The Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – Chaired by Robert Francis QC

On the day briefing by the Foundation Trust Network (FTN)

1. Background

The following briefing provides a summary of our action to date, the Francis recommendations and an initial response from the FTN.

2. Initial Reaction from the FTN

In the run up to publication of the Francis Report, our Chair, Peter Griffiths and Chief Executive, Chris Hopson wrote an open letter to members acknowledging that pockets of poor quality care can exist in all types of trust, but emphasising that failures as serious, protracted and devastating as Mid Staffordshire are rare and isolated.

We recognised that the FTN and the wider NHS need to do much more to identify and share best practice on improving quality of care and to provide practical tools to support trusts in doing so. Our work programme will identify how the FTN can help develop sector led support to complement government led initiatives, focussing on:

- The drivers of quality identified through research such as culture, ward level leadership, team effectiveness, staff satisfaction and support;
- The role of the board;
- Defining what support could be provided to trusts finding it difficult to meet standards;
- Exploring the link between increasing financial pressure and quality.

Clearly, today's announcements and recommendations will have a major impact on everyone in the NHS. We are committed to engaging fully in the evolving debate, and to consulting widely with members and stakeholders to address the issues raised. Therefore, any views presented here are our initial responses to proposals.

On behalf of the Foundation Trust Network (FTN) and our members, Chris Hopson, chief executive, today said:

'Our deepest sympathy is with the patients and relatives who were affected by this appalling failure of care that must never happen again.

'The evidence shows that incidents like Mid Staffordshire Foundation Trust where failures were so serious, so protracted and had such a devastating and widespread patient impact are rare and isolated. It is clear, however, that pockets of poor care do exist right the way across the NHS. Hopefully the Francis report will now help us get to the nub of why poor care continues despite persistent attempts by trusts to resolve this complex problem.

'Trust boards, commissioners, regulators and staff need to work together to create a culture where patients and their voices are truly at the heart of the NHS.'

3. Recommendations from the Francis Report and FTN initial reaction

The report emphasises the need to avoid further structural change, and does not seek to scapegoat individuals. It makes a total of 290 recommendations along the following four themes. For the full detail, please refer to the report.

A STRUCTURE OF FUNDAMENTAL STANDARDS AND MEASURES OF COMPLIANCE

NHS Constitution and values:

- Strengthen NHS Constitution to place patients first as an 'overriding value' and to articulate fundamental standards of staff behaviour;

Development of fundamental standards – of behaviour, safety and quality:

- List of clear, fundamental quality and safety standards, which any patient is entitled to expect, and to permit any hospital service to continue;
- NICE should produce standard procedures and guidance to enable organisations and individuals to comply with these fundamental standards. They should work with professional and patient organisations to do so, and cover clinical outcomes as well as staff mix and cultural outcomes;
- 'Enhanced standards' should be developed and made available to commissioners to raise standards. Clear focus on the role of commissioners in driving standards;
- Non-compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service;
- Causing death or serious harm to a patient by non-compliance without reasonable excuse of the fundamental standards should be a criminal offence.

Regulation of standards:

- CQC should become the single regulator dealing with corporate governance, financial competence, viability and compliance with patient safety and quality for all trusts (i.e. combining CQC's current role with Monitor's previous role as an FT regulator);
- Consider transferring the regulation of governance, and fitness of persons to be directors, governors etc. from Monitor to CQC;
- CQC should have a duty for monitoring the accuracy of the data providers supply and to require providers to provide a fuller narrative about patient complaints. Provision of misleading information to a regulator should become a criminal offence;
- CQC should expand its work with overview and scrutiny functions and foundation trust governors as a valuable source of intelligence and feedback;
- Routine and risk based monitoring, notably inspection, is advocated as a key source of regulatory information and regulators are encouraged to adopt 'zero tolerance' and 'a low threshold of suspicion.' Regulators must have policies in place to intervene to protect patients and to repeatedly review if intervention is necessary;
- CQC must develop well trained, specialist inspectors, integrate patient representation into its structures and consider formalising partnership input from professional bodies such as the GMC;
- Government should look at moving responsibility for conducting criminal prosecutions in the NHS away from the Health and Safety Executive to CQC;

- Providers to comply with risk schemes of equal rigour to the NHS LA. Various recommendations for the NHS LA to consider how it evaluates elements of risk, including staffing levels;
- All regulators to improve information sharing;
- National Patient Safety Agency and Health Protection Agency functions to be protected and potentially transferred to another regulator;
- Transfer of FT authorisation process to CQC with support from TDA in developing quality of care as a pre-condition for authorisation. Inspection should be strengthened as part of the authorisation process. Aspirant trusts should be subject to a 'duty of utmost good faith';
- However, any evolution of the CQC should be gradual and staged. The report explicitly states the CQC should not be dissolved and replaced by another organisation.

Initial views from the FTN

We welcome moves to clarify the standards of care which patients can expect and the recommendation that standards are developed in partnership with patients, the public and clinicians. We also welcome the involvement of NICE within this process, and hope that this will build naturally on their growing library of quality standards.

If a growing number of standards are to become mandatory, we would welcome sector input, and indeed sector leadership of elements of this process to ensure healthcare professionals contribute their expertise and to enable the NHS to take greater ownership for its own improvement.

