HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

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REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY: IMPLICATIONS FOR MEDWAY COUNCIL

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Summary

The public inquiry into the serious failings at Mid Staffordshire NHS Foundation Trust identified failures in the systems, which should identify and remedy non- compliance with acceptable standards of care. The Inquiry Chair, Robert Francis QC, made 290 wide ranging recommendations to ensure that patients are the first and foremost consideration of the system and everyone who works in it. This report considers the implications of the Francis Report for Medway Council.

1. Budget and Policy Framework

1.1. There are cross-cutting issues arising from the Francis Inquiry. A report on the implications for Medway Council has been requested by this Committee because of its role in relation to scrutiny of health service and also because the Inquiry report makes several recommendations which may impact on the arrangements for local authority scrutiny of health in the future.

2. Background

2.1. The public inquiry was set up in June 2010 by the former Secretary of State, Andrew Lansley, to examine the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The inquiry builds on the work of an earlier independent inquiry by Robert Francis QC into the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, and the previous report of the Healthcare Commission, during which time care at the hospital fell short of expected levels of quality and safety. Examples of such poor care included patients being triaged in A&E by untrained staff, not given assistance

with eating and drinking, being left in soiled bedclothes for long periods, lack of privacy and dignity and filthy wards and toilets. There were an estimated 429 more deaths than expected between 2005 and 2008.

3. Summary of the Francis report

Overview

3.1 The Inquiry examined the actions of the hospital and the roles of the organisations with oversight including the Department of Health, the local strategic health authority, the local primary care trust, national regulators, local patient and public involvement and health scrutiny.

3.2 The report identifies numerous warning signs, which should have alerted these organisations to the problems developing at the Trust:

- Loss of star rating from three to zero by the Commission for Health Improvement (CHI) in 2004.
- Poor peer reviews, Healthcare Commission (HCC) reports (including patient and staff surveys) and auditors' reports.
- Instances of whistle blowing ignored.
- Financial recovery plan and associated staff cuts not consistent with maintaining quality and safety.

Trust and Trust Board - Stafford Hospital

3.3 The report highlights the poor leadership, lack of appreciation of the enormity of the failings and downplaying of their significance. It indicates the organisation's culture of accepting poor standards, prioritising financial issues, meeting targets and achieving foundation trust status rather than quality of care and safety and failure to put patients at the centre of care. There was no culture of listening to patients or acting on complaints or patient surveys. Clinical governance was not introduced effectively.

3.4 The report states:

"Overall, the Trust Board operated with a "culture of self-promotion rather than critical analysis and openness" and the performance monitoring organisations accepted the hospital's version of events at face value and failed to carry out their own inspections."

GPs, Primary Care Trust (PCT) and Strategic Health Authority (SHA)

3.5 The report identifies the adverse impact of the constant reorganisation within the commissioning system as well as national guidance that focused on financial control and access targets rather than quality of care. The PCT is criticised for the time taken to address issues, insufficient focus in developing systems and processes to monitor performance and a willingness to accept that clinical safety was not compromised despite evidence that it was.

3.6 The SHA were also subject to extensive reorganisation and financial challenge. There was a lack of clarity about their role in addressing quality and safety. They were criticised for being too ready to trust providers, for

failing to provide important information to the Department of Health (DH) regarding the application for foundation trust status and not consulting with HCC.

Regulators (Monitor, HCC, Care Quality Commission (CQC), Professional Bodies)

3.7 Monitor failed to achieve its primary objective, which is in ensuring that only organisations with the ability and capacity to deliver services compliant with minimum standards were given foundation status. The report also highlights undue delay in Monitor intervening when problems were identified, with Monitor and HCC failing to communicate with each other and share knowledge.

3.8 The report further suggests that, although the HCC was the first organisation to identify serious concerns and take action, the reliance on self-assessment and self-declaration, the top-down system and the inadequacy of the systems in place contributed to why the problems were not detected earlier.

3.9 The report points to the many organisational challenges CQC has had to face since its inception–the merging of three organisations, new system of regulation and standards and new registrations. It further indicates that although CQC aspires to be an open organisation, it was defensive and generally did not respond well to criticism.

3.10 An inadequate response from General Medical Council, Nursing and Midwifery Council, universities/deaneries, Health and Safety Executive and Health Protection Agency was highlighted in the report. It describes the Royal College of Nursing as, “ineffective both as a professional organisation and a trade union, failing to uphold standards or address concerns and problems identified by its members.”

Department of Health (DH)

3.11 The report indicates that although DH was concerned about the failings of the Trust and sincere about improving quality for patients, it struggled between many policy changes over successive governments.

