TO: THE EXECUTIVE
11 MARCH 2014

OVERVIEW AND SCRUTINY REPORT ON "APPLYING THE LESSONS OF THE FRANCIS REPORT TO HEALTH OVERVIEW AND SCRUTINY"
Director of Adult Social Care and Health and Housing

1 PURPOSE OF REPORT

1.1 To determine the Executive's response to the recommendations in the report by the Health Overview and Scrutiny Panel's Working Group on "Applying the Lessons of The Francis Report to Health Overview and Scrutiny". This is attached as Annex A to this report.

1.2 The review undertaken by the Panel has been wide ranging and although there is only one direct recommendation for the Executive, there are a number of recommendations for other organisations and the way members of the Panel organise their workload.

2 RECOMMENDATIONS

That the Executive:-

2.1 accepts the following recommendation of the Working Group on "Applying the Lessons of The Francis Report to Health Overview and Scrutiny":-

The Executive Member for Adult Services, Health and Housing should carry out a stock take of all the Council's external positions on NHS bodies, and works with Members to ensure that all suitable opportunities are taken up.

2.2 supports the recommendations set out in the report for other organisations and the way the Panel works within available resources.

3 REASONS FOR RECOMMENDATIONS

3.1 The Overview and Scrutiny Working Group has spent considerable time on the review and the Executive recognises the change being proposed in respect of the way Panel members undertake their role in this complex area.

4 ALTERNATIVE OPTIONS CONSIDERED

Not applicable

5 SUPPORTING INFORMATION

5.1 On 9 June 2010 the Secretary of State for Health announced 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 established under the Inquiries Act 2005 and was chaired by Robert Francis QC.

5.2 The Francis inquiry* followed a series of investigations and reports, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis QC.

5.3 The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on Wednesday 6 February 2013. The number of excess deaths between 2005 and 2008 at Stafford Hospital was estimated at 492 people. Examples of poor care include patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

5.4 The Francis Inquiry report recommended that a fundamental change in culture was required which put patients and their safety first. Mr Francis made 290 recommendations, framed around:-

- A structure of fundamental standards and measures of compliance
- A requirement for openness, transparency and candour
- Improved support for compassionate, caring and committed nursing
- Stronger, patient centred healthcare leadership, with increased accountability
- Accurate, useful and relevant information to allow effective comparison of performance by patients and the public.

5.5 The Francis Inquiry attributed accountability for the appalling care at Stafford Hospital to the Trust Board, but also pointed to a systemic failure by a range of national and local organisations – including the Health Overview and Scrutiny Committees of both the County and District councils concerned - to respond to concerns. The report indicated that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS. On O&S specifically, Mr Francis said, *'The Overview and Scrutiny Committees in Stafford were happy to take on a role scrutinising health services but did not equate this with responsibility for identifying and acting on matters of concern; and they lacked expert advice and training, clarity about their responsibility, patient voice involvement, and offered ineffective challenge.'*

5.6 <u>Recommendation to the Council's Executive Member</u>

5.6.1 The Executive Member will as recommended undertake a review of the Council's external positions. Of course, there may well be Councillors who are on various boards due to their own personal interest.

5.6.2 This is agreed.

5.7 <u>Other Recommendations</u>

5.7.1 There are a considerable number of recommendations which have emerged as a consequence of this review. Those pertaining to other organisations reflect good practice and it is hoped that a positive result will be forthcoming.

5.7.2 The Executive would support any reprioritisation of the Overview and Scrutiny Commission work necessary to enable the recommendations to be addressed within existing resources.

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* All documentation relating to the Francis Inquiry can be found at http://www.midstaffspublicinquiry.com/

5.7.3 Finally, the most challenging recommendations are to the Health Overview and Scrutiny Panel themselves. It is to be commended that in the course of undertaking this work, the Working Group focussed 'inwards' on the way they have done business in the past. This reflection has resulted in what the Panel believes will be more effective scrutiny. It will require commitment from all Panel members to make it work.

5.7.4 The Adult Social Care, Health and Housing department will support this new way of working and establish key officers across the department to link in with the Health Overview and Scrutiny Panel.

5.8 The recommendations for the Health Overview & Scrutiny Panel are not a matter for Executive determination but for the Panel when put alongside other potential priorities at that time. The Executive is content for that to be the case.

5.9 The Executive Member would like to thank the Lead Member, Councillor Mrs McCracken and the Working Group on a thorough piece of work looking at the impact and context of the department's work in Applying the Lessons of the Francis Report.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal issues are addressed within the main body of the report.

Borough Treasurer

6.2 The Borough Treasurer is satisfied that there are no financial implications arising directly out of this report.

Equalities Impact Assessment

6.3 N/A

Strategic Risk Management Issues

6.4 N/A

7 CONSULTATION

Principal Groups Consulted

7.1 None

Method of Consultation

7.2 None

Representations Received

7.3 None

Background Papers

Applying the Lessons of The Francis Report to Health Overview and Scrutiny by a Working Group of the Heatlh Overview and Scrutiny Panel

Contact for further information

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