Summary of the recommendations of the Francis Report

1 Accountability for implementation of the recommendations - Ensuring implementation of the inquiry’s recommendations

The report outlines the determination that the Inquiry's recommendations and findings be implemented and not suffer the same fate as many previous inquiries. Its first recommendation sets out requirements for oversight and accountability to ensure implementation of its proposals, including:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should reflect on the report and its recommendations and decide how to apply them to their own work.

- Each organisation should announce at the earliest opportunity its decision on the extent to which it accepts the recommendations and what it intends to do to implement them.

- Each organisation should publish, at least annually, a report on its progress in achieving its planned actions.

- The DH should publish a report, at least annually, collating information about the decisions, actions and progress reported by other organisations.

- The House of Commons Select Committee on Health should incorporate progress on implementation as part of their reviews of organisations in their normal business.

2 Creating the right culture and putting the patient first

The report highlights the importance of establishing a shared positive safety culture that permeates all levels of the healthcare system, which aspires to prevent harm to patients and provide where possible, excellent care and a common culture of caring, commitment and compassion. This requires:

- shared values in which the patient is the priority of everything done

- zero-tolerance of substandard care

- empowering frontline staff with the responsibility and freedom to deliver safe care.

- strong and stable cultural leadership and organisational stability

- comparable data on outcomes

- expectations of openness, candour and honesty.

Leaders of organisations are expected to adopt the shared culture themselves, and be seen to do so. This should be supported by measures such as open board meetings, personally listening to complaints, and an open and honest admission where there is an inability to offer a service. At a system level, this should be demonstrated by constantly considering how the wellbeing of patients is protected or improved by proposed measures.
As the NHS evolves into a network of increasingly autonomous units, the overall culture will define what the NHS means and does. However, a positive culture will not emerge through the good intentions of those working in the system. It needs to be defined, accepted by those who are to be part of it, and continually reinforced by leadership, training, personal engagement and commitment. This will be the principal means to ensure uniformity of the standard of care and treatment. Real change can only come by addressing the mindset of staff.

“Even if all 290 recommendations were implemented now, the fundamental shift in culture can only be achieved if patient care is put top of the agenda for boards and is the first responsibility of professionals working in the NHS. That will take time and commitment over many years.”

(The King’s Fund 2013)

The Inquiry recommends that the NHS, and all who work for it, adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires:

- a common set of core values and standards shared throughout the system
- leadership at all levels from ward to the top of the DH, committed to and capable of involving all staff with those values and standards
- a system which recognises and applies the values of transparency, honesty and candour
- freely available, useful, reliable and full information on attainment of the values and standards
- a tool or methodology, such as a cultural barometer, to measure the cultural health of all parts of the system.

**Putting the patient first**

The report underlines the importance of making patients the main priority in all that the healthcare system does. Within available resources, patients must be expected to receive effective services from caring, compassionate and committed staff, working to a common culture. They must also be protected from avoidable harm and any deprivation of their basic rights. Recommendations to achieve this are:

- Clarity of values and principles underpinning NHS care with the NHS Constitution being the first reference point for all NHS patients and staff, setting out:
  - the system’s common values, and the respective rights, legitimate expectations and obligations of patients
  - clearly ensuring that patients are put first.

- Consideration should be given to include expectations in the NHS Constitution that staff:
  - put patients before themselves
  - do everything in their power to protect patients from avoidable harm
  - will be open and honest with patients, regardless of the consequences for themselves
  - direct patients to someone that can provide assistance with their needs if they are unable to
  - apply the NHS values in all their work.
• Revision of the handbook to the Constitution to include a more prominent reference to the NHS values and their significance.

• A requirement that all NHS staff enter into a commitment to abide by the NHS values and the Constitution, which should be incorporated into employment contracts.

• Contractors of outsourced services should also be required to abide by these requirements – these requirements could be included in the terms on which providers are commissioned.

3 Fundamental standards of behaviour
The report proposes that fundamental standards of behaviour, which apply to all staff that work and serve in the healthcare system, be enshrined in the NHS Constitution. Recommendations to achieve this include:

• Incorporating explicit reference in the Constitution to all professional and managerial codes by which NHS staff are bound, and an expectation that staff will follow and comply with standards relevant to their work.

• Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work.

• Professional bodies should work to provide evidence-based standard procedures for as many interventions and pathways as possible.

• Managers need to ensure that their employees comply with these requirements.

• Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary.

• Employers must insist on the reporting of concerns relating to patient safety – employees should receive feedback on any action taken.

4 An integrated hierarchy of standards of service
The report proposes establishing an integrated hierarchy of service standards to promote the likelihood that a service will be delivered safely and effectively. Standards range from mandatory fundamental service standards to discretionary developmental standards, with clear expectation of zero-tolerance towards any organisation providing services that do not comply with the fundamental standards. The standards are set to be evidence-based and measurable, and be clear about what needs to be done to comply. They should also be subject to regular review and modification. Recommendations include:

• Distinguishing between different types of standards to clarify their status and purpose.

• Fundamental safety and care standards covered by regulation – these should:
  o set out clearly what is expected of providers, covering what is important for patients and advice on best practice for each area
  o clearly define universally agreed outcomes for patients that must be avoided
  o provide strong and practical guidance on what can be done and how it can be achieved and measured
include defined duties to maintain and operate effective systems to ensure compliance
be applied by all those working in the healthcare system with “zero tolerance of breaches”.

