Health Overview and Scrutiny
Meeting to be held on 10 June 2014

Electoral Division affected: All

Update on Lancashire County Council Response to the Francis Inquiry

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Executive Summary

Sir Robert Francis was commissioned in July 2009, to chair a non-statutory inquiry into the happenings at mid Staffordshire. A recommendation was made that there needed to be an investigation into the wider system to consider why issues had not been detected earlier and to ensure that the necessary lessons were learned. The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry made 290 recommendations, grouped into themes. It is recommended that all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations and decide how to apply them to their own work. Further sharing of information across Lancashire County Council is continuing to identify all the relevant work areas, and to consider if there are any further significant actions or opportunities to improve our work.

Recommendation

The Committee is asked to note and comment on the work undertaken so far.

Background and Advice

Sir Robert Francis was commissioned in July 2009, to chair a non-statutory inquiry into the happenings at mid Staffordshire. The primary purpose of this being to give a voice to those who had suffered and to consider what had gone wrong. This initial report was published in February 2010**.**

Conclusions of the report included:

- Lack of basic care
- A culture not conducive to providing good care
- Management thinking was dominated by financial pressures and achieving Foundation Trust Status
- Management failure to remedy deficiencies in staff and governance
- Lack of urgency in response to problems
- Focus on systems not outcomes
- Lack of internal and external transparency

A key issue raised was the role played by external organisations which had oversight of the trust.

A recommendation was made that there needed to be an investigation into the wider system to consider why issues had not been detected earlier and to ensure that the necessary lessons were learned. As such, it was decided that a further inquiry should be held under the inquiries act 2005. This would be required to build on the work and conclusions of the first inquiry.

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (http://www.midstaffspublicinquiry.com/report) made 290 recommendations, grouped into themes. Where possible, recommendations identify the organisation it is suggested should take them forward. It is recommended that all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations and decide how to apply them to their own work.

The Government's initial response, *Patients First and Foremost* (https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report) set out an initial overarching response on behalf of the health and care system as a whole, to the Mid Staffordshire NHS Foundation Trust Public Inquiry. It set out plans to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. *Hard truths – the journey to putting patients first, the government response to the Mid Staffordshire NHS Foundation Trust public Inquiry (https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response)* builds on this to provide a detailed response to the 290 recommendations the Inquiry made across every level of the system.

Consultations

In order to ascertain the extent to which the recommendations in the Francis report apply to LCC, a workshop was held which representatives from the Directorates for Adult Services, Health and Wellbeing, and Children and Young People and Democratic Services attended. The participants identified current implications and challenges, where we want to get to, and opportunities to take action.

Work areas identified as having direct implementations to the Francis recommendations included: Commissioning for standards, Workforce, Safeguarding, Overview and Scrutiny and Duty of Candour.

From initial conversations we know that work relevant to these topics is contained within existing work streams across the council, for example all public health commissioned services will be subject to review, redesign and re-procurement – in line with the integrated health and wellbeing framework plans and within the principles of the Social Value Act.

In order to embed the work in a sustainable way we are identifying existing work streams and reporting mechanisms, rather than duplicate with a separate programme of work.

Further sharing of information across LCC is continuing to identify all the relevant work areas, and to consider if there are any further significant actions or opportunities to improve our work.

Implications:

This item has the following implications, as indicated:

Commissioning for standards - LCC has extensive commissioning responsibilities within the health and care system. The Francis report put increased emphasis on the responsibilities of commissioners to secure high standards and safe care.

The Care Bill received Royal Assent on 14 May and has now been passed into law as the Care Act 2014 (the Act). The Act introduces major reforms to the legal framework for adult social care, to the funding system and to the duties of local authorities and rights of those in need of social care. Part of the act includes care standards, providing the Government's legislative response to the Francis Inquiry, within this section:

- It provides for an extended 'failure regime' for NHS healthcare providers
- It introduces Ofsted-style ratings for hospitals and care homes, empowering the new Chief Inspector of Hospitals at the (CQC) to identify problems with care quality and then take action
- It makes it a criminal offence for care providers to give false and misleading information about their performance.

Workforce – consideration needs to be given to how we maintain a values driven culture with opportunity for development in the current financial climate. There is a need to share resources and training across the health and social care system.

Openness and transparency - A structure needs to be established to report and investigate incidents/quality or safety concerns.

Our key actions so far:

1. Advising the NHS on quality and safety issues – particularly on infection prevention and control advice to the CCGs. We are also a member of the Quality Surveillance Group, hosted by NHS England Lancashire Area team. We will also be recruiting to a senior role to lead on quality and safety across the health and care system in Lancashire.

2. We are also responsible, through the functions of the Director of Public Health, for providing oversight and assurance of the quality of screening, vaccination and immunisation programmes in Lancashire.

3. Strengthening our procurement and contract management capacity to incorporate commissioning standards and to monitor quality and safety of services commissioned by us.

4. Our Adult Safeguarding Board receives progress updates on Francis report recommendations.

5. We have recently adopted a serious untoward incident policy and are working in partnership with our providers on key improvement areas.

6. We are also working with organisations like Advancing Quality Alliance in the North West to develop our workforce capability in quality improvement.

Risk management

There are no risk management implications arising from this report which is for information.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
N/A		

Reason for inclusion in Part II, if appropriate

N/A