Borders NHS Board

QUALITY AND GOVERNANCE IN SCOTLAND

Aim

To advise the Board of several issues raised by the Cabinet Secretary at a meeting with NHS Chairs held on 11 March 2013.

Francis Report

The quality and governance implications of the Francis Report was considered in relation to the attached paper with Chairs invited to debate how questions raised might inform and strengthen the approach to quality and governance in Scotland (Attachment 1).

Francis stresses the need for cultural change and says the Mid-Staffs enquiry demonstrated a system where “corporate self interest and cost control were put ahead of quality and patient safety and where mechanisms which might have challenged and corrected this failure proved to be ineffective.”

Whilst the Scottish approach to healthcare is very different to that in England, as the attached report notes, “there is no place for complacency or assumptions about the Scottish system.”

Scottish Government is considering what actions are needed to respond to the Francis recommendations.

Derek Feeley has made clear the expectation that Boards should consider the implications of the report for their organisations and the Cabinet Secretary asked Chairs to ensure Boards considered specifically the questions in the concluding paragraph of the attached report prepared by the Quality Unit.

The Board should determine and set in train a programme to review the implications of the Francis Report for NHS Borders in particular around quality and governance, including the role of the Board, taking account in due course of Scottish Government guidance and directives and relevant aspects of the Westminster government response.

Unscheduled Care

The recently announced £50m improvement plan for unscheduled care planning to assist Boards in delivering the 4 hour emergency department waiting time target was referred to by the Cabinet Secretary. There was now no excuse for failing to meet this target; no excuse for adverse publicity around patients waiting on trolleys.

Patient Opinion Website

A website which allows patients to rate NHS care was demonstrated at the meeting prior to the announcement of the roll-out across NHS Boards on 19th March. Derek Feeley`s subsequent letter explains the initiative.

National Confidential Alert Line

Cabinet Secretary referred to the award to Public Concern at Work of the contract for the national confidential alert line for "NHS Scotland employees". The service becomes available on 2nd April. The functioning and purpose of the service is outlined in the attached correspondence (Attachement 2).

Recommendation

The Board is asked to **note** the update.

Policy/Strategy Implications	N/A
Consultation	N/A
Consultation with Professional Committees	N/A
Risk Assessment	N/A
Compliance with Board Policy requirements on Equality and Diversity	N/A
Resource/Staffing Implications	N/A

Approved by

Name	Designation	Name	Designation
John Raine	Chairman		

Author(s)

Name	Designation	Name	Designation
John Raine	Chairman		

Paper no: NHSCH/12/13/11 **Meeting date: 11 March 2013** **Agenda item: 6**

Purpose: **FOR INFORMATION**

Title:	**Quality and Governance Implications of the Francis Report**

Key Issues:	The Francis Report was published on 6 February 2013. The report outlines the "serious failings" that resulted in up to 1200 deaths at Mid Staffordshire NHS Foundation Trust between 2005 and 2008; examines the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital during this period; considers why the serious problems at the Trust were not identified and acted on sooner; and identifies important lessons to be learnt for the future of patient care. The report makes 290 recommendations. Parts of the report concern issues which will need to be addressed on a UK basis (such as professional regulation) and many of the report's recommendations do not apply directly to Scotland. However, the report does provide an important opportunity to reflect upon the Scottish model of healthcare and consider if current mechanisms are sufficiently robust to meet the challenges highlighted by Francis. The Quality Strategy (May 2010) continues to underpin the Scottish approach to healthcare. This foundation has been built upon, for example the Governance for Quality Healthcare in Scotland paper discussed at the previous meeting.

Action Required:	The Chairsare invited to discuss howthe questions raised by the Francis Report might be used to inform and strengthen our approach to quality and governance in Scotland in order to ensure and assure that all patients receive a safe, effective, compassionate and person centred service.

Author: David Cline **Date: 06 March 2013**	**Director: Jason Leitch** **Date: 06March 2013**

Quality and Governance Implications of the Francis Report

1. The Francis Report was published on 6 February 2013. The Report:
   - outlines the "serious failings" that resulted in up to 1,200 deaths at Mid Staffordshire NHS Foundation Trust between 2005 and 2008
   - examines the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital during this period
   - considers why the serious problems at the Trust were not identified and acted on sooner
   - identifies important lessons to be learnt for the future of patient care.

2. The criticisms detailed within the Francis Report are spread broadly amongst the responsible agencies, however it makes clear that while the Board of Mid Staffs Foundation Trust must accept a share of the blame, "the system as a whole failed in its most essential duty". Warning signs were not acted on even though they were present as early as 2007, the time when the Board chose to apply for Foundation Trust status process itself should have been a rigorous process and yet quality of patient care did not seem to be a factor. This, the second Francis Report focuses primarily on asking why the failings in care were undetected for so long, and Francis identifies a number of partners and agencies that could have raised or acted on concerns but failed to do so. Nonetheless he attaches primary responsibility to Mid Staffordshire NHS Trust.

Francis Report Recommendations

3. Francis makes a number of recommendations, with specific relevance to the English NHS system, such as improvement of the foundation trust process and specific structural changes to the English regulatory landscape. He also recommends changes to areas of reserved power, such as professional regulation and the Health and Safety Executive which will affect Scotland. Francis himself summarised his 290 recommendations under the following themes.

Fundamental standards of patient care: Francis recommends fostering a common culture, underpinned by integrated standards understood by all staff and patients in order to put patients first. He makes recommendations to ensure these standards are professionally endorsed, rigorously enforced and effectively policed by regulators.

Culture of openness and honesty, backed by law: Francis makes recommendations to ensure openness, transparency and candour throughout the system, to ensure safety and care concerns are brought to light, to this end he recommends a statutory, contractual duty of candour, and proposes that attempts to prevent this are criminalised.

Support for compassionate nursing and care: Francis recommends accountability for all who provide care, and that the quality of care is improved through changes to recruitment, training, education and support. He focuses on Nurses, but also recommends similar improvements to other medical professionals and healthcare support workers. He recommends revalidation for nurses, greater ward time for managers and a named key nurse for each patient top ensure continuity of care. He also recommends greater regulation of healthcare support workers.

Better leadership: Despite not recommending individuals be held to account for the failings at Mid-Staffordshire Francis does recommend changes to enhance the accountability of senior managers, whether through regulation or a contractual code of conduct with penalties for non-compliance.

Collection and use of accurate, relevant data, including inspection, monitoring and escalation: Francis identifies many forms of data or intelligence, and recommends enhanced systems for sharing and using this data to identify problems and support improvement.

4. Francis argues against further radical reorganisation in England and instead stresses the need for cultural change. He identifies a number of negative aspects of the culture and sets out the changes required; (see table below).

Negative aspects of culture in the system	Cultural change required
• A lack of openness to criticism • A lack of consideration for patients • Defensiveness • Looking inwards not outwards • Secrecy • Misplaced assumptions about the judgements and actions of others • An acceptance of poor standards • A failure to put the patient first in everything that is done	• Emphasis on and commitment to common values throughout the system by all within it • Readily accessible fundamental standards and means of compliance • No tolerance of non-compliance and the rigorous policing of fundamental standards • Openness, transparency and candour in all the system's business • Strong leadership in nursing and other professional values • Strong support for leadership roles • A level playing field for accountability; • Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.

Next Steps

5. The Scottish approach to healthcare is very different to that in England, not least the size and organisational structure of NHSScotland which allows for a more collaborative approach and a much shorter distance between Government and Ministers and the frontline of care. Nevertheless, the complexity of consistently delivering high quality health and social care means that there is no place for complacency or assumptions about the Scottish system.

6. Work is continuing within Scottish Government to consider what actions need to be taken to address the questions raised by the Report's recommendations. On 11 February Derek Feeley circulated a letter to all NHS Board Chief Executives to highlight the expectation that Boards would consider the implications of the Francis Report for their organisation. The Report was raised at the NHS Chairs meetings on 18 February and 6 March and was discussed at the HR Directors meeting on 1 March. The report is also on the agendas of the Scottish Partnership Forum (SPF) Secretariat meeting on 2 April and the full SPF on 7 June.