- Individual cases of non-compliance leading to serious harm or death should remain as offences for which prosecutions can be brought against organisations.

- Enhanced quality standards designed to drive improvements in services, which would be devised and performance managed by the NHS Commissioning Board and clinical commissioning groups (CCGs) and take account of the availability of resources.

- Discretionary developmental standards formulated by commissioners and providers, which would set longer term goals for providers to improve effectiveness.

- Including generic requirements for a governance system in regulations, bringing together all the required elements of governance into one comprehensive standard to ensure compliance with the fundamental standards, and the provision and publication of accurate information about compliance with fundamental and enhanced standards.

Changes to fundamental standards will require new regulations, but these should be developed with extensive consultation, with patients, the public and healthcare professionals to ensure that they all have confidence in them.

5 Responsibility for, and effectiveness of, healthcare standards

The report highlights the importance of simplifying the regulation regime for NHS trusts to eradicate overlap and minimise the gaps between the functions of the different regulators. It proposes significant changes to the current division of regulatory responsibilities between Monitor and the Care Quality Commission (CQC), with the creation of a single regulator for all trusts, including foundation trusts. Monitor would retain its residual role as a regulator of the health economy. It suggests that these changes be implemented incrementally after thorough planning, and should not be used to justify reducing resources allocated to regulatory activity. It also stresses the importance of retaining the corporate memory of both organisations.

Recommendations cover:

Creating a single regulator for all trusts

It is proposed that Monitor focuses on regulating the health economy, with the regulation of foundation trusts' governance passing to a single regulator, the CQC. This aims to produce a common approach and accountability, dealing with:

- corporate governance
- financial competence and viability
- compliance with patient safety and quality standards for all trusts.

Monitoring compliance with standards

- The CQC would be responsible for policing compliance, as the quality regulator, with the fundamental standards, developing its core outcomes and specifying the indicators and metrics it would use to monitor compliance with these standards.

- The CQC should only be responsible for policing the accuracy of information provided about compliance with enhanced or developmental standards.
• The regulator should have a duty to monitor the accuracy of information from providers and commissioners on their compliance with standards and requirements of honest disclosure. The regulator should be able to consider individual cases of gross failure as well as systemic causes for concern.

Setting standards and developing evidence-based compliance

• Where possible, the National Institute for Health and Clinical Excellence (NICE) should provide the evidence-base for procedures and practices to support compliance with the fundamental standards. NICE Quality Standards for individual procedures and areas of treatment should be extended as soon as possible. These standards identify the minimum acceptable level of precaution to be taken, which is sufficient for the purposes of regulation.

• In the absence of NICE Quality Standards, the Royal Colleges or other approved, third party organisations could be commissioned to develop relevant procedures, metrics or guidance.

• A recognised system of review for these standards should be introduced, managed and supervised by NICE.

• Any standards should include evidence-based tools for establishing the staffing needs of each service, in terms of staff numbers and skill mix, although it is recognised that guidance would need to be flexible and give due regard to the need of different specialties and limitations on resources.

Effective assessment of compliance with standards

• Direct observations of the delivery of care and audit of records should take priority over monitoring and auditing protocols and policies.

• The CQC should retain an emphasis on inspection as a central method of monitoring compliance. This should be supported by establishing a specialist inspectorate for hospitals. The inspectorate should lead inspections of NHS hospital care, supported by teams including service users, clinicians and any other specialisms. Consideration should also be given to applying the same principle to the independent sector.

• The CQC should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.

• No system of information gathering and analysis is perfect or sufficient, therefore routine monitoring is essential.

• The regulatory system should retain capacity to undertake in-depth investigations where these appear to be required.

• Regulators should work together to share intelligence more readily to identify potential concerns earlier, and work should be undertaken to develop an agreed template for the sort of information each organisation would find useful.

• In assessing compliance, better use should be made of patient information and feedback, including complaints, and the CQC should actively seek out information on complaints.
• The CQC should introduce mandated returns from providers about complaints, how they were dealt with and outcomes. This should include greater attention being paid to the narrative in the complaints as well as numbers.

• CQC Quality and Risk Profiles should not be regarded as a substitute for active regulatory oversight by inspectors of the compliance in each provider.

**Effective assessment of compliance and enforcement of compliance with standards**

• Any service that does not consistently meet the relevant fundamental standards should not be allowed to continue.

• Effective enforcement should be ensured by installing a low threshold for suspicion, and no tolerance of non-compliance with fundamental standards.

• It should be a criminal offence where death or serious injury is caused by breaching fundamental standards.

• Failure to disclose breaches of fundamental standards should also attract regulatory actions.

• Interim measures:
  - The CQC should be able to take immediate steps to protect patients where it has reasonable cause for concern about an issue, even if it is still investigating non-compliance.
  - A public interest test should decide whether there are reasonable grounds to make the interim requirement or recommendation.

**CQC independence, strategy and culture**

• Any attempts to abolish the CQC and create a new organisation should be avoided, and its role should develop on an evolutionary basis.

• The CQC needs to be seen as acting entirely independently of government, and the Government should only consider it necessary to intervene in the CQC in the most extreme circumstances.

• The relationship between the CQC and the Department of Health (DH) must be meticulously transparent and where issues relating to regulatory action are discussed, they must be properly recorded to allay any suggestion of inappropriate interference.

• Transferring power to define standards to NICE, or a similar body, may protect the regulator's autonomy while retaining powers for the Secretary of State to define outcomes.