We also agree that the consequences for non-compliance should be clear and form a deterrent at organisational and individual staff member levels. However we will need to give careful consideration to proposals for individuals to be at risk of criminal prosecution for failures in care. We will undertake more research to understand how this compares to other industries, and to evaluate the costs and benefits of what may risk becoming a 'litigation culture' within the NHS at odds with the spirit of the Francis recommendations.

We would add as a general point, that many of the recommendations within the Francis Report are aimed at secondary care. Poor quality care can occur in all sectors of the NHS, including primary care, and we would like to see the spirit of the Francis recommendations enacted across the system.

We are keen to see, and have consistently lobbied for, greater synergy and co-operation between the regulators to avoid issues of 'double jeopardy' (where providers are penalised twice by different regulators for the same issue). Our members would welcome any streamlining of the regulatory burden in the interest of patients and the best use of resources. However the inspections of care quality and finance require very different skill sets and the potential merging of the regulators could provide too broad a remit for one single organisation. While we are keen to see a strong, and effective quality regulator in the CQC, we feel that some of Monitor's existing responsibilities, particularly around policing compliance with competition legislation and mergers and acquisitions, may not sit well within a single regulator of trusts and that the regulation of individual organisations (both quality and financial regulation) should be treated separately from regulation in terms of compliance with competition law.

We recognise that the CQC has improved, and is a changing organisation. However, we would be cautious about a large and hurried expansion of the CQC's role at a time when they are consolidating their core and fundamental role as a regulator of essential quality standards. Further reform of what is essentially a new regulatory framework will need to be a carefully managed process over time.

OPENNESS, TRANSPARENCY AND CANDOUR THROUGH THE SYSTEM, UNDERPINNED BY STATUTE

- A statutory duty to be truthful to patients where harm has or may have been caused;
- Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient;
- Trusts have to be open and honest in their quality accounts which will be consistent, publicly available. Quality and risk profiles should also be made public;
- The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence;
- It should be a criminal offence for the directors of trusts to give deliberately misleading information to the public and the regulators;
- Proposals for strengthening support for governors, and for strengthening the role of governors and NEDs including their accountability to the public;
- Complaints handling must be improved nationally and locally;
- There should be a consistent structure for local Healthwatch across the country;
- Each provider board should have a member responsible for information;
- The CQC should be responsible for policing these obligations.

Initial views from the FTN

We welcome measures to enhance transparency and openness within the culture of the NHS at local and national levels and the principles behind the recommendations.

We would encourage trusts to act on, and respond to, local complaints which form an important source of information about the quality of their care.

We have supported the organisational, contractual 'duty of candour' as all providers strive to act on the information available to them to improve services, and protect patients. However we are cautious that the development of some of the legal duties proposed at individual employee levels may work against a culture in which staff feel empowered to highlight and act on issues of concern by perpetuating, and exacerbating fear of blame and repercussions. We will take more time to review the recommendations, and their legal implications in detail, and we welcome members' views on this issue.

We look forward to contributing to the discussion about proposals to strengthen the role of governors, and NEDs who play a crucial role in representing and being held to account by members, and the wider community in the foundation trust accountability model.

IMPROVED SUPPORT FOR COMPASSIONATE, CARING AND COMMITTED NURSING

- Nurses should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients;
- Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard;
- Nurses need a stronger voice with suggestions NMC strengthens its role;
- Healthcare workers should be regulated by a registration scheme, with a uniform description of their role;
- Patients should be allocated a key nurse for each shift. Ward leaders should not be office-bound. Particular attention should be given to care for the elderly.

Initial views from the FTN

We have welcomed developments to adopt a more value based approach to nursing, such as the publication of 'Compassion in Practice' and are fully supportive of training and development measures which enable nurses to fulfil their roles effectively and compassionately.

We remain of the view that it is for individual providers to ascertain the skills mix, and patient/staff ratio for their services. While professional guidance on these issues is always welcome, we would wish to resist a prescriptive approach which could undermine local innovation and provider autonomy and fail to serve the best interests of patients.

We would also highlight the need for all staff within NHS settings in both primary and secondary care to adopt and enact the values of compassion in their interactions with patients. While nurses form a crucial interface with patients in relation to quality of care, we would not wish to see their profession unduly singled out when all healthcare professionals have a central role to play.

STRONGER HEALTHCARE LEADERSHIP

- An NHS leadership college to offer potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct;
- It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts;
- A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations;
- Requirements on FTs to provide adequate training for directors;
- Strengthened role for training organisations in providing safety information, for instance recommended skill mix and staff ratios;
- Professional regulators to play a tougher role in relation to protecting patients and the public;
- Health Education England should have a medical director and a lay person on its board. LETBs should have a post of medically qualified post graduate dean.

Initial views from the FTN

We remain cautious about measures to introduce regulation of managers, beyond what might be expected in comparable industries outside of the NHS. It is for the provider board to assure themselves of the quality of leadership and management within the trust and to act accordingly. We are interested to hear further detail about how these recommendations might be implemented and which organisation might fulfil this role.

We do however welcome moves to strengthen medical input to training plans nationally and locally.

FOUNDATION TRUST NETWORK
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