HEALTH AND WELLBEING BOARD

4 June 2013

Title: The Francis Report	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** Yes
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Summary:	

Robert Francis QC described the extent of older people's care service failures that led to the inquiry, saying: "I heard so many stories of shocking care. These patients were not simply numbers they were husbands, wives, sons, daughters, fathers, mothers, grandparents. They were people who entered Stafford Hospital and rightly expected to be well cared for and treated. Instead, many suffered horrific experiences that will haunt them and their loved ones for the rest of their lives."

The Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of the Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. It was followed by the Government's response on 26 March 2013, which sets out how the quality of patient care is to be put at the heart of the NHS. Both should have far-reaching implications for the care and support system, not just the NHS. The Public Inquiry's comprehensive Report rightly looks across the whole care system. Robert Francis' emphasis on developing the right culture of care within the NHS, through better leadership, training, information and transparency is the right approach. It is clear that the causes of the Mid Staffordshire Foundation NHS Trust scandal go beyond the NHS and are multi-factorial, requiring solutions that are equally complex and diverse.

Anna Dixon, director of policy at The King's Fund, states "This Report is the latest in a long line of reports on failures of patient care, dating back to the Ely Hospital Inquiry of the late 1960s that have come to similar conclusions. This shows that the real challenge is not the diagnosis and prescription for the problem, it is ensuring that the remedy is administered effectively. Even if all 290 recommendations were implemented now, the fundamental shift in culture can only be achieved if patient care is put top of the agenda for boards and is the first responsibility of professionals working in the NHS. That will take time and commitment over many years."

There were warning signs that spanned patient stories, high hospital death rates

(demonstrated by Hospital Standardised Mortality Ratios), complaints, staff concerns, whistleblowers, governance issues, financial problems and staff reduction. Against this background the challenge remains in every situation to answer the question:

"***What is the 'Index of Suspicion' and at what point do you call time on an NHS or Care Provider?"***

The answer is complex as demonstrated recently when Leeds General Infirmary's children's heart surgery unit was closed for 11 days after NHS England's Medical Director, Sir Bruce Keogh, suspended procedures for what he called a "constellation" of reasons. However, data cannot give the whole picture; it has to be triangulated with other evidence, and there are professional and political judgments to be made. Francis notes this may leave a number of NHS and care providers "on the edge of acceptability".

This Inquiry and earlier well documented systems failings in institutional care settings (such as hospitals or care homes) or community settings (including people's own homes) demonstrate that when individual children or adults are not adequately safeguarded or their quality of care is poor the consequences are both significant and far reaching. It is clear the role of local organisations is very much around ensuring that patients and the public are safeguarded and that poor care is prevented in the first place. This report for the Health and Wellbeing Board, focuses on what needs to be done locally to address the relevant recommendations of the Inquiry.

Recommendation(s)

The Health and Wellbeing Board is asked to:

(1) Consider the report and discuss the implications for Barking and Dagenham.

(2) Agree that the group established by the CCG develops a local response to the Francis Report involving all partners on behalf of the Health & Wellbeing Board.

(3) Refer the following issues to the task and finish group for consideration:-

- the role of GPs in reviewing care standards
- formalised early warning systems and the part they might play
- how patient /user involvement can be strengthened and the mechanisms
- needed for the patient/user voice to be heard by decision makers
- whether the single agency action plans are adequate and what changes are needed to ensure a whole systems approach
- how the Health and Wellbeing Board can gain assurance on behalf of local residents about the quality of our local health and care system
- review progress made by the Clinical Commissioning Group, local NHS Trusts and Foundation Trusts in the implementation of their action plans
- consider the views of the Safeguarding Adults Board and Local Safeguarding

Children Board.

(4) The Health and Wellbeing Board is asked note that a separate report will be presented to the Health and Adult Services Select Committee on the Francis recommendations.

(5) The Director of Public Health meets with his colleagues from neighbouring boroughs to agree an approach to both the identification of problems and solutions required from the analysis of hospital mortality rates.

(6) Receive a progress report to its September meeting.

Reason(s): Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to review and comment on public inquiries into health and social care and make recommendations to improve the quality of care.

1 Introduction

1.1 On 9 June 2010 the then Secretary of State for Health, Andrew Lansley MP, announced a full Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust ("MSFT"). The Inquiry was established under the Inquiries Act 2005 and chaired by Robert Francis QC, who made recommendations to the Secretary of State based on the lessons learnt from MSFT.

