Learning from Francis: Haringey CCG’s response

Summary of key findings

1.0 Timeline of the Francis inquiries and summary of the recommendations

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, Mid-Staffordshire NHS Foundation Trust. During this period of time the Trust had come under close scrutiny in relation to its application for Foundation Trust status by the Department of Health, the Strategic Health Authority, Monitor the Healthcare Commission, and the NHS Litigation Authority alongside local scrutiny groups and public involvement groups all of which had found that the Trust met the applicable standards and found no systematic failings. The truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them.

1.2 Robert Francis QC was asked to undertake a public inquiry into the failings at Mid Staffs and he published his first inquiry report into Mid-Staffordshire NHS Foundation Trust in 2010. This first inquiry followed concerns about standards of care at the Trust, and an investigation and report published by the Healthcare Commission in March 2009.

1.3 Within the final report, Robert Francis listed 18 recommendations in a number of areas. These areas included the interface between the regulation of governance, finance, and quality and safety standards; the use of commissioning to require and monitor safety and quality standards; and the means of embedding the patient voice throughout the system. Particular emphasis was placed on recruitment, training, and regulation of staff, including the senior managers of NHS organisations, and the exercise of the fitness to practice functions of professional regulatory bodies.

1.4 On the 9 June 2010 the 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 Foundation NHS Trust. This Inquiry was also chaired by Robert Francis QC.

1.5 This second and final report of the public inquiry into Mid Staffordshire NHS Foundation Trust published on the 6th of February 2013 provides detailed and systematic analysis of what contributed to the failings in care at the trust. It identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the Trust's problems for so long, even when the extent of the problems were known.

1.6 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:
It recognizes that what happened in Mid Staffs was a system failure, as well as a failure of the organisation itself. Rather than proposing a significant reorganization 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.

The report makes 290 recommendations, which focus primarily on securing a greater cohesion and culture across the system, which ‘will not be brought about by further “top down” pronouncements, but by the engagement of every single person serving patients’. However, no single recommendation should be regarded as the solution to the many concerns identified.

The National Quality Board released a draft report in May 2012, which was finalised January 2013: Quality in the new health system; maintaining and improving quality. The report focuses on how the new health system should prevent, identify and respond to serious failures in quality and provides a collective statement from the NQB members as to:

- The nature and place of quality in the new health system
- The distinct roles and responsibilities for quality in the different parts of the system
- How the different parts of the system should work together to share information and intelligence on quality to ensure an aligned and co-ordinated system wide response in the event of a quality failure
- The values and behaviours that all parts of the system will need to display in order to put the interests of the patient and public first and ahead of organizational interests

The paper also has recommendations for all boards to consider in relation to quality.

Ensuring implementation of the inquiry’s recommendations

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.

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1 The National Commissioning Board has since been renamed NHS England
3.1 Creating the right culture

The report highlights the importance of establishing a shared positive safety culture that permeates all levels of the healthcare system, which aspires to prevent harm to patients and provide where possible, excellent care and a common culture of caring, commitment and compassion.

Leaders of organisations are expected to adopt the shared culture themselves, and be seen to do so. This should be supported by measures such as open board meetings, personally listening to complaints, and an open and honest admission where there is an inability to offer a service. At a system level, this should be demonstrated by constantly considering how the wellbeing of patients is protected or improved by proposed measures.

As the NHS evolves into a network of increasingly autonomous units, the overall culture will define what the NHS means and does. However, a positive culture will not emerge through the good intentions of those working in the system. It needs to be defined, accepted by those who are to be part of it, and continually reinforced by leadership, training, personal engagement and commitment. This will be the principal means to ensure uniformity of the standard of care and treatment.

3.2 Putting the patient first

The report underlines the importance of making patients the main priority in all that the healthcare system does. Within available resources, patients must be expected to receive effective services from caring, compassionate and committed staff, working to a common culture. They must also be protected from avoidable harm and any deprivation of their basic rights.

3.3 Fundamental standards of behaviour

The report proposes that enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.

3.4 An integrated hierarchy of standards of service

The report proposes establishing an integrated hierarchy of service standards to promote the likelihood that a service will be delivered safely and effectively. Standards would range from mandatory fundamental service standards to discretionary developmental standards, with clear expectation of zero-tolerance towards any organisation providing services that do not comply with the fundamental standards. The standards should be evidence-based and measurable, and be clear about what needs to be done to comply. They should also be subject to regular review and modification.

3.5 Responsibility for, and effectiveness of, healthcare standards
The report highlights the importance of simplifying the regulation regime for NHS trusts to eradicate overlap and minimize the gaps between the functions of the different regulators. It proposes significant changes to the current division of regulatory responsibilities between Monitor and the Care Quality Commission (CQC), with the creation of a single regulator for all trusts, including foundation trusts. Monitor would retain its residual role as a regulator of the health economy. It suggests that these changes be implemented incrementally after thorough planning, and should not be used to justify reducing resources allocated to regulatory activity. It also stresses the importance of retaining the corporate memory of both organisations. Recommendations cover:

- Creating a single regulator for all trusts
- Monitoring compliance with standards
- Setting standards and developing evidence-based compliance
- Effective assessment of compliance with standards
- Effective assessment of compliance and enforcement of compliance with standards
- CQC independence, strategy and culture

4.0 Responsibility for, and effectiveness of, regulating healthcare systems governance
This area of recommendations covers the following issues:

- Consolidating Monitor's regulatory functions
- Authorisation of Foundation Trusts (FTs)
- Role of FT governors
- Accountability of directors

5.0 Commissioning for standards
The section on 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 a service as well as what it provides as a service (outcomes in quality as well as activity). This section should be an area of particular focus for Haringey CCG and contains 21 recommendations specifically for commissioning organisations - with six of these specifically around the role of commissioners in performance management and oversight of quality.

