HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 19th July, 2013

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 19th July, 2013, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (3):	Mr L Burgess, Mr J Elenor and Mr R A Latchford, OBE
Labour (2):	Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor C Woodward, Councillor Mr M Lyons, and Councillor S Spence (one vacancy)

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UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

Item	Timings
1. Introduction/Webcasting	

2. Substitutes

3. Declarations of Interests by Members in items on the Agenda for this meeting.

4. Minutes (Pages 1 - 34)

5. The Francis Report: Update (Pages 35 - 64)

6. Date of next programmed meeting – Friday 6 September 2013 @ 10:00 am

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

11 July 2013

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 23 May 2013.

PRESENT: Mrs A D Allen, Mr M J Angell, Mr R E Brookbank, Mr L Burgess, Mr N J D Chard, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr R A Latchford, OBE, Mr G Lymer and Mr C R Pearman

IN ATTENDANCE: Mr P Sass (Head of Democratic Services)

UNRESTRICTED ITEMS

1. Membership
(Item 1)

The Committee noted its Membership as set out above.

2. Election of Chairman
(Item 3)

RESOLVED that Mr R Brookbank be elected Chairman.

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 7 June 2013.

PRESENT: Mr R E Brookbank (Chairman), Mrs A D Allen, Mr M J Angell (Vice-Chairman), Mr L Burgess, Mr N J D Chard, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr R A Latchford, OBE, Mr G Lymer, Mr R A Marsh (Substitute for Mr A J King, MBE), Mr C R Pearman, Cllr Mrs A Blackmore, Cllr M Lyons and Cllr R Davison (Substitute for Ms Sarah Spence)

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

2. Election of Vice-Chairman
(Item 3)

Mr R Brookbank proposed and Mrs A Allen seconded that Mr M Angell be elected Vice-Chairman.

Carried unanimously.

3. Declarations of Interest
(Item)

(a) Mr Nick Chard declared a personal interest in the Agenda as a Non-Executive Director of Health Watch Kent.

(b) Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

4. Minutes
(Item 5)

RESOLVED that the Minutes of the meeting held on 8 March 2013 are correctly recorded and that they be signed by the Chairman.

5. East Kent Hospitals University NHS Foundation Trust Clinical Strategy
(Item 6)

Liz Shutler (Director of Strategic Development and Capital Planning, East Kent Hospitals NHS University Foundation Trust), Marion Clayton (Divisional Director, Clinical Support Services, East Kent Hospitals NHS University Foundation Trust), Rachel Jones (Divisional Director, Surgical Services, East Kent Hospitals NHS

University Foundation Trust), and Felicity Cox (Kent and Medway Area Director, NHS England) were in attendance for this item.

(a) The Chairman welcomed the Committee's guests who then explained that they would be delivering a presentation covering three areas (see Appendix). Although representatives from East Kent Hospitals NHS University Foundation Trust (EKHUFT) had attended HOSC meetings in the past to discuss their clinical strategy, the first part of the presentation would provide some background as there were a number of Members new to the Committee. The other parts of the presentation would focus on two areas, the outpatients' strategy and options for breast surgery.

(b) By way of background it was explained that EKHUFT was a good Trust but that it still aimed to improve and deliver sustainable, efficient, services. The Trust was looking to boost outcomes as well as improve facilities and ensure they were fit for purpose. There were four workstreams: emergency care; planned care including general surgery and breast surgery; outpatients care; and trauma. Real progress had been made in outpatients' care and breast surgery.

(c) Beginning with the outpatients' strategy, it was explained that the clinical strategy aimed to make sure patients saw the right person at the right time in the right place. Currently services were delivered across more than 20 sites. Much of the estate the services were delivered from was substandard and only a limited range of services were available. The plan was for outpatient services to be consolidated across 6 sites. These would be 'One Stop' services where the results of diagnostic tests would be available on the same day and patients would have a treatment plan agreed before they left. Where the appointment was for a surgical assessment, a day for surgery would be agreed before the patient left. This would reduce the need for follow up and return appointments. These services would be open longer hours than the normal 9-5 now and would open from 8am to 8pm, 7 days a week. Members questioned the detail of how this would work and whether it would involve spending a whole day at one site. It was explained that the expectation was for patients to have to attend for 2-3 hours at most. Many diagnostic tests could produce results quickly or even immediately. This would not be the case in every instance, so there would be occasions when patients would need to return.

(d) It was further explained that a full booking service was introduced in January. This meant an appointment time was negotiated with the patient and this result in a drop of those who did not attend their appointments (DNAs) of 10% to 6.9%. The average waiting time had reduced from 8 to 6 weeks as waiting times reduce when access is improved. It was hoped that the same system would be introduced for follow-up appointments. Urgent referrals were seen in 2 weeks.

(e) The Trust aim was for the majority of patients to be within a 20 minute care journey of any site and for there to be a 15% increase in people accessing services locally. This would mean 75,000 patients travelling shorter distances. 5 sites for outpatients' services were clear, and in response to a direct question about one of them it was confirmed that services would be expanded

at the Royal Victoria Hospital in Folkestone. There was more discussion about the site in North Kent, but the representatives of EKHUFT believed that the Estuary View Medical Centre in Whitstable was the preferred choice. Only 8.7% of patients accessed services locally, and it was believed this could be increased to 21.4%. This would mean an increase in the number of people visiting Estuary View from 6,500 to 19,000. Concern was expressed about the capacity at Estuary View. It was explained that the current GP reception area would not also be the reception for the services under discussion. There was a large area of the first floor which was being vacated and which would be utilised. The increase in demands on car parking would be offset by the extended opening hours. Estuary View also had diagnostic machines, including an MRI, and these would be available as part of the rental agreement. This meant Estuary View was also the best option following financial analysis.

