Title: Reflecting on the Francis Report and the implications for Health Scrutiny

Report of the Corporate Director of Adult & Community Services

Open

For Information

Report of Scrutiny

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This Report was provided to the formal meeting of the Health and Adult Services Select Committee (HASSC) on 29 July 2013 where members discussed the report and agreed with the recommendations at section 5.1.

As the HASSC of the municipal year 2014/15 comprises new members, it was considered imperative to re-present the report to the Committee because of the important implications of the Francis Report on health scrutiny.

Members are also provided an update at section 8 on the progress made since the original report went to the HASSC on 29 July 2013.

Summary:

The Francis Inquiry into the failure in care standards at Mid-Staffordshire NHS Foundation Trust uncovered some harrowing stories of poor care, neglect and institutional failure. Whilst primary responsibility rested with the hospital, its management and staff, there were also a number of criticisms levelled at commissioners and those with a responsibility for overseeing and scrutinising the provision of healthcare in the area. This included the local councils’ health overview and scrutiny arrangements.

Robert Francis QC acknowledged that it was difficult for anyone from supervisory, regulatory or scrutiny organisations to truly understand how Mid-Staffordshire NHS Trust was failing or bring to light the negligence taking place within the hospital. However, while the Mid-Staffordshire scrutiny committees were not to blame for any of the suffering that took place at the Trust, their failure to perform their role implicates them in the scandal and reveals some universal weaknesses about the concept of health scrutiny as carried out by elected members.

This report explores the issues raised by Francis and provides an opportunity for members of the Health & Adult Services Select Committee (HASSC) to reflect for themselves on the extent to which local arrangements are robust, and that they are being operated to maximum effect. In particular, it prompts a series of questions about how well the local health scrutiny arrangements hold local NHS (and social care)
agencies to account, and shine a spotlight on poor care and institutional risk. The Francis Report and its recommendations provide an opportunity for HASSC to review its work, and make sure it is upholding local residents’ interests in the provision of health and social care services.

**Recommendation(s)**

The HASSC is asked to:

- Reflect on the findings and recommendations of the Francis Report under the headings described in this report, namely:
  - Operation of the committee, and preparedness of committee members;
  - Support to Members;
  - Relationship of Scrutiny to other accountability mechanisms;
  - Patient voice and proactive scrutiny;
- Assure itself that Scrutiny, as practiced in Barking and Dagenham, is effective and robust;
- Take necessary measures in response to Francis’ recommendations and issues arising from this report (paragraphs 5.2 to 5.6);
- Note the progress made in implementing the recommendations of Francis in Section 8 of the report.
1. **Introduction – What is the Francis Report?**

“This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.”

— Rt Hon. Jeremy Hunt MP, Secretary of State for Health

1.1. Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area. Eventually, after tireless campaigning from local people, persistent complaints from patients, and interrogation of mortality rates at the hospital, the truth of the failings at Mid-Staffordshire General Hospital NHS Trust was uncovered. Following the scandal the Government launched a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid-Staffordshire Foundation NHS Trust. The Inquiry was chaired by Robert Francis QC, the findings (generally known as the Francis Report) were published on 6 February 2013.

1.2. The Francis Report tells a story of unacceptable suffering of many patients within an organisational culture of secrecy and defensiveness. Although the public inquiry was focused on one organisation, it highlights a ‘whole system’ failure: a system which should have had checks and balances in place, and working, to ensure that patients were treated with dignity, and suffered no harm. The 1,782 page report has 290 recommendations which cut across, and have major implications for, all levels of the health service across England.

1.3. In his report, Francis calls for a whole service, patient-centred focus. It is noteworthy that the 290 recommendations do not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that the events of mid-Staffordshire do not happen again. Broadly the recommendations of Francis can be distilled into these themes:

- Emphasis on, and commitment to, common values throughout the system by all within it;
- Readily accessible fundamental standards and means of compliance;
- Zero tolerance of non-compliance and the rigorous policing of fundamental standards of care;
- Openness, transparency and candour in all the system’s business;
- Strong leadership in nursing and other professional values;
- Strong support for leadership roles;
- A level playing field for accountability;
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisations.

