Leeds Health & Wellbeing Board

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Report of: **Integrated Commissioning Executive**

Report to: **Leeds Health and Wellbeing Board**

Date: **22 May 2013**

Subject: **Key findings of the Mid Staffordshire inquiry report (Francis report), the Government's initial response, next steps and our local response**

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☐ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☐ No

Summary of main issues

1. The Sir Robert Francis Report highlighted a lack of care, compassion and leadership across the whole health economy, with a fundamental failure to deliver care quality within Mid Staffordshire NHS Foundation Trust.
2. This briefing paper summarises the key themes from the Sir Robert Francis Report and begins to consider how organisations in Leeds are responding to these findings and the role that various boards can play to ensure that lessons are learned and that quality and safety is upheld across the system.

Recommendations

The Health and Wellbeing Board is asked to:

- Receive the paper and note its contents
- To support the outlined next steps
- To receive an update on the proposed next steps in 3 months

1 Purpose of this report

1.1 This briefing paper summarises the key themes from the Sir Robert Francis Report following the public enquiry into the quality of care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The paper also begins to consider how local organisations are responding to these findings, the next steps and the role of the health and wellbeing board in this context.

2 Background information

2.1 In 2010 an independent inquiry, chaired by Sir Robert Francis QC, examined the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The inquiry considered individual cases of patient care, so that further lessons not already identified by previous investigations could be learned. The independent inquiry reported on 24 February 2010.

2.2 A copy of this report is at http://www.midstaffsinquiry.com/documents.html. A range of other background information can be found on the previous inquiry's website at: www.midstaffsinquiry.com

2.3 In February 2013 Sir Robert Francis QC published his findings following the completion of the subsequent public inquiry into the care provided by Mid Staffordshire NHS Foundation Trust. A copy of the executive summary of the report, full copies of the inquiry and supporting papers can be found at http://www.midstaffspublicinquiry.com/

2.4 In summary, the report describes a lack of care, compassion and leadership across the whole health economy, with a fundamental failure to deliver care quality within the Trust.

2.5 The report highlights how all parts of the system contributed to this failure including the staff and Board of the Trust, commissioners and the strategic health authority, and the national bodies who regulate providers, such as the Care Quality Commission and Monitor.

3 Main issues

3.1 Key Themes from the Public Inquiry Report

3.1.1 The findings and lessons from the experience in Mid-Staffordshire have very significant implications for the whole of the NHS and can be summarised under five key themes highlighted by Robert Francis in his press statement, as follows:

- Fundamental standards of care with rigorous inspection and sanctions should be created. Standards to be defined by patients and the public and should include staffing matters. Non-compliance should not be tolerated.
- Openness, transparency and candour are essential, throughout the system. Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and

organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.

- Improved support for compassionate caring and committed nursing are required. An increased focus on proper standards of nursing care and the caring and compassionate aspect of the nursing role is needed. There should be values-based assessment for entry to the profession and training must include hands-on education. Nurses should be given effective support and recognition, and be empowered to use the qualities of compassion, caring and commitment to maintain standards. Healthcare support workers need adequate training and regulation. No one should provide hands-on care if not properly trained and registered to do so.
- Strong and patient-centred leadership is needed. The report recommends that an NHS Leadership College should be established to promote common training for senior NHS staff. Leaders should be held to account for failures of care.
- Accurate, useful and relevant information should be available. More sophisticated information is needed to demonstrate compliance with fundamental standards. The Trust Board is accountable for compliance with fundamental standards and it should be a criminal offence to wilfully omit information.

3.1.2 The executive summary presents 290 recommendations for change within the NHS as a whole, based on the five themes, and all the supporting findings and analysis in the report. These recommendations span the whole of the culture, operations and regulation of the NHS.

