Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 3 July 2013

Subject: The 'Francis' Report

Report of: Dr Martin Whiting, Chief Clinical Officer, North Manchester Clinical Commissioning Group

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Summary

This report provides a summary of the recommendations from the Francis report, and outlines how Manchester's health scrutiny committee will monitor the responses from NHS organisations in Manchester.

Recommendations

1. The Board is asked to:
   - Note the report
   - Note that external scrutiny of NHS organisations' responses to the Francis Report will occur at Manchester's Health Scrutiny Committee

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Board Priority(s) Addressed:

All

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Background documents (available for public inspection):

None
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The 'Francis' report

1. Introduction:

1.1 Between 2005 and 2008 conditions of appalling care were apparent in the main hospital serving the people of Stafford and its surrounding area- Mid Staffordshire NHS Foundation Trust. In 2008 the Healthcare Commission (HCC) began an investigation into unusually high mortality rates at the Trust. This was published in March 2009.

1.2 In July 2009 the first independent inquiry into the failings of care at Mid Staffordshire NHS Foundation Trust was announced. The chair of this inquiry was Robert Francis QC and the report was published in February 2010. The first report contained 18 recommendations. Recommendation 16 stated:

"The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified."

1.3 This report and all recommendations were fully accepted by the Trust and the Department of Health and it was announced on the 9th June 2009 that in line with recommendation 16 a full public inquiry into the failings of Mid Staffordshire NHS Foundation Trust would be held.

1.4 The report of this second independent inquiry, held in public and chaired by Robert Francis QC, was published in February 2013 and contained 290 recommendations. This is colloquially known as the 'Francis Report'. The government's response was published in March 2013.

1.5 This report summarises the findings of this second inquiry, gives an overview of how local NHS organisations are responding to it and explains how these actions will be monitored and scrutinised going forward.

2. The second inquiry:

2.1 In line with the findings from the 2010 Francis Report, the second inquiry focussed on the commissioning, supervisory and regulatory organisations, and other agencies with a responsibility over the care in Mid Staffordshire NHS Foundation Trust. It built on the findings of the previous reports setting out a detailed & systematic analysis of what contributed to the failings and identified how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the trust's problems even when the problems were known. The implications were in the main for commissioning organisations, Care Quality Commission, Monitor, Nursing and Midwifery Council, General Medical Council, and the Department of Health. The report itself runs to 1781 pages with an executive summary of 125 pages and had 290 recommendations

3. Recommendations:

3.1 The recommendations' themes are as follows:

- The patient must come first. The NHS needs to work with patients and understand the patient experience and build it into everything - from both a commissioner and provider perspective.
- Strong leadership and a culture. A culture of quality improvement is required- for the patients, but also to support staff. This must come from the top.
- Clear standards for quality and quality data metrics are required along with an early warning system for quality
- The NHS must be candid and transparent in everything they do
- Staff should be supported, and have the right training, to be able to give the best care in the best place at the right time. The environment they work in must be safe and one where they can raise concerns without fear.
- To improve quality, the NHS must work collaboratively with all key stakeholders.

4. Local work

4.1 Whilst this inquiry only reported in February of this year, commissioners and providers in Manchester have been working together for a number of years now to improve the quality of services in the city. Together there is a shared accountability and responsibility for the care delivered in the city. Much of this work is in evidence in the Quality Accounts which NHS Trusts produce each year.

4.2 Specifically in response to this inquiry, organisational and collaborative action plans are being developed across the city. These are based on a gap analysis of existing work in comparison to the 290 recommendations in Robert Francis' report. In addition, Greater Manchester, and Manchester-specific, Quality Surveillance Groups have been established which will monitor key quality indicators, and early warning signs, enabling immediate action if any problems are identified.

5. Monitoring progress

5.1 Each NHS Trust and CCG will be taking their 'Francis action plans' through their own organisation governance structures over the next 3 months. It will then be the responsibility of the individual organisations' Boards and key committees to monitor implementation of these plans.

5.2 In May 2013, the Clinical Commissioning Groups and Hospital Trusts in the city gave a presentation to Manchester City Council's Health Overview and Scrutiny Committee (OSC) where they summarised their response to the second Francis Inquiry. It was agreed that they would be invited back later in 2013, when their plans were finalised, to provide further detail and to allow the committee to scrutinise and discuss their work. In addition, the Health OSC consider and comment on the NHS Trusts' Quality Accounts each year.

Recommendation

The Board are asked to:

- Note the report
- Note that external scrutiny of NHS organisations' responses to the Francis Report will occur at Manchester's Health Overview and Scrutiny Committee