1.2 It is important to note that this Public Inquiry built on the work of the previous Independent Inquiry, also chaired by Robert Francis QC, which looked at the care provided by MSFT between January 2005 and March 2009. This Inquiry considered individual cases of patient care, so that further lessons not already identified by previous investigations could be learned. The Inquiry reported on 24 February 2010.

1.3 The impact of both Inquiries is far reaching across health and social care, and from the highest levels of management to frontline service delivery. A summary of the key findings of both Inquiries is as follows:-

The 2010 Independent Inquiry Report:

- Patients deprived of dignity and respect.
- Most basic standards of care were not observed.
- Staff lacked care, compassion, humanity and leadership.
- Corporate self-interest and cost control were put ahead of patients and safety.
- The patient voice was not heard; nothing effective was done to address patients' complaints.
- Local GPs did not raise concerns until too late.
- PCTs did not effectively ensure the quality of the health services they were buying.

The 2013 Public Inquiry Report:

- Provides detailed and systematic analysis of what contributed to the failings.
- Identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the MSFT's problems even when the problems were known.

It is important to note that parts of the system the Inquiry was set up to examine have changed significantly in the past two years following the introduction of the Health and Social Care Act 2012. There are no real successor organisations as the responsibilities have been spread across a number of newly created organisations including clinical commissioning groups, NHS England, NHS Trust Development Authority, Public Health England as well as local authorities, Monitor and the Care Quality Commission. In this context the 2013 Public Inquiry Report focuses its recommendations on cultural change rather than structural re-organisation.

2. The Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust – Chaired by Robert Francis QC

> '***The system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital***' **Robert Francis QC**

2.1 The Final Report of the Public Inquiry into MSFT provides detailed and systematic analysis of what contributed to the failings in care at the Foundation Trust. It identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address MSFT's problems for so long, even when the extent of the problems were known.

2.2 The Report builds on the first Independent Inquiry, also chaired by Robert Francis QC. Its three volumes and an executive summary run to 1,782 pages, and is structured around:

- Warning signs that existed and could have revealed the issues earlier.
- Governance and culture.
- Roles of different organisations and agencies.
- Present and future.

2.3 It recognises that what happened in MSFT was a system failure, as well as a failure of the organisation itself. Rather than proposing a significant reorganisation of the system, the Report concludes that a fundamental change in culture is required to prevent this system failure from happening again, and that many of the changes can be implemented within the current system. It stresses the importance of avoiding a blame culture, and proposes that the NHS, collectively and individually, adopt a learning culture aligned first and foremost with the needs and care of patients.

2.4 After a million pages of documentary material, 250 witnesses and 139 days of oral hearings the Report made 290 recommendations, which focus primarily on securing greater cohesion and culture across the system. Francis states that 'change will not be brought about by further "top down" pronouncements, but by the engagement of every single person serving patients'. However, he adds no single recommendation should be regarded as the solution to the many concerns identified.

2.5 Key findings:

- The Strategic Health Authority did not prioritise patient safety and defended MSFT rather than holding them to account.
- Monitor focused on corporate governance and financial control without considering patient safety.
- The Department of Health did not give Ministers a full picture when advising that the Trust's application for Foundation Trust status should be supported.
- Healthcare professional regulators, training and professional representative organisations failed to uncover the lack of professionalism and to take action to protect patients.

In summary, the bottom line is, the Inquiry found a fundamental failure of the regulatory and supervisory system which should have secured the quality and

safety of patient care at both a national and local level. Francis states further, that as a result, the public's trust in the NHS was betrayed.

2.6 On the question of "How to re-build that trust?" Robert Francis is clear that a fundamental change in culture is needed which puts patients and their safety first, this involves:

- Every single person and organisation in the NHS needs to reflect on what needs to be done differently in future and how they can contribute to a safer, committed, compassionate and caring service.
- Patients need to be the first and foremost consideration of the system and all those who work in it.