• The structure under which the CQC is required to work is over-bureaucratic and does not separate clearly what is absolutely essential from what is merely desirable.

• The strategic direction of the new regulatory model being developed by the CQC is encouraging, but the leadership of the CQC should communicate this clearly to the public and its staff.

• CQC should review its processes to ensure that it is capable of delivering effective regulatory oversight and enforcement in accordance with the principles set out in the inquiry's report.
• The CQC should undertake a formal evaluation of how it would detect and act on the warning signs or other events causing concern similar to events that occurred at Mid Staffordshire Hospital, and open that evaluation to public scrutiny.

• The culture within the CQC needs to change – there is a pattern consistent with a negative and closed culture of the sort they should be combating; it must be a model of openness, so that it can encourage employees in regulated organisations to come forward with concerns.

• The CQC board should have closer involvement with the healthcare professional community and patient representative groups.

6 Responsibility for, and effectiveness of, regulating healthcare systems governance

Consolidating Monitor’s regulatory functions

• As long as it retains responsibility for the regulation of foundation trusts (FTs), Monitor should incorporate greater patient and public involvement into its structures.

• Monitor must publish all side letters and any rating issued to trusts as part of their authorisation or licence.

Authorisation of FTs

• The processes of authorising FTs and monitoring compliance with FT standards should pass to the CQC, which should incorporate the relevant departments of Monitor

• The NHS Trust Development Authority (NTDA) must develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a FT application

• No NHS trust should be supported to apply for FT status unless it meets the criteria for authorisation, including compliance with fundamental standards and a full physical inspection of its primary clinical areas and all wards.

• The stakeholder consultation process for assessing potential applicant NHS trusts for FT status should be jointly reviewed by DH, NTDA and Monitor.

• There should be a duty on applicants for FT status of utmost good faith to disclose any significant material information to the application, alongside ongoing obligations of transparency, openness and honesty.

Role of FT governors

• The role of FT governors should be enhanced, and become more accountable.

• Monitor and post-merger CQC should publish guidance to clarify what is expected of governors, what the fit and proper person test means, and what steps an FT should take if a governor fails to fulfil requirements.

• Guidance should also cover the principles governors should follow to ensure effective public accountability, not just to immediate membership, but to the public at large

• Monitor and the NHS Commissioning Board should review the resources and facilities available for training and development of governors to enhance their independence and their ability to expose deficiencies in a provider’s services.
Accountability of directors

- All directors of all bodies registered by the CQC and Monitor should be, and remain, a fit and proper person for the role.

- Consideration should be given to including as criteria for fitness a minimum level of expertise and/or training.

- Monitor and the CQC should produce guidance on procedures to be followed in the event of an executive or non-executive director being found guilty of serious failure in the performance of their office.

- FTs should be required to have in place an adequate programme for the training and development of directors.

7 Commissioning for standards

The section on commissioning for standards extracts the reflections and lessons learned by GPs. The report suggests commissioning as a practice must be refocused to procure the necessary standards of a service as well as what it provides as a service (outcomes in quality as well as activity). Below are the recommendations for future commissioners:

- Commissioners should be closer to the public. The engagement of the public needs to be visible in the commissioning process, at board level, through consultations, surveys and transparent decision making.

- Commissioners should set the commissioning agenda and make the final decision on what services are provided at a local level.

- Commissioners should be entitled to lay down a fundamental safety and quality standard/specification for services, as well as how the commissioner will measure compliance.

- In addition to fundamental standards, commissioners can promote improvement by requiring compliance with or development towards enhanced standards.

- Wherever possible, commissioners need to identify/make available alternative sources of provision so they are not constrained to one provider. To achieve this, commissioning may need to be undertaken collaboratively among commissioning groups to add collective weight to discussions with more dominant providers.

- Commissioners need specialist clinical expertise (not all of which can come from GPs), as well as procurement expertise to undertake their role effectively. Where commissioning groups are too small in themselves to acquire such support, they will need to collaborate with others.

- Commissioners must have the capacity and resources to monitor the performance of every commissioning contract on a continuing basis during the contract period, this may include:
  - quality information generated by the provider
  - commissioners undertaking their own (or independent) audits, inspections, and investigations
  - the possession of accurate, relevant, and useable information
  - monitoring compliance both with the fundamental standards and with any enhanced standards adopted.
• Commissioners must be entitled to intervene in the management of an individual complaint when they feel it is not dealt with satisfactorily (while the provider has primary responsibility). They must monitor complaints and their outcomes on as near a real time basis as possible.

• Commissioners should have contingency plans in place to mitigate risk from substandard or unsafe services.

• Commissioners should intervene where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from harm. These powers should align and compliment the role/action of regulators – acting jointly where needed. One method of action may be through the issuing of performance notices.

• The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive.

• GPs in primary care should undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services, developing an ongoing relationship and recording this through a systematic shared process. This will enable them to be aware of patterns of concern at a population level and effectively influence commissioning decisions.

8 Performance management and strategic oversight
In relation to the work of the local Strategic Health Authority (SHA), the Inquiry points to “a significant gap between the legislative and policy theory of the role...and their capacity to carry this role out.” For example, Francis highlights concerns around the prioritisation of “targets not patients” and “an over-ready acceptance of action plans” from the Mid Staffordshire board, without ensuring robust scrutiny was undertaken. Strategic oversight by SHAs will no longer be an issue after April 2013; however the strategic oversight by the NHS Commissioning Board will require review. The report’s recommendations include:

• Ensuring fundamental patient safety and quality standards are being met and are the top priority for all NHS performance managers. It is essential that “convincing evidence” is provided before assurance is offered.