(f) The Committee were informed that work was being carried out with Stagecoach on ways to improve access by public transport.

(g) A direct question was asked about services on Sheppey. A Member explained that it was common to be referred to Medway Hospital from Sheppey even when a particular service was available locally and the request was made to improve communications within the NHS. In response it was explained that the importance of services remaining local to Sheppey was recognised and the Trust was in discussions with the local Clinical Commissioning Group (CCG) on this. It was suggested as well that Sheppey could perhaps be the site of a 7th service at some point in the future.

(h) There was also specific discussion about the future of Deal Hospital. It was explained that although Deal Hospital was not one of the sites of Outpatient Services, it had a definite future and this had been confirmed recently at a meeting by the local CCG. Some ¾ of patients local to Deal chose to go elsewhere and most outpatient appointments at Deal were follow-ups, with local commissioners aiming to reduce the number of follow-up appointments. It was further explained that no services would move to Buckland Hospital in Dover until the new site had been built. Services such as diagnostics, phlebotomy and community dermatology would remain at Deal. The NHS would work with local patients and GPs on the best services for the area. In addition, telehealth would be available to allow access to consultants based on other sites.

(i) Telehealth, telecare and other related technologies more broadly formed a big part of the outpatients' strategy. Pilots in cardiology and stroke care were beginning. In response to a specific question, it was acknowledged that Kent County Council had done a lot of good work in these areas but that the terms telehealth and telecare covered a wide range of different services. The pilots were being carried out to build confidence in the system and technologies.

(j) In addition, the importance of educating patients was recognised and using pharmacists to explain medicines was expecting to produce benefits for patients as well.

(k) EKHUFT representatives explained that they were interested in the Committee's views on whether they needed to go to carry out a full public consultation on the outpatients' strategy. They also explained that they had already delivered 130 presentations on the issue. Some Members felt that if there was a clear case for change, it was important for the NHS to progress with the plans but that it was very important to make certain the public were given clear information about the changes and why they were happening. One Member felt that this was a topic where the public would be likely to want to express a view, particularly in North Kent. The view was also expressed that if there was not a real choice, then ensuring clear information was available would be the appropriate route.

(l) When the discussion moved onto breast surgery, it was explained by way of background that in October and November of 2012, the Royal College of Surgeons (RCS) had been invited in over concerns regarding the delivery and training of general surgery. Two reports had been received from the RCS and as a result an immediate investment of £600,000 made. This funded two additional new breast surgeons, two at Queen Elizabeth the Queen Mother in Margate (QEQM) and the William Harvey Hospital in Ashford (WHH). Reports from the Deanery had also been considered. Clinical leadership was also looked at and the level of this leadership was increased on each site. The RCS reports were available on the Trust's website (http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/statements-and-declarations/royal-college-of-surgeons/.)

(m) EKHUFT representatives further explained that recently vascular surgery had been separated out from general surgery and become a separate specialism. There was a move nationally for breast surgery to make the same move away from general surgery to being a separate specialism. Another issue to take into account was the separation of emergency and elective on call rotas. They were already separate at WHH, but mixed at QEQM. This meant a different solution was required for each site as historically different practices had evolved. The separation of breast surgery as a specialism and separation of emergency and elective pathway management was what the Trust was aiming towards.

(n) The upshot was that there was a need to look closely at the service delivery of medium and high risk breast surgery. The Committee were informed that the choice between the different options was a real one and there was a proper discussion to be had. On being asked for their opinions about whether to go to public consultation, several Members commented that if the options were viable and there was a real choice, this would be appropriate. Representatives from EKHUFT explained that they would also be consulting with local Health and Wellbeing Boards across East Kent as well as the local CCGs.

(o) EKHUFT representatives outlined the different possible options and Members asked questions about the details.

(p) Option 1 was to do nothing meaning no patients would need to move for their surgery. This would be sustainable as it would be a continuation of the current situation, with breast surgeons taken off the emergency general surgery rota. However, there were concerns about delivering the necessary standards in

elective care. The view was expressed that if there was a public consultation, the benefits of any change would need to be strongly emphasised to overcome the public's resistance to change.

(q) Option 2 would involve centralising all day and major surgery, meaning 763 patients would need to move for their surgery.

(r) Option 3 would centralise major surgery, have stereotactic wire localisation at the Kent and Canterbury Hospital but continue day surgery on all 3 sites. This would require 355 patients moving for surgery.

(s) Option 4 would provide all surgical services on all 3 sites and resource stereotactic wire localisation at WHH and QEQM. No patients would need to move for their surgery.

(t) It was further explained that specialist breast surgery was currently carried out at East Grinstead and that it was unlikely that it would be possible to centralise this specialist surgery in East Kent for at least 5-7 years.

(u) Option 2 was favoured by the RCS but local clinicians rated Option 3 highest. In addition, they put forward an additional option where a single Breast unit for East Kent would co-locate out-patient clinics, diagnostics, screening and surgical services. This was more of a long-term vision, it was explained.

(v) No specific site was named for any centralisation. All of the options would keep one-stop outpatient services at all 3 hospitals. Breast screening in the community would also remain unaffected. Screening would continue as currently, although it was conceded that more needed to be done to reach certain groups in society and increase uptake in screening. It was emphasised that only those on the surgical pathway would be affected. In response to a specific question, the Committee were informed that all breast referrals were seen within 2 weeks, and this was the national standard and applied whether it was suspected cancer or not.