3.12 Furthermore, the report argues that the DH failed to involve senior clinicians in all policy decisions; that DH officials were sometimes too remote from patients and frontline staff and it failed to assess the impact of key policies on quality.

Voice of the local community

3.13 Failure to engage with patients and the public was identified as a major problem. The report indicates that the formal process of engaging patients and the public was generally ineffective, with the campaigning patients’ group (Cure the NHS) serving as the only effective local voice.

3.14 The report concludes that with the abolition of Community Health Councils (CHC) in 2002, the standard of representation of patient and public concerns declined. In addition, the Trust’s Patient and Public Involvement Forums and Local Involvement Networks (LINKs) failed to offer a route through which

patients and members of the public could link into the health services and hold them to account.

3.15 The report indicates that without a national framework to ensure consistency, the Local Healthwatch (LHW) is in "danger of the repetition of the arguments which so debilitated Staffordshire LINKs."

3.16 With regards to the health overview and scrutiny committees (HOSCs), the report states: "The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the inquiry exposed a number of weaknesses in the concept of scrutiny, which means that it will be an unreliable detector of concerns, however capable and conscientious committee members may be."

Recommendations

3.17 The report makes 290 recommendations and calls for all healthcare organisations to consider the findings and recommendations and how to apply these to their work. The recommendations cover the following themes:

- Accountability for implementation of the recommendations
- Putting the patient first
- Fundamental standards of behaviour
- Common culture throughout the system – an integrated hierarchy of standards of practice
- Responsibility for and effectiveness of healthcare standards and their governance
- Effective complaints handling
- Commissioning for standards
- Performance management and strategic oversight
- Patient, public and local scrutiny
- Medical training and education
- Openness, transparency and candour
- Nursing- culture of caring
- Leadership
- Professional regulation of fitness to practice
- Caring for the elderly
- Information
- Coroners and inquests
- Department of Health leadership

4. Implications for Medway Council

4.1 Although the inquiry related to failings within the NHS there are specific recommendations that are aimed at Local Authorities as well as more general findings which are applicable to any organisation whose actions can impact on the quality and safety of services provided to the public.

Commissioning of health, public health and social care

"The experience of Stafford shows an urgent need to rebalance and refocus commissioning into an exercise designed to procure fundamental and

enhanced standards of service for patients as well as to identify the nature of the service to be provided."

4.2 As a result of the Health and Social Care Act 2012 local authorities have a duty to commission or provide public health services. These are currently provided by NHS and non NHS providers. Although all are delivered on an outpatient or community basis there is still potential for the factors which impacted in Mid Staffordshire to occur and cause failings in care.

4.3 The Council has recently signed a section 256 agreement with NHS Medway CCG to cover partnership commissioning arrangements for health and social care. This will be overseen by a Joint Commissioning Board.

4.4 For these new arrangements and existing arrangements for commissioning and providing relevant services it is important that the Council's systems ensure that:

- services are commissioned or provided to meet relevant standards relating to quality and safety
- governance arrangements (including for complaints) are in place to monitor and performance manage service quality
- arrangements are in place for obtaining the views of the public on the quality of services and the health and social care system
- there is transparency of decision making through public meetings

4.5 The MOU between the Council and Medway CCG for provision of specialist public health support includes provision of work to monitor and evaluate the quality of health services. The Public Health Directorate is currently supporting Medway CCG in work to address the high mortality ratios at Medway NHS Foundation Trust.

Healthwatch

"The community in Stafford was reticent in raising concerns and accepting of poor care; those who did make a complaint were not heard or given a voice."

4.6 Healthwatch is a new service, which will be commissioned by Local Authorities from April 2013. Its key functions are to engage with the public in order to influence the delivery and design of local health and social care services, signposting and independent complaints advocacy. The Procurement Board awarded the contract for Healthwatch for Medway on 13 March 2013 to CAB Medway (the Citizens Advice Bureau).

4.7 The Francis Report recognises the failings of previous public engagement activities and the new service provides an opportunity to ensure that this key element of the health and social care system is provided effectively.

4.8 The key actions to be taken to ensure that the benefits of Healthwatch are realised locally are:

- Ensuring that adequate support and training is provided to Healthwatch to enable them to deliver their function effectively

- Ensure that the centrally provided funds designated for Healthwatch are passed to Healthwatch
- Ensure that systems are established to feed in concerns about health and social care services, identified by Healthwatch, to commissioners
- Develop effective performance management arrangements
- Develop protocols to promote co-ordination and co-operation between Healthwatch, the Health and Wellbeing Board and Overview and Scrutiny.

