REPORT TO:	Health Policy and Performance Board
DATE:	4 June 2013
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Adults
SUBJECT:	Francis Inquiry
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide to the Board an overview of the key findings and recommendations of the second Francis Inquiry and the actions to be delivered locally to ensure the quality and safety of health care provision for the population of Halton.

2.0 RECOMMENDATION: That the Board:

i) Note the contents of this report and the findings of the Inquiry; and

ii) Note the actions planned locally.

3.0 SUPPORTING INFORMATION

3.1 The Francis 2 High Level Enquiry (following on from the first published 2009) tells the story about the appalling suffering of many patients at the Mid Staffordshire Hospital. This was caused by a serious failure on the part of the Provider Trust Board who did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.

3.2 This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking and maintaining foundation trust status to be at the cost of delivering acceptable standards of care. The story continued as the checks and balances which should have prevented serious systemic failure of this sort including agencies, scrutiny groups, commissioners, regulators and professional bodies also failed

3.3 The report is three volumes and runs to just under 2000 pages. The findings of the inquiry when read alongside the findings of Francis One and the stories included within the report as described by the families and friends of patients involved make harrowing reading.

The findings of the inquiry whilst not a surprise as much was known in advance, outlines the following key areas:

- The culture focused on doing the system's business – not that of the patients;

- The 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.

- 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.

3.4 All NHS Provider Trusts are now required review this High level Enquiry and assess and have an action plan in place for monitoring by the Governance Committee on behalf of the Board of Directors. This is a requirement within the Quality Contract for 13/14 for submission to the Commissioners during early 2013.

3.5 The report outlines nine areas of action for commissioners:

Commissioning Impact

- The report requires that commissioning organisations in healthcare should consider the findings and recommendations and that they should announce the extent to which they accept the recommendations and how they will implement them (reporting on a regular basis). The report suggests that the health select committee should receive regular updates on actions to deliver all recommendations.

Culture

The reports outlines the need to ensure a common culture made real throughout the system – an integrated hierarchy of standards of service

- Fundamental standards of minimum quality and safety- where non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations
- Enhanced quality standards- such standards are higher than fundamental standards. The NHS commissioning board together with CCGS should devise enhanced quality standards designed to drive improvement. Failure to comply should require performance management by commissioners rather than the regulator.
- Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness, these are implemented by commissioners and progressive providers

Responsibility for, and effectiveness of healthcare standards

- A co-ordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in real time

Effective Complaints handling

- Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and the outcomes on as near a real time basis as possible

Commissioning for Standards

- GPs must have continuing partnership with their patients. They have a responsibility to all their patients to keep themselves informed of the standards of service available at various providers in order to make patient choice a reality.
- Consider whether commissioners should be given responsibility for commissioning patient advocates and support services for complaints against providers.
- Commissioners should wherever possible apply a safety and quality standard in respect of each item of service it is commissioning and agree a method of measuring compliance and redress for non-compliance, including powers of intervention where substandard or unsafe service are being provided
- Commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards.
- THE NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure information conveyed is both candid and comprehensive.
- Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist

clinical advice and procurement expertise.

- Commissioners need to have close engagement with patients (via membership forums, patient representatives etc.) to ensure fundamental safety and quality standards are maintained.
- Commissioners- not providers- should decide what they want to be provided, in consultation with clinicians both from potential providers and elsewhere.
- Commissioners wherever possible need to identify and make available alternative sources of provisions.
- Commissioners must have the capacity to monitor performance of every commissioning contract on a continuing basis during the contract
- Commissioners should be entitled to intervene in the management of an individual compliant on behalf of the patient where it appears to them it is not being dealt with satisfactorily.
- NHSCB and local commissioners must ensure proper scrutiny of commissioned provider services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.

Performance management and strategic oversight

- The NHS Commissioning Board (through regional offices) should support the development of metrics on quality and outcomes of care for use by commissioners in managing performance of providers.

Openness, transparency and candour

- There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner. The care quality commission's duties should be supported by monitoring undertaken by local commissioners.

Nursing

- All commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non- executive directors.

Information

- 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. These accounts should be lodge with and contain observations of commissioners.

3.6 The Government produced its response to Francis Two in March 2013 –Patients First and Foremost, in which it states that the NHS is there to serve patients and must therefore put the needs, the voice and the choice of patients ahead of all other considerations. The response outlines actions in five key areas:

- Preventing problems – consistent culture of compassionate care including Chief Inspector of Hospitals role, transparency and excellence in leadership, consequences for failure and clear accountability. Time to care and safety in the DNA of the NHS delivering the safety review by Professor Don Berwick.
- Detecting problems quickly –data systems, early warnings, outcomes for all services, ratings, expert inspection, duty of candour, ban on clauses to prevent public interest disclosures and a complaints review
- Taking action promptly –fundamental standards, regime for failure (quality as well as

finance)
- Ensuring robust accountability professional regulation, health and safety executive to use sanctions, barring failed managers in the NHS and clear responsibilities for tackling failure
- Ensuring staff are trained and motivated – revalidation for nurses, code of conduct and minimum training for health care assistants barring system for health care assistants, attracting professional and external leaders to senior management roles.

Actions for Commissioners

3.7 To ensure the full implementation of all areas of the inquiry recommendations, NHS Halton Clinical Commissioning Group has/will:

- Included within the contract requirements the submissions of review and action plan for the Francis inquiry report including a commitment to the Duty of Candour.
- Included within the contract quality metric (CQUIN) in relation to time to care, nursing/Care assistant training, clinical leadership and organisational culture.
- Will receive and review outcomes including delivery of actions required of internal reviews and respond appropriately.
- Develop and maintain a process to ensure cost improvement programmes within providers are reviewed and impact assessed for any potential impact on quality and safety.
- Develop and maintain process for GPs and others including members of the public to raise concerns regarding the quality of care and ensure these are investigated and acted upon.
- Develop and maintain a robust early warning system for care quality across all providers and ensure any issues are acted upon effectively.
- Be an active member of the Quality Surveillance Group locally to ensure early warnings of issues in local providers are identified and managed.
- Work with providers in a supportive way to support continuous improvements and developments in quality whilst ensuring any issues are monitored and managed effectively.
- Ensure open, regular and robust reporting of performance of providers locally and ensure local people are engaged in these processes for reporting.

4.0 POLICY IMPLICATIONS

4.1 None identified

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The quality of Health care provision impacts directly on the life expectation and potential for independence of people post periods of ill health. It is important to note that health care is not just delivered in hospitals but is also delivered in people's homes, in care homes, in nursing homes and in community services. All of these services need to be delivered to a high level of quality. It is essential that as we commissioner care in an integrated way we develop further our processes to ensure quality across all care provision and work together to ensure the safe and effective provision of care for all locally.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified

6.2 **Employment, Learning & Skills in Halton**
None identified

6.3 **A Healthy Halton**
Safe and effective health care provision is essential to the on-going delivery of healthy Halton. It is essential that the services commissioned deliver high quality safe and effective care. The people of Halton have many health and other challenges the quality of the health care they receive when they are their most vulnerable must not add to these challenges and therefore it is incumbent on us as commissioners to ensure that all providers are delivering the highest quality of care to the people of Halton.

6.4 **A Safer Halton**
None identified

6.5 **Halton's Urban Renewal**
None identified.

7.0 RISK ANALYSIS

7.1 Health care by its nature is risky, care is provided across a large number of organisations and venues and can provide both complex and difficult to manage. The greatest areas of risk at this time in health care relate to managing the complexity of service provision, including the changing landscape of providers, the complexity of care need and the need to manage the cost of care provision. It is essential therefore that impact assessments in any developmental or cost reduction areas are carried out effectively.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 All service must be delivered in line with the requirements of Equality and Diversity legislation and these requirements are monitoring and measured through the contracting process for all NHS providers

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

None under the meaning of the Act.