2.7 In response to the evidence Francis fashioned his recommendations around five key themes, which he believes will rebuild public trust in the NHS. The themes are:

- **Standards**: fundamental standards of care 'owned' by staff and patients, policed by Care Quality Commission, non-compliance a criminal offence in some cases;
- **Openness, transparency and candour**: a willingness to receive and act on complaints and feedback; transparency about performance (positive and negative) – an offence to wilfully mislead and honesty with patients (duty of candour with sanctions);
- **Leadership:** strengthened with firmer accountability (fit and proper person test and possible disqualification);
- **Compassion and care**: stronger voice for nursing, values at the heart of recruitment and management, standards, revalidation, regulation of healthcare support workers; and;
- **Information**: all healthcare professionals have a responsibility to help formulate measures of the effectiveness of what they do and to make publicly available.

2.8 At the heart of the Report is a determination that the Inquiry's recommendations and findings be implemented and not suffer the same fate as many previous inquiries. Its first recommendation sets out requirements for oversight and accountability to ensure implementation of its proposals. There are a number of issues falling out of Francis recommendations that the Council, NHS Barking and Dagenham Clinical Commissioning Group and other key players in the local health and social care economy may wish to work through collectively. These include:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should reflect on the Report and its recommendations and decide how to apply them to their own work.
- The oversight and scrutiny function of the local authorities needs to be strengthened to introduce focused challenge, ensuring patient's views are considered and holding the system to account.
- The newly established health and wellbeing boards need to set down how they will bring that local health and social care system overview and accountability ensuring poor care does not happen in the first place.
- Each organisation should publish, at least annually, a report on its progress in achieving its planned actions.

I hope that the recommendations in this Report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it' **Robert Francis QC**

3. Initial Government Response (26 March 2013)

3.1 The Government has issued an initial formal response to the Public Inquiry entitled *"Patients First and Foremost" which was* published at the end of March 2013.

- The response was developed on behalf of the health and social care system and sets out how we are expected to respond to Francis's challenge to make patients 'the first and foremost consideration of the system and everyone who works in it'.
- It includes a statement of common purpose, jointly developed and signed by a wide range of partners who share responsibility for patient care.
- It does not respond to all of the 290 Francis's recommendations but it addresses the key themes of the Francis Report, and sets out the actions to be pursued immediately.
- It focuses on five key areas, with a common thread running throughout of how we can create a culture of compassionate care.

3.2 *Patients First and Foremost* includes a five point plan which is summarised below:

1) Preventing Problems

- **Reducing Regulatory and Information Burdens by One Third**
  Single national portal (Health and Social Care Information Centre) for collecting information and reducing the information burden on the service year on year.
  NHS Confederation has been commissioned to review how the bureaucratic burden on frontline and NHS providers can be reduced.
- **Safety in the DNA of the NHS – The Berwick Review**
  Professor Don Berwick will be working with NHS England to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

2) Taking Action Promptly

Key measures

- **Fundamental Standards -** The Chief Inspector will draw up new simple fundamental standards, which make explicit the basic standards beneath which care should never fall.
- **Time Limited Failure Regime for Quality as Well as Finance -** A new time limited three stage failure regime, encompassing not just finance, but for the first time, quality, will ensure that where fundamental standards of care are being breached, firm action is taken until they are properly and promptly resolved.

3) Detecting Problems Quickly

Key measures

A new regulatory model led by the following:

- **Chief Inspector of Hospitals making assessments based on judgement as well as data.**
- **Chief Inspector of Social Care and possible Chief Inspector of Primary Care**
- **Ratings – A Single Balanced Version of the Truth** - Single assessment biased towards patient experience, comparable to OFSTED reports for schools.
- **Care Quality Commission no longer responsible for putting right any problems identified in hospitals** - Their enforcement powers will be delegated to Monitor and the NHS Trust Development Authority.

Honesty and transparency –

- **Publication of Individual Speciality Outcomes -** This has driven up standards in heart surgery so will be extended to other specialities.
- **Statutory Duty of Candour** - On health and care providers to inform people if they believe treatment or care has caused death or serious injury.
- **Criminal Penalties for Disinformation** - Consider legal sanctions at a corporate level for organisations that alter figures or conceal truth about performance data.
- **A Ban on Gagging Clauses** - NHS staff can speak out and not be vilified.

Engaging and Involving patients –

- **Complaints Review** - Review of best practice being led by Ann Clywd MP and Tricia Hart.
- **All key organisations within the health and care system listening to patients, service users, families, parents and carers.**
- **Patient and Staff Feedback** - Friends and Family Test and NHS Staff Survey.
- **HealthWatch -** Ensuring that the voice of the patient is listened to within the new system.