• All appropriate information should be shared “wherever possible” by performance managers with regulators in circumstances when concerns are highlighted.

• While any disagreements between performance managers and regulators around patient safety "should be discussed...and resolved where possible", Francis emphasises that each body "should recognise its retained individual responsibility" to act to alleviate any safety concerns.

• "Unambiguous lines of referral and information flows" are integral to ensure the performance manager "is not in ignorance of the reality."

• Francis advocates a clear set of quality and safety metrics that can be universally applied to support prompt identification of both outliers and trusts that are experiencing declining performance.

• The NHS Commissioning Board is tasked with developing quality and outcomes metrics for commissioners to utilise in performance managing providers.
9 Patient, public and local scrutiny
The report concludes that the standard of representation of patient and public concerns declined since the abolition of Community Health Councils (CHCs) in 2002. It suggests that Patient and Public Involvement Forums and local involvement networks (LINKs) failed to offer a route through which patients and members of the public could link into health services and hold them properly to account.

- The report recommends that there should be a consistent basic structure for Local Healthwatch throughout the country and local authorities should pass over centrally provided funds to Local Healthwatch, "requiring the latter to account to it for its stewardship of the money". Proper training should also be made available to Local Healthwatch leadership, as well as expert advice when needed.

- Local scrutiny committees should be given more support, such as accessible guidance and benchmarks. They should also have powers to inspect providers, rather than relying on local patient involvement structures to fulfil this role.

- Guidance should be issued, in order to promote the coordination and cooperation between Local Healthwatch, health and wellbeing boards and local government scrutiny committees.

- MPs are asked to consider adopting a simple system to identify trends in complaints and to consider if individual complaints have wider significance.

10 Effective complaints handling
The report recognises that there should be a uniform process for managing complaints and that the “recommendations and standards suggested in the Patients Association's peer review into complaints at the trust should be reviewed and implemented nationally.”

- Provider organisations must actively promote their desire to learn and act on comments and complaints. They must make it easy for those who wish to do so using a number of different methods. Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website.

- Overview and scrutiny committees, Local Healthwatch, commissioners and the CQC should all have access to complaints information. Where necessary, complaints should be investigated through an arms length independent investigation or where there are large scale clinical failures, the response should be coordinated through the National Quality Board.

- Commissioners should require access to complaints information at the time the complaints are made and should receive complaints and their outcomes “on as near real-time basis as possible”

11 Openness, transparency and candour
The report concludes that "insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding.” The overall recommendations include:
• Full disclosure where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff – whether or not the patient asks.

• All organisations should review their contracts of employment, policies and guidance to ensure they reflect the need for openness, transparency and candour, as well as the National Patient Safety Agency’s (NPSA) “Being open” guidance. At a national level, this would include reviewing the NHS Constitution and amending the Code of Conduct for NHS Managers.

• Conditions of registration or authorisation of healthcare organisations should be amended:
  o to include a standard requirement that any information provided to the public about services, compliance with statutory standards and statistical results is truthful and not misleading. Compliance with the standard should be regulated by the CQC.
  o to oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.

• Healthcare organisations, regulators and commissioners should be banned from policies and contracts which seek, or appear to seek, to limit genuine public interest disclosure on patient safety and care (“gagging clauses”).

• A statutory obligation should be imposed to observe a duty of candour on healthcare providers, registered medical practitioners, registered nurses and other registered professionals who believe or suspect that treatment or care provided has caused death or serious injury to a patient.

• An additional statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation.

• It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation to:
  o knowingly to obstruct another in the performance of these statutory duties; provide information to a patient or nearest relative intending to mislead them about such an incident
  o dishonestly make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.

• The duty should be policed by the CQC, which should have powers to prosecute.

12 Medical training and education and professional regulation of fitness to practice
A brief summary of the workforce-related recommendations, including those relating to medical training and education and professional regulation of fitness to practice, can be found on the NHS Employers website – (nhsemployers.org)

The report makes clear that medical education and training systems provide an opportunity for enhancing patient safety. Students and trainees should not be placed in establishments which do not comply with the fundamental standards, outlined in section 5, and those charged with
overseeing and regulating these activities should, like all other participants in the system, make the protection of patients their priority.

In summary, the issues relevant to medical training are:

**Medical training**
- Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.
- The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the GMC the CQC and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.
- The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.

**Matters to be reported to the GMC**
- The GMC should set out a clear statement of what matters deaneries are required to report to the GMC either routinely or as they arise. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation.

**Training and training establishments as a source of safety information**
- The GMC should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.
- Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.
- The GMC should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed.

**Safe staff numbers and skills**
- The GMC’s system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.

**Approved Practice Settings**
- The DH and the GMC should review whether the resources available for regulating Approved Practice Setting are adequate and, if not, make arrangements for the provision of the same.
Health Education England
- Health Education England should have a medically qualified director of medical education and a lay patient representative on its board.
- All Local Education and Training Boards should have a post of medically qualified postgraduate dean responsible for all aspects of postgraduate medical education.

Proficiency in the English language
- The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.

13 Nursing
The report recognises that, "much high-quality, committed and compassionate nursing is carried out day in and day out, often with inadequate recognition." However it states, "it is clear that the nursing issues found in Stafford are not confined to that hospital but are found throughout the country" and argues the NHS needs to give the highest priority to "reversing the scandalous decline in standards." The report focuses on the culture of caring requiring more focus on delivering compassionate care at the point of recruitment, in training and through annual appraisal.