2. **What does the Francis Report say about Scrutiny?**

2.1. Chapter six of the Francis Report explores the reasons why more concern about the suffering of patients was not raised through patient and public involvement bodies, MPs, LINks, local media outlets and local government scrutiny. Within this chapter Francis looks in-depth at the role of Staffordshire County Council Scrutiny Committee
and Stafford Borough Council Overview and Scrutiny Committee and draws some important conclusions as to how and why they failed. The particular criticisms and observations of Francis can be summarised into the points below.

- The scrutiny committees got caught up in the Hospital Trust’s Foundation Trust application instead of keeping focus on standards of care and what was happening in the hospital itself.

- The scrutiny forum became bland and meaningless with members passively noting information and receiving reports without asking questions on the content or surrounding issues. The lack of challenge was reflected in the public records of the meetings making it difficult for scrutiny to inform decision-making processes or demonstrate to the public that scrutiny had happened at all.

- The scrutiny committees did not make use of alternative sources of information to challenge the Trust and became wholly reliant on the information supplied by the body it was scrutinising. Complaints data was not made available and nor was it asked for. The scrutiny committees showed a lack of interest in mortality data and took no steps to consider the implications of, or follow, the Health Care Commission’s investigation into the Trust.

- The scrutiny committees did not attempt to engage with or solicit the views of the public and were slow to acknowledge the campaign of Julie Bailey. When Julie Bailey attended the Committee to ask questions directly she was not permitted to speak.

- The scrutiny committees did not escalate or make submissions to any NHS body or the Secretary of State. The Borough Scrutiny Committee did not refer any matters to the County level.

- The scrutiny committees did not prioritise the issues for scrutiny and insufficient significance was given to information coming from the public. The scrutiny committees did not make a connection between the negative experiences of patients that were reported and underlying problems the Trust had in delivering safe and high quality care.

- There was a lack of clarity about roles and responsibilities (this in part relates to scrutiny in two-tier authorities) in terms of who was holding the Trust to account. This was further hazed by Councillors taking the ‘critical friend’ role too literally undermining robust scrutiny/challenge.

- Councillors lacked specific health scrutiny training and had insufficient support and resources at hand to effectively carry out their role.

2.2. Taken together the criticism and failings of the Scrutiny Committees of Staffordshire are significant and damning, opening a Pandora’s Box of issues for health scrutiny functions across the country to confront. Appendix 1 brings together relevant extracts from the Francis Report and testimony to the Inquiry to further elucidate the bullets above.

3. Specific recommendations from the Francis Report

3.1. Emerging from the criticisms and observations (described above) six recommendations are proposed by Francis to empower and strengthen Scrutiny. The implications of taking forward some of these recommendations are discussed in the commentary in section four.
<table>
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<tr>
<th>#</th>
<th>Recommendation</th>
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<tr>
<td>47</td>
<td>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.</td>
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<td>119</td>
<td>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 for patient confidentiality.</td>
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<tr>
<td>147</td>
<td>Guidance should be given to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards and local government scrutiny committees.</td>
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<td>149</td>
<td>Scrutiny Committees should be provided with appropriate support to enable them to carry out their scrutiny role including accessible guidance and benchmarks.</td>
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<td>150</td>
<td>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 inspection reports without comment or suggestions for action.</td>
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<td>246</td>
<td>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 or 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 and Local Healthwatch.</td>
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4. Exploration of the recommendations

4.1. Upon reading chapter six of the Francis Report we feel the following issues require exploration/consideration by the HASSC as part of the process of reflecting on, and responding to, the findings of Francis.

Operation of the committee, and preparedness of committee members

4.2. One of the main criticisms of Francis about the scrutiny functions of Stafford Borough and Staffordshire County Council was that the committee forums became “pleasant little talking shops” and as such did not offer challenge or pursue issues on behalf of affected residents. Moreover, the Committees did not understand their role or appreciate the responsibility on them to carry out rigorous health scrutiny.
4.3. The passivity which Francis criticises implies the need for Members to arrive at meetings prepared and well-briefed so that precious committee time is well utilised and witnesses are thoroughly interrogated. HASSC may therefore wish to consider:

- Whether briefing materials provided by officers meet their needs and that they fill any gaps in knowledge or background about the issue under scrutiny;
- Whether Members are aware of the purpose of each business item and the key issues that are to be explored at the meeting;
- Whether sufficient time is given by Members to ensuring that they have an understanding of surrounding and related issues under discussion, so that issues are scrutinised taking into account the wider health and social care context of Barking and Dagenham - and whether they are supported to do this by the briefing materials provided to them;
- Whether the Committee prepares lines of enquiry, including supplementary questions, so that questions are directly relevant, succinct, and that the committee takes a co-ordinated approach.

