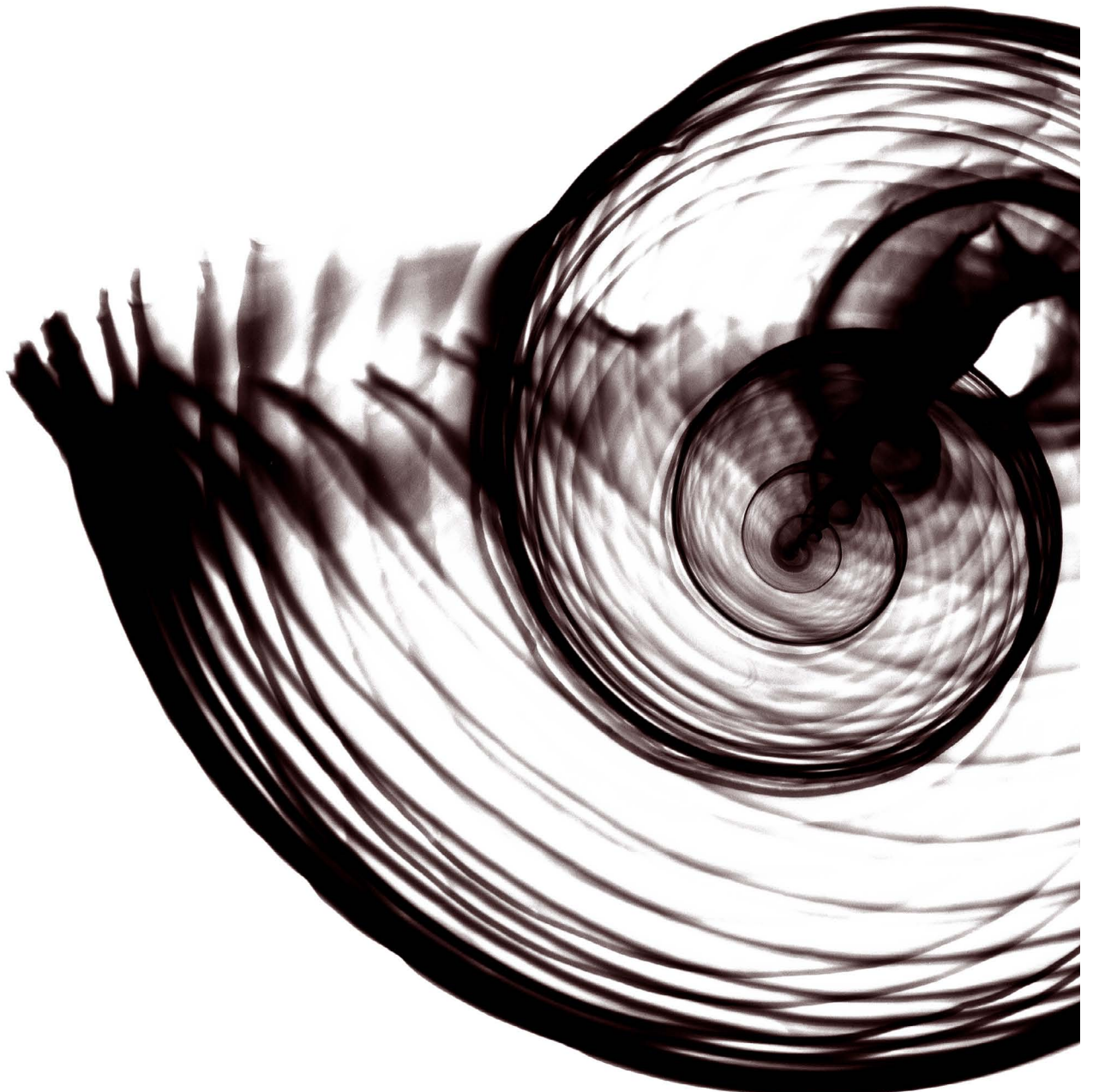
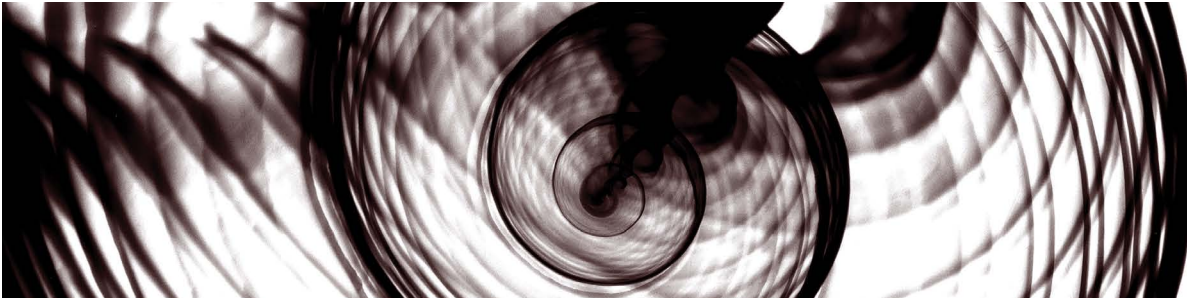