3.2 Initial National Response

3.2.1 The government's formal response to the Francis public inquiry, 'Patients First and Foremost', was received published in March this year and sets out an initial overarching response on behalf of the whole health and social care system. Patients First and Foremost details clear key actions required to ensure that patients are the 'first and foremost consideration of the system and everyone who works within it'. This response acknowledges that between 2005 and 2009 in one hospital Mid Staffordshire NHS Foundation Trust, many patients received appalling care and the wider system established to identify and prevent poor care failed. It sets in context that many thousands of committed, caring and hardworking NHS Staff provide good or excellent care every day of the year. But the response is clear in that there are pockets of poor care elsewhere in the system and that the tragedy of Mid Staffordshire should never be allowed to happen again. It suggests that some of the features that contributed to the tragedy – patients and families ignored, staff disengaged or unable to speak up – point to wider problems.

3.2.2 The initial response sets out a five point plan which, it suggests, will revolutionise care within the NHS, putting an end to failure and issuing a call for excellence:

A. Preventing problems
B. Detecting problems quickly
C. Taking action promptly
D. Ensuring robust accountability
E. Ensuring staff are trained and motivated

3.2.3 The report suggests that delivering this response will end decades of complacency about poor care, ensuring that the system takes real responsibility for fixing problems urgently and effectively. Whilst it acknowledges that the Inquiry focused on acute hospitals, like Mid Staffordshire NHS Foundation Trust, it explicitly recognises that many of the messages from the Inquiry are equally relevant to other health and care settings. Issues such as the culture of care and the vital importance of listening to and being open with patients, their families and advocates apply across the health and care system. It makes the link that these sorts of problems were also identified in the terrible failures of care at the independent sector assessment and treatment unit, Winterbourne View.

3.2.4 A copy of the Executive Summary is available in Appendix 1.

3.3 Initial Local NHS Response

3.3.1 All local NHS organisations have held discussions and/ or taken papers on the Francis Report to their respective Boards/ Governing Bodies. NHS Providers have held listening exercises with staff to hear their views on the Francis Report and the Government's interim response. A citywide workshop hosted by NHS Leeds West Clinical Commissioning Group (CCG) on behalf of all 3 Leeds CCG's which will include representatives from each of the main providers to discuss the Mid Staffordshire Inquiry Report and the implications of the government's response will be held in June. CCG's have raised the findings of the reports in a number of different ways, talking to member practices and staff.

3.4 Implications of the reports for the NHS and its stakeholders in Leeds

3.4.1 One of the central messages to take from the Francis Report and Patients First and Foremost is the need to reinvigorate the very core of NHS values and culture, as enshrined in the NHS Constitution, and rebuild public confidence; confidence both in the quality of care that can be expected within NHS services, and confidence in the organisations held jointly accountable for the outcomes for patients.

3.4.2 In particular, the message that rings through the report is that the quality of patient care is paramount, and achieving a caring and compassionate service is everybody's responsibility.

3.4.3 The NHS has embarked on the response to Francis just at the point when the commissioning changes created by the passage of the Health and Social Care Act take effect.

3.4.4 While there is a need to examine the recommendations for organisation specific challenges and actions, there is also a "call to action" here for the NHS as a whole.

The initial response by the government goes further in that it details actions to ensure that patients are the first and foremost consideration of the health and care system and everyone who works within it. It outlines how a culture of compassion will be a key marker of success, hospital and care homes will be encouraged to strive to be the best; best values of dignity and respect will be central to care training; and if things go wrong patients and their families will be informed.

3.4.5 The establishment of commissioning organisations (including NHS England at national level, and local Clinical Commissioning Groups at a local level) has led to a range of new arrangements being created within the NHS which came into effect on a statutory basis from 1st April 2013.

3.4.6 It is important that in Leeds the local Health and Wellbeing Board, Healthwatch, and Scrutiny Boards understand the specific impact of these changes on roles and responsibilities with respect to care delivery and quality assurance.

3.5 **Safeguarding**

3.5.1 It is recognised that if the recommendations of both the Inquiry and the Government's response are implemented effectively, problems that might otherwise result in neglect or abuse of children or adults at risk of harm will be dealt with swiftly, preventing the need for the instigation of safeguarding procedures. Both the Leeds Safeguarding Adults Board and the Leeds Safeguarding Children's Board include all the NHS organisations as full members, and are keen to support the implementation of the recommendations.