4.4. Further to preparation before committee meetings, Members are recommended to satisfy themselves that they are fully conversant with the legislative standing of health scrutiny, including how to use the range of powers at the disposal of local authorities, and the ways in which the authority can (through the health scrutiny function) escalate matters of concern, when required. Members’ attention is drawn to the work that was undertaken in response to Government proposals to amend the previous Department of Health guidance on health scrutiny from 2003. This, taken together with the previous experience of exercising health scrutiny powers (CQC investigation of BHRUT, IRP review of H4NEL proposals), should provide Members with confidence about their awareness of the statutory under-pinning of the HASSC.

4.5. However, Members may wish to consider whether refresher training/briefing on health scrutiny powers is required, especially in light of changes to the HASSC’s membership in recent years. Where there has been lots of structural change to the NHS it might be necessary for the HASSC to look at its place in the new system and the roles and remits of the bodies/organisations (old and new) therein.

4.6. Another criticism of Francis of the Scrutiny Committees of Staffordshire is that they got caught up in the Hospital Trust’s Foundation Trust application instead of keeping focus on standards of care and what was happening in the hospital itself. To avoid losing touch with reality work programmes should maintain balance between review work/policy development and regular more traditional Q&A style ‘holding to account’. The HASSC regularly reviews its work programme either in the committee setting or through agenda planning meetings to ensure that business is topical/relevant. Post-Francis the HASSC might wish to make its topic selection process more open to input from residents and find ways to solicit suggestions to the work programme from the public.

4.7. A key learning point from the Francis Report is that councillors must, by necessity, be reliant on a limited pool of evidence to inform their scrutiny of NHS bodies. It is essential, therefore, that the reports, presentations, and other materials being supplied to Members have the right information at the right level for lay readers to understand and work constructively with. The scrutiny process should therefore try to use a blend

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1 Overview and Scrutiny of Health: Guidance (Department of Health, July 2003)
of more anecdotal or qualitative sources of evidence alongside ‘harder-edged’ performance data, which can be difficult to analyse or relate back to the patient or service user experience of using services.

4.8. Recommendation number 119 of the Francis Report calls for Overview and Scrutiny Committees (and Local Healthwatch) to have access to detailed information about complaints. In light of this the HASSC should reflect on whether the information it is supplied with gives it a platform from which to scrutinise performance and detect problems and consider ways in which information might be presented differently to make it more user friendly and patient oriented. In this endeavour, they may well wish to call on the support of Healthwatch to gather and summarise issues of concern that are being presented to them.

Support to councillors

4.9. Despite being critical of the health scrutiny committees of Staffordshire, Francis recognises that scrutiny by local councillors is an important part of the framework of health service accountability, and he stresses that it should be resourced and valued accordingly.

4.10. Recommendation number 149 calls for Scrutiny Committees to be given the appropriate level of support to enable them to carry out their role. Reflecting on this recommendation it is suggested that Barking and Dagenham has a well-resourced Scrutiny function that draws on skills and expertise from across the directorates to increase the capacity and capability of Scrutiny (which is further boosted by the transfer of public health responsibilities to local authorities). Furthermore, the Council benefits from a having a full-time Member Development Officer to pick up on training and development needs of members, individually and collectively.

4.11. In view of this we feel that support and resource behind health scrutiny is at a high level. However, Members should be demanding of these resources, ensure that the support provided is useful, and be unafraid to ask for further support or to point out gaps in the support Members receive. While previous Annual Scrutiny Satisfaction Surveys have indicated Members are happy with the level of support they receive, officers would welcome current and specific feedback on this from the HASSC.

Relationship of Scrutiny to other accountability mechanisms

4.12. A key lesson to take from Francis is that Scrutiny cannot operate in isolation from the wider system of checks and balances. Recommendation number 147 calls for guidance about the co-operation and co-ordination between local government scrutiny committees, local Healthwatch organisations and health and wellbeing boards.

4.13. In the absence of guidance LBBD has made considerable effort to develop relationships and define roles and responsibilities. The Shadow Health and Wellbeing Board worked through scenarios and case studies to establish how various parts of the system might work together to ensure system-wide leadership and accountability.