(w) Members asked questions about numbers of patients and future demand. The Committee's guests did not have the exact figures relating to breast cancer prevalence in East Kent to hand but informed the Committee that there were around 900 breast cancer surgical interventions each year. The numbers of breast surgical interventions increased with the expansion of breast cancer screening. There was an increase in the numbers needing treatment when the age for screening was lowered 18 months ago. The Trust representatives were confident they had a good understanding of prevalence and future demand.

(x) On a different topic, EKHUFT representatives were asked a question about neurosurgery. It was explained that neurosurgery required a huge support infrastructure and so it was still the best option to have services centralised at King's College Hospital. However, the Committee were informed that Level 2 community rehabilitation was available at the Kent and Canterbury Hospital.

(y) The Chairman proposed the following recommendation, seconded by Mrs A Allen:

- "The Committee thanks its guests for their attendance and contributions today, agrees that the proposed changes to outpatient services and breast surgery services do represent a substantial variation of service and look forward to receiving further updates in the future; and also requests that East Kent Hospitals NHS University Foundation Trust take on board the Committee's comments regarding public consultation before the Trust takes any final decision on wider consultation."

(z) AGREED that the Committee thanks its guests for their attendance and contributions today, agrees that the proposed changes to outpatient services and breast surgery services do represent a substantial variation of service and look forward to receiving further updates in the future; and also requests that East Kent Hospitals NHS University Foundation Trust take on board the Committee's comments regarding public consultation before the Trust takes any final decision on wider consultation

6. Date of next programmed meeting – Friday 19 July 2013 @ 10:00 am
(Item 7)

East Kent Hospitals University NHS
NHS Foundation Trust

EKHUFT Clinical Strategy

Update to the Health Overview and Scrutiny Committee on the

7 June 2013

Putting patients first

East Kent Hospitals University NHS
NHS Foundation Trust

EKHUFT Clinical Strategy

Introduction by Liz Shutler

Director of Strategic Development and Capital Planning

Putting patients first

Agenda

- Background for new Members

- Update since our last visit to the HOSC
  - Outpatients Strategy
  - Royal College of Surgeons Feedback
  - Breast Surgery Options

- Next steps overall

Why do we need to change

- Although we achieve good outcomes for patients, we need to continue to improve.
- Improved treatments require improved facilities.
- We need to make the best use of the resources we have.

East Kent Hospitals University NHS
NHS Foundation Trust

Background

- Improving outcomes for patients and meeting improving standards are the main driver

- Every NHS Trust in the country is expected to plan services to make them sustainable, drive efficiency and deliver high quality care.

- So our current focus is on areas that we know we need to change and improve:
  - Emergency care (across all specialties)
  - Planned Care
  - Out patients care
  - Trauma care

East Kent Hospitals University NHS
NHS Foundation Trust

Engagement

- We have had a number of suggestions for change from our clinicians.
- This stage of our engagement with stakeholders is to test the validity of those ideas.
- We recognise that some of the ideas are more achievable than others.
- We have made over 130 presentations to staff, patient groups, GPs/Commissioners, local authorities/Health and Well Being Boards, health stake holders and voluntary organisations.

East Kent Hospitals University NHS
NHS Foundation Trust

Outpatients Strategy

Marion Clayton
Divisional Director, Clinical Support Services

Putting patients first

East Kent Hospitals University NHS
NHS Foundation Trust

Update since our last visit to the HOSC

- **Outpatient Clinical Strategy**

  – The Outpatients Improvement Strategy is to ensure that patients are seen by the appropriate clinician, at the right time and at an appropriate venue of their choice.

  – Many of our outpatient facilities are sub-standard and do not support new types of care, leading to patients having to visit multiple sites for assessment and treatment.

Proposed improvements

- Move to a ‘One Stop Shop’ approach, with patients attending an appointment, being then sent for diagnostics, and then receiving a treatment plan all on the same day, in the same hospital.

- Move to ensure that more patients (88%) are within 20 minutes drive time by car

- Provide access to an increased choice of appointments in the morning, early evening and Saturday mornings

