TRUST BOARD IN PUBLIC	Date: 28 March 2013 Agenda Item: 2.5
REPORT TITLE:	**Response to the Sir Robert Francis Public Inquiry (2013)**
EXECUTIVE SPONSOR:	Susan Aitkenhead, Chief Nurse Dr. Des Holden, Medical Director
REPORT AUTHOR:	Susan Aitkenhead, Chief Nurse Dr. Des Holden, Medical Director
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Trust-wide including the Quality and Safety Committee, the Management Board for Quality and Safety, and various staff meetings.

Purpose of the Report and Action Required:		**(√)**
Sir Robert Francis QC published the report of the *Public Inquiry into the Mid Staffordshire NHS Foundation Trust* on 6 February 2013. He highlighted the "appalling and unnecessary suffering" in which corporate interests were put ahead of patients and stated that there was a failure of the NHS system at every level to react to this. 290 recommendations are made; with the government due to provide further detail on the implementation of these shortly. This paper sets out the initial local response to the report.	**Approval**	
	Discussion	
	Information/Assurance	**(√)**

Summary: (Key Issues)

The report is clear that the pursuit of targets, financial balance and Foundation Trust status all contributed to the failings. An institutional culture in which the business of the system was put ahead of the wellbeing of patients, proclaimed successes and said little about failings is set out.

It is a long and concerning report, touching on all stages of the patient's journey as well as culture, competence and leadership. 290 recommendations are made; with the government due to provide further detail on the implementation of these shortly. However, there are many areas of learning that are clear warning signs to all organisations to consider without having to wait for direction on mandated or non-mandated recommendations.

Francis states that each organisation should report publicly on how it has enacted the recommendations and that all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work.

Relationship to Trust Corporate Objectives & Assurance Framework:

Learning should be central.

Corporate Impact Assessment:

Legal and regulatory implications	YES – awaiting further detail from Government

Financial implications	YES – dependent on recommendations to be mandated
Patient Experience/Engagement	YES – key and will require to be robustly demonstrated
Risk & Performance Management	YES – key and will require to be robustly demonstrated
NHS Constitution/Equality & Diversity/Communication	YES – key and will require to be robustly demonstrated
Attachments:	
Web link: http://www.midstaffspublicinquiry.com/report	

TRUST BOARD REPORT – 28th MARCH 2013
RESPONSE TO THE SIR ROBERT FRANCIS PUBLIC INQUIRY

1 BACKGROUND

1.1 The first report into the care provided by Mid Staffordshire NHS Foundation Trust was published in February 2010. The Inquiry Chairman, Robert Francis QC, stated that 'patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care'.

1.2 Eighteen recommendations were made for both the Trust and central government. The report is based on evidence from over nine hundred patients and families who contacted the Inquiry with their views.

2 FINAL REPORT PUBLISHED 6 FEBRUARY 2013

2.1 The final report published on the 6th February 2013, follows a request in June 2010 by the former Health Secretary Andrew Lansley to conduct the inquiry, after he had recommended in the previous report that there should be 'independent scrutiny of the actions and inactions of the various organisations to search for an explanation of why the appalling standards of care were not picked up'.

2.2 Terms of reference were 'to examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, and to examine why problems at the trust were not identified sooner and appropriate action taken'.

3 PRIORITY CHANGES RECOMMENDED BY FRANCIS

3.1 Francis states that five changes are required now:

- That there should be clearly understood and implementation of fundamental standards – it should be a criminal offence to cause death or harm to a patient by non-compliance.
- There should be openness, transparency and candour throughout with a duty of candour being imposed, underpinned by statute and with the deliberate obstruction of this duty being a criminal offence.
- That no person is allowed to deliver hands-on care of a patient without being properly trained and registered; with an additional calling particularly for a new registered status for those working with older patients.
- That there is a strong patient-centred healthcare leadership with the public being entitled to see leaders held to account; and that there is a disqualification of those leaders seriously breaching the code of conduct.
- That there is accurate, useful and relevant information available with patients being able to have access to this.

4 ORGANISATIONS RESPONDING TO THE REPORT PUBLICLY

4.1 Francis also states that each organisation should report publicly on how it has enacted the recommendations. It is recommended that:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;

- Each such organisation should announce 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;

- In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;

- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

5 INITIAL GOVERNMENT RESPONSE

5.1 On publication of the Report, David Cameron, the Prime Minister has apologised for the 'appalling treatment' suffered by patients at Mid-Staffordshire NHS Foundation Trust. He thanked Robert Francis QC for his report, which, he said 'shows how the system as a whole failed', then specifically highlighted three themes from the report:

- The focus on financial targets at the expense of patient care
- The attitude of patient care being 'someone else's problem'
- The defensiveness and complacency instead of facing up to and acting on data which should have implied a cause for concern.