Overview and Scrutiny

"The Overview and Scrutiny Committees (OSCs) in Stafford were happy to take on a role scrutinising health services but did not equate this with responsibility for identifying and acting on matters of concern; and they lacked expert advice and training, clarity about their responsibility, patient voice involvement and offered ineffective challenge"

4.9 The Francis Inquiry has made several recommendations as a consequence of evaluating the overview and scrutiny arrangements in Mid Staffordshire as follows:

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

(b) The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.

(c) 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.

(d) Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards and local government scrutiny committees.

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

(f) 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 suggestions for action.

(g) 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.

4.10. Scrutiny of health and social care services in Medway is the responsibility of the Health and Adult Social Care and Children and Young People's Overview and Scrutiny Committees

4.11 In December 2012 the Business Support Overview and Scrutiny Committee considered the outcome of a comprehensive review of the overview and scrutiny arrangements in Medway and agreed an improvement/development programme. This includes further member development in scrutiny of partners and, in particular, the scrutiny of health services, looking at the respective roles of the Health and Wellbeing Board, Healthwatch and Overview and Scrutiny Committees. Use of performance information in scrutiny has also been identified as an area requiring further development locally. The learning from the Francis Inquiry and any consequential guidance issued by the Government will be built into the planning for implementation of improvements to the overview and scrutiny arrangements in Medway.

Medical Examiners

4.12 A new Medical Examiner system will be introduced from April 2014 to scrutinise and confirm the cause of death in all cases not referred to the coroner. Implementation of this system is the responsibility of Local Authorities and arises from the recommendations in the Shipman Inquiry.

4.13 Consultation by the Department of Health on reforms to the death certification process has been delayed but is anticipated before Easter. The Francis Report makes recommendations relating to the independence, capacity, capability and responsibilities of Medical Examiners.

4.14 Once guidance has been issued by the Department of Health arrangements will be made to secure a Medical Examiner service for Medway.

Sharing concerns

"The responsibilities and accountabilities of external agencies were not well defined, often resulting in "regulatory gaps" or failure to follow up warning signs. Organisations operated in silos, without consideration about the wider implications of their role, even guarding their territories on occasion."

4.15 The Francis Report makes recommendations about organisations sharing concerns about provider service quality so that commissioners and regulators are fully aware of the full range of issues of concerns in a timely fashion.

4.16 The NHS Commissioning Board Kent and Medway Area Team has recently established a Quality Surveillance Group which will fulfil the requirement of organisations sharing concerns about provider quality. The Director of Public Health and Director of Children and Adults are both members of the group

4.17 There is a specific recommendation that the Health Protection Agency or the Director of Public Health, through their work on health care acquired infections, may have information about the quality of care in trusts which should be brought to the attention of regulators.

4.18 Guidance is still being produced by the Department of health on the Local Authority's new public health role in respect of infection prevention and control. Once this is received appropriate arrangements will be established by the DPH with Public Health England and Medway CCG to ensure that concerns relating to healthcare acquired infections are identified and escalated.

Culture

"A culture focussed on doing the system's business – not that of the patients."

4.19 The report identified many negative aspects to the culture in the system around Mid Staffs including:

- a lack of openness to criticism
- a lack of consideration for patients
- defensiveness
- looking inwards not outwards
- secrecy
- misplaced assumptions about the judgements and actions of others
- an acceptance of poor standards
- a failure to put the patient first in everything that is done.

4.20 Whilst it was not suggested that these characteristics are present everywhere in the system all of the time equally it is not suggested that they are unique to the system in Stafford or the NHS.

4.21 The report's recommendations focus on making patients the first priority, ensuring they receive services from caring, compassionate and committed staff working within a common culture, and they must be protected from avoidable harm. It is important that this is reflected in the Council's commissioning and provision of relevant services.

5. Advice and analysis

5.1. The Francis Report clearly has significant implications across a range of Council responsibilities. The report is lengthy and detailed and it is beyond the scope of this briefing paper to consider all the implications in detail. More detailed plans to address the recommendations will need to be developed by relevant lead officers.

6. Risk management

6.1 Risk management is an integral part of good governance. The Council has a responsibility to identify and manage threats and risks to achieve its strategic objectives and enhance the value of services it provides to the community.

Risk	Description	Action to avoid or mitigate risk	Risk rating
Local replication of the circumstances which led to the failures in patient care in Mid Staffordshire	Failure to act on the recommendations arising from the Public Inquiry or the consequent guidance from the Department of Health.	Internal actions to be identified to address implications identified in this report. To work with the NHS and regulatory system to address wider system issues.	B2

7. Financial and legal implications

There are no direct legal or financial implications arising from the report. However there are important implications for the way in which the Council delivers statutory duties relating to health, public health and social care.

8. Recommendations

To note the report and agree to receive an update on action proposed by the Council in response to the findings and recommendations of the Francis Inquiry.

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Background papers
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry