working and simplify complaints investigations that involve more than one organisation.
- Identify ways in which the learning and patient experience elements of the complaints process can be better utilised and evidenced.
- Promote the rights of patients as outlined in the NHS Constitution.

**Please refer to the Local NHS Complaints Pledges (appendix 3)**

## 3.3 Staff role in Experience

**Chair:** Angie Mason, Deputy Chief Executive/Director of Nursing, Humber NHS Foundation Trust

### *Focus of the sub group*

To review the role that staff play in creating a positive patient experience and exploring how this can be further supported and strengthened.

### *Actions taken by the sub group*

- Best practice tools, methodologies and approaches to capturing and learning from patient experience across organisations were shared by sub group members.
- Discussions were held both within the sub group and at Stakeholder Programme Board level to understand the impact that staff have on patient experience.
- Tools and approaches that exist to improve staff skills around patient experience have also been mapped.

### *Key results*

Local challenges and examples of good practice for the staff role in patient experience have been produced.

**Please refer to the Experience Subgroup output report (appendix 4)**

## 4. Patient & Public Event `Putting Patients First`

### *Putting Patients First Event – 16 July 2014*

The Stakeholder Programme Board facilitated an event for patients and members of the public on 16 July 2014. It was attended by 89 members of the public from across Hull and the East Riding of Yorkshire.

For the first time commissioning and provider organisations worked together to publicise the event and to share membership lists in order to promote participation from a broad cross section of the local population.

The aim of this event to take forward the direction of travel as described by Jane Cummings, CNO, NHS England who stated:
*"We need to embrace transparency and learning, unequivocally and everywhere, so as to build trust with the public and knowledge within the NHS. We need to embed compassion in every part of the NHS, placing patients' wellbeing at the centre of every decision we make.* ***And we need to involve patients, their families and carers as much as possible in that process****."*

The *Putting Patients First* event was designed to share the principles and good practices gathered by the sub-groups and gain a public perspective and feedback on these outputs in order that robust action plans could be developed to take the shared principles forward.

Delegates were given a broad overview of the Francis Report before being provided with the opportunity to comment on the work so far through facilitated workshops around each of the three workstreams. Common themes and trends were identified and these will form the basis of specific Action Plans in each of the three areas. This will turn the focus of activity to delivery against an agreed set of outcomes. The Stakeholder Programme Board has committed to updating delegates on progress in January 2015.

The key themes and focus for future activity were:

### *Duty of Candour*

- Produce a set of Duty of Candour principles for patients and members of the public which gives them an understanding of what they mean for them.
- Continue to work with a wide range of stakeholders on developing the Duty of Candour principles.
- Develop an audit and evidence framework which will enable organisations to share their progress on developing the Duty of Candour principles.

### *Complaints*

- Provide patients with more accessible information about how to make a complaint and the support available.
- Provide independence, openness and transparency in complaints investigations

- Provide greater awareness of advocacy and support to help people make a complaint and have their voices heard
- Provide realistic timescales for the investigation and resolution of complaints and keep patients updated on progress
- Make it easier for people to provide compliments and positive feedback on services
- Enable under-represented groups such as children and young people and BME communities to make complaints
- Develop a range of new and creative mechanisms to allow people to complain and provide feedback, including social media and on-line reporting

### *Patient Experience*

- Recruit more nurses and ensure that they are supported to gain the necessary skills and training to do their job
- Empower nurses and staff to have a greater role in providing the best possible experience for patients
- Better engagement with children and young people, especially those with complex needs
- Improve discharge planning and transfers of care

### *Patient and Public Feedback from the Event*

- "I found the event very useful to hopefully give some input to improvements being made and receiving feedback within six months".
- "It was a really well organised event and I found it really informative".
- "Events of this sort are very important. It is a good way of communicating between the patients and the organisation that is the NHS"
- "As someone who is not a complainer I have learned that it is right and proper to complain when it is needed".
- "Stands were useful, especially Healthwatch".
- "Still a lot to do, more information needed to be fed out to patients and the public".

Delegates were also offered the opportunity to discuss the key issues and concerns with a Panel of senior NHS leaders and decision makers, who publically re-inforced their continued commitment to the joint work being undertaken.

**Communicating with Staff**

The Board has also agreed to commit to engaging with staff in autumn 2014 to provide an opportunity for celebration of good practice, practice-sharing, networking and discussion, to embed the principles and outputs from the sub-groups across organisations.