4) Ensuring Robust Accountability

Key measures

- **Health and Safety Executive (HSE) to use Criminal Sanctions** - Where the Chief Inspector identifies negligent practice in hospitals, he will refer the matter to HSE to consider whether criminal prosecution is necessary.
- **Faster and Proactive Professional Regulation -** Seeking to overhaul 150 years of complex legislation into a single Act that ensures much faster and less reactive actions on individual professional failings.
- **Barring Failed NHS Managers -** Introduction of a national barring list for unfit managers, based on the barring scheme for teachers.
- **Barring System for Health and social care assistants enforced by Chief Inspector** - Ensure that hospitals meet their existing legal obligations to ensure that unsuitable health and social care assistants are barred.
- **Clear Responsibilities for Tackling Failure** - These proposals will resolve the confusion of roles and responsibilities in the system, so it is clear where the buck stops on poor care.

5) Ensuring Staff Are Trained and Motivated

Key measures

- **Health Care Assistant (HCA) Training before Nursing Degrees** - Pilots for students that seek state funding for nursing serve as an HCA for up to a year to ensure frontline caring experience and values, as well as academic strength.
- **Revalidation for Nurses** - Introduce a national scheme for already qualified nurses to ensure that they are up to date.
- **Training, Code of Conduct and Minimum Standards for Healthcare Assistants published** - Additionally, the Camilla Cavendish review will look at how HCAs can provide the safest and most compassionate care.
- **Attracting Professional and External Leaders to Senior Management Roles** - NHS Leadership Academy to build on existing programmes and initiate in programmes for fast-tracking professionals outside the NHS and clinicians from within into leadership roles.
- **Frontline Experience for Department of Health (DH) Staff** - DH will learn from the criticisms of its own role. By 2016, every civil servant in the Department will have real and extensive experience of the frontline.

3.3 Next steps

The Government has committed to the following next steps and will be reporting back in the autumn:

- Considering the 290 recommendations in full.
- Some recommendations will require further development and consultation.
- Further engagement – working across the system and with our stakeholders.

- A further, more detailed response to the 290 in due course, which will include actions resulting from the range of reviews currently underway (complaints, safety, bureaucratic burdens, HCAs).

4. Implications for London Borough of Barking and Dagenham

4.1 Health and Wellbeing Board

The Francis Report touches on a number of the Council's functions: democratic functions including the Health & Wellbeing Board and Health Scrutiny, service delivery and commissioned services. The specific issues are set out below.

4.1.1 The Inquiry did not make reference to health and wellbeing boards as its investigations predate their establishment. The now statutory Health and Wellbeing Board is in a position to take a strategic oversight of how the health and social care system is operating.

4.1.2 It is interesting to note that clinical commissioning groups, NHS Foundation Trusts and NHS Trusts are required by NHS England to review and reflect on the Report at board level. On reading the Governing Body Report of NHS Barking and Dagenham Clinical Commissioning Group and the Board Reports of North East London NHS Foundation Trust and Barking, Havering, Redbridge University Hospitals NHS Trust it is clear that all three are taking the Francis recommendations seriously. However, these initial reports are not surprisingly focussed on the issues for their organisation rather than the wider system. This therefore presents an opportunity to look together through the Health and Wellbeing Board at this system. In addition, the Board should focus on the various reviews that are ongoing following on from Francis such as the review of safety and "zero harm" led by Professor Don Berwick and which are all scheduled to report ahead of the Department of Health's autumn update on the next steps following Francis.

RECOMMENDATION

The Health and Wellbeing Board supports the establishment of a time limited group to develop a local response to the Francis Report involving all partners but led by NHS Barking and Dagenham Clinical Commissioning Group.

4.2 Health and Adult Services Select Committee

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 may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be. Robert Francis QC

4.2.1 A separate report on the implications of the Francis Report will be presented to the Health and Adult Services Select Committee for consideration.

RECOMMENDATION

The Health and Wellbeing Board is asked note that a separate report will be presented to the Health and Adult Services Select Committee on the Francis recommendations.

4.3 **Director of Public Health**

4.3.1 The Francis Report puts specific focus on the Regional Director of Public Health's role in the identification of problems from the analysis of hospital mortality rates. In particular as a public health doctor, Francis noted that even without the benefit of hindsight, the Director did not at the time look more deeply into whether patients' interests were being protected adequately by the steps being taken by the Trust.

4.3.2 Francis makes the following recommendation:

If the local director of public health, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS England, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.

4.3.3 In the new Public Health system, there is not a Regional Director of Public Health. From 1 April 2013, protecting the public's health is part of the statutory responsibilities of the Council's Director of Public Health. The Director of Public Health for Barking and Dagenham working with his colleagues in the London boroughs of Havering and Redbridge and Waltham Forest needs to consider the following four specific messages:

- Patient safety, the effectiveness of treatment and the quality of basic care needs to be prioritised. The Director of Public Health has a statutory responsibility to ensure all three areas are supported, through the provision of information and evidence of what works to colleagues in the acute sector and to NHS Commissioners.
- Targets and outcomes are important, but not at the expense of patient care. They should be meaningful and not a box ticking exercise.
- Francis's fifth recommendation in his Summary is for "*accurate, useful and relevant information"*. The Director of Public Health needs to support a greater understanding and use of measures such as Hospital Standardised Mortality Ratios (HSMRs) as a measure of clinical quality, but also understand the caveats in their use. Data varies in quality and depth, and can be "gamed." The Director of Public Health needs to assure they are accurately interpreted to identify the preventable deaths.
- There were three peer reviews at Mid Staffordshire NHS Foundation Trust between 2004-2007: cancer, critically ill care and care of critically ill children. All raised serious concerns but seen in isolation did not trigger concern. The Director of Public Health has a responsibility to see the wider picture and give advice and should use their Annual Report to highlight areas of concern following analysis of mortality and other indicators. The Health and Social Care

Act 2012 includes a duty on the Director of Public Health to write a report, and a duty on the Council to publish it. The requirement for the report to be annual also allows progress to be recorded and evaluated.

RECOMMENDATION

The Director of Public Health meets with his colleagues in neighbouring boroughs to agree an approach to both the identification of problems and solutions required from the analysis of hospital mortality rates.

4.4 **Social Care**

4.4.1 Whilst there has been an understandable focus on NHS culture and processes, the key findings of the Francis Report also have implications for those working in the social care sector. Like the NHS, social care has a history of serious incidents of care failings, including the death of baby Peter Connelly in Haringey and the independent review into adult care services at Wirral Metropolitan Borough Council. Vulnerable people are at risk of care failings not only in institutions, but also in their own homes and communities.

4.4.2 The reality is that social workers, as well as health professionals**,** worked in MSFT and other hospitals at a time of serious failings, and we should therefore reflect on the role that they might have played to bring to light the unacceptable levels of patient neglect that took place. Francis's 290 recommendations, whilst aimed primarily at NHS care providers, have obvious resonance for the vast army of care workers, care homes and support organisations responsible for the health and wellbeing of the old and vulnerable throughout England. It is acknowledged by the Association for the Directors of Adult Social Services (ADASS) that the Francis Report should not make easy reading for Directors or staff in adult social services departments.

4.4.3 Not only are there similarities in the pressures on social care and the NHS, but the regulator and ministers overlap. The Care Quality Commission remains in place as a cross-service regulator despite its failings and the more stringent inspection and monitoring regime proposed by Francis would certainly impact on social care. Moreover ministers have explicitly made the links, not least as the unsolved issue of integration of health and social care looms large. The analysis and comment outlined in section 6 later on, in this report on the Implications for NHS Commissioners, NHS Barking and Dagenham Clinical Commissioning Group and NHS England is as relevant for Social Care commissioners as it is for NHS.

4.4.4 Commentators are consistent in their view on which of the Report's 290 recommendations have the greatest relevance for social care. They include:

- The proposed duty of candour for the NHS and social care which would require staff to admit mistakes that have caused "death or serious injury" to patients to their employer as soon as possible and calls for prosecution of employers and managers preventing staff exercising their statutory duty (including whistle-blowing over serious concerns).
- A proposed more stringent inspection regime led by the Care Quality Commission including a new power for the Commission to police this duty of candour and prosecute organisations and individuals who break the rule.