The Francis Report and Beyond
A practical toolkit





Introduction

No-one in the field of healthcare can doubt the profound implications of the report by Robert Francis QC into failings at Mid-Staffordshire NHS Foundation Trust.

In an NHS landscape that is already changing rapidly, the report calls for a seismic shift in the way organisations operate so that patients' wellbeing is prioritised demonstrably and without exception.

Some of the changes proposed by the Francis report are subject to government acceptance or legislation. Many are not – and acute trusts must show by the end of this year how they intend to respond.

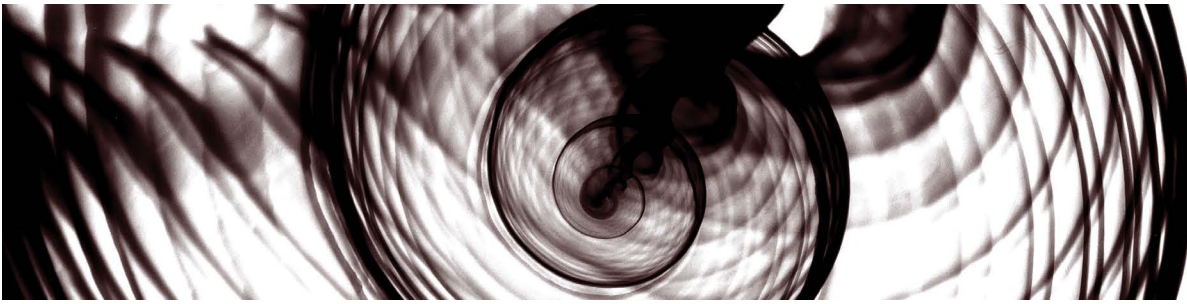
This toolkit is aimed at guiding trusts and other NHS bodies through the necessary steps, with practical advice and pointers to the most useful resources.

As well as explaining clearly the requirements and recommendations of the Francis report, it sets out the existing framework of guidance and standards in key areas including governance, board responsibilities, information-sharing and complaints.

It draws on our long experience at Capsticks in supporting healthcare organisations large and small through the challenges of NHS provision.

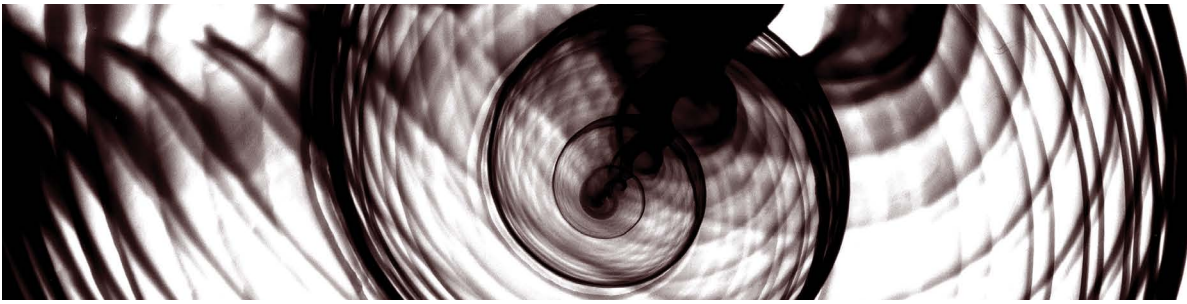
We hope it will provide a comprehensive, easily-accessible and lasting aid to realising Robert Francis' vision of best practice.