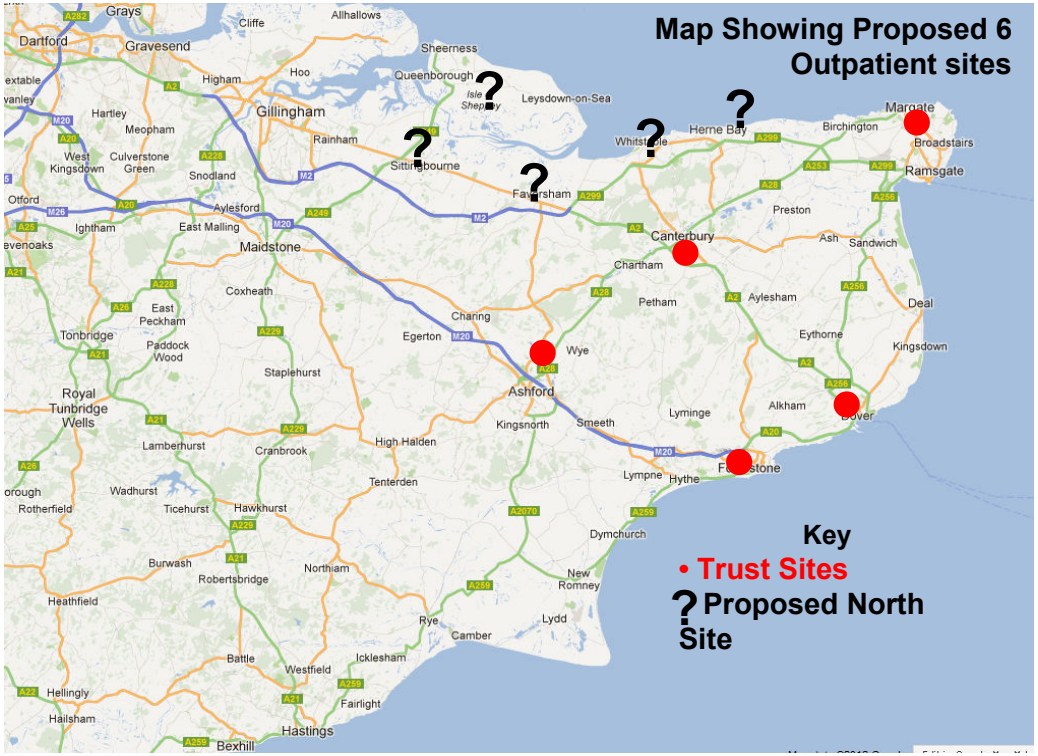
Proposed improvements

- Reduces the need for multiple visits
- Explore the increased use of Tele-health and Tele-medicine; and
- The feasibility of including other Healthcare Professional advice into the patient journey, i.e. Pathology and Pharmacy, either directly to the G.P and/or the patient

Outpatients

- What might it look like

The Outpatient Modelling tool has shown that by implementing the Trust's six site Outpatient Strategy - will increase the percentage of patients seen locally by 15% (20 minutes drive time).



East Kent Hospitals University NHS
NHS Foundation Trust

Outpatients – Site for North Kent Coast

- So what happens currently for patients who live on the North Kent Coast?
  - We looked at the number of patients who are resident in either Faversham, Whitstable and Herne Bay.
  - This showed that for each area a very small percentage of patients receive their OPD appointment at their respective local site. (Faversham 2.9%, Herne Bay 5.7% and Whitstable 5.8%)
  - This means that 91.3% patients from the North Kent Coast travel to Canterbury, Ashford or Thanet for their appointment.

East Kent Hospitals University NHS
NHS Foundation Trust

Outpatients – Site for North Kent Coast

- What might it look like
  - Given that we want to increase local access on the North Kent Coast , recent work shows that Estuary View Medical Centre is the preferred choice.
  - This will mean that more patients from the North Kent Coastal area will be able to be seen locally.

Putting patients first

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NHS Foundation Trust

Proposed improvements

We feel that the proposals for our Outpatient Strategy does not represent a substantial change. This is because:

- currently very few patients access services on the North Kent Coast
- the Trust plans to provide greater local access (from 8.7% to 21.4% of patients); and
- provide a more responsive and flexible out-patient service.

However, due to the nature of the proposed changes, a view is sought from HOSC as to whether public consultation is required for our proposed changes

East Kent Hospitals University NHS
NHS Foundation Trust

Royal College of Surgeons Feedback and Breast Surgery Options

Rachel Jones

Divisional Director, Surgical Services

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Royal College of Surgeons

- We invited the Royal College of Surgeons (RCS) to visit the Trust because we wanted to seek advice including validation of considered concerns in some areas of service delivery and training in general surgery.

- We in addition wished the RCS to advise on how our future services in general surgery might need to be developed to sustain a high quality service.

Royal College of Surgeons

- We received their report and produced an action plan based on their recommendations.

- We have made an immediate investment of over £600,000 for new consultant posts across East Kent to support emergency and elective pathway management.

- Increased the level of clinical leadership on each site.

Royal College of Surgeons

- Other measures included
  - revitalising support to emergency care and training within general surgery across East Kent, led by the Divisional Medical Director and supported by a senior surgeon to be recommended by the RCS.
  - clarification of clinical pathways of care.
  - enhanced monitoring of outcomes.

Royal College of Surgeons

- Clinical Strategy and General Surgery
  - The Royal College of Surgeons has agreed that the current configuration of high and medium risk surgical services in East Kent must change.
  - Their report raises a number of questions about the future configuration of services in East Kent which we need to continue to discuss with our partners and stakeholders.
  - They supported the move to a “hub”

East Kent Hospitals University NHS
NHS Foundation Trust

Breast Surgery

- Part of the Clinical Strategy Surgical Services work stream is to improve the breast care provision in line with the Royal College of Surgeons report, Peer reviews and the Quality Assurance document and NICE Guidelines.

- This will ensure all patients are seen by the right clinician, at the right time and receive the right care in a one stop approach.

- We are currently working with clinicians and Patient Groups to review the options that will allow us to do that.

- This is another area we would like HOSC's view whether or not we would need to consult?

Breast Surgery

- In all options one stop out-patient clinics will be provided on all 3 main sites, with sufficient capacity for all patients requiring diagnostic assessment to be seen in 14 days.

- The difference in the options is how the surgical aspect is provided.

