Coventry City Council

Briefing note

To: **Health and Social Care Scrutiny Board** **Date: 25th September 2013.**

Subject: The Francis Inquiry into Mid-Staffordshire NHS Foundation Trust – response of local providers.

1 Purpose of the Note

1.1 The Scrutiny Board has been invited by the Health and Wellbeing Board to investigate the local response to the Report of the Francis Inquiry and to satisfy itself that recommendations are being taken on board by local providers and where appropriate other agencies. Senior managers from the three provider Trusts serving Coventry will be present at the meeting to discuss the implications of this Report. They are:

(i) Coventry and Warwickshire Partnership Trust
(ii) University Hospitals Coventry and Warwickshire
(iii) West Midlands Ambulance Service

2 Recommendations

2.1 To note the Briefing Note and appendices provided by local organisations, and consider any further Scrutiny work the Board might like to conduct around the Francis Inquiry.

3 Information/Background

3.1 The Francis Inquiry report attributes accountability for the appalling and systematic failures in care at Stafford Hospital to the Trust Board. The report also identifies to a network of failures by national and local organisations to respond to concerns about the hospitals services.

3.2 The report's overarching conclusion is that 'a fundamental culture change is needed' to put patients first, 'which can largely be implemented within the system that has now been created by the new reforms'. Importantly the report acknowledges regular organisational change as a factor in the background to the events leading to the Inquiry.

3.3 Whilst the report focuses on the events surrounding Stafford hospital between January 2005 and March 2009 the repercussions of the recommendations of the report are seen to be far wider than one Trust, given a wide range of smaller scale but similarly alarming failures in patient care across the health and social care environment.

3.4 The report is critical of many of the organisations which surround NHS provider Trusts, including commissioners, regulators, strategic health authorities and the various organisations involved in patient and public involvement in the health service. This criticism extended to the local authority Overview and Scrutiny Committees which covered the Stafford area.

Francis Inquiry Recommendations

3.5 In total 290 recommendations are made covering all affected parties from the Department of Health through NHS providers, commissioners, regulators and professional bodies through to local authority scrutiny committees and patient and public involvement mechanisms.

3.6 The theme of the report's recommendations is to promote greater cohesion and a more common culture across the health system. The Report makes clear that 'This will not be brought about by yet further "top down" pronouncements, but by the engagement of every single person serving patients'.

3.7 The report identifies the importance of compassionate caring and committed nursing.

3.8 Recommendations include proposals to create a single regulator for provider Trusts (amalgamating the Care Quality Commission [CQC] and Monitor). This would promote consistent regulation of corporate governance, financial competence, viability and compliance with patients' safety and quality standards.

3.9 The report recommends zero tolerance of a failure to reach fundamental standards. Criminal liability could follow should serious harm or death result from a breach.

3.10 Complaints handling should be improved by introducing sensitive but responsive, accurate and transparent communication and learning (for example with Scrutiny Committees and Local Healthwatch).

3.11 Commissioners are given clear guidance about greater involvement with patients and the public in commissioning; promoting alternative sources of provision (and choice); and for GPs (in their roles in Clinical Commissioning Groups) to take a monitoring role on behalf of patients.

3.12 Perhaps amongst the most significant recommendations for providers are around the so called 'Duty of Candour'. Providers will be placed under a legal responsibility to be more open, transparent to report failings in the services delivered. Criminal proceeding can be brought against any officials behaving dishonestly with regulators, commissioners or the public regarding their services.

3.13 Also of importance is the emphasis placed on strong patient centred healthcare leadership, and for the voices of patients to be significantly louder for decision-makers than appeared to be the case in Mid Staffordshire NHS Foundation Trust during the period covered by the two Francis Inquiry Reports.

Overview and Scrutiny / Local Healthwatch / Health and Wellbeing Boards

3.14 The report is far from complimentary about the role of scrutiny committees and patient and public engagement structures in challenging poor standards at Stafford hospital.

3.15 To improve this for the future the report makes a number of recommendations related to the City Council and its role in public and patient involvement in health services. These include:

- Closer collaboration between overview and scrutiny committees and the Care Quality Commission – perhaps including 'sounding board events'(Recommendation no 47).

- That scrutiny committees and Local Healthwatch should have better access to detailed information about complaints (whilst being mindful of patient confidentiality) (119).

- That guidance should be given to promote the co-ordination and co-operation between Local Healthwatch, Health and Wellbeing Boards and scrutiny committees (147).

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

- Scrutiny committees should have powers to inspect providers, rather than relying on local patient and public 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 (150).

- Department of Health / NHS Commissioning Board / CQC etc. should publish quality accounts or other reports in a common format 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.

More Recent Developments.

3.16 In March of this year the Government published 'Patients First and Foremost – the Initial Response of the Government to Report of the Mid Staffordshire Foundation Trust Public Inquiry. The Government accepted the Report in general terms and gave a commitment to establish the 'Duty of Candour' and other recommendations requiring legislation at the next opportunity. The Government said that "This is a watershed moment for the NHS and a call to action for every clinician, everyone working in health and care, and every organisation."

3.17 The Government also outlined plans for significant changes to regulation of NHS provider Trusts. In June CQC produced its key document 'A New Start' which was the subject of a recent report and City Council consultation response. This included realising the Government ambition of establishing 'Chief Inspector of Hospitals' plus a further series of appointments to produce improved inspection outcomes.

Local Responses

3.18 Attached are briefing notes prepared by the three NHS provider Trusts serving patients in Coventry. Officers from these Trusts will be present at the meeting to discuss the implications of the Francis Report for them and to answer Members questions.

For more information about the Public Inquiry Report into the Mid-Staffordshire NHS Foundation Trust please see:
http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

To view the Government's initial response to the Inquiry Report:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

All of these documents (above include Executive Summaries).

For the CQC document 'A New Start':
http://www.cqc.org.uk/media/cqc-launches-consultation-future-inspection-and-regulation

Finally the Centre for Public Scrutiny has produced 'Safety, Quality, Trust' a guide into the Francis Report which Members may find to be of interest:

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