Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

enabling and empowering people to reach their potential and live fulfilling lives

Summary Report – Trust Board Meeting (Part 1)	**Date: 27th February 2013**
Report Title: Initial response to Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Robert Francis QC	
Agenda Item: 09	**Enclosures:**
Sponsor: Medical Director	**Presenter: Hayley Richards**
Report Author: Hayley Richards	
Report discussed previously at:	*n/a*

Purpose of the Report and Action required		
	Approval	
	Discussion	
	Information	X

Executive Summary of Key Issues

The Francis report arises from the public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust between January 2005 and March 2009. The report makes 290 recommendations (R1-290), to the department of health, which, if implemented, will have profound effects on whole of the NHS. Many recommendations will impact directly on AWP practice and governance.

R1 exhorts each healthcare organisation to consider the findings and recommendations and apply them to its own work, announcing ‘at the earliest practicable time’ its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, ‘on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions’.

This paper identifies main areas for note, and suggests immediate and medium term responses for consideration.

Francis Report

Which Strategic Objective does this paper address	
A sustainable value for money business	Y
Excellent service user access and experience	Y
Excellent partnership working with other organisations	
Effective engagement and improvement in staff satisfaction	

Link to Fit for the Future Implementation Plan	
Specify objective number	n/a

Recommendations to other committees
n/a

Recommendation/Decision
The Board is recommended to **note** the report

Francis Report

The report recommendations fall under headings as below. Accompanying each is a necessarily brief summary

1. Putting the patient first

1.1. In this context, putting the patient first requires every healthcare worker and manager to examine their own practice, to contribute to a safer, committed, caring and compassionate service.
1.2. All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.

2. Fundamental standards of behaviour

2.1. Enshrined in the NHS Constitution should be the commitment to fundamental standards No provider should provide any service that does not comply with fundamental standards of service.

3. A common culture

3.1. Reporting of incidents needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about actions taken or reasons for not acting.

4. Responsibility for and effectiveness of healthcare standards

"I suggest that the Board of any Trust could reflect on their own work in the light of what is described in my report". Robert Francis, QC

4.1. The report identifies prevalent themes and behaviours in Mid-Staffordshire trust, against which the Board may wish to self-assess, including degrees of openness, positive culture, tendency to be inward looking and others.
4.2. The application of a 'fit and proper person' test is proposed as is a common code of conduct and ethics for Senior Managers.
4.3. Criminal sanctions are proposed where a wilfully or recklessly false statement is made. This links to the duty of candour

5. Requirement of training of directors

5.1. A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.

6. Effective complaints handling

6.1. Patients raising concerns about their care will have their entitlements to a timely, thorough and candid response formalised.
6.2. Patients will have the matter dealt with as a complaint unless they **do not** wish it;
6.3. There is an obligation of utmost good faith on a Trust when applying to become a Foundation Trust, and an obligation to publish anonymised statements of outcomes for all complaints relating to clinical care, with these being shared on a real-time basis with commissioners.

7. Investigations

7.1. The provider trust should initiate investigations where:

- A complaint amounts to an allegation of a serious untoward incident;
- Subject matter involves clinically related issues and requires an expert clinical opinion;
- A complaint suggests professional misconduct or relates to the performance of senior managers;
- A complaint involves issues about the nature and extent of the services commissioned

8. Medical training and education

8.1. There should be greater cooperation and information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor, with regard to patient safety issues.

8.2. Providers must seek feedback from students and trainees on standards of patient safety and quality of care. Providers should also encourage openness from trainees and protect them from any adverse consequences.

8.3. The GMC should take into account the numbers and skills of staff in the provider organisation for the provision of training and to ensure patient safety in the course of training.

9. Openness, transparency and candour

9.1. A statutory obligation should be imposed for a duty of candour.

9.2. The obligations under the duty of candour include:

- full disclosure & support where a patient is injured by the organisation.
- full and truthful answers to any reasonable question by a patient.
- Full disclosure of unacceptable practice within the provider organisation.

9.3. Provision of such information should not be taken as evidence of, or an admission of, liability, but failure to provide information would have consequences.

10. Implementation of duty

10.1. Organisations should review their contracts of employment, policies and guidance to ensure that they are consistent with the duty of candour and openness.

11. Nursing

11.1. The report includes many recommendations relevant to nursing practice, including:

- an increased support for compassionate, caring and committed nursing and a stronger voice
- an entry level aptitude test of a person's ability to provide proper care.
- R229 the NMC should introduce a system of revalidation similar to that of the GMC
- strong nursing leadership at ward level with specific and detailed recommendations for the duties of the ward manager and the key nurse.

- R191 employers must assess values, attitudes and behaviours towards patients part of recruitment of qualified or unqualified staff.
- Healthcare Support Workers should be regulated and there should be developed a Registered Older Person Nurse R200
- R197: Training and continuing professional development for nurses should include leadership training at every level.
- Healthcare support workers must be easily distinguishable from registered nurses.
- Commissioners should require boards to seek the advice of the nursing director on the impact on the quality of care and safety of any major change to nurse staffing, and record the outcome.

12. Measuring cultural health

12.1. Healthcare providers should monitor cultural health by means of a "cultural barometer".

13. Leadership

13.1. Board-level healthcare leaders must abide by a new code of ethics and oblige all such staff to comply. A new leadership academy may provide a route to voluntary accreditation.

14. Information

14.1. The public need access to information in order to compare relative performance and compliance with appropriate standards.

14.2. Patients should have:

- Access to electronic records in real time
- Real time access to information about clinicians' performance
- Details of compliance with fundamental standards by way of quality accounts, available on the Trust's website.

It should be a professional duty of healthcare professionals to collaborate in the provision of such information.

15. Coroners and inquests

15.1. Healthcare providers should be obliged 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.

16. Proposed response to be initiated by Clinical Executive

Trust-wide discussion of report	16.1. Website statement; HW & HR programme of visits; forums including TNAG, TMAG, Professional Council; trainees
Putting the patient first Implementing duty of candour	16.2. Review contracts of employment 16.3. Recruitment for quality and core values
Common culture	16.4. Response to staff after incident reporting 16.5. Cultural barometer
Board	16.6. Process of self-assessment 16.7. Training and continuous development of directors
Complaints	16.8. Sharing outcomes with commissioners 16.9. Review policy
Training & education	16.10. Engage trainees re: safety concerns & reporting 16.11. 'See, Act, Lead'
Nursing	16.12. Review roles, deployment, leadership, identification, support for nursing director role, assess readiness for revalidation.
Information	16.13. Review patient access to records, availability of quality accounts and performance data