- The report cites Delivering Dignity, the report jointly produced by the NHS Confederation, Local Government Association and Age UK, which recommended staff are recruited for values and evaluated for compassion, as well as technical skills.
- Nurse education should be reviewed to ensure consistent standards. Prior to entry, pre-registration training students will be required to spend "at least three months working on the direct care of patients under the supervision of a registered nurse".
- The DH and Nursing and Midwifery Council (NMC) should appoint a responsible officer for nursing appointed by and accountable to the NMC.
- Effective support and professional development for nurses should be made the responsibility of professionally accountable responsible officers for Nursing, and, in due course, reinforced by a system of revalidation.
- Nurses should be required to have an up-to-date annual learning portfolio showing up-to-date knowledge of nursing and demonstrating care, commitment and compassion.
- Ward managers should act in a supervisory capacity as role models and with knowledge of the care plans of all patients.
- A robust methodology for understanding the culture of the ward should be used, such as the use of a cultural barometer.
- Every patient should have a named nurse.
- Consideration to be given to the status of a registered older person's nurse.

The leadership function of nurses
- The Royal College of Nursing should consider dividing its Royal College and employee representative/trade union functions.
• Nurses need to be given sufficient time to fulfil representative roles.

• A forum should be established for directors of nursing from NHS and independent organisations.

• At least one executive director who is a registered nurse on the board of all healthcare organisations and commissioning boards and consider recruiting nurses as non-executive directors.

• Boards to seek advice of their nurse director on all changes affecting staffing and service provision and document if the advice is accepted or rejected

**Healthcare support workers**

• The Inquiry concludes that the balance of the evidence is strongly in favour of a compulsory registration scheme for healthcare support workers, and the imposition of common standards of training and a code of conduct. It recommends that the NMC be the regulator. Such a register should include a record of the reasons for any termination of employment as a healthcare support worker. The possibility of a wider system for excluding those unfit to hold such posts should be kept under review.

• Until the NMC is charged with the recommended regulatory responsibilities, the DH should institute a nationwide system to protect patients and care receivers from harm.

• Healthcare support workers will be clearly identified, including by uniform, as distinct from registered nurses.

**14 Leadership**

• The report focuses on the leadership and development of a staff college or training system to:
  - provide common professional training on leadership and management
  - promote healthcare leadership and management as a profession
  - administer an accreditation scheme
  - promote and research best leadership practice.

• A code of ethics to be produced and enforced by employers. Serious non-compliance will disqualify board directors and managers from holding such positions in the future.

• Regulation of managers is to be considered after reviewing the impact of a licensing provision for managers.

• Consideration to be given to regulatory oversight of the competence and compliance of appropriate standards by non foundation trust boards of similar rigour to foundation trusts.

**15 Caring for older people**

The report concludes that “the true measure of the NHS’s effectiveness in delivering hospital care can be found in how well the elderly are looked after” and makes the following recommendations:

• Hospitals should review whether to reintroduce identifying a senior clinician who is in charge of a patient’s case, to help ensure there is clarity over who is in overall charge of a patient’s care. Nominating a named nurse for each patient for each shift is also recommended to improve the coordination of care.
• Emphasis is placed on the importance of team working, including recognising and valuing the contribution of cleaners, maintenance staff and catering staff.

• Regular interaction between nurses and patients should be systematised through regular ward rounds:
  o All staff need to be enabled to have constructive and friendly interactions with patients
  o Where possible, wards should have areas where patients and relatives can meet in relative privacy and comfort
  o There should be a greater willingness to communicate by email with relatives
  o The current common practice of summary discharge letters followed up by more substantive ones should be reconsidered
  o Information about a patient’s condition, progress, care and discharge plans should be shared with that patient and where appropriate those close to them.

• The care offered by a hospital should not end “merely because the patient has surrendered a bed”; patients should never be discharged in the middle of the night or without assurance that a patient will receive the care they need when they arrive at a planned destination. Discharge areas in hospital need to provide continued care to the patient.

• All visitors and staff need to be reminded to comply with hygiene requirements, including junior staff being encouraged to remind anyone, including senior staff.

• Arrangements and best practice for providing food and drink require “constant review, monitoring and implementation”.

• In the absence of automatic checking and prompting, the nurse in charge of the ward, or their nominated delegate, needs to over see the administration of medication, underpinned by a frequent check.

• Where possible, recording of observations on the ward should be done automatically as they are taken, with results immediately accessible to all staff electronically in a form.

16 Information
The report is clear about the positive role that information can play, encompassing issues such as: highlighting inadequate performance; accountability; informing the public; and supporting patient choice. Francis advocates an integrated system with common information practices, while acknowledging that the Government's information strategy "appears to contain most if not all" of his suggested elements.

• Any electronic patient information system should have the facility to collect performance management and audit data automatically; is designed in partnership between health professionals and patient groups; and have the capability to go "over and above nationally required minimum standards."

• All providers should appoint a board member that holds responsibility for information.

• Quality accounts should outline information in a standardised format to enable comparison. They should be subject to independent audit and all directors should sign a declaration to verify the contents. The CQC and/or Monitor "should keep the accuracy, fairness and balance of quality accounts under review", they should also have the ability to place a requirement on providers to make corrections where necessary.
• Information utilised for quality and risk profiles should be publicly available "as far as is consistent with maintaining any legitimate confidentiality."