5.2 The government will respond in the very near future to the report in detail; however the PM stated that the recommendations will include three core areas in which immediate attention and progress should be paid:

- Patient care,
- Accountability;
- Defeating complacency.

6 INITIAL LOCAL RESPONSE TO THE REPORT

6.1 The report is a long and extremely concerning report, touching on all stages of the patient's journey as well as culture, competence and leadership. Although the next steps in relation to mandatory requirements are awaited; it has been strongly agreed by the Board that there are many areas of learning to consider without having to wait for that direction on those recommendations.

6.2 The report has been discussed and debated at several Trust and divisional committees such as the Quality and Safety Committee, the Management Board for Quality and Safety, and various staff meetings such as the Senior Leaders' meeting, the Chief Executive's monthly staff meeting and at meetings with nursing, medical and healthcare support staff.

6.3 The Board agreed that a specific briefing and highlighting of how the report actually translates into the 'everyday care of patients and their families/carers' should also be produced locally and sent to each individual Trust member of staff to ensure that everyone whatever their role and whether clinical or non-clinical, understood the significance of the report and importantly their own accountability to the delivery and influencing of safe and quality care.

6.4 The current work on the Surrey and Sussex Healthcare (SaSH) NHS Trust Nursing and Midwifery Strategy 2013-16 *Frontline Focus* (working title) is ensuring that the learning in particular about demonstrating compassion and delivering optimal standards of care are not just taken as "a given" but are implicit throughout and will be clearly articulated within the strategy, as to how these will be achieved, measured, monitored and sustained, with the patient always at the centre of all that we do.

6.5 The current work on developing the role of the ward manager by working with Bucks New University in running a bespoke ward manager leadership course is considered to be key in improving our front-line nursing leadership and placing these leaders at the centre of the teams caring for patients. The report stated that the decline in standards was associated with inadequate staffing levels and skills, and a lack of effective leadership and support and our local aim to empower and enable the ward manager to lead and drive safety and quality right at the centre of that care is now going to be even more important considering the learning from the report.

6.5.1 The learning from the report has also helped further shape the course content and associated objectives. Additional work on allocating coaches/mentors to the ward managers in the form of senior multi-professional clinical and non-clinical colleagues during and importantly following the course is aimed at continuing that support and advice when change management is being implemented and sustained.

6.6 Additionally the report highlights that Healthcare support workers (HCSWs) constitute a very large proportion of the healthcare workforce with often little if any voice that is being heard; it raises concerns that there is almost no protection available to patients or the public and no minimum standards of training or competence. Again this learning is helping shape the development and delivery of our bespoke SaSH Healthcare Assistant Development Programme and our plan to run three cycles of this course in 2013/14 to include content of:

- Teamwork, communication skills, empathy and compassion;
- Quality, patient safety and patient experience;
- The changing landscape of the NHS;
- Accountability, learning from the Francis Report and regulation.

6.6.1 The Trust Healthcare Assistants already undertake 'task based' training days but this development programme has a wider aim in relation to embedding the relevant critical thinking and compassionate behaviours.

7 CHALLENGES

7.1 We are however, in no way at all complacent, and have many challenges that we continue to strive to meet on a daily basis and the learning from the report strengthens our requirement to overcome these challenges such as:

7.1.1 Reducing our usage of agency nursing staff and recruiting to all of our nursing vacancies; with the additional objective of ensuring that those staff settle and remain in the Trust for several years to help form and consolidate strong quality local nursing teams.

7.1.2 Quickly embedding our new clinical governance structure and supporting our staff in undertaking the associated roles to ensure that the care provided across the Trust is always of a high quality, promotes the safety of patients and contributes to a positive patient experience.

7.1.3 Ensuring that our intelligence from all sources such as complaints, compliments and relevant reports is analysed effectively and learning always implemented quickly, efficiently and equitably across the Trust with transparency and as highlighted within the report – candour.

8 SUMMARY

8.1 The report has been read and digested at many levels across the Trust; and to particularly ensure that our more junior or less experienced staff who may not see the report as having much bearing on their every day working lives we have produced a pocket sized guide to help them understand the learning and the associated importance and accountability of every staff member that a patient comes in contact with – both for direct and indirect care.

8.2 We have considered much of our current work and mapped it positively against some of the report's learning, many in relation to failures of staff leadership and empowerment and looked at how we mitigate against these failures happening potentially at a local level.

8.3 However, again we must reiterate that we are by no means complacent as to the work that still is yet to be continually achieved, such as driving out inequity across the Trust in relation to every patient having an optimal experience twenty-four hours a day, seven days a week; and embedding the highest achievement of all quality indicators into a 'business as usual' culture.

8.4 We now need to ensure that safety, quality and compassion is always integrated into everyday systems and processes at every stage of the patient's journey, and continue to make this our priority on a daily basis, while awaiting the government's response to the recommendations and the associated mandatory requirements.