7. The inquiry into events at Mid-Staffs demonstrated, at heart, a system where corporate self-interest and cost control were put ahead of quality and patient safety and where mechanisms which might have challenged and corrected this failure proved to be ineffective. Whilst there is ongoing detailed consideration of the Francis Report findings and recommendations and work being taken forward to strengthen, or perhaps refresh, specific policies and programmes in Scotland, NHS Boards should each consider:

- What is the Board doing to promote a culture which supports the delivery of safe, effective, compassionate and person centred care and ensures openness, transparency and candour?

- How doesthe Board measure and monitor the safety and quality (including care and compassion) of the services it provides?

- How can the Board demonstrate that it acts upon information suggesting that care has fallen below standard in an area?

- What changes or support would you wish to see put in place at national level to help deliver this agenda?

The Quality Unit
06 March 2013

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The Scottish Government
Riaghaltas na h-Alba

LEGACY 2014
XX COMMONWEALTH GAMES
SCOTLAND

Chief Executives,
HR Directors,
Employee Directors,
NHSScotland Health Boards and Special Health Boards

Copy to: Chairs
Directors of Communication

15 March 2013

Dear Colleague

NATIONAL CONFIDENTIAL ALERT LINE

The Cabinet Secretary for Health and Wellbeing wrote to you on 29 November 2012 advising that a National Confidential Alert Line for NHSScotland employees will be established, as a pilot, to provide an additional level of support for staff who wish to raise a concern about practices in NHSScotland. This telephone line will take account of the existing Partnership Information Network (PIN) Policy *Implementing and Reviewing Whistleblowing Arrangements in NHSScotland*.

Following a procurement exercise, the contract to provide the Alert Line was awarded to Public Concern at Work (PCaW) on 31 January 2013. We have begun what will be regular discussions with the provider about the detailed operation and marketing of the Alert Line with a view to the service being available to NHSScotland staff **from 2 April 2013**.

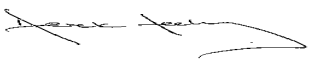
We met with PCaW, Healthcare Improvement Scotland, Health and Safety Executive and Audit Scotland on 21 February to discuss the process by which PCaW will refer cases to the appropriate regulator, including HIS, and the procedure to be adopted by the latter in investigating and reporting back to the complainant. We subsequently agreed a set of principles of operation for the Alert Line and a flow chart summary of the process (Annexes A and B). These have been endorsed by the Cabinet Secretary for Health and Wellbeing.

Health and Safety Executive and Audit Scotland are both prescribed persons under the Public Interest Disclosure Act (PIDA) and both have established procedures for dealing with concerns raised with them. HIS is not a prescribed person under PIDA but are a key organisation for ensuring the quality and safety of care of our healthcare services. We are therefore in the process of clarifying the role and authority for HIS to carry out investigations referred to them by PCaW.

PCaW would find it helpful to have a named first point of contact in each NHS Board so that, when the need arises, they can discuss how best to take forward complex individual cases. They would also find it helpful to have a copy of each Boards policy for raising concerns about patient or staff safety risks, or other wrongdoings, to help them in tailoring advice to individuals and assisting them in finding the appropriate contact at their NHS Board. If you are happy to provide this information, please send contact details and a copy of your Board's policy for raising concerns to Andrew Anderson at Andrew.anderson@scotland.gsi.gov.uk

We are working with PCaW to produce promotional materials to help raise awareness of the Alert Line and Boards' Directors of Communications will receive supplies of posters and business cards in the week beginning 25 March. These materials will include details of how to contact the Alert Line and I would be grateful if the posters could be displayed appropriately and the business cards distributed to members of staff. In the meantime, I enclose a draft letter to staff and a quick reference guide showing when and how to raise concerns. These are designed to communicate the message that Boards are open to staff raising concerns, preferably using internal processes. You may wish to considering tailoring these to reflect local arrangements and issuing to staff.

Yours sincerely



DEREK FEELEY