• A consistent approach nationwide for gathering patient and public feedback about NHS services.

• The Health and Social Care Information Centre should have an enhanced role, with proposed tasks including, for example: independent collection, analysis, publication and oversight" of health information; the transferral of information functions from the NPSA to the Centre.

• All providers should implement information systems that can offer real-time performance data on services, specialist teams and consultants. The information should be published "to the extent practicable" and made fully available to both commissioners and regulators.

• It is stressed that "all healthcare professionals" should acknowledge their duty "to collaborate in the provision of information required" for treatment effectiveness data. Such information should be published and regularly.

• The DH, Information Centre and UK Statistics Authority should undertake a review of patient outcome statistics. The first two should collaborate on ensuring that summary hospital-level mortality indicators (SHMIs) "or any successor hospital mortality figures" are "recognised as national or official statistics."

17 Enhancement of the role of supportive agencies

NHS Litigation Authority (NHS LA)

• The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS LA.

• The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3.

• The NHS LA should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiencies in risk management, such as occurred at the Trust.

• As some form of running record of the evidence reviewed must be retained on each claim in order for these reports to be produced, the NHS LA should consider development of a relatively simple database containing the same information.

• As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed over risk reports, consideration should also be given to allowing the CQC access to these reports.
The NHS LA should make more prominent in its publicity an explanation comprehensible to the general public of the limitations of its standards assessments and of the reliance which can be placed on them.

**National Patient Safety Agency (NPSA)**

- The resources of the NPSA need to be well protected and defined. The report recommends that considerations should be given to transferring the resource provided by the National Reporting and Learning System from the NHS Commissioning Board to a semi-independent system regulator.

- The CQC should be enabled to exploit the potential of the safety information obtained by the NPSA or its successor to assist it in identifying areas for focussing attention. There needs to be a better dialogue between the two organisation concerning how they can assist each other.

**Health Protection Agency (HPA)**

- The report concludes that more robust arrangements for sharing infection control concerns with regulators and performance managers are needed. It calls on the HPA and its successor to work with the Health and Social Care Information Centre to coordinate the collection, analysis and publication of provider data, relating to healthcare associated infections.

- Where HPA or its successor is concerned that a provider is not adequately managing healthcare associated infections to protect the public and patients, they should immediately inform commissioners, the CQC and, where relevant, Monitor of their concerns.

**Health and Safety Executive (HSE)**

- The HSE is not the right organisation to be focusing on healthcare. Either the CQC should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has power to launch a prosecution.

- The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts’ practice in reporting fatalities and other serious incidents.

- Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.

- In order to determine whether a case is so serious, either in terms of the breach of safety requirements or the consequences for any victims, that the public interest requires individuals or organisations to be brought to account for their failings, the HSE should obtain expert advice, as is done in the field of healthcare litigation and fitness to practise proceedings.

**18 Coroners and inquests**

- Terms of registration/authorisation should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function.

- Urgent need for unequivocal guidance for trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.
• Responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient’s case or treatment.

• Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise concerns with the independent medical examiner.

19 Department of Health leadership
The report argues that the DH lacks a sufficient unifying theme and direction with regard to patients’ safety. It also states that the DH has struggled to get the balance right between "light touch" regulation and the need to protect service users from harm. The report recommends the DH should:

• Bring together regulators to work with professionals and the public in developing a framework for implementing the values and standards recommended in the report.

• Set an example by being open about deficiencies, ensuring those harmed receive remedy and that information about performance is easily available.

• Ensure there is senior clinical involvement in all policy decisions which may impact on patient safety and wellbeing.

• In addition, the report argues that while the DH asserted the importance of quality of care and patient safety, it failed to recognise that the structural reorganisations have on occasion made such a focus very difficult in practice. The report recommends that:

• Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted.

• The report found that at times DH officials were too far removed from the reality of the service they oversee. The report recommends:
  
  o DH officials connect more to the NHS by visits and by personal contact with those who have suffered poor experience.

20 Outside the report
David Cameron has confirmed a new post of chief inspector of hospitals would be created from the autumn and demanded that the GMC and NMC, explain why no one had been sanctioned for their part in the failings. He also stated the Health and Safety Executive must say why there had been no prosecution.

Professor Sir Bruce Keogh is to lead an investigation into hospitals which are persistent outliers in hospital performance, in relation to consistently high HSMR and provide practical help for them. These are:

• Colchester Hospital University NHS FT
• Tameside Hospital NHS FT
• Blackpool Teaching Hospitals FT
• Basildon and Thurrock University Hospitals NHS FT
• East Lancashire Hospitals NHS FT
A further nine acute Trusts were highlighted

- North Cumbria University Hospitals NHS Trust
- United Lincolnshire Hospitals NHS Trust
- George Eliot Hospital MHS Trust
- Buckinghamshire Healthcare NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS FT
- The Dudley Group of Hospitals NHS FT
- Sherwood Forest Hospitals NHS FT
- Medway NHS FT, and
- Burton Hospitals NHS FT.

