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

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[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

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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.