- Gagging clauses against whistleblowers that prevent disclosure of care safety concerns would be abolished.
- Healthcare assistants would be regulated. At present, the vet who checks your cat is better regulated than the person who looks after your mum in hospital. What will this mean for social care workforce?
- Senior general managers would have contractually enforceable ethical codes and a "negative register" for the utterly unfit.
- Francis says nothing about the Health and Care Professions Council (HCPC) but warns the Nursing and Midwifery Council that "to act as an effective regulator of nurse managers and leaders, as well as more frontline nurses, [it] needs to be equipped to look at systemic concerns as well as individual ones". This would surely lead to the HCPC having to review its code to provide greater support for whistleblowers and hold managers to account for their conduct.

4.4.5 Social Care is in the spotlight amid almost weekly reports confirming the growing gap between rising need and falling resources in social care. The perfect storm of rising safeguarding referrals, rising numbers receiving care, and rising eligibility thresholds is the most obvious consequence. At the same time there are serious and repeated concerns nationally about conditions in some care homes and support for adults needing support from social workers. The Francis Report was clear that MSFT is not unique, but was the tip of a much wider problem. It is therefore incumbent on the Council to reflect on the implications for its social care services for adults and children, as well as, keeping a tight focus on the safeguarding arrangements.

4.4.6 The Corporate Director for Adult and Community Services and the Corporate Director for Children's Services should delegate the appropriate Council Officers to provide the social care and safeguarding input into the proposed task and finish group to be led by NHS Barking and Dagenham Clinical Commissioning Group.

4.5 **HealthWatch**

"The standard of representation of patient and public concerns has declined since the abolition of Community Health Councils in 2002. It is now quite clear that what replaced them, two attempts at reorganisation in 10 years, failed to produce an improved voice for patients and the public, but achieved the opposite." Robert Francis QC

4.5.1 A key conclusion of Francis is that local patient groups in MSFT were weak, over-reliant on uninformed and untrained volunteers, sometimes in dysfunctional relationships and beset with infighting.

4.5.2 Perhaps the most worrying aspect of the Francis Report is the decline of patient power in the NHS in recent years. Given that government after government has stressed the importance of public and patient involvement and that the coalition has actually made, 'no decision about me without me' its mantra for the NHS, this is the cruellest irony. The Francis Report reminds all of us that whatever pressures we face from commissioners or providers to ignore their needs and their voice is not acceptable.

4.5.3 Francis recommends that patient groups should be properly funded, with training on offer and the ability to carry out inspections something we have known for many

years. Councillors, service users and organisations representing patients and disabled people have shouted it out loud and clear. The simple truth though is that if patients have effective lines of communication and their voices are heard, tragedies such as that at MSFT might never have happened.

4.5.4 At a recent Department of Health Stakeholder's event for patient voice representatives the prevailing view was that the focus should move from so-called paper-based recipes such as patient reported outcome measures, as we have seen both the Winterbourne and Mid Staffordshire NHS Foundation Trust scandals, to making an effective voice real for the individual patient and for their representative groups, organisations and families.

4.5.5 HealthWatch should provide active input in the proposed task and finish group on improving patient involvement and acting on patient's concerns voice.

4.5.6 Alongside the work of HealthWatch, all health and social care organisations will need to respond to concerns from their own patient and service user involvement mechanisms. Separately on this agenda the Board is invited to consider its approach to engagement.

4.6 Local Safeguarding Boards

4.6.1 The report covers a wide range of issues including the need to ensure appropriate safeguarding arrangements for both children and adults at risk. It will be important therefore that the Safeguarding Adults Board and Local Safeguarding Children Board consider the report and that their views form part of the report back to the Health and Wellbeing Board.

5. Implications for North East London NHS Foundation Trust and Barking Havering and Redbridge University Hospitals NHS Trust

It is clear that not just the Trust's Board but the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm, and in some cases inhumane treatment that should never be tolerated in any Hospital. Robert Francis QC

5.1. NHS England, acting on Robert Francis's first recommendation, have instructed clinical commissioning groups, NHS Trusts and NHS Foundation Trusts to urgently consider and review what happens in their own organisations in light of the Inquiry's findings, and identify any actions they may need to take to ensure what happened in Mid Staffordshire NHS Foundation Trust does not happen in their organisation.

5.2 This internal review is required to go to the governing body and boards of the various organisations. NHS England and the NHS Trust Development Authority did not mandate an action plan submission, although both North East London NHS Foundation Trust and Barking Havering and Redbridge University Hospitals NHS Trust have developed local action plans for which their boards have taken direct oversight of implementation. It is expected that there could be further central requirements as part of the assurance framework later this year.

