ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**27 February 2013**
3.	**Title:**	**The Francis Report: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009**
4.	**Directorate:**	**Public Health**

5. Summary:

The Francis Report and accompanying reports (Thomé, Alberti) are the culmination of the Inquiry into complaints of substandard care provided by Mid Staffordshire NHS Foundation Trust prompted by unusually high hospital mortality statistics.

Its recommendations and conclusions are many and far reaching, with implications for commissioners and providers far beyond those of healthcare. The report finds that the failures at the Trust were essentially failures of culture and systems and does not single out any one individual for blame.

Common themes repeated through the reports include:

- Accountability and responsibility for healthcare standards.
- Putting the patient first, ahead of all other considerations.
- Fundamental standards of staff behaviour.
- Consolidation of monitoring and regulation responsibility and compliance
- Transparency, use and sharing of information, including performance management by outcomes, not process.

6. Recommendations:

That the Health and Wellbeing Board:

- **Acknowledges the findings of the Francis Report and ensures all commissioning and provision of Healthcare in Rotherham follows the principles and recommendations laid out in the report**

- **Requests all Rotherham healthcare providers and commissioners to report back to the Board with assurances that their organisation and practices are in-line with all the Francis recommendations, and in particular in relation to safe staffing levels, and the prioritisation of patient safety ahead of financial pressure**

7. Proposals and Details

The Francis Report (the *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust*) is one of three reports into care standards at the Trust between 2005 and 2009 which also includes:

- *A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report* by Professor George Alberti.
- *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation* by Dr David Colin Thomé.

The Francis Report covers a wide range of healthcare issues and reaches many conclusions including:

- **Long-term failure** and deficiencies in staff and governance existed prior to 2005. However, the **action** taken by management to address many of the issues they identified was **ineffective**, and included long-term habituation, denial, lack of engagement and commitment, and weak leadership
- **Financial issues were prioritised** ahead of safe staffing levels
- **A confused view of responsibilities** by the Trust Board between strategic and operational issues and a disclaimer of responsibility for the latter, and that it was necessary for Directors to "roll up their sleeves and see for themselves what was actually happening"
- **Staff were disengaged** from the process of management, with a lack of support for staff through appraisal, supervision and professional development
- The Board's approach to problems such as lack of effective governance **lacked urgency** and were not comprehensive. The lack of urgency was accompanied by an absence of follow-up, review and modification
- There was a corporate **focus on process at the expense of outcomes**
- A common response to concerns has been to refer to generic data or benchmarks such as star ratings, **rather than the experiences of actual patients** and their families. The story of Stafford shows graphically and sadly that benchmarks, comparative ratings and foundation trust status do not in themselves bring to light serious and systemic failings
- The evidence before the inquiry exposed a number of **weaknesses in the concept of scrutiny and Local Involvement networks**. Local scrutiny committees and public involvement groups detected no systemic failings; neither did they appreciate the significance of any signs suggesting serious deficiencies at the Trust

The conclusions of the inquiry have led to the production of a set of recommendations, based on a number of key themes, including:

- Putting the patient first
- Fundamental standards of behaviour for all professionals
- An integrated hierarchy of standards of service
- Regulating healthcare systems governance
- Enhancement of the role of supportive agencies

- Effective complaints handling
- Commissioning for standards, Performance management and strategic oversight
- Patient, public and local scrutiny
- Medical training and an increased focus in nurse training and professional development
- Openness, transparency, candour and leadership
- Professional regulation of fitness to practise
- Improving communication and responsibility of care for the elderly
- Common information practices, shared data and electronic records

Summary of themes of the two related reports

Thomé Report:

- ***Involving patients and the public:***

- 'Real time' patient feedback.
- Holding commissioners to account for engaging patients.
- A duty to report concerns.
- Review of complaints procedures.

- ***Commissioning for outcomes supported by excellent use of appropriate data and information:***

- All organisations should ensure they are focussing on the broader picture of improving health outcomes, NOT on interim process measures.
- All concerns should be investigated.
- An increased capacity to review, interpret and use data.
- All patient safety and quality data should be publicly available

- ***Ensuring governance and clarity of accountability of all the different organisations in the system***

- Ultimate responsibility for patient safety rests with the commissioner.
- All providers must allow commissioners ready access to review their services.
- Greater co-operation between Health commissioners and Monitor including data sharing

- ***Clinical Leadership***

- Arrangements should be reviewed at Board level with separate responsibility for medical and nursing director input at board level.
- Review the role of PEC in relation to quality assurance.
- An overarching duty for clinicians to speak up for patients when they witness poor quality care.
- A greater awareness and responsibility for awareness of provider staff issues by health commissioners

Alberti Report:

- This reports conclusions relate specifically to progress of Mid Staffordshire since the healthcare commission.

For further details please see each of the background papers

8. Finance

There are no financial implications directly associated with this report.

9. Risks and Uncertainties

Failure to learn from the findings of this report and consider where all local commissioners and providers of healthcare services may need to do things differently in future could have detrimental consequences to our local services.

There is an opportunity presented by this review, to assess current practices and ensure that we are locally fit for purpose, delivering the best possible outcomes for local people and have the appropriate mechanisms in place to deal with performance and leadership issues should they arise.

10. Policy and Performance Agenda Implications

The Health and Wellbeing Board and their locally agreed strategy sets out the priorities for all health and wellbeing partners to be focusing on over the next 3 years. The performance management framework, which includes the monitoring of the national outcomes frameworks (for NHS, public health and adult social care) will form a crucial element of ensuring that we are successful locally in delivering positive outcomes for people.

11. Background Papers and Consultation:

- *The Francis Report: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. Stationary Office, London.*

- *A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report by Professor George Alberti. Stationary Office, London.*

- *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation by Dr David Colin Thomé. Stationary Office, London.*

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