The Options

East Kent Hospitals University NHS
NHS Foundation Trust

Option 1 - Do nothing (no patients will need to move for their surgery)

Option 2 - Centralise all day and major surgery (763 patients will need to move for their surgery);

Option 3 - Continue to provide day surgery on all 3 sites, but centralise major surgery (in-patient) and those patients requiring stereotactic wire localisation at KCH (355 patients will need to move for their surgery); and

Option 4 - Continue to provide all surgical services on all 3 sites, but resource stereotactic wire localisation equipment at the WHH and the QEQMH (no patients will need to move for their surgery)

The Options

East Kent Hospitals University NHS
NHS Foundation Trust

•As part of the engagement process the local hospital clinicians have looked at the options and Option 3 scores higher from a quality, access and strategic perspective (355 patients will need to move).

•They have also raised another option which looks at the long term vision which would co-locate all one stop out-patient clinics; diagnostics; screening services and surgical services in a single Breast Unit for East Kent Hospitals.

East Kent Hospitals University NHS
NHS Foundation Trust

Next Steps Overall

- Continuing to engage with stakeholders;
- Test our plans with the long term commissioning plans;
- Developing business cases to test clinical and financial viability;
- Implement the action plan following the advice from the Royal College of Surgeons; and
- Gain a specific view from HOSC around whether consultation is required on our outpatient and breast proposals.

Questions

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 19 July 2013

Subject: Francis Report: Update.

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the Francis Report and the work being done locally arising from it.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) Robert Francis QC was originally asked in July 2009 to chair an independent inquiry into care provided at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. This followed on from the publication of a report into the Trust by the Healthcare Commission in March 2009 and the reaction to its findings.

(b) The Department of Health and Trust Board accepted the recommendations of this first inquiry in full following publication in February 2010. Recommendation 16 was for Robert Francis to chair a non-statutory inquiry in public. A second non-statutory inquiry was commissioned. On 9 June 2010 the Secretary of State for Health announced this would be a public inquiry.

(c) The final report of this public inquiry was published on 6 February 2013.[1] It is in 3 volumes along with an Executive Summary (1782 pages across volumes 1-3). The report contains 290 recommendations covering a wide range of areas.

(d) Given its length and the number of recommendations, together with the changes to the health sector underway as a result of the Health and Social Care Act 2012, the implications and impact of the Francis Report will take time to become clear. It is also important to see the findings of the report in their proper context. Robert Francis QC writes in the report: "What are perceived to be critical comments should not be taken out of context or in isolation from the rest of the report."[2]

(e) The Committee received an initial written update on how the Francis Report recommendations were being taken forward in Kent at its meeting of 8 March 2013. The Minutes for this discussion are appended to this paper.

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[1] http://www.midstaffspublicinquiry.com/report
[2] Volume 1, p.43.

2. Key Points

(a) Volume 1 of the report considers the warning signs about what was occurring at Mid-Staffordshire which existed during and prior to the relevant period. These included the loss of 'star ratings' which used to be issued by the Commission for Health Improvement, the findings of peer reviews, Healthcare Commission reviews and surveys, auditors reports, whistleblowing, a Royal College of Surgeon's report in January 2007, the Trust's financial recovery plan and evidence produced during the Trust's application for Foundation Trust (FT) status.

(b) The report then goes on to consider what prevented concerns raised from being addressed and this continues through volumes 1 and 2. The actions undertaken by a broad spectrum of organisations is considered and analysed. This list includes the Trust itself, other NHS organisations, the Department of Health, professional and sector regulators, local authority health scrutiny committees and patient groups like LINk and other local groups like CURE the NHS.

(c) From out of this a set of common themes as to why the problems were not discovered sooner are set out:[3]

- The Trust lacked insight into the reality of care being provided and was defensive in reaction to criticism.
- There were regulatory gaps in the responsibilities and accountabilities of external agencies.
- A lack of effective communication across the healthcare system.
- Loss of corporate memory from constant NHS reorganisation.
- A combination of the three above lead to a systemic culture where assurances given were not sufficiently challenged.
- This culture operated in a structure where identifying processes and meeting targets were how performance was measured.
- Finance and targets were prioritised over consideration of the quality of care.

(d) Volume 3 moves on to consider the culture and values in the NHS system before moving on to the recommendations and assorted appendices.

[3] Adapted from Executive Summary, pp.64-5.

3. The Francis Report and Local Authorities

(a) The focus of the Francis Report was on the NHS. There was a detailed look at the role played by local authorities through their role in establishing LINks and Health Watch as well as how the statutory health scrutiny function was carried out.

(b) Chapter 6 of Volume 1 takes a detailed look at "Patient and public local involvement and scrutiny."[4]

(c) Although Community Health Councils were abolished in 2002, the report traces the development of patient and public involvement bodies in Mid-Staffordshire from Community Health Councils, through Patient and Public Involvement Forums (PPIF) and LINk before looking forward to the creation of Health Watch. In Mid-Staffordshire, the Francis Report suggests that neither the PPIF nor the LINk provided an effective route for patients and the public to link into their local health services and hold them properly to account. The report puts forward recommendations in this area with a view to preventing the same failings recurring following the establishment of Health Watch and Local Health Watch.

(d) As local authority health scrutiny was organised in Staffordshire, there was an Overview and Scrutiny Committee dealing with health matters at Staffordshire County Council and Stafford Borough Council. The report takes a detailed look at the activities of both of these OSCs. The report argues that, "The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust."[5] The weaknesses identified in the concept of scrutiny adopted were:

- "The combination of responsibility for scrutiny of performance and for representation of the public view on strategic health issues is a demanding one for lay councillors with limited or no expert support;
- "Councillors are by the nature of their position more likely to respond to concerns raised with them by constituents than to feel able to make proactive inquiries;
- "As politicians dependent on local votes, councillors will be subject to a conflict between the duty to offer criticism and challenge and the need to be seen to support important local institutions. It is a conflict which will reinforce the tendency to receive and accept assurances from organisations such committees are meant to scrutinise;
- "The distribution of powers necessary for scrutiny is at best confusing and at worst an inhibition on effective performance of these duties."[6]

[4] Volume 1, pp.481-588.
[5] Volume 1, p.582.
[6] Ibid.