21 Areas where the Trust has work underway which will contribute to achievement of the recommendations outlined in the Francis report

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| 1 | **Accountability for implementation of recommendations – Ensuring implementation of the inquiry’s recommendations**  
Action plan is being drawn up by the Executive team to address the recommendations relevant to NHS Foundation Trusts |
| 2 | **Creating the right culture and putting patients first**  
“We care” programme is clarifying our values based on feedback from patients and staff. The values into action will identify how we will hold each other to account for living those values  
The ‘shared purpose framework’ has identified the competencies we require of our staff to deliver person-centred, safe, and effective care. These include the 6Cs (compassion, care, communication, courage, commitment & competence)  
Improving team effectiveness is being cascaded through the Executive team, Divisional leadership teams, and clinical teams within divisions using ‘Aston Team-working’ approach |
| 3 | **Fundamental standards of behaviour**  
The values and competencies (as above) are being built into job descriptions and person specifications and will inform recruitment and selection and personal development planning.  
We are exploring ways in which we could ensure that we are recruiting for values |
| 4 | **An integrated hierarchy of standards of service**  
The balanced scorecard and the various quality dashboards provide a mechanism for managing the performance of divisions and their constituent wards and departments  
All forms of standards (quality, operational, financial) will need to be reviewed in
response to NHS - Outcome framework, Everyone Counts framework, Monitor risk assessment framework and any additional output from NICE.

### 5 Responsibility for, and effectiveness of, healthcare standards

The Trusts Standards Monitoring Group is responsible for governance of compliance with CQC and NHS-LA standards. The group is accountable to the Risk Management & Governance Group which in turn reports to the Integrated Audit & Governance Committee and the Board of Directors.

Patient feedback through Compliments, Concerns and Complaints is being used at all levels of the organisation to ensure staff are aware of the impact of attitudes, behaviours and poor communication has on patients and their families.

Friends & Family Test will be implemented by 1 April 2013.

Triangulation of data and information on quality (person centred, safe and effective care) is beginning to inform decision for quality improvement and needs to be further developed and at a pace.

### 6 Responsibility for, and effectiveness of, regulating healthcare systems governance

The Board and divisions will be undertaking additional team development around the Board Assurance Framework and the understanding and management of risk during March 2013.

Divisional leadership teams have undertaken a gap analysis against the standards within the Monitor Quality Governance framework and will be implementing actions arising from this during 2013/14. This will help to build and strengthen the governance of patient safety, patient experience and effectiveness of clinical services.

### 7 Commissioning for standards

We are currently working with CCGs to agree local CQUINs for 2013/14 which will focus on local priorities. This will complement the CQUINs that are nationally mandated.

Procurement of services by the Trust do build in quality standards which in the light of Francis we may need to review to ensure that all elements of quality have been included.

Generally we have developed good working relationships with commissioners and share openly all aspects of quality including episodes where our services do not meet the standards we expect, for example serious incident reports and complaints, and the range of quality indictors that form part of contractual requirements.

### 8 Performance management and strategic oversight

Clinical quality, patient safety and patient stories form the first part of performance discussion at the Board of Directors.

The Board often requests further information or clarification on aspects of
performance improvement and will request that specific issues are subject to a 'deep dive' by IAGC, for example safeguarding of children, young people and adults;

This can include the involvement of internal or external audit or an external expert opinion, for example the review of increased unexpected admission of term babies to NICU

Deterioration of risk highlighted through the CQC Quality & Risk profile has been subject to review and detailed presentation to IAGC and BoD, for example nutrition, delayed transfers of care, consent to treatment & assessment of mental capacity.

### 9 Patient, public and local scrutiny

The Trust has an active Patient & public involvement forum, and the Council of Governors have regular engagement events with members of the Foundation Trust and the public

The Council of Governors actively supports the Trust in themed reviews of aspects of our services and provide constructive feedback to the Board of Directors, for example the recent work with staff on what it feels like to work in the Trust

The Trust has had an effective relationship with LINks facilitating local visits and reviews of our services. The Trust will begin to develop relationships with the new local Healthwatch

### 10 Effective complaints handling

In general terms the handling of informal and formal complaints has developed over the passed 18 months with much more emphasis on face-face meetings with complainants with clinicians and other staff involved in the care of the complainant

A greater proportion of complaints have been resolved at a local level, with fewer complaints being referred to the PHSO; and very few that are referred are upheld by the PHSO office, suggesting that our process for handling complaints is effective.

However, the Trust feels that further work is required to improve the quality of the written responses, the timeliness of responses and to reduce the proportion of complaints that are not resolved through the first response.

An external review of our approach, systems & processes and the service provided by the Patient Experience Team is about to be scoped and will be undertaken over the next 2-3 months

### 11 Openness, transparency and candour

Serious incidents that have resulted in death or harm are reported monthly to the Board of Directors. Each incident is subject to a Root Cause Analysis where learning is captured and disseminated.

Trust policy clearly identifies the responsibility to disclose information to the family when death or harm has occurred as a result of clinical care or delays in
care. The policy reflects the NPSA ‘being open’ guidance.

Further discussion will be needed to consider how the duty of candour will apply, and how we can further improve our openness & transparency to the public