6.0 Performance management and strategic oversight
In relation to the work of the local Strategic Health Authority (SHA), Francis points to "a significant gap between the legislative and policy theory of the role...and their capacity to carry this role out." For example, he highlights concerns around the prioritization of "targets not patients" and "an over-ready acceptance of action plans" from the Mid Staffordshire board, without ensuring robust scrutiny was undertaken. The importance of communication and clear information flow from performance managers to regulators was highlighted in the recommendations in this section.
7.0 Patient, public and local scrutiny
The report concludes that the standard of representation of patient and public concerns declined since the abolition of Community Health Councils (CHCs) in 2002. It suggests that Patient and Public Involvement Forums and local involvement networks (LINKs) failed to offer a route through which patients and members of the public could link into health services and hold them properly to account. It makes several recommendations in relation to how this should be addressed moving forward into the new quality architecture.

7.1 Effective complaints handling
The report recognises that there should be a uniform process for managing complaints and that the “recommendations and standards suggested in the Patients Association’s peer review into complaints at the trust should be reviewed and implemented nationally”.

7.2 Openness, transparency and candour
The report concludes that "insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding".

8.0 Nursing
The report recognizes that, "much high-quality, committed and compassionate nursing is carried out day in and day out, often with inadequate recognition." However it states, "it is clear that the nursing issues found in Stafford are not confined to that hospital but are found throughout the country' and argues the NHS needs to give the highest priority to 'reversing the scandalous decline in standards. "The report focuses on the culture of caring requiring more focus on delivering compassionate care at the point of recruitment, in training and through annual appraisal. The report also examines and makes recommendations in relation to the role of nursing leadership and that of healthcare support workers.

9.0 Leadership
The report focuses on the leadership and development of a staff college or training system to:

- provide common professional training on leadership and management
- promote healthcare leadership and management as a profession
- administer an accreditation scheme
- promote and research best leadership practice.

A code of ethics to be produced and enforced by employers. Serious non-compliance will disqualify board directors and managers from holding such positions in the future. Regulation of managers is also to be considered after reviewing the impact of a licensing provision for managers.

Consideration to be given to regulatory oversight of the competence and compliance of appropriate standards by non-foundation trust boards of similar rigor to foundation Trusts.
10.0 **Caring for older people**
The report concludes that “the true measure of the NHS’s effectiveness in delivering hospital care can be found in how well the elderly are looked after” and makes several recommendations in relation to this area in relation to the role of the senior clinician, named nurses, the importance of team working, regular ward rounds, private areas for patients and families, appropriate discharges well planned and timed, and other recommendations.

11.0 **Information**
The report is clear about the positive role that information can play, encompassing issues such as: highlighting inadequate performance; accountability; informing the public; and supporting patient choice. Francis advocates an integrated system with common information practices, while acknowledging that the Government's information strategy "appears to contain most if not all" of his suggested elements.

12.0 **Medical training and education and professional regulation of fitness to practice**
A brief summary of the workforce-related recommendations, including those relating to medical training and education and professional regulation of fitness to practice, can be found on the NHS Employers website.

13.0 **Enhancement of the role of supportive agencies**

*National Patient Safety Agency (NPSA)*

The resources of the NPSA need to be well protected and defined. The report recommends that consideration should be given to transferring the resource provided by the National Reporting and Learning system from the NHS Commissioning Board to a semi-independent system regulator.

The CQC should be enabled to exploit the potential of the safety information obtained by the NPSA or its successor to assist it in identifying areas for focusing attention. There needs to be a better dialogue between the two organisations concerning how they can assist each other.

*Health Protection Agency (HPA)*
The report concludes that more robust arrangements for sharing infection control concerns with regulators and performance managers are needed. It calls on the HPA and its successor to work with the Health and Social Care Information Centre to coordinate the collection, analysis and publication of provider data, relating to healthcare associated infections.

Where HPA or its successor is concerned that a provider is not adequately managing healthcare associated infections to protect the public and patients, they should immediately inform commissioners, the CQC and, where relevant, Monitor of their concerns.

14.0 **Coroners and inquests**
Terms of registration/authorization should oblige healthcare providers to provide all relevant information to enable the coroner to perform his
function.

15.0 **Department of Health leadership**

The report argues that the DH lacks a sufficient unifying theme and direction with regard to patients' safety. It also says that the DH has struggled to get the balance right between "light touch" regulation and the need to protect service users from harm.

In addition, the report argues that while the DH asserted the importance of quality of care and patient safety, it failed to recognise that the structural reorganisations have on occasion made such a focus very difficult in practice, it also found that at times DH officials were too far removed from the reality of the service they oversee.

The report sets out recommendations to address these issues.