Item No.	Classification: Open	Date: 11 October 2013	Meeting Name: Health, Adult Social Care, Communities & Citizenship Sub-Committee
Report title:		Scrutiny draft response to Francis Inquiry	
Ward(s) or groups affected:		All	
From:		Scrutiny Project Manager	

RECOMMENDATIONS

1. That the scrutiny sub committee considers this draft report's recommendations, alongside the submissions from Hospital Trusts, Adult Social Care , Healthwatch and Southwark Clinical Commissioning Group , with a view to finalizing a scrutiny response to the Francis Inquiry by the end of the year.

The Francis Inquiry background and purpose

2. Robert Francis QC was commissioned in July 2009 by the then Secretary of State for Health, the Rt Hon Andy Burnham MP, to chair a non-statutory inquiry, the principal purpose of which was to give a voice to those who had suffered at Stafford and to consider what had gone wrong at the Hospital. It was not within that inquiry's Terms of Reference to examine the involvement of the wider system in what went wrong. Francis reported that the evidence was very shocking and the report published in February 2010 made disturbing reading.

3. He concluded that there needed to be an investigation of the wider system to consider why these issues had not been detected earlier and to ensure that the necessary lessons were learned. The victims who gave evidence also called for this and many wanted this to be a public inquiry. Francis recommended that an inquiry be held, a recommendation which was accepted by the then Secretary of State who asked Francis to chair a further non-statutory inquiry. Following the general election, Mr Burnham's successor, the Rt Hon Andrew Lansley CBE MP, the first Secretary of State for Health of the Coalition Government, confirmed his appointment but decided that the Inquiry should be a public inquiry under the Inquiries Act 2005.

4. The overriding concern of the second report was the failure of the healthcare system to respond to the warning signs about very poor patient care and bring about change in a timely fashion. The report noted the NHS system includes many checks and balances which should have prevented serious systemic failure of this sort and that there were a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care.

Francis Inquiry's identification of key causes for system failure

5. The report identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust.

Francis identified these key causes:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

Patient and public local involvement and scrutiny

6. The report contains in Volume One a chapter on 'Patient and public local involvement and scrutiny', which considers the role of scrutiny, the local involvement networks, the role of the local media and MPs.

7. There were two scrutiny committees concerned with Mid – Staffordshire Hospital; the local Stafford Borough Council and wider Staffordshire County Council scrutiny committee. The later was much more highly resourced and had the formal responsibility, although there was a lack of clarity around the scrutiny committee's respective roles. The report is largely critical of both committees.

8. Francis notes that the lack of full minutes of the borough committee meetings made it difficult to ascertain the committee lines of inquiry. The report notes that the committee did question cost cutting measures, but in the absence of benchmarks for staffing found it difficult to challenge the hospital's assurance that services would not be affected. The committee's scrutiny of the hospital children's services and the successful application by the Trust for Foundation Status were debated, however Francis found no evidence of robust questioning. The committee was also hampered in its ability to make a judgement because it did not have sight of a children's service peer review which might have alerted councillors to problems. The committee did take some action in response to cleanliness issues as a result of a presentation by Mid Staffordshire Forum, but the committee was largely prepared to accept the hospital's explanations on cleanliness, as was the Forum. Julie Bailey of Cure the NHS approached the committee with her concerns and her questions were passed on to the Trust to respond, but the records suggested that the committee accepted the hospitals explanations and did not publish Julie Bailey's response. When Julie Bailey wrote again to the committee she received what Francis describes as an unacceptably dismissive letter written by a senior council officer who viewed her letter as an individual complaint. However a committee member wrote a much more empathetic and encouraging response and the letter did prompt further work into mortality and infection rates by the committee, but by that late stage a HCC investigation had been called which ultimately exposed the appalling level of care.

9. The chair of Staffordshire County scrutiny committee took the view that scrutiny should play the role of critical friend, however other councillors were uncomfortable with what they perceived as potentially over cosy relationship and lack of challenge with local Trusts. The committee considered the Borough scrutiny committee had the primary responsibility for the hospital however is was involved in some scrutiny work. It was approached by dissident community members of the Mid Staffordshire Forum and took some action in response to concerns raised about cleanliness issues and infection rates but the committee was largely prepared to accept the hospitals explanation and the investigations conducted into *Clostridium difficle* were not in depth. The county OSC was aware that Dr Foster had given the Trust a Standardised Mortality Rate (SMR) for 2005/6 of 127, which was considerably higher that the national standard of 100, but the OSC was prepared to accept the Trust explanation that this was down to coding issues.

10. Two local public involvement structures were present during the critical period of 2005/8. The Mid Staffordshire Forum did undertake a number of visits to the hospital and some members were very concerned with the cleanliness, and wanted to swiftly and robustly hold the hospital to account, however the majority view was that criticism should be balanced with praise and the hospital response concentrated on this rather than steps to address the substantive concerns. The forum took a presentation to the Borough OSC on cleanliness but in this the hospital was presented in a fairly favourable light. Dissident members were unsatisfied with this approach and went to the local media and the county OSC, which did result in some action and reports. The Forum was replaced by the LINks which was largely preoccupied with internal conflict over governance issues and visited no hospitals. Although one of the dissident members offered to give Julie Bailey a place on the board Cure the NHS concluded that LINks was dysfunctional. There was no evidence that the LINk was actively engaged with concerns at the Trust and did not send anybody to a large community meeting called by national LINKs.