## 5. Summary

The Stakeholder Board has been a great success in introducing a new way of working between providers and commissioners of local NHS care to come together to make improvements for our patients and their families.

The achievements to date have been the result of extremely positive engagement and partnership working between health and care organisations in Hull and the East Riding of Yorkshire. The participating organisations have given their time and expertise and have contributed openly to these challenging topics. The work of the sub groups has provided an opportunity to learn from each other on patient experience and the role that staff can play in this. The resulting developments of the sub groups have set high standards for local health and care organisations for candour and for patient complaints.

The lessons from the two Francis reports into Mid Staffordshire hit home hard. All organisations have committed to making positive changes as a result of the reports and the Stakeholder Board has provided a useful opportunity to share experiences, sense-check our local status and build on the good work that is already taking place. There is assurance that much of what we do is positive and of high quality; the Stakeholder Board and the work of its sub groups has identified areas where we can make further positive impact by working together, rather than apart, which was a key lesson from the Francis reports.

The members of the Stakeholder Board are pleased to have the opportunity through the planned events to take the good work of the sub groups to patients, the public, local leaders and staff to make them 'real` within our organisations, and put in place plans for review to see the difference that has been made through this joint working initiative.

***This report has been produced on behalf of The Hull and East Riding Francis 2 Stakeholder Board, May 2014.Updated November 2014.***

**For the Hull and East Riding Francis 2 Stakeholder Board member organisations:**

- NHS Hull Clinical Commissioning Group
- NHS East Riding of Yorkshire Clinical Commissioning Group
- Hull and East Yorkshire Hospitals NHS Trust
- Humber NHS Foundation Trust
- Spire Hull and East Riding
- Hull City Council
- East Riding of Yorkshire Council
- City Health Community Partnership CIC
- NHS Yorkshire and Humber Commissioning Support Unit
- Healthwatch Hull and East Yorkshire
- University of Hull

**Appendix 1**

## Programme Board Members

| | |
|---|---|
| Hilary Gledhill | Director of Quality and Governance/Executive Nurse<br>NHS East Riding of Yorkshire Clinical Commissioning Group (Chair) |
| Jonathan Appleton and Helen Grimwood | Healthwatch Hull and East Riding |
| David Eadington | Consultant Nephrologist and Deputy Postgraduate Dean<br>Hull and East Yorkshire Hospitals NHS Trust |
| Caroline Grantham | Medicines Management Nurse on behalf of the Chief Nursing Officer, Hull and East Yorkshire Hospitals NHS Trust |
| Alexandra Henderson | Lay Member, NHS East Riding Clinical Commissioning Group |
| Angie Mason | Deputy Chief Executive/Director of Nursing and Service Delivery<br>Humber NHS Foundation Trust |
| Kieth O'Brien | Clinical Governance Lead, Spire Hull and East Riding Hospital |
| Jason Stamp | Lay Member – Patient and Public Involvement<br>NHS Hull Clinical Commissioning Group |
| Sarah Smyth | Director of Quality & Clinical Governance/Executive Nurse<br>NHS Hull Clinical Commissioning Group |
| Lynda Whincup | Operational Services Director (Adults & Professional Lead for Non-Medical Professions)<br>City Health Care Partnership CIC |

***With input from:***

- Trevor Collinson, Safeguarding Adults Board, East Riding of Yorkshire
- Carol Franklin, Associate Dean for Education, University of Hull
- Kate Galvin, Professor of Nursing Practice, University of Hull
- Carole Wright, Post Doctorate Research Associate, University of Hull
- Tanya Matilainen, Interim Director of Quality & Clinical Governance/Executive Nurse, NHS Hull Clinical Commissioning Group

***Project Support***

Carla Ramsay, Quality Lead, North Yorkshire and Humber Commissioning Support Unit with assistance from Nic Berry, Project Manager, North Yorkshire and Humber Commissioning Support Unit.