(e) Recommendations are put forward at the end of Chapter 6 directly referring to the powers and effectiveness of health scrutiny committees. These are as follows:[7]

- Recommendation 147 - Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

- Recommendation 149 - Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

- Recommendation 150 - Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.

4. Francis Report: First Steps

(a) The Prime Minister's statement on the issue on 6 February 2013[8] highlighted "three fundamental problems with the culture of our NHS." These are:

1. A focus on finance over patient care;

2. An attitude that patient care was always someone else's problem; and

3. Defensiveness and complacency.

(b) The statement also included a number of things which had already been put into place and set out some actions which would be taken immediately. The Care Quality Commission has been asked to create a new post, that of 'chief inspector of hospitals.'

(c) Prior to this post being established, the NHS medical director, Professor Sir Bruce Keogh was asked "to conduct an immediate investigation into the care at hospitals with the highest mortality rates and to check that urgent remedial action is being taken."

(d) There are a number of different ways to measure mortality rates in the NHS. Sir Bruce Keogh initially named five Trusts who had been outliers for a period of two years against the Summary Hospital-level Mortality

[7] Volume 1, pp.587-8.
[8] House of Commons Hansard, *Mid Staffordshire NHS Foundation Trust (Inquiry)*, 6 February 2013, cols. 279-306.
http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130206/debtext/130206-0001.htm#13020677000003

Indicator (SHMI).[9] This was followed up by naming 9 Trusts who had been outliers for a period of two years against the Hospital Standardised Mortality Ratio (HSMR).[10] These Trusts are:

- Colchester Hospital University NHS Foundation Trust (SHMI)
- Tameside Hospital NHS Foundation Trust (SHMI)
- Blackpool Teaching Hospitals NHS Foundation Trust (SHMI)
- Basildon and Thurrock University Hospitals NHS Foundation Trust (SHMI)
- East Lancashire Hospitals NHS Trust (SHMI)
- North Cumbria University Hospitals NHS Trust (HSMR)
- United Lincolnshire Hospitals NHS Trust (HSMR)
- George Eliot Hospital NHS Trust (HSMR)
- Buckinghamshire Healthcare NHS Trust (HSMR)
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (HSMR)
- The Dudley Group NHS Foundation Trust (HSMR)
- Sherwood Forest Hospitals NHS Foundation Trust (HSMR)
- Medway NHS Foundation Trust (HSMR)
- Burton Hospitals NHS Foundation Trust (HSMR)

5. Francis Report: Government's Initial Response

(a) 6 March 2013 the Government published its initial response to the Francis Report, *Patients First and Foremost*.[11] This was not a full response to all 290 recommendations. While the Government accepts most of the recommendations either in full or in principle, it intends to take time to produce a fully considered response to all the recommendations.

(b) Part of this report sets out some of the actions taken by Government since the publication of the first inquiry. These include:

- A revised NHS Constitution;
- Changes to CQC inspections.
- PLACE inspections (Patient Led Assessment of the Care Environment) to commence from April 2013.
- Improved protection for whistle-blowers.
- The establishment of the NHS Leadership Academy in 2012.
- Launch of *Compassion in Practice*, the nursing, midwifery and care staff strategy in December 2012 (introducing the '6Cs' – Care,

[9] NHS Commissioning Board, *Professor Sir Bruce Keogh to investigate hospital outliers*, 6 February 2013, http://www.commissioningboard.nhs.uk/2013/02/06/sir-bruce-keogh/
[10] NHS Commissioning Board, *Sir Bruce Keogh announces final list of outliers*, 11 February 2013, http://www.commissioningboard.nhs.uk/2013/02/11/final-outliers/
[11] Government's Initial Response to the Francis Report, *Patients First and Foremost*, published 26 March 2013, https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

Compassion, Competence, Communication, Courage and Commitment.)
- Setting up regional Quality Surveillance Groups (QSGs) to share information across the system.
- Responding to the Winterbourne inquiry.

(c) Further steps to be taken are grouped in the Government response under the following five points:

1. Preventing Problems:

- Creation of the post of Chief Inspector of Hospitals by the CQC.
- Establishing the Health and Social Care Information Centre as a single hub for information to reduce duplication and bureaucracy.
- Consult further on amendments to the NHS Constitution.
- Professor Don Berwick to work with the NHS Commissioning Board on creating a zero harm culture.
- The NHS Confederation will produce a report by September on reducing bureaucracy in the NHS.

2. Detecting problems quickly:

- The Chief Inspector of Hospitals will assess the performance of every NHS hospital.
- Generalist CQC inspectors will be replaced by specialists.
- Ofsted style aggregate ratings for hospitals alongside information available on individual specialties.
- Creation of the post of Chief Inspector of Social Care.
- Statutory duty of candour.
- A ban on gagging contractual clauses.
- A review of best practice in complaints.
- Consideration of possible Chief Inspector of Primary Care.

3. Taking action promptly:

- Simpler fundamental standards beneath which care should not fall.
- New time limited failure regime covering quality and finance issues.
- A single set of expectations for hospitals, progress against which will be published in Quality Accounts.
- A clearer role for the CQC in the FT application process, but Monitor will still be the authorising agency.