11. Francis conducted a qualitative and quantitative analysis of local media reports which showed an increasing level of reporting on the Trust as community concerns rose. The report acknowledges that media reports may not be a reliable or complete account of a matter, and frequency is not a reliable guide to the presence of issues; however Francis does advise that it would be reasonable to expect those charged with oversight and regulatory roles in healthcare to monitor media reports about organisations they have responsibility for.

12. Francis concludes that the scrutiny committees failed to make clear which committee had responsibility for scrutinising the Trust (although in practice both were engaged). The committees tended to be passive receipt of reports with little evidence of challenging questioning. The county OSC made no attempt to solicit the views of the public and there was no procedure for the public to come forward with concerns, nor did they make much use of media reports or complaints data. Likewise the Borough OSC made no attempt to solicit the views of constituents, PALS, the PCT, the Mid Staffordshire Forum/LINks and just waited to be approached. The county OSC made little attempt to question or unpick the poor mortality data, nor did it react to concerns raised by Cure the NHS or the investigation by HCC. The Borough reaction to CURE the NHS was initially dismissive and contradictory; however the Borough OSC did eventually step up its scrutiny once the HCC investigation was initiated and in response to Julie Bailey's dogged raising of concerns.

Francis Inquiry overall aims and recommendations for scrutiny

13. Francis made 290 recommendations, and said no single one on its own would be a solution to the many concerns identified. He outlined the following essential aims of the recommendations:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

14. Francis identified a number of recommendations which have a direct relationship to scrutiny. The very first it that all commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of the report and decide how to apply them to their own work. Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions.

15. The second recommendations is that the NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in

everything done. This recommendation said that this required a common set of core values and standards shared throughout the system with leadership at all levels from ward to the top of the Department of Health committed to and capable of involving all staff with those values and standards. He recommended that the system recognises and applies the values of 'transparency, honesty and candour' . Furthermore he recommended that there be freely available, useful, reliable and full information on attainment of the values and standards with a tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.

16. The third recommendation calls for clarity of values and principles. Francis states that the NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.

17. Other recommendations that are relevant to scrutiny are :

35 Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful**.**

43 -Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

47 -The CQC should further expand its work with OSCs and foundation trust governors as a valuable information resource. For example it should further develop its current 'sounding board 'events.

88 -Information sharing: The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.

119 -Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.

147 - Guidance should be given to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

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

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 suggestion for action.

246 – Comparable quality accounts: Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.

286 -Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. Such assessments should cover at least the following issues:

- What is the precise issue or concern in respect of which change is necessary?
- Can the policy objective identified be achieved by modifications within the existing structure?
- How are the successful aspects of the existing system to be incorporated and continued in the new system?
- How are the existing skills which are relevant to the new system to be transferred to it?
- How is the existing corporate and individual knowledge base to be preserved, transferred and exploited?
- How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change?
- How are necessary functions to be performed effectively during any transitional period?
- What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?

Draft recommendations for Southwark health scrutiny

18. The committee's response to the Francis Inquiry could include the following
    a. Affirm the NHS Constitution core values
        i. Working together for patients.
        ii. Respect and dignity.
        iii. Commitment to quality of care.
        iv. Compassion.
        v. Improving lives.
        vi. Everyone counts.
    b. Explicitly conduct health scrutiny with "transparency, honesty and candour", and model and promote these values across the system.
    c. Scrutinise Hospital Trusts, Adult Social Care, CCG and GP complaints, with request for some sample detail, at least annually.
    d. Scrutinise & contribute to Hospital Quality and Council Local Accounts, with particular reference to 'fundamental and other standards' and outcome statistics.
    e. Scrutinise hospital mortality and morbidity statistics.

f. Receive and consider South East London Serious Incident Reports, including analysis of root causes.

g. Receive lay inspectors reports regularly and consider them annually

h. Conduct face to face work with patients & providers, either directly or in conjunction with Healthwatch, as part of scrutiny's regular work, and in response to relevant concerns.

i. Develop strong partnerships, communication and complementary practice with other bodies that have a regulatory role e.g. Healthwatch, CCG, Adult Social Care, and develop a framework to share concerns.

j. Ensure that the community and public have clear avenues and fora to raise concerns with scrutiny.

k. Require that Impact and risk assessments are made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. When making an assessment consider the Francis guidance that at least the following issues are covered:

- What is the precise issue or concern in respect of which change is necessary?
- Can the policy objective identified be achieved by modifications within the existing structure?
- How are the successful aspects of the existing system to be incorporated and continued in the new system?
- How are the existing skills which are relevant to the new system to be transferred to it?
- How is the existing corporate and individual knowledge base to be preserved, transferred and exploited?
- How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change?
- How are necessary functions to be performed effectively during any transitional period?
- What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?