4.14. The HASSC has received a report exploring the role and remit of Healthwatch, where this overlaps with scrutiny, and discussed how the two bodies can use those synergies for maximum impact. As Healthwatch and the Health and Wellbeing Board continue to develop within this new system, so will their understanding of each other’s roles.
4.15. Further to the findings of Francis, the HASSC might want to consider how it links up with the regulatory bodies to report concerns, or uses intelligence collected through inspections and auditing to inform local scrutiny activity. Recommendation number 47 of the Francis Report calls for CQC to expand its work with scrutiny committees and Foundation Trust Governors to collect and share information.

4.16. The HASSC does have experience of working with CQC. In 2011, following the CQC launching a full investigation into care provided by BHRUT, the HASSC formally gave evidence to the investigation sharing its concerns and the records of scrutiny meetings. The HASSC has also required representatives from BHRUT to answer on performance issues in the formal committee-setting on a number of occasions, following the publication of CQC inspection findings.

4.17. Post-Francis the HASSC may wish to further develop its relationship with CQC so that there is more regular dialogue and awareness of local inspection activity. Guidance about how CQC should work with Overview and Scrutiny Committees (OSCs) was released in 2011; it outlined an expectation that OSCs should have contact (phone, e-mail, or meeting) from CQC staff once every 3 months. This regular communication with CQC does not exist locally and is something that the HASSC might wish to address in order that it can obtain oversight of inspection activity and report concerns easily.

4.18. The CQC was heavily criticised in the Francis Report and is currently undergoing major reform to change how it inspects health and social care providers and the benchmarks of quality that it will inspect providers against. This overhaul should give the CQC a chance to re-imagine its relationship with local scrutiny committees and give fresh impetus to local CQC teams to be pro-active in nurturing such relationships. The HASSC may wish to seize the opportunity in the wake of the Francis Report to approach the local CQC team (and other regulators/scrutineers) to kick-start this process.

Patient voice and pro-active scrutiny

4.19. More than anything, the Francis report draws out the absolute necessity of using the experiences and views of local people to hold health service providers and commissioners to account. The Scrutiny Committees of Stafford Borough Council and Staffordshire County Council failed because they became reliant on what representatives from the Hospital Trust were telling them and had no other sources of evidence to inform their opinion or use to challenge the Trust.

4.20. In order to be relevant and powerful health scrutiny needs to be in touch with the latest patient views and their experiences of using services (this point is further explored in Paragraph 2.5). It is difficult to draw out the patient experience in the committee forum, even where is regular attendance by members of the public, and cover all the issues that may be topical at any given time. The health agenda is dynamic and transient and as such requires constant monitoring and input from those with a scrutiny role.

4.21. For these reasons members must engage with local people whenever they can, even if this means working outside of the formal meeting structure. By being pro-active and responsive members can ensure that the committee is on top of its brief and up-to-date on issues and developments so that in the committee setting members are

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3 A Guide for Overview and Scrutiny Committees for Health and Social Care: How your committee can work with the Care Quality Commission (September 2011)
informed and equipped to conduct meaningful scrutiny that is reflective of local concern.

4.22. Scrutiny outside of the committee-setting could take many different forms, most, if not all, of which members will be familiar with or have direct experience of. These approaches/techniques include:

- site visits;
- focus groups;
- surveys.

4.23. Following the Francis report the HASSC may wish to consider whether its programme of public engagement and activity outside of the committee-setting is enough and think of utilising a range of approaches that might make scrutiny more dynamic and centred on the experiences of service users.

4.24. One of Francis’s suggestions for OSCs to get closer to the patient experience and find alternative sources of evidence is for them to be granted the power to inspect providers of health and social care services (recommendation number 150). This recommendation is not felt to be entirely practical, since it would require very specific training for councillors and duplicate Healthwatch’s power to conduct ‘Enter and View’ inspections. Also there is a danger that inspections carried out by OSCs could give false assurances about performance to regulators.