5.3 Given that the Clinical Commissioning Group is the main commissioner of both North East London Foundation Trust and Barking Havering and Redbridge

University Hospitals NHS Trust and it is proposed it leads this work, it is also proposed that it provides assurance to the Health and Wellbeing Board on the progress made in the implementation of the Francis Report by both Trusts.

6. Implications for NHS Commissioners, NHS Barking and Dagenham Clinical Commissioning Group and NHS England

6.1 Commissioners are public bodies, visibly acting on behalf of the public and the section of the Inquiry Report about commissioning for standards pulls out the reflections and lessons learned by the Primary Care Trust. The Report suggests commissioning as a practice must be refocused to procure the necessary standards of service as well as what service is provided (outcomes in quality as well as activity). The obvious next steps for Commissioners are to:

- Agree and announce their response to the Francis recommendations.
- Ensure that 2013/14 contracts are 'Francis compliant'.
- Review systems and processes to identify what steps are required to implement relevant recommendations.
- Agree with the North Central and East London Commissioning Support Services areas for joint working to ensure that both the Clinical Commissioning Group and the Support Services are 'Francis compliant'.

6.2 An analysis of where NHS Commissioners should focus and benchmark their approach in moving from the Pre Francis Quality Assurance Culture to the Post Francis Culture one is outlined in the table below:

Pre Francis Culture	Post Francis Culture
Passive	Proactive - looking for signs of concern
Reliant on provider self-declarations	Independent triangulation which tests provider self-declarations
Little patient involvement	Patient experience key to quality assurance
Few effective levers to create change	A range of levers for clinical commissioning groups and NHS England to intervene and ensure improvement

6.3 For the Health and Wellbeing Board the following points could form a useful basis for discussion in working through the scale and impact of Francis's recommendations for NHS and care commissioners:

- the need to improve the understanding of both patients and the public of the role of commissioners;
- the need to demonstrate how nursing practice can be strengthened;
- the need to demonstrate close engagement with patients past, present, and potential to ensure that their expectations and concerns are addressed;
- the need to demonstrate effective complaints handling; and
- the need to demonstrate how we are strengthening information on quality and performance.

7. Implications for General Practitioners (GPs) in Barking and Dagenham

"When analysing the evidence from general practitioners, the inquiry found that local GPs only expressed substantive concern over care at the Trust following the news of the investigation. The inquiry goes on to say that this is not a direct criticism of GPs as they were not explicitly required to act in this way, although it does say that it is unfortunate that "it did not occur to any of them [GPs practicing in the local area] to report" the concerns they had at an earlier stage". Robert Francis QC

7.1 GPs are the most continuous presence in the health system over many years. They are the most important guide and advocate on a patient's journey through the healthcare system.

7.2 The MSFT saga reinforces the patient view that their GP needs to know about the strengths and weaknesses of the local hospitals, and Francis gives GPs "a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice a reality". This means every GP having a responsibility to be satisfied that each of their patients received quality care, especially the ones that die or are re-admitted.

7.3 Both Francis Reports were clear that GPs in primary care should undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services, developing an ongoing relationship and recording this through a systematic shared process. The Royal College of General Practitioners Guidance and recommendations to its members following their review of the Francis Report, highlights that:

- GPs should have a role to check on the quality of service, in particular in relation to an assessment of outcomes.
- Internal systems are needed to enable GPs to flag any patterns of concern. In some areas there are alert schemes where feedback goes from GPs to the hospital if they have any concerns.
- GPs have a responsibility to their patients to keep themselves informed of the standards of local services and service providers to inform patient choice.
- GPs have an ongoing responsibility for their patients and that responsibility does not end on referral to hospital.
- GPs should take advantage of their position as commissioners to ensure patients get safe and effective care.

7.4 NHS Barking and Dagenham Clinical Commissioning Group should progress their current work to develop and implement an early warning system that ensures that all member practices' feedback, issues and concerns are formally addressed with providers rather than each GP raising individual issues outside of a formalised early warning system.

8. Implications for Local Members of Parliament

Francis also made reference to the involvement of MPs and their roles. He recommended that MPs be asked to consider adopting a simple system to identify trends in complaints and to consider if individual complaints have wider significance.

