THE FRANCIS REPORT

DEAN ROYLES' BRIEFING

INTRODUCTION

There are 290 recommendations within the Francis Report which are fully outlined in the Report's Executive Summary. This briefing is a summary of the key recommendations that Dean Royles, director of NHS Employers, has identified as having a workforce focus. Dean is a regular conference speaker, published in a number of journals and provides expert opinion in the national media. He was voted **HR's Most Influential Practitioner in 2012.**

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In 2010 the Secretary of State for Health, Andrew Lansley MP, announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The Inquiry was chaired by Robert Francis QC, who made recommendations to the Secretary of State based on the lessons learnt from Mid Staffordshire. The Francis Report published on 6th February 2013 built on the work of his **earlier independent inquiry** into the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009.

The report states ***"there needs to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care… frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations. To achieve this does not require radical reorganisation but re-emphasis of what is truly important":***

- Emphasis on and commitment to common values throughout the system by all within it
- Readily accessible fundamental standards and means of compliance
- No tolerance of non-compliance and the rigorous policing of fundamental standards
- Openness, transparency and candour in all the system's business
- Strong leadership in nursing and other professional values
- Strong support for leadership roles
- A level playing field for accountability
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation"

KEY WORKFORCE RECOMMENDATIONS

Putting the patient first

Patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.

- **R4:** The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first.
- **R5:** In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that:
- Staff put patients before themselves
- They will do everything in their power to protect patients from avoidable harm
- They will be honest and open with patients regardless of the consequences for themselves
- Where they are unable to provide the assistance a patient needs, they will direct them
- Where possible to those who can do so; They will apply the NHS values in all their work.
- **R7:** 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.
- **R8:** Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well.

Fundamental standards of behaviour

Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. A common culture made real throughout the system – an integrated hierarchy of standards of service. No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service.

- **R9:** The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.
- **R12:** Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer 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 any action taken or reasons for not acting.

eWIN HOT TOPIC

NHS North West

Responsibility for, and effectiveness of, regulating healthcare systems governance

Monitor's healthcare systems regulatory functions. Accountability of providers' directors

- **R79:** There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.
- **R80:** A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust's constitution.
- **R82:** Provision should be made for regulatory intervention to require the removal or suspension from office after due process of a person whom the regulator is satisfied is not or is no longer a fit and proper person, regardless of whether the trust is in significant breach of its authorisation or licence.
- **R83:** If a "fit and proper person test" is introduced as recommended, Monitor should issue guidance on the principles on which it would exercise its power to require the removal or suspension or disqualification of directors who did not fulfil it.
- **R84:** Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.
- **R85:** Monitor and the Care Quality Commission should produce guidance to NHS and foundation trusts on procedures to be followed in the event of an executive or non-executive director being found to have been guilty of serious failure in the performance of his or her office, and in particular with regard to the need to have regard to the public interest in protection of patients and maintenance of confidence in the NHS and the healthcare system.

Requirement of training of directors

- **R86:** A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.

Effective complaints handling

Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.

Investigations

Patients raising concerns about their care are entitled to: have the matter dealt with as a com

- **R115:** Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply:
- A complaint amounts to an allegation of a serious untoward incident
- Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion
- A complaint raises substantive issues of professional misconduct or the performance of senior managers
- A complaint involves issues about the nature and extent of the services commissioned

Medical training and education Medical training

- **R152:** 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.
- **R153:** 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 General Medical Council, the Care Quality Commission 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.
- **R156:** 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

- **R157:** The General Medical Council should set out a clear statement of what matters deaneries are required to report to the General Medical Council 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

- **R158:** The General Medical Council 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.
- **R160:** 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.

- **R162:** The General Medical Council 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

- **R163:** The General Medical Council'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

- **R164:** The Department of Health and the General Medical Council 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

- **R170:** Health Education England should have a medically qualified director of medical education and a lay patient representative on its board.
- **R171:** 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

- **R172:** 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.

Implementation of the duty

Ensuring consistency of obligations under the duty of openness, transparency and candour

- **R178:** The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.

Restrictive contractual clauses

Ensuring consistency of obligations under the duty of openness, transparency and candour

- **R179:** 'Gagging clauses' or non-disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

Criminal liability

- **R183:** 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:
- Knowingly to obstruct another in the performance of these statutory duties
- To provide information to a patient or nearest relative intending to mislead them about such an incident
- Dishonestly to 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.

Nursing

Focus on culture of caring

- **R185:** There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires:

▸ **Selection of recruits to the profession who evidence the:**

- Possession of the appropriate values, attitudes and behaviours
- Ability and motivation to enable them to put the welfare of others above their own interests
- Drive to maintain, develop and improve their own standards and abilities
- Intellectual achievements to enable them to acquire through training the necessary technical skills

▸ **Training and experience in delivery of compassionate care**

- Leadership which constantly reinforces values and standards of compassionate care
- Involvement in, and responsibility for, the planning and delivery of compassionate care
- Constant support and incentivisation which values nurses and the work they do through
- Recognition of achievement
- Regular, comprehensive feedback on performance and concerns
- Encouraging them to report concerns and to give priority to patient well-being

- **R187:** TThere should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care.

Aptitude test for compassion and caring

- **R188:** The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.

Recruitment for values and commitment

- **R191:** Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.

Standards for appraisal and support

- **R193:** Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.
- **R194:** As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.

Nurse leadership

- **R195:** Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.
- **R196:** The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.
- **R197:** Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.

Measuring cultural health

- **R198:** Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer".

Key nurses

- **R199:** Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.
- **R200:** Consideration should be given to the creation of a status of Registered Older Person's Nurse.

Strengthening the nursing professional voice

- **R201:** The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls".
- **R202:** Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.
- **R204:** All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider re-cruiting nurses as non-executive directors.
- **R205:** Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.

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NHS North West

Strengthening identification of healthcare support workers and nurses

- **R207:** There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.
- **R208:** Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.

Registration of healthcare support workers

- **R209:** A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents.

Code of conduct for healthcare support workers

- **R210:** There should be a national code of conduct for healthcare support workers.

Training standards for healthcare support workers

- **R211:** There should be a common set of national standards for the education and training of healthcare support workers
- **R212:** The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council.
- **R213:** Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.

Leadership

Shared training

- **R214:** A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare.

Shared code of ethics

- **R215:** A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.

Leadership framework

- **R216:** The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.

Common selection criteria

- **R217:** A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have.

Enforcement of standards and accountability

- **R218:** Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.

A regulator as an alternative

- **R219:** An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.

Accreditation

- **R220:** A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least initially the objective should be to require all leadership posts to be filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime.

- **R206:** The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.

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Ensuring common standards of competence and compliance

- **R221:** Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts.

Professional regulation of fitness to practise

General Medical Council: Systemic investigation where needed

- **R222:** The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.
- **R229:** It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.

Coordination with internal procedures

- **R231:** It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.

Employment liaison officers

- **R232:** The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing.

Caring for the elderly

Approaches applicable to all patients but requiring special attention for the elderly

Teamwork

- **R237:** There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.

THE GOVERNMENT'S RESPONSE

In response to the Francis report, David Cameron announced that the Government will study the 290 recommendations and respond in detail in March, but he announced the following immediate actions:

- The Government creating a single failure regime where the suspension of the Board can be triggered by failures in care, as well as failures in finance.
- Patients, carers and members of staff will be given the opportunity to say whether they would recommend their hospital to family and friends, with the results being published and the Board held to account for their response.
- Where a significant proportion of patients or staff raise serious concerns about what is happening in a hospital, immediate inspection will result and suspension of the hospital board may follow.
- There will be a new hospital inspection regime which examines the quality of care and makes a clear and publicly-available judgment on it. The new role of chief inspector of hospitals will take personal responsibility for this task and be created by the CQC with the new system of hospital regulation will beginning in the autumn.
- Professor Sir Bruce Keogh, NHS Medical Director, has been asked to conduct a review of all hospitals with high morality rates.
- The Secretary of State for Health has also invited the NMC and GMC to explain what steps they will take to strengthen their systems of accountability in light of the Francis report and the Law Commission will also be asked to advise on 'sweeping away the NMC's outdated and inflexible decision making processes.'
- The Prime Minister also raised the possibility of linking pay to the quality of care provided rather than just time served at a hospital and cited the need for a style of leadership from senior nurses which means poor practice is not tolerated and is driven off the wards.

SUPPORT FROM NHS EMPLOYERS

NHS Employers have updated their Francis Report web pages to reflect these announcements and will be adding to these over the coming days as more information becomes available. The organisation has also running r Francis workshops during February, where detailed views were sought on how these recommendations might work in practice and to inform the Government's response.

CONTACT FOR FURTHER INFORMATION

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