5. Summary of recommendations

5.1. From the discussions above, the recommendations for the Health and Adult Services Select Committee to consider to take forward locally in response to the Francis Report can be summarised as the following:

- Ensure that clear information on how the committee works, responsibilities of health scrutiny and sources of information is included in the first meeting of any municipal year where membership changes;
- Request officers to review the forward plan and scrutiny project plans to ensure that the user voice is clearly incorporated. It is recommended that HASSC liaise with Healthwatch in taking this recommendation forward;
- Make contact with the local CQC Team and other regulators and scrutineers to consider how it links up with regulatory bodies to report concerns and use intelligence collected through inspections and auditing to inform local scrutiny activity;
- Reflect on the issues planned for the coming year and identify early where HASSC members may need additional background briefing or technical assistance;
- Consider, in conjunction with the Cabinet Member for Health, how information can be regularly gathered and collated from Ward Councillors regarding the views of their constituents on local health services.

6. Conclusion

6.1. Health scrutiny by elected members is a key part of public accountability of health services and is not a responsibility to be taken lightly. The Francis Report provides a unique opportunity to reflect on the effectiveness of local government health scrutiny and accountability across the health and social care system. Furthermore, the Francis
Report re-focuses members’ minds on what is at the core of health scrutiny and invites members to step back and look objectively at the effectiveness of local scrutiny arrangements.

6.2. Sadly, the events of mid-Staffordshire reveal that no matter how engaged, methodical and conscientious elected members are, inevitably some things are beyond control. A big theme that runs through the Francis Report is ‘duty of candour’ in respect of how NHS professionals were complicit in the scandal through their failure to report what was going on at Mid-Staffordshire. Successful scrutiny depends on the culture and values of those giving evidence, principally openness, transparency and honesty, without which scrutiny councillors face an uphill challenge to perform their role. However, as explored in this report, there are steps and measures members can put in place to ensure scrutiny is as robust as it can be.

7. Implications

7.1. Legal

(Implications completed by: Lucinda Bell, Adult Social Care and Education)

The Health and Social Care Select Committee operates within terms of reference described at Section F, C21 of the Council’s constitution. As such is has responsibility for scrutinising issues falling within its defined remit. The Frances report makes recommendations that include actions that can be taken by the Committee, to enhance its performance.

7.2. Finance

(Implications completed by: Carl Tomlinson, Group Manager Finance)

Paragraphs 4.9 to 4.11 of the report stress the need for health scrutiny to be given suitable levels of resource and support in order to effective. Further to the points raised in that section, the HASSC should be advised that LBBD has a dedicated Member Development budget which should be able to meet all health related scrutiny training and development needs. Members are able to make requests on this fund through the Member Development Steering Group via the Member Development Officer.

Members should also be reminded that the Scrutiny function has a small discretionary budget to meet the costs of site visits, commissioning independent research or undertaking public engagement activities. Members are free to call on this fund where its use will add value to the scrutiny process. The budget for 2013/14 is £6k and is shared across the five themed select committees; requests of the fund can be made through the Statutory Scrutiny Officer (Democratic Services).
7.3. **Risk Management**

With the well documented performance issues at Barking and Dagenham’s local Hospital Trust (BHRUT) it is important that public accountability through the HASSC is robust, rigorous and demonstrable. In response to the findings and conclusions of Francis several recommendations are offered in the report (see summary in section 5) to strengthen health scrutiny and show learning from the events of mid-Staffordshire.

8. **Summary of Progress since 29 July 2013 HASSC meeting**

8.1 The Health and Wellbeing Board at its meeting on 4 June 2013 established a Task and Finish Group Chaired by Conor Burke Accountable Officer NHS Barking and Dagenham Clinical Commissioning Group to develop a local response to the Francis Report involving all partners on behalf of the Health & Wellbeing Board.

8.2 The Group presented its final report to the Health and Wellbeing Board on 11 February 2014. The Board noted the recommendations and an action plan was developed by the task and finish group, with implementation of the actions across the Barking and Dagenham, Havering and Redbridge social care and health economy.

8.3 Partners have been working to implement the action plan over the last six months, focusing on ensuring that all local NHS Trusts are compliant with the statutory Duty of Candour requirements from October 2014 and all other Providers by April 2015.

**Duty of Candour**

8.4 Medical treatment and care is not risk free. Errors will happen and nearly half of all of these will be due to failures in organisational systems or genuine human errors. The Government expects the NHS to admit to patient safety incidents, apologise to those affected, and ensure that lessons are learnt to prevent them from being repeated. This is the Duty of Candour. There are a number of initiatives, policies and levers in place to encourage openness. Some of these include The Health Act 2009, professional codes for doctors, nurses and NHS managers, and the NHS Litigation Authority. The National Patient Safety Authority published policy guidance in 2009 called ‘Being Open’; this guidance set out the principles of communication and the processes that organisations should follow to ensure mistakes are communicated to patients, relatives and/or carers.