Majid Hassan
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1. Governance and internal reporting

1.1 Accountability for implementation of the recommendations (Recommendations 1 and 2)

Overview

The Francis report says that in order for its recommendations to be implemented effectively, “every single person” serving patients must contribute to a safer, committed, compassionate and caring service.

It expresses concern that, while previous inquiries have been welcomed with “initial courtesy” - and with indications that recommendations will be accepted or viewed favourably – the reality is that progress towards implementation becomes slow or non-existent.

The report’s first recommendation is that [pg 89 of 125]:

“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.”

They should then [pg 89 of 125]:

- Announce which recommendations they accept;
- Explain what they intend to do to implement those accepted;
- Publish information at least annually about their progress.

This recommendation underlines the report’s view that all healthcare organisations should account for their decisions and actions - and that change will only happen if everyone who works with or on behalf of patients is engaged.

In addition, the report recommends that:

- The Department of Health should collect and publish information at least once a year about organisations’ decisions and actions in response to the Francis report;
- The House of Commons Select Committee on Health, which reports on the performance of health-related organisations that are accountable to Parliament, should consider incorporating into its reports a specific review of those organisations’ actions and decisions taken in response to Francis.

The aim of these recommendations is to embed oversight of, and accountability for, the report’s recommendations. They seek to harness initial enthusiasm for real and positive change in the wake of the report.

The report’s second recommendation states that:

“The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done.”

The report calls for:

- A common set of core values and standards shared throughout the system;
- Leadership at all levels from the ward to the top of the Department of Health, 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;

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- A tool or methodology to measure the “cultural health” of all parts of the system.

These points encapsulate what the Francis report deems necessary to change the culture of the NHS and deliver care appropriately.

Each one is dealt with in detail later in this toolkit.

The Government has accepted the recommendations about accountability and implementation and has issued a call to action for every part of the system.

Jeremy Hunt, Secretary of State for Health has said:

“Every individual, every team and every organisation needs to reflect with openness and humility about how they use the lessons from what happened at Mid Staffordshire NHS Foundation Trust to make a meaningful difference to people who use their services and their staff, and on how they are transparent and honest in demonstrating the progress they make to the public.”

Foreword to Patients First and Foremost [pg 6-8 of 84]

Checklist of practical steps

- Review the recommendations in the Francis report that apply to your organisation and decide how to respond;
- State publicly by the end of 2013 the extent to which your organisation accepts the recommendations and what you intend to do to implement them;
- Publish at least annually information about progress;
- Liaise with other relevant NHS organisations about plans and progress.

How Capsticks can help:

We have extensive experience of working with NHS boards. We understand the critical role they play in shaping and exemplifying an organisational culture that is open, accountable and compassionate – and which puts patients first.

We can:

- Run seminars offering new insights to boards, helping to ensure they build transparent, accountable relationships with patients, staff and partner organisations;
- Undertake a range of diagnostic and development work with your board to address some of the very real challenges that follow the Francis report;
- Help create NHS boards that have robust, accountable, engaged and transparent corporate governance arrangements;
- Host a board seminar to go through action already taken and the points that still need to be addressed, so that the whole board is involved in formulating the trust’s response;
- Review your action plan before publication to ensure it is clear, has missed nothing and is easily understandable;
- Work with you to help you compile your annual report on progress.

1.2 Putting the patient first (Recommendations 3 to 8)

Overview

Putting the patient first is the theme which underpins the Francis report.

The report states: *“The 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.”

This section of the report echoes the Hippocratic Oath, under which doctors pledge to protect patients from harm and injustