DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		PATIENTS FIRST AND FOREMOST: THE INITIAL GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY		
DATE OF DECISION:		29th MAY, 2013		
REPORT OF:		CHAIR, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
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STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

The report of the public inquiry into the Mid Staffordshire NHS Foundation Trust led by Robert Francis QC (the Francis report) was published in February 2013. The government has now published its initial response, and the key points from this response are summarised for the Board's consideration.

RECOMMENDATIONS:

(i) That the Board receives and notes the issues highlighted in "Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC - *Patients First and Foremost*".

(ii) That the Board notes the work that is going on locally within the NHS and partner organisation to respond to the challenge of the Francis Report, supports its direction of travel and expects that the NHS and partner organisations foster a culture of care, with continuous improvement of quality, safety and patient experience.

REASONS FOR REPORT RECOMMENDATIONS

1. The Francis report and the government's response both raise a number of important issues for the local health and care system. As a high profile leadership board within the local system, it is appropriate for the Health and Wellbeing Board to consider the implications of the recently published government response.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. The Health and Wellbeing Board could choose not to consider and comment on the government's response, but this was rejected on the basis that the Board has a contribution to make in respect of this very important matter.

DETAIL (Including consultation carried out)

3. The Francis Report into failings at Mid-Staffordshire NHS Foundation Trust between 2005 and 2008 was published on 6 February 2013. It tells the story of an appalling breakdown of basic patient care, which probably resulted in the death of about 500 patients. Even more disturbing, this breakdown occurred against the backdrop of the trust becoming a foundation trust, with the board's emphasis on financial management rather than patient care. Though the many regulatory and supervisory bodies had concerns about the trust's performance, they failed to prevent or deal with the problems.

4. The lengthy 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. A number of causes were identified, including:

- 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 the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

5. The report contained 290 detailed recommendations, the essential aims of which were to:

- 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 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.

6. The Department of Health has considered the inquiry report and published an "initial government response", in which the Secretary of State says: "Action is needed at each level to enable the excellent care that already exists in the health and care system to become the norm, and to become what every person can expect of the NHS". This is statement that the Health and Wellbeing Board would want to endorse across local health and care systems.

7. The government response sets out a 5 point action plan to "revolutionise the care that people receive from our NHS…" The 5 key points are:

- Preventing problems
- Detecting problems quickly
- Tackling action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

The main actions proposed under each of these heading are summarised below.

8. **Preventing problems**

- Time to care.
  A commitment to decrease bureaucracy, enabling staff to spend more time with patients.

- Safety in the DNA of the NHS – The Berwick Review
  Professor Donald Berwick, a well-known American expert on health safety will be working with NHS England to ensure a robust safety

culture in the NHS.

9. **Detecting problems quickly**

- The appointment of a Chief Inspect of Hospitals at the Care Quality Commission.
  This appointment will be made later this year, and the Chief Inspector will make an assessment of every NHS hospital's appointment, drawing on local views.

- Expert Inspectors, not Generalists.
  This measure will lead to more thorough inspections of hospitals. There will also be a "comply or explain" approach to known good practices such as nursing rounds.

- Ratings – A single balanced version of the truth
  The Care Quality Commission will work with the Nuffield Trust to develop a rating system, including clinical quality measures as well as financial ones. This will be similar to OFSTED ratings, and will include the Friends and Family Test.

- The appointment of a Chief Inspector of Social Care
  This Chief Inspector will adopt a similar approach to social care and rating care homes.

- Publication of Individual Speciality Outcomes.
  The publication of outcome measures about individual hospital departments will be extended to another nine areas.

- Penalties for Disinformation and a Statutory Duty of Candour.
  While the government has shied away from creating a criminal offence, as recommended by Francis, there will be a statutory duty of candour, which means that providers will have to inform people if their treatment has resulted in serious harm and provide an explanation.

- A Ban on Clauses Intended to Prevent Public Interest Disclosures
  NHS England has already instructed provider trusts not to use "gagging clauses".

- Complaints Review.
  A review of best practice on complaints to ensure that lessons are learnt by the NHS.

10.. **Taking action promptly**

- Fundamental Standards
  The Care Quality Commission will draw up an explicit list of minimum basic standards, which will be readily accessible.

- Time Limited Failure Regime for Quality as well as Finance.
  If failing hospitals do not improve, ultimately they will be put into administration (with arrangements to ensure continuity of care).

11. **Ensuring robust accountability**

- Health and Safety Executive to use criminal sanctions.
  It is of note that recommendation 87 of the Francis Report stated "The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare." The government response, however, gives it the role of considering criminal prosecution where the Chief Inspector identifies criminally negligent practice.

- Faster and more proactive professional regulation
  The General Medical Council, the Nursing and Midwifery Council, and other professional regulators will be reviewed in order to simplify and update legislation.

- Barring Failed NHS Managers.
  There will be a national barring list for unfit managers, based on the scheme for teachers.

- Clear responsibilities for tackling failure

12. **Ensuring staff are trained and motivated**

- HCA training before nursing and other degrees.
  This is not one of Francis' recommendations. The proposal is that every student who seeks NHS funding for a nursing degree should be required to work for up to a year as a healthcare assistant.

- Revalidation for Nurses.
  This mirrors the revalidation system that has just been introduced for the medical profession.

- Code of Conduct and Minimum Training for Health and Care Assistants
  Standards of training and a code of conduct for Health and Care Assistants have been published, and the Chief Inspectors will ensure that they are properly supported.

- Attracting Professional and External Leaders to Senior Management Roles
  The NHS Leadership Academy will encourage clinical professionals and people from outside the NHS into top leadership positions.

- Frontline Experience for Department of Health Staff.
  Within 4 years every civil servant in the Department will have "sustained and meaningful experience on the front line".

13. The response also contains a Statement of Purpose signed by the leaders of 14 professional bodies; a pledging to bring about the necessary personal and institutional change to prevent a further incident of this nature. In

addition the government is proposing that all NHS hospitals will indicate how they intend to the Inquiry's conclusions before the end of 2013.

Implications and Issues for the Local Health and Care System

14. The two reports that Robert Francis has written about the failings in Stafford have shocked those working NHS, and produced a resolve for change to prevent a recurrence. It is apparent that we need to change our culture, and it is debatable how much the top down approach of this report will achieve that. One theme of the second report was that there was a failure of management culture, which was not only focussed on finance at the expense of quality, but was prepared to bully anyone who questioned what was going on. There have been calls for the resignation of the Chief Executive of NHS England, Sir David Nicholson, who was for a short while Chief Executive of the Strategic Health Authority responsible for Stafford. In this context, it is a pity that NHS England was not a signatory to the Statement of Common Purpose.

15. Another theme of the Francis Report was that nursing staff spent too much time on administration at the direct expense of patient care. The commitment to reduce bureaucracy is admirable, but the inspection regime proposed sounds bureaucratic. There is a parallel with OFSTED, which may have improved standards in schools, but is onerous for teachers.

16. We also need to accept the challenges of improvement in a health service which is facing substantial financial challenges. Francis commented on the problems resulting from inadequate staffing. We need to be sure that this does not become a reason to retain inefficient practices rather than face the discomfort of moving to efficient ones.

17. Nonetheless, there are undoubtedly opportunities for the NHS and social care systems in Southampton, and we must nurture the genuine desire of those working in local organisations to do their best for their patients, clients and customers. In Southampton City CCG we are committed to make quality the central theme of everything we do, and to do so using the transparent, supportive, "no blame" approach. This has improved safety in, for example, the aviation world and is very much the approach taken by Donald Berwick. We have set up a clinical governance committee, and have regular meetings with local provider trust to discuss quality and safety issues.

18. Francis was particularly scathing about the patient representative organisations in Stafford, which were over-deferential and consumed by in-fighting. Whilst Southampton LINk avoided those traps, we need to ensure that HealthWatch develops into an effective patient representative, and holds health and social services to account.

19. The response has quite rightly highlighted that within the NHS it is common

to see complaints as irritations to be managed defensively rather than vital information for improvement. We await the results of the review of best practice with interest. As a CCG, we would be pleased to act as a recipient of any complaints, particularly those reaching councillors from their constituents. We have already had a similar conversation with one of our local MPs.

20. The failures in Stafford were detected by many organisations, but were viewed separately. The Wessex Area Team has set up a Quality Surveillance Group to ensure that it, local clinical commissioning groups, Monitor, the CQC and patient representative organisations meet regularly to discuss safety matters. Southampton City CCG is also going to meet next month with West Hampshire CCG, the Local Medical Committee and consultants from University Hospitals of Southampton Foundation Trust to discuss how we exchange "soft" information about poor performance, particularly when that involves individual practitioners.

Conclusion

21. The events at Stafford Hospital have shocked the NHS, and led to a resolve to avoid a recurrence. There is much good work going on, though we need to ensure that momentum is maintained and leads to a change of culture in the NHS where quality and safety are considered much more systematically than they have in the past.

RESOURCE IMPLICATIONS

Capital/Revenue

22. The costs of implementing the recommendations in this report will be met from existing council and CCG budgets.

Property/Other

23. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

24. The powers and duties of Health and Wellbeing Boards are set out in the Health and Social Care Act 2012.

Other Legal Implications:

25. None.

POLICY FRAMEWORK IMPLICATIONS

26 None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED:	

SUPPORTING DOCUMENTATION

Appendices

1.	None

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out.	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

	Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	