| Sub Group Members | |
|---|---|
| **Duty of Candour** | |
| Alexandra Henderson | NHS East Riding of Yorkshire CCG (Chair) |
| Jules Williams | Humber NHS Foundation Trust |
| Ian Mather | Hull and East Yorkshire Hospitals NHS Trust |
| Jacqui Laycock | City Health Care Partnership CIC |
| Jeanette Beer | NHS Hull CCG |
| **Complaints** | |
| Jason Stamp | NHS Hull CCG (Chair) |
| Mike Napier | NHS Hull CCG |
| Susan Cameron | Humber NHS Foundation Trust |
| Jonathan Appleton | Healthwatch, Hull and East Riding |
| Ian Mather | Hull and East Yorkshire Hospitals NHS Trust |
| Claire Attwood | City Healthcare Partnership |
| Zoe Wray | NHS North Yorkshire and Humber Commissioning Support Unit (representing Hull and East Riding CCG Complaint services) |
| **Staff role in Patient Experience** | |
| Angie Mason | Humber NHS Foundation Trust (Chair) |
| Diane Heaven | Humber NHS Foundation Trust |
| Denise Anderton | City Healthcare Partnership |
| Sally Ann Spencer Grey | NHS East Riding of Yorkshire CCG |
| Susan Lee | NHS Hull CCG |
| Karen Thirsk | Hull and East Yorkshire Hospitals NHS Trust |
| Jonathan Appleton | Healthwatch Hull and East Riding |

**Appendix 2**

# Duty of Candour Framework

## Hull and East Riding of Yorkshire Local Health Economy Duty of Candour

### *Introduction*

All providers of NHS care in Hull and the East Riding of Yorkshire are committed to being open with our patients and their families, and to act in their best interests at all times, even when this is challenging to us as professionals and to our organisations.

Duty of Candour in Hull and the East of Riding of Yorkshire is nothing new, however building upon the challenges of what happened at Mid Staffordshire Hospitals NHS Foundation Trust, we have challenged our systems and processes to create a local agreement

The local duty of candour extends to openness and co-operation between providers of NHS services and commissioners. We commit to applying a duty of candour to each other in the best interests of patient care.

### *Scope*

This Duty of Candour will be applied through good governance processes within each of our own organisations and between our organisations. The framework within this Duty of Candour describes some of the steps these governance processes should include.

### *Principles*

We will always act in the best interests of our patients, demonstrating strategic leadership and management.

Our staff are asked to raise concerns within our organisations and our organisations will respond positively. We will engage with the issue and support our staff to voice concerns about the care and services we provide and commission.

Through our corporate governance framework, including our Boards, management teams and senior staff we will lead by example by acting upon and addressing the concerns that we hear from our patients and our staff.

We will be open with patients if things go wrong. In doing so, we will apply the principles of the Berwick report – we will be candid when a patient has been harmed but we should not erode confidence in our services.

We have a Duty of Candour to ourselves and our partners to share learning. We will expect that any harm is reported in and across our organisations. Through this, we can work together to make improvements, reduce harm and respond positively whenever concerns are raised.

We will develop, implement and sustain a culture of candour with our staff. We will not tolerate a culture where patients' needs are not put first and foremost and we will hold each other to account on this.
As providers and commissioners of care, we will publish what we have done to make improvements to our services.

### *Framework*

The Duty of Candour must work at all levels in the organisation to reflect the principles above.
The Duty of Candour should be reflected in:

- Organisational development – the on-going development of organisational culture around the duty of candour, including staff training
- Policies – staff should be supported to report harm and our policies will set out our staff responsibilities in relation to the duty of candour. Staff should be able to speak out at any time if they are concerned
- Incident reporting – harm should be recorded and acted upon within and across the organisation. We will support our staff when being open to a patient when something has not gone to plan.
- Informed consent – a duty of candour applies when explaining risks and treatment with patients
- Partnership working – there will be good governance processes to share a duty of candour issues between organisations, taking full account of information governance requirements
- Public information – we will publish what we have done about making our services safer
- Professional registration, legal and regulatory requirements – these will be part of the duty of candour for each organisation

### *The Case for a local Duty of Candour*

**The challenge: Francis 2 Report: Definition of Duty of Candour (recommendation 181):**
"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

**Taken from the "Statement of Common Purpose" from Hard Truths: the Government's Response to the second Francis report (November 2013)**
"10. We believe that patients are best served and our values nurtured by a spirit of candour and a culture of humility, openness, honesty and acceptance of challenge. Things do go wrong, but when they do we must learn from mistakes, not conceal them. We will seek out and act on feedback, both positive and negative. We will listen to patients who raise concerns, respond to them and learn from them. We will listen to staff who are worried

about the quality of care, praising them for doing so, even if a concern was misplaced. We have a duty to challenge ourselves and each other on behalf of patients and we will do so."

