Healthwatch Leicestershire, Leicester and Rutland (LLR) respond to the Government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry: Francis report

Context

The final report of the Mid Staffordshire NHS Foundation Trust (Francis[1] report) Public Inquiry was published on Wednesday 6 February 2013. The release of the report which investigated the failings into Mid Staffordshire NHS Foundation Trust; sparked an array of responses and recommendations to change the culture of the NHS and health care on a national scale. Trusts across the country pledged to put patient care at the heart of the NHS and care homes were encouraged to deliver basic standards and values such as dignity and respect.

The inquiry evidenced a whole system failure, a system that should have had rigorous processes and procedures in place, however on close inspection proved to be part of the problem.

Background

'Patients First and Foremost'[2] was the Governments initial response to Francis, which set out a clear plan to prioritise care and improve transparency as well as clear lines of accountability. The Government later commissioned six independent reviews in order to better respond to the key issues identified by the Francis Inquiry. This response encompasses all the findings and lessons learnt from those reports. The following lists the reports;

1. Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England.
2. The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish.
3. A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Professor Don Berwick.
4. A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart.
5. Challenging Bureaucracy, led by the NHS Confederation.
6. The report by the Children and Young People's Health Outcomes Forum, co-chaired by Professor Ian Lewis and Christine Lenehan.

Robert Francis said, "The system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital".

---

[1] The Mid Staffordshire NHS Foundation Trust Public Inquiry

[2] The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry

Healthwatch Leicestershire, Leicester and Rutland (LLR) initial response

The recommendations from the Government report divides into five main areas, some of which would require new laws. These are.

- Compassion and care
- Values standards
- Openness and transparency
- Leadership
- Information

The Government response to the recommendations from the Francis report should signify a point of instant accountability and effective action towards any future incidents of care. Internally and externally, everyone that is involved in the health care system must feel that this response means a change in culture and that the failings that had previously been so publically highlighted will not be tolerated at any point in the future.

Compassion and care

Compassion within care can only come from a shift to patient centred care and to many who receive care, this empathy and understanding is the first step to better care. Healthwatch LLR welcomes the new care certificate that will be put in place to ensure that healthcare assistants and social care support workers have the right fundamental training and skills; and evidence for the training for both band 2 and band 3 Health care assistants and support workers must be available for verification.

However for the patient to notice a marked difference this training must include an element to ensure that concerns about care raised through feedback, PALS, patient complaints and quality inspections are welcomed and acted on.

The government has asked the National Institute for Health and Care Excellence, the official advisory body for the Health Service, to look at how safe staffing should be measured and what level of staffing needs to be in place in hospitals, clinics, District nurses, Health Visitor and allied professional community staff. Healthwatch LLR would like to stress that the fundamental issue is to ensure that the staff in place deliver the standard of care according to patient need. This is best supported through systems in place to monitor consistency, accuracy and rigor towards the physical aspects of care and the patient's emotional wellbeing.

Values and standards

Care standards must be determined by patient need; it is paramount that staff and patient's are aware of these standards. When standards have not been met there must be effective and timely actions implemented.

Healthwatch LLR approve of the new " Intelligent monitoring " system introduced by the Chief Inspector of Hospitals. We believe that, in addition to standards, peer review is also a powerful motivator.

Openness and transparency

In order for the culture of the NHS to change it is important to recognise that openness and transparency will allow for lessons to be learnt and provide an opportunity for staff and patients to impact improvements. To restore any trust from the general public there must be honesty at all levels of the care system.

Healthwatch LLR welcomes the Government response that asks hospitals to clearly set out how patients and their families can raise concerns or complaints, with independent support available from NHS complaints advocacy services, Healthwatch or alternative organisations.

In addition to this the Government asks that lessons be learnt from complaints, which is a request that Healthwatch LLR will continue to champion.

Patients and members of the public have informed Healthwatch LLR that there is a link between the patients feeling a lack of confidence towards the complaints procedure and lessons learnt i.e. finding routes to complain hard to access and genuine outcomes invisible. Healthwatch LLR has recently been in conversation with the University Hospitals of Leicester (UHL) discussing the agenda of complaints. Healthwatch LLR will be seeking to work in partnership with UHL to improve the patient experience in response to 'A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture' [3] (Clwyd Hart review) and the Government response.