9. Mandatory Implications

9.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall mortality analysis as well as a detailed safeguarding element within it. The Director of Public Health will include a dedicated section on hospital mortality rates within the JSNA going forward. This would be supported by greater understanding and use of measures such as Hospital Standardised Mortality Ratios as a measure of clinical quality, but also understand the caveats in their use.

9.2 Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The strategy is based on four priority themes that cover the breadth of the frameworks and in which a large number of Francis's recommendations can be picked up within. These are: Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

9.3 Integration

One of the outcomes we want to achieve for our joint Health and Wellbeing Strategy is to improve health and social care outcomes through integrated services. The Department of Health (DH) have invited health economies to bid to become "pioneers" running large scale experiments in integrated care by September 2013. This will be supported by two further initiatives published in the autumn:

- DH together with the patient group National Voices is developing a set of indicators for integration.
- DH is developing a "plan" for how "how we look after older people most in need of support from the NHS and social care".

9.4 Financial Implications

At the point of writing this report, the financial implications of the recommendations made by this report are not quantified. However any financial implications will have to be contained within council core funding or the ring fenced Public Health grant.

Implications completed by: Dawn Calvert, Group Manager Finance, LBBD

9.5 Legal Implications

This paper sets out the detail and background that led to the Public inquiry of the Mid Staffordshire NHS Foundation Trust chaired by Robert Francis QC. It made findings of serious and systematic failures on the part of the provider Trust Board. The report identified numerous warning signs which should have alerted the Trust to the serious problems that were developing in the Trust.

The report makes very many recommendations which will prevent such failures from ever happening again. In the Governments re- organisation of the NHS it established under the Health and Social Care Act 2102 health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce

health inequalities. They will have strategic influence over commissioning decisions across health, public health and social care. They took their statutory role as of April 2013. This paper makes recommendations to the Health and Wellbeing Board in direct response to the findings of the Francis Report and its implications at a local level.

Implications completed by: Shahnaz Patel, Senior Lawyer, Legal Services, LBBD

9.6 **Risk Management**
The risk is that patient care may be compromised if there is a failure to implement recommendations. The Health and Wellbeing Board needs to take a view on sensible and effective implementation to mitigate and manage risks.

10. Non-mandatory Implications

10.1 **Safeguarding**
Both Inquiries by their very nature had implications for safeguarding for both adults children. The safeguarding arrangements at MSFT failed to prevent, over a number of years, serious incidents of care failings. The Local Safeguarding Childrens Board and the Local Safeguarding Adults Board are considering the Francis recommendations and its implications for local safeguarding arrangements.

11. Background Papers Used in the Preparation of the Report:

The Mid Staffordshire NHS Foundation Trust Inquiry. Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. February 2010. Chaired by Robert Francis QC
http://www.midstaffsinquiry.com/pressrelease.html

The Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Robert Francis QC. February 2013. http://www.midstaffspublicinquiry.com/report

Patients First and Foremost. The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry. Department of Health. March 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

NHS Confederation Member Briefing. Government response to the Francis report.
http://www.nhsconfed.org/Documents/NHS%20CONFED%20BRIEFING%20GOV%20FRANCIS%20RESPONSE.pdf

Association of Directors of Adult Social Services (ADASS) Francis - Government response to be considered in relation to all health and social care services. 25th March 2013.
http://www.adass.org.uk/index.php?option=com_content&view=article&id=913&Itemid=489

Kings Fund. Francis Report Lesson learnt from Stafford.
http://www.kingsfund.org.uk/events/francis-inquiry?gclid=CI3hjdOy97YCFcXKtAod118A0w

Royal College of General Practitioners Position Statement on the Recommendations of the Mid Staffordshire NHS Foundation Trust public inquiry report.

http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z%20policy/RCGP-Response-to-Francis-Recommendations.ashx

Nursing Midwifery Council welcomes the Government's response to Francis.
http://www.nmc-uk.org/media/Latest-news/NMC-welcomes-the-Governments-response-to-Francis/

HealthWatch England. Initial response from HealthWatch England to the Francis recommendations
http://www.healthwatch.co.uk/sites/default/files/francis_position_statement_final.pdf

HealthWatch Essex. The 'Francis Report' – understanding the implications for HealthWatch Essex February 2013.
http://www.healthwatchessex.org.uk/sites/default/files/documents/Agenda%20item%206%20-%20implications%20of%20the%20Francis%20Report.pdf