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<tr>
<th>12</th>
<th>Medical training and education and professional regulation of fitness to practice</th>
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<tr>
<td></td>
<td>Revalidation of Doctors is being led by the Medical Director who has recently been through the revalidation process himself</td>
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<td></td>
<td>Clinical leadership development is provided to all new medical consultants which includes a high focus on effective team leadership, patient safety and other aspects of quality.</td>
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<td></td>
<td>The Trust has a Director of Medical Education who leads the programme of work with the deanery and the clinical tutors to ensure that there is effective education, training and supervision of doctors in training.</td>
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<td>The Trust has developed systems and processes to implement the GMC guidance on ‘maintaining high professional standards’</td>
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<tr>
<th>13</th>
<th>Nursing</th>
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<td></td>
<td>The shared purpose framework has been developed initially with nursing staff and has subsequently been developed further with other staff groups.</td>
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<td></td>
<td>The framework has a central focus of delivering patient-centred, safe and effective care. The fourth dimension of the framework is on how we develop further the culture of caring (for all professional groups)</td>
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<td></td>
<td>Recruiting for values is an aspect which needs further consideration to ensure that staff evaluated for their ability to care as well as technical skills. The main professional attributes that enable compassionate care includes:</td>
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<td></td>
<td>• Integrity</td>
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<td>• Empathy</td>
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<td>• Resilience</td>
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<td>• Team-working</td>
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<td></td>
<td>• Situational judgement tests (work-relevant assessments that present challenging situations likely to be encountered and require candidates to make judgements about possible responses)</td>
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<td></td>
<td>The Trust has developed an effective clinical leadership programme for ward managers and other clinical leaders which is based around the competencies within the ‘shared purpose framework’</td>
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<td>Observations of care combined with ward quality dashboards are used by Matrons and other senior nursing and midwifery staff to monitor the quality of care, the care environment, and the culture within the ward team</td>
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<td></td>
<td>Increasingly a method focussing on ‘emotional touch-points’ of care are being used by ward managers and matrons to understand the experience of care from direct feedback from patients</td>
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|    | Ward staffing establishments were reviewed in 2012 and reported to the Board. The establishments are currently being re-reviewed in response to the ‘We
The Trust has Matron who leads on dementia care supported by hospital site facilitators & Senior Nurse for Adult Safeguarding with leads on each site.

14 Leadership

The Trust has a range of opportunities for staff to support leadership and management development

The Board of Directors have regular opportunities to access personal development both from within the Trust and external to the Trust through FTN, Kings Fund, NHS Confederation and other organisations

15 Caring for Older People and the co-ordination of care within wards

The Trust has a emphasis on healthcare for the older person which is clinically lead by Consultants in elderly care and stroke care

Effective decisions are generally made by teams that are well led and have an emphasis on incorporating the views of the whole multi-disciplinary team.

The productive ward facilitators have been working with clinical teams to improve the effectiveness of ward rounds. Further work will be needed in this area to ensure that best practice is embedded.

A number of wards have already implemented regular nurse-led ward rounds to ensure that essential aspects of patient care are being met. The principles of primary nursing or named nurse are more difficult to implement and will require further consideration

16 Information

The Trusts current IT strategy is building our capability of creating a comprehensive electronic patient record, the pace is determined by capital money available and the maturity of the technology available – although this is rapidly changing, for example electronic prescribing of medication

Clinical staff are now able to access detailed clinical information about the patients they are responsibly for electronically and via mobile devices.

Nursing staff have adapted there way of working to incorporate electronic document of risk assessments and vital sign capture giving real time information.

The Trusts capability to produce and make available real time information has matured significantly over the past 18 months.

The Trust publishes information on the website about clinical quality, patient safety and financial performance. This includes information on mortality and level of harm
The Trust has internal systems in place to test data quality, and this is subject to both internal and external audit.

The Trust publishes an annual quality report as part of the overall annual report, this is examined by external auditors and an opinion includes assessment of the balance within the report.

### NHS Litigation Authority

The Trust has achieved and maintained level 3 for the general risk management standards. This is the highest level current available. Further work is underway to ensure that gaps in compliance are resolved and that the standards are embedded at all levels of the organisation.

The Trust has achieved level 2 for the Maternity CNST standards and is currently working towards level 3.

The Trust is aware that the NHS-LA are reviewing the standards and that the future framework will focus on outcomes. It is unclear at this stage what the implication will be for the Trust and how the transition will be managed.

### Coroners and Inquests

The Trust has developed open relationship with Coroners and their offices. The Trust shares information proactively and on request.

There is further work to ensure that the Trust receives timely feedback from post mortems although they currently are not obliged to do this proactively. The Trust is required to write to the office requesting a copy of the post mortem.

The Trust must focus on further work with families who have been recently bereaved. Feedback from families suggests that there is more to do to ensure that families feel supported and have an opportunity to talk with relevant staff about any concerns or clarification of events surrounding the death (expected or unexpected).

### Summary

The report attempts to summarise the main thrust of the Francis report into themes for the Trust to address. The main areas to consider as priorities include:

- Continuing the work on ‘We Care’ – Values into action
- Continuing to listen and respond to patients and the public – through regular ‘In Your Shoes’
- Continuing to listen and respond to staff and encouraging them to raise their concerns about any aspect of clinical care; running regular ‘In Our Shoes’ events and feeding back
- Ensuring that we are listening and responding to feedback from staff who are in training both pre-registration and post registration
- Ensuring that all teams have the opportunity of undertaking the Aston Team working approach to clarify roles, responsibilities, accountabilities, approaches to improving communication amongst the team
• Reviewing our approach to the publication of performance information on the public website to ensure we have the appropriate balance and that it is accessible and easy to read.

• Exploring the meaning of the Duty of candour and recommending any adjustments that may need to be made on our approach to openness and disclosure

The Board may have additional areas they see as priorities to add to the summary above

23. Next Steps

a) The Executive Team to draw together an action plan to address the recommendations

b) The Clinical Commissioning groups have requested that we share the top five priorities with them at the next Whole System Board

c) The Chief executive will be leading site-based open forum discussions with staff to discuss the outcomes of the report and to listen to feedback to inform the action plan