Healthwatch LLR is concerned that the Government does not accept the Francis recommendation that when funding local Healthwatch, local authorities should be required to pass over centrally provided funds on to local Healthwatch. While the Government believes that local authorities are best placed to make decisions about funding services that meet the needs of their local communities Healthwatch LLR considers that this will lead to inconsistent Local Healthwatch services and weaken the strength of these consumer champions.

Lord Harris of Haringey on the 5th November 2013 asked Her Majesty's Government what assessment they have made of the number of local Healthwatch bodies whose budgets are less than the amount that has been allocated to the relevant local authorities for that purpose.

All local Healthwatch organisations will be required to set out the amount of funding it receives in its annual report. Healthwatch England will then work with the government to see what further steps can be taken and must continue to advocate on behalf of local Healthwatch's.

Healthwatch LLR supports the comments of Healthwatch England regarding the code of candour:

"Whilst we recognise that many professional codes of practice across health and social care contain specific mentions of candour and openness we are concerned that these did not act as sufficient safeguards in the past. As such, we believe the duty must also apply to individuals, to mark out those who wilfully cover up incidents, do not provide honest accounts or obstruct others from being candid

[3] A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture

themselves… Applying it to only the most serious of cases would mean significant incidents could still be covered up resulting in the tragic failings we read about in the reports of Sir Robert Francis QC, Sir Bruce Keogh, Professor Don Berwick, Rt. Hon. Anne Clwyd MP and Professor Tricia Hart".

Leadership

The drive for change and staff empowerment must come from strong leadership. Development of a leadership programme to recruit clinicians and external talent and minimising bureaucratic burdens on trusts by the signing of protocols is welcome to support the change process.

However, this portion of the response lacks any real weight behind how the changes will deliver better and more consistent leadership. A recent survey by the Care Quality Commission[4] found that a third of NHS staff that took part in the survey said communication between senior managers and staff was not effective. Good internal communications between staff and management plays a key role in filtering down the messages and the change needed within the area of leadership.

Information

The Francis report identified the poor communication of information not only concerning the patient and stakeholders but also within the health care system itself. This has in the past contributed to a sub standard process for those in care.

Healthwatch LLR welcomes the forthcoming dedicated hospital safety website for the public and would ask that all efforts be made to make this website user friendly. A positive change is that hospitals in England are to be made to publish monthly details of whether they have staffing required to manage their wards.

The question of access to information in all forms for all users is still a matter that is often forgotten. For example, easy read versions of documents.

Experiences in LLR

Recent consultation with Leicester, Leicestershire and Rutland residents has echoed the continued concern of bureaucracy and 'tick box' exercises that do not match patient need being the top priority. The Berwick[5] report recommended that use of quantitative targets should be done with caution and that such goals do have an important role en route to progress, but should never displace the primary goal of better care.

The consultation also highlighted themes that were consistent across Leicester, Leicestershire and Rutland in particular patients knowing the options available to them regarding health and social care service provision and knowing what is going to happen to themselves and their families. Residents found difficulty in negotiating the processes of health and social care bureaucracy was also an issue, in terms of accessibility for bookings, transparency of costs and the difficulty of not having a

[4] State of Care 2012/13 – Care Quality Commission

[5] Improving the Safety of Patients in England, Don Berwick

central contact 'point' for their care; For example, lots of different treatments with a lack of coordination or one point of access.

A number of local residents raised issues in relation to GPs, including the length of waiting times at GP surgeries, length of appointments and corresponding problems of delays caused by overrunning appointments, and booking arrangements. Additionally some respondents noted that there were no emergency appointments available at their GP, and that at some surgeries there could be a 1-2 week wait to see a named doctor.

Issues were raised in relation to improving information for patients including signposting to the right services, access to local information points and better information provided in GP surgeries and in hospitals.

When a discussion was had about actually putting patients first, a number of comments made reflected concerns about the need for a more holistic approach to health and social care needs. For example the transfer or transition between GP services, health and social care and a perceived missing link between adult and children's health services and social care.

Information collated from people who attended Healthwatch LLR Public Meetings and the engagement sessions undertaken with local community networks, including seldom heard residents; found common issues emerging around the discharge process of hospitals and the lack of communication between hospital staff and community health care. In some cases patients had waited up to eight hours for transport after discharge.

Healthwatch LLR commits to championing consumer interest and best practice for the benefit of local residents in matters of health and social care.