Health Scrutiny Committee:
28th February 2013

AGENDA ITEM 8

THE FRANCIS REPORT – OUTCOMES AND POTENTIAL IMPLICATIONS FOR HEALTH SCRUTINY

1.0 Matter for consideration

1.1 The Committee to consider a report summarising the potential implications for health scrutiny arising from the Francis report into the Mid-Staffordshire NHS Foundation Trust.

2.0 Recommendations

2.1 To consider the report.

2.2 To agree the consideration of a more developed overview of the recommendations at an appropriate time.

3.0 Background

3.1 A separate briefing paper on this topic was forwarded to members of the Health Scrutiny Committee via Email and hard copy on 12th February.

3.2 Following consideration of that paper, Councillor Mrs Henderson MBE has requested that due to the importance of the topic, that it be considered as a substantive agenda item at this Committee meeting.

4.0 Summary of key issues

4.1 The report and recommendations arising from the comprehensive review of failings in patient care at the Mid Staffordshire NHS Trust between 2005 and 2009 was published on Wednesday 6 February. Conducted by Sir Robert Francis QC, his approach featured evidence gathering from 250 witnesses and the consideration of 1 million pieces of information.

4.2 At the scheduled press conference, Sir Robert opened with a robust reflection of the review and stated that he had heard of appalling and unnecessary suffering of patients and that the hospital in question had failed in its duty to protect patient safety. Furthermore, Sir Robert called for a culture change within the NHS, one which focussed on patient outcomes and not the corporatist culture of performance and financial targets.

4.3 In a long and wide ranging fashion, 290 recommendations have been made in the following broad areas: -

5.0 Patient Care, Nursing and Leadership

It was evidenced that in some areas of the NHS, there is a lack of care, compassion, humanity and leadership in respect of patient care and safety and that this must be remedied. The needs of patients must come first and that nurses and managers who are complicit in practices which compromise patient care and safety must be held accountable for their actions in a Court of law – an equalisation of the accountabilities held by clinicians.

5.1 There is also a need for common values of care, set by the National Institute for Health and Clinical Excellence (NICE) and non compliance must not be tolerated.

5.2 Nursing, as a practice, should be valued more and have a stronger voice within NHS Trusts. Furthermore, consideration should be given to the development of a post of registered older people's nurse and that healthcare support workers should be registered and adhere to a code of conduct.

5.3 A recommendation is also devoted to the establishment of a Leadership College for NHS staff.

6.0 Corporate Culture

6.1 Sir Robert found that corporate culture within the Trust was corrupted by a value system at variance with patient care and believed that the public's trust in the NHS had been betrayed as a result of the scandal at Mid Staffordshire.

6.2 Recommendations have been made in relation to the Trusts having an obligation to produce and report honest data, as well as uphold a duty to be transparent and open. Failure to do so must also be punishable by law.

6.3 In response to Sir Robert's report, all Trusts have been asked to publicly state whether they are accepting the recommendations and what actions they are taking to implement them.

7.0 Inspection and Regulation

7.1 The review found that there were warning signs in relation to the Trust's failure to ensure a duty of care; however a series of individual failings coupled with a corporate culture not centred on patient outcomes meant that these were not addressed soon enough.

7.2 It was highlighted in the findings that compliance, from a patient safety, quality and a corporate governance point of view should be undertaken by one organisation – currently this responsibility is split across Monitor and the Care Quality Commission. Furthermore, Quality Accounts should be independently audited.

7.3 Reference was given to Scrutiny Members not being well equipped enough to challenge information by the Trust which was presented to them as an accurate picture of standards at the hospital.

7.4 Furthermore, a recommendation was made in relation to all Trusts publicly stating whether they accept the recommendations, or otherwise, and evidence what they are planning to do to implement the recommendations. The progress of actions by those organisations which are accountable to Parliament should be monitored by the Parliamentary Health Select Committee.

8.0 Recommendations Relating to / Impacting On Overview and Scrutiny

8.1 Overview and Scrutiny is a powerful tool to ensure that NHS Trusts are held to account for the way in which they provide services to the public. Whilst it is not the job of Scrutiny Committees to manage the performance of the NHS, it does have the responsibility to challenge patient outcomes. The following recommendations have been made which would have an impact on the conduct and work programme of the Health Scrutiny Committee: -

Recommendation 47: 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'.

Recommendation 119: 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.

Recommendation 147: Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

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

Recommendation 150: 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.

Recommendation 246: 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. This should 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.

9.0 Further action

9.1 The Francis report's recommendations to strengthen the health scrutiny function are useful and the Centre for Public Scrutiny (CFPS) are pursuing them with the Department of Health and a wide variety of other bodies. The Department of Health will be making a response to the report which is when there will be an indication as to whether any legislative or regulatory changes are likely.

10.0 Witnesses / representatives

10.1 As requested by the Committee members, the following person has been invited to attend the meeting to speak on the matter:

- Steve Sienkiewicz, Scrutiny Manager.

Relevant officer:
Steve Sienkiewicz. Scrutiny Manager.
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Appendices attached:
None.

Background papers:
Francis report briefing paper issued to members of the Health Scrutiny Committee on 12th February.