**Extract from the Berwick Review into Patient Safety in the NHS**

Where an incident qualifying as a Serious Incident (as defined by NHS England) occurs, CQC regulations should require that the patient or carers affected by the incident be notified and supported. We do not subscribe to an automatic 'duty of candour' where patients are told about every error or near miss, as this will lead to defensive documentation and large bureaucratic overhead that distracts from patient care. However, patients should be given all the information they ask for. Research should be commissioned to study how proactive disclosure of serious incidents, and the process of engaging with patients in relation to less serious incidents, can best be supported.

**Appendix 3**

# Complaints Pledges

### *Introduction*

Our organisation is committed to continually developing and improving our services based on the experiences of the people who use them.

We recognise that raising issues and concerns and making formal complaints are a valuable way of engaging and empowering patients and are an important way for us to learn and improve.

We will encourage and support every person who wants to make a complaint to do so.

### *We commit to Listening to people who raise a complaint and:*

- Having a complaints process that is easy for you to use.
- Telling you how to make a complaint and offer you support to do this if you need it.
- Having a complaints process that focuses on the needs of our patients rather than our organisation.
- Dealing with all complaints with sympathy and compassion. We will work with our staff to consistently improve how we deal with these.
- Guaranteeing that raising a complaint or issue will not detrimentally affect the quality of care that you receive from the NHS or social care.
- Resolving your complaint as quickly as possible.
- Agreeing with you about how your complaint will be investigated and keeping you updated on our progress.
- Saying sorry where upon investigation it is found that the care we have provided is sub- standard and telling you how we intend to put things right.
- Working jointly with other organisations who may be involved in your complaint to resolve it quickly
- Identifying learning from all of our complaints and routinely sharing publically how this feedback has contributed to an improvement in the services you receive.
- Continuing to work together to develop a consistent approach to complaints across Hull and the East Riding of Yorkshire.

**Appendix 4**

## Key Results of the Experience Sub Group

### *The Challenge:*

Staff play a key role in gathering and responding to real time patient experience.
This is in two areas:

1. The experience of patients, their carers and their families from the NHS services they receive from our staff
2. The empowerment of staff to make improvements as an individual, within a team and within an organisation as a result of patient experience feedback, such as complaints, incidents, surveys and other sources of intelligence

### *The Sub Group has identified:*

- That staff need to be empowered by their organisation to make change as a result of patient experience feedback
- That the culture of an organisation needs to be open to the honest reflections and feedback from our patients, make improvements and tell patients and their families what difference their feedback has made. The organisation therefore needs the culture and tools to collect and respond to feedback and to publish how patients' views on their experience has made a difference

### *So:*

- Does your organisation give staff the time and space to make improvements as an individual?
- Does your organisation use and triangulate patient experience data in a way that teams can use these to reflect on messages from patients, their carers and families, and make positive improvements?
- Does your organisation systematically ask patients, their carers and their families for their feedback, and provide this to the teams delivering services as well as oversee this as an organisation?
- Does your leadership team set an example to give staff the time, training and tools they need to understand patients' experience?
- Do you publish in clinical and corporate areas, including noticeboards, newsletters and on your website, the difference that patient experience feedback has made?

***Current national practice examples include:***

- NHS Institute: Quick Guide to Improving Patient Experience 2011
- NHS Confederation publication 2010: Feeling better? Improving patient experience in hospital
- Nursing Times February 2013 Exploring how to improve patients' experience in hospital at both national and local levels
- The 6 Cs – Compassion in Practice- nursing, midwifery and care staff- our vision and strategy

***Local examples include:***

- Values-based recruitment at Humber NHS Foundation Trust: recruiting staff whose values reflect those of a caring organisation
- The use of patient experience feedback by staff at ward level at Hull and East Yorkshire Hospitals NHS Trust; involvement of children in giving their feedback to improve services
- Approach to using patient experience feedback with staff – Spire Hull and East Riding: asking for frequent feedback and sense-checking this with patients during their admission
- Recovery-based models, Humber NHS Foundation Trust
- Approach to patient experience from a commissioning perspective, ERYCCG – the role of commissioners to use patient experience data in the decisions taken by commissioners
- The approach to lay representative recruitment for Enter and View powers, Healthwatch Hull and East Riding – recruiting lay representatives with integrity and values to see NHS care from a patient perspective
- Tools and techniques for patient experience, City Health Care Partnership CIC – a range of data collection and analysis methods for patient experience data