8.5 Since 1 April 2013 it has been a requirement under the NHS Standard Contract 2013/14, that NHS commissioned organisations ensure patients or their next of kin, if the patient has consented to them being informed or does not have capacity, are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences (2012-14 NHS Standard Contract, Technical guidance). The culture of ‘Being Open’ should be fundamental in relationships with, and between, patients and/or their carers, the public, staff and other health care organisations.

8.6 The Duty of Candour is the contractual requirement to ensure the ‘Being Open’ process is followed when a patient safety incident results in moderate or severe harm or death. The NHS standard contract outlines the framework that commissioners are expected to adhere to, to gain assurance that providers of services are compliant with the ‘Being Open’ policy and the contractual requirements of the Duty of Candour (it is
noted that further guidance may be published following the conclusions of the public consultation for introducing the Statutory Duty of Candour).

Implementation of Duty of Candour – main provider performance

8.7 **Barking Havering Redbridge University Trust (BHRUT)** – has assured commissioners that they are compliant with the Duty of Candour. The Trust has confirmed that all incidents reported on the Trust incident reporting system must be discussed with the patient or next of kin and that this is now a mandatory field so must be completed by the reporter before the incident can be notified.

8.8 **North East London Foundation Trust (NELFT)** – has confirmed to commissioners that they have had a targeted focus on raising awareness of the requirements of the Duty of Candour with both staff and the public. The Chief Nurse has communicated this to staff in a weekly newsletter, with an entire page dedicated to the new requirements. NELFT has also informed commissioners that the Duty of Candour requirement is a mandatory field on their incident reporting system and therefore must be completed before the incident can be submitted. An internal audit to assure compliance has commenced.

8.9 **Barts Health NHS Trust (BH)** – the implementation process for BH is still under development. Whilst this process is being developed the Nurse Director has been ensuring that the Duty of Candour requirement of informing the patient within 10 days of the incident occurring is being implemented on an individual patient basis for all CCG patients.

8.10 **Partnership of East London Co-operatives (PELC – 111, Out of Hours and Urgent Care Centre)** – The contractual requirements for the Duty of Candour have been communicated to PELC, and a process for implementation is under development. PELC report small numbers of serious incidents, making it straightforward to monitor each of these on an individual basis until the reporting process has been embedded.

8.11 **Independent Sector (Spire, Holly House and the North East London NHS Treatment Centre)** All three organisations rarely have serious incidents occurring on their premises; they are all aware of their contractual responsibilities and have started reporting on the Duty of Candour requirements. These organisations are compliant at the time of writing.

8.12 **Care homes with nursing** - all homes will be having a quality assurance visit during quarter 3 and 4 2014/15. During this visit the requirement to implement the Duty of Candour will be discussed and next steps agree with the provider. The arrangements to monitor compliance are still under development.

List of appendices

APPENDIX 1 Extracts from the Francis Report
Background Papers Used in the Preparation of the Report:

- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1: Analysis of evidence and lessons learned (part 1) Chapter 6, Patient and Public local Involvement and Scrutiny
- The lessons councils must learn from the Francis report (Local Government Chronicle, February 2013)
- Francis criticises council scrutiny ‘failure’ (Local Government Chronicle, February 2013)
- Francis: give councils more scrutiny power (Health Service Journal, February 2013)
- ‘Francis Inquiry is ‘wake-up call’ to refresh culture & improve patient care’ (Centre for Public Scrutiny, Press Release, February 2013)
- Spanning the System: Broader Horizons for Council Scrutiny (Centre for Public Scrutiny, March 2013)
- Minutes and agenda - Health and Wellbeing Board, 4th June 2013
- Minutes and agenda - Health and Adult Services Select Committee, 17 April 2013
- A Guide for Overview and Scrutiny Committees for Health and Social Care: How your committee can work with the Care Quality Commission (September 2011)
- Patients First and Foremost. The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (March 2013)
- Overview and Scrutiny of Health: Guidance (Department of Health, July 2003)
- Minutes and agenda - Health and Adult Services Select Committee, 29 July 2013