4. Ensuring robust accountability:

- The CQC will be able to refer issues to the HSE, who will be able to use legal sanctions.
- The legislation underpinning the General Medical Council and the Nursing and Midwifery Council to be overhauled into a single piece of legislation.
- NHS managers deemed unfit for the role will be barred.
- There will be clarity on the responsibility for tackling failure.

5. Ensuring staff are trained and motivated:

- The idea that those wishing to receive NHS funding for nursing studies should work as a healthcare assistant for a year will be piloted. This scheme should be cost neutral and may be extended to other NHS trainees.
- A revalidation scheme for nurses will be introduced.
- There will be core training standards for healthcare assistants as well as a barring system.
- The NHS Leadership Academy will improve leadership skills.
- All Department of Health staff are to gain front-line experience in the health sector.
- Key organisations will need to report on what progress has been made against the Francis recommendations each year.

(d) On 20 May 2013, a joint policy statement on changes to the regulation and oversight of NHS Trusts and NHS Foundation Trusts was produced by the Department of Health, the Care Quality Commission, Monitor, NHS England and the NHS Trust Development Authority. The intention is for these changes to be brought in as part of the Care Bill currently going through Parliament.[12]

5. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from NHS England.

[12] Department of Health et al., *The Regulation and Oversight of NHS Trusts and NHS Foundation Trusts. Joint Policy Statement To Accompany Care Bill Quality Of Services Clauses*, published 20 May 2013, https://www.gov.uk/government/publications/regulation-of-nhs-hospitals

Appendix

Extract from the Minutes for the 8 March 2013 meeting of the Health Overview and Scrutiny Committee.[13]

Background Documents

Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published 6 February 2013, http://www.midstaffspublicinquiry.com/report

Government's Initial Response to the Francis Report, *Patients First and Foremost*, published 26 March 2013, https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

Agenda, Health Overview and Scrutiny Committee 8 March 2013, Item 5, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5070&Ver=4

Department of Health et al., *The Regulation and Oversight of NHS Trusts and NHS Foundation Trusts. Joint Policy Statement To Accompany Care Bill Quality Of Services Clauses*, published 20 May 2013, https://www.gov.uk/government/publications/regulation-of-nhs-hospitals

Contact Details

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[13] The full set of minutes are available here: https://democracy.kent.gov.uk/documents/g5070/Printed%20minutes%2008th-Mar-2013%2010.00%20Health%20Overview%20and%20Scrutiny%20Committee.pdf?T=1

Appendix - Extract from the Minutes for the 8 March 2013 meeting of the Health Overview and Scrutiny Committee

1. The Francis Report
(Item 5)

(a) The Chairman introduced the item and indicated that Members had before them letters received from Medway NHS Foundation Trust and NHS Kent and Medway on various matters arising from the Francis Report into events at Mid-Staffordshire Hospital. Attention was drawn to the website where Members would be able to access and read the full detailed Report. Given the importance of the Report, the Chairman felt certain this was something the Committee would look at again in the future and asked if Members had any comments. Members proceeded to express a range of views.

(b) One Member identified two of the themes from the Francis Report set out on p.10 of the Agenda as being particularly important, namely the loss of corporate memory from constant reorganisation and the prioritisation of finance and targets over the quality of care.

(c) On the subject of reorganisations, concern was expressed about patients and services potentially being overlooked during the transition from Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs). However, the view was also expressed that the constant reorganisations meant little to frontline staff in the NHS as they were continually working and focussed on patients.

(d) There was a discussion over whether the kind of issues identified in the Francis Report were the result of the actions of a tiny minority of staff when the rest were dedicated and hard working, paying tribute to all staff groups including managers, or the result of a broader cultural problem. On this last point, the view was expressed that the NHS was not sufficiently self-critical. Connected with this, the view was expressed that patients felt reluctant to complain about a service they used and that within the NHS the potential penalties for whistle-blowing were too high.

(e) On the subject of Medway NHS Foundation Trust, the view was expressed that the quality of service varied markedly by ward and service. Concern was expressed about what exactly the mortality statistics did and did not include.

(f) It was commented that the Francis Report also had important lessons for patient and public involvement in the future. It was reported that representatives of the Kent LINk had visited the one in Staffordshire to provide support.

(g) Members felt the role of HOSC in maintaining an overview of the actions taken resulting from the Francis Report was a challenging and

important one. To this end, there was detailed discussion on the wording of the recommendation. The issue of timing was of particular concern, with the view expressed that not setting a specific time to look at this topic again meant it could slip of the Forward Work Programme, but other views expressed the notion that it was important to wait until the report into Medway NHS Foundation Trust was made available. It was also felt that it would not be possible to ignore the outcomes of the Francis Report.

(h) The Chairman proposed the following recommendation:

- That the Committee recognise the importance of the Francis report and the strength of feeling arising from it and recommends that the HOSC put this item on its forward work programme as a priority.

(i) AGREED that the Committee recognise the importance of the Francis report and the strength of feeling arising from it and recommends that the HOSC put this item on its forward work programme as a priority.

Sharing Information

- Quality Surveillance Group.
- Community Partnership.
- Working together e.g. Mental Health Services.
- Responding to the media.
- Commissioning for standards.
- Commissioners articulate the service required, not the provider.

Putting the Patient First

- Providers are asked to comment on how they are monitoring adherence to the constitution.
- Comments complaints and compliments.
- PPGs.
- Governing Body Meetings
- West Kent Health Network
- Lay member involvement.