**Appendix 5**

## Attendees at the Healthcare Leaders' Summit 28 May 2014

- Hilary Gledhill, Director of Quality and Integrated Governance/ Executive Nurse, East Riding of Yorkshire Clinical Commissioning Group (Chair)
- Jane Hawkard, Chief Officer, East Riding of Yorkshire Clinical Commissioning Group
- Richard Davies Chair, Healthwatch East Riding of Yorkshire
- Julie Taylor-Clark, Assistant Director of Nursing, NHS England
- Kieth O'Brien, Governance Lead, Spire Healthcare
- Jason Stamp, Lay Member Public and Patient Involvement, NHS Hull Clinical Commissioning Group
- Alexandra Henderson, Lay Member, East Riding of Yorkshire Clinical Commissioning Group
- Yvonne Rhodes, Strategic Service Manager, East Riding of Yorkshire Council
- Rosy Pope, Head of Adult Social Care, East Riding of Yorkshire Council
- Dr James Moult, GP NHS Hull Clinical Commissioning Group
- Julia Weldon, Director of Public Health, Hull City Council
- Helen Grimwood, Contract Manager, Healthwatch Hull
- Angie Mason, Deputy Chief Executive & Director of Nursing & Integrated Governance & Quality, Humber Foundation Trust
- Dr Dasari Michael, Medical Director, Humber Foundation Trust
- Andrew Burnell, Chief Executive Officer, City Healthcare Partnership
- Amanda Pye, Chief Nursing Officer, Hull and East Yorkshire NHS Hospitals Trust
- John Saxby, Chief Executive, Hull and East Yorkshire NHS Hospitals Trust
- Lynda Whincup, Operations and Services Director, City Healthcare Partnership
- John Skidmore, Director, East Riding of Yorkshire Council
- Caroline Grantham, Medicines Management Nurse, Hull and East Yorkshire Hospitals NHS Trust
- Tracey Heath, Director of Post Graduate Training, Hull University
- Emma Sayner, Chief Finance Officer, NHS Hull Clinical Commissioning Group
- Dr Luigina Palumbo, Chair, East Riding of Yorkshire Clinical Commissioning Group

**Appendix 6**

## Glossary of Terms

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|---|---|
| **Acute Care** | Medical or surgical care and treatment usually provided in a general hospital. |
| **Clinical Commissioning Group (CCG)** | CCGs are the local NHS organisations that are responsible for meeting the health needs of local populations and they usually cover the same or a similar area as the Local Authority. They commission (buy) health and care services including the majority of planned hospital care, rehabilitation care, urgent and emergency care, most community health services, mental health and learning disability services.<br><br>CCGs work with patients, healthcare professionals and in partnership with local communities and local authorities. All GP practices have to belong to a CCG. The governing body includes GPs, a nurse, a hospital consultant, executive officers and local authority officers for public health and social care. |
| **Commissioning** | A continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring. |
| **Community Care** | Care or support provided by social services departments and the NHS to assist people in their day-to-day living. |
| **Community Health Services** | Treatment provided to people outside of hospitals, together with preventative services such as immunisation, screening or health promotion. |
| **Duty of Candour** | How organisations ensure they are open and honest with patients/carers, the public and with each other when things go wrong |
| **Foundation Trusts (FT)** | NHS hospitals that are run as independent, public benefit corporations, controlled and run locally. Foundation Trusts have increased freedoms regarding their options for funding to invest in delivery of services. |

| | |
|---|---|
| **Francis Inquiry** | This Inquiry was requested by the Government who tasked Robert Francis QC to lead an examination into the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The Inquiry considered why the serious problems at the Trust were not identified and acted on sooner, and identified important lessons to be learnt for the future of patient care.<br><br>The serious problems identified at Mid Staffordshire cannot be allowed to happen again and NHS organisations have been tasked with considering the recommendations within the two reports produced by the Francis Inquiry and taking action to ensure that this is the case. |
| **Local Authority** | Local Authorities are democratically elected local bodies with responsibility for providing a range of services as set out in local government legislation. They have a duty to promote the economic, social and environmental wellbeing of their geographical area. This is done individually and in partnership with other agencies, by commissioning (buying) and providing a wide range of local services. |
| **Primary Care** | Services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic practitioners together with district nurses and health visitors, with administrative support. |
| **Primary Care Services** | Care provided by GPs and other healthcare workers in the community. |
| **Providers** | Organisations proving healthcare services such as hospitals and community trusts. |
| **Secondary Care** | Specialist health care services that treat conditions which normally cannot be dealt with in the community or that occur as a result of an emergency. It covers medical treatment or surgery that patients receive in hospital following a referral from a GP. Secondary care is made up of NHS hospital, foundation, ambulance, children's and mental health trusts |