3.5.2 Reports from each Leeds NHS organisation have been provided to the Leeds Safeguarding Adults Board. The Leeds Safeguarding Children's Board recognise that whilst the Francis Inquiry mostly related to adults, the implementation of the new "Working Together to Safeguard Children" guidance will require the Board to have a mind to the findings of the Francis Inquiry.

3.5.3 Given the changes within the structures and the challenge that Francis presents to tackle cultural change, it is important that a joint commitment is made by local NHS and Social Care leaders showing how a culture of care and compassion will be driven in Leeds and that there is public confidence in these developments.

3.5.4 It is therefore essential that:

- A clear, credible and coordinated approach is taken in Leeds to respond to the Francis report and the initial response from the government
- Assurance of quality and safety is secure in the new system
- New roles and responsibilities, especially within new commissioning structures, are clear
- Assurance is delivered in the context of improved democratic accountability in health.

3.6 **Proposed Next Steps**

3.6.1 It is proposed that a briefing is requested from the identified NHS and Social Care leads on quality assurance and safety in the health and care system. Quality and safety within the NHS are the responsibility of Executive Directors. Director Leads from within adult and children's Social Care have been or are being identified.

3.6.2 The requested briefing should be designed to enable discussion within the Health and Wellbeing Board and should include:

- A clear description of the roles and responsibilities for quality assurance within the new commissioning arrangements, including how local and regional level quality surveillance groups contribute to the arrangements
- A clear description of the roles and responsibilities for quality assurance within social care
- How local Boards will improve the transparency of care quality and quality assurance, through for example routine reporting in public board meetings and the process to produce and publish annual quality accounts.

3.7 **Clarifying Roles for Health Scrutiny and Health and Wellbeing Boards in Quality Assurance**

3.7.1 The role of the Health and Wellbeing Board does not duplicate existing commissioning roles and responsibilities in quality assurance but is necessarily concerned with the collective strategic intent and performance of local commissioning partners to deliver improved outcomes for health and wellbeing across the local population.

3.7.2 The Health and Wellbeing Board will therefore be concerned that the three key strands of NHS quality assurance (safety, effectiveness and user experience) are secure in the delivery of the Joint Health and Wellbeing Strategy, and if there are deficits to address, that these are being tackled through the appropriate governance routes, for example via the governance arrangements within individual commissioner or provider organisations, through accountabilities between these organisations contractually, or with the involvement of regulatory bodies.

3.7.3 There may be specific activities where the Health and Wellbeing Board will need to seek further information, feedback or assurance in the process of discharging its duties. The intention is that the NHS and Social Care briefing recommended above will promote this dialogue as well as provide an up to date picture about the quality assurance systems that operate in the NHS and Social Care landscape.

3.7.4 Local Healthwatch organisations will be similarly interested in the NHS and Social Care Quality and Safety Briefing, as they develop their relationships with local health and care organisations. The information and intelligence they gather with respect to consumer views and experiences will be a further strand of quality assurance and challenge within the system. Their representation at the Health and Wellbeing Board will ensure they are engaged in the work to shape the local response to the Francis report at the earliest opportunity.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 This paper was written in partnership between CCG and Council quality/safeguarding leads

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 There are no specific issues in this paper

4.3 Resources and value for money

4.3.1 There are no specific issues in this paper

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no specific issues in this paper

4.5 Risk Management

4.5.1 Failure to understand and act on the implications and recommendations of the Francis report poses a threat to patient safety

5 Conclusions

5.1 The initial steps outlined above are intended to promote an early informed dialogue about the local response to the Francis report and the government's initial response, clarify roles and responsibilities for quality assurance, and to ensure a coordinated response within Leeds to improve the culture of care, compassion and transparency within our local NHS and Social Care Services.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Receive the paper and note its contents
- To support the outlined next steps
- To receive an update on the proposed next steps in 3 months

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