THE FRANCIS REPORT AND KENT CCGS

'The Patient at the Centre'

Patient Safety

- Chief Nurses are made aware of all Serious Incidents and Never Events; root cause analysis, action plans and lessons learned are monitored.

Promoting the Quality of Services

- The number of complaints to providers are monitored.
- Interrogation of staff surveys, quality visits and clinical work by Chief Nurses.
- Regular Quality Meetings and Quality Accounts

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NHS

West Kent
Clinical Commissioning Group

The Francis Report – An Update

Dr Steve Beaumont
Chief Nurse - West Kent CCG

July 2013

Valuing individuals,
providing quality,
improving outcomes

The Francis Report
'An Unhealthy and Dangerous Culture'

West Kent Clinical Commissioning Group

- Bullying
- Target-driven Priorities
- Disengagement by medical leaders
- Discouragement of feedback from trainees
- Low staff morale
- Isolation
- Lack of candour
- Acceptance of poor behaviours
- Reliance on external assessments
- Denial (*Kings Fund, 2013*)

Leadership is Crucial

NHS
West Kent
Clinical Commissioning Group

- 290 Recommendations.
- The need for effective leadership '*From Boards to Wards*' .
- No difference for CCGs.
- Everyone in the CCG have a responsibility to put the patient at the heart of all activity.

Valuing individuals, providing quality, improving outcomes

What Kent CCGs are doing?

West Kent Clinical Commissioning Group

Putting the patient first

- The NHS Constitution
- Listening to the voice of the public.

Actions

- Providers are asked to comment on how they are monitoring adherence to the constitution.
- Comments complaints and compliments
- Public Participation Groups
- Governing Body Meetings
- West Kent Health Network
- Lay member involvement

Valuing individuals, providing quality, improving outcomes

Promoting Quality of Services	Actions
• Timely feedback following complaints.	• The number of complaints to providers are monitored.
• Listening to staff.	• Interrogation of staff surveys, quality visits and clinical work by Chief Nurses.
• Monitoring of quality	• Regular Quality Meetings and Quality Accounts

Patient Safety

- Serious Incidents and Never Events.

Actions

- Chief Nurses are made aware of all Serious Incidents and Never Events; root cause analysis, action plans and lessons learned are monitored.

Sharing Information

West Kent Clinical Commissioning Group

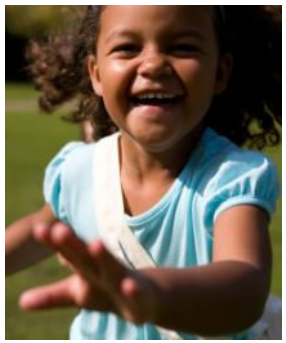
- Sharing information about good practice and concerns

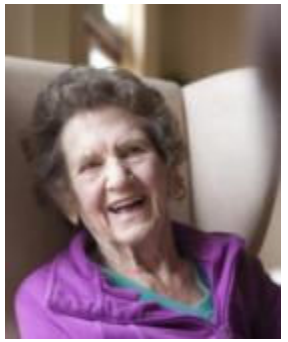
- Quality Surveillance Group.
- Community Partnership.
- Working together e.g. Mental Health Services.
- Responding to the media.
- Commissioning for standards.
- Commissioners articulate the service required, not the provider.

Valuing individuals, providing quality, improving outcomes

Valuing individuals,
providing quality,
improving outcomes

So what else will make a difference?





Sally Allum
Director of Nursing
Kent and Medway

THE NHS CONSTITUTION
the NHS belongs to us all

National Review and Regulation Impact

- **Cavendish review:** published 10 July focused on support workers in health and social care
- **Keogh reviews**: Quality/Mortality in acute hospitals (Medway Foundation Trust): published 16 July
- **Berwick review**: independent on NHS safety standards: expected July
- **Complaints review**: expected July
- **CQC Consultation**: fundamental and expected standards: closes 12 August

More to come

- **Burdens review** – reduce regulatory and information burden by a third
- **Accountability review**:
  - individual
  - organisational
  - system failure

Openness and Transparency

- **Ratings** – single version of the truth

- **A Chief Inspector for**:
  - Hospitals
  - Social Care
  - Primary Care

Leadership

- Clinical leadership
- Attract professionals and leaders into senior roles
- ‘Front line’ experience – keep in touch!
- Time taken to train good staff v time to knock the good stuff out of them!

Access to information

- Healthwatch: strengthen collective voice
- Patient access to records: 2015
- Outcome data for 10 surgical specialities: benchmarks: what does good look like?

Education

- Support staff and progression
- Training periods
- Open up access to training: different approaches
- Pre-degree experience (Nursing):
  - Spend one year in practice
  - Impact on attrition
- Regulation of support staff – opposing views

Staffing

- 5 billion a year spent on staffing in health
- Does the workforce have the right culture?
- What is the workforce of the future?
- Are we recruiting for right values and behaviours?

What next?

- **Maximise opportunities to hear patients, families and carers voices**: Friends and family test – maternity, prisons, primary care, dentistry
- **Community Staffing Review:** with Canterbury Christchurch University, International Practice Development Unit
- **Work to bring about change together**: learning of Winterbourne View and Francis
- **Excellent experience of care**

References and Contacts

- www.midstaffspublicinquiry.com/report
- www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report
- www.cqc.org.uk/inspectionchanges
- sally.allum@nhs.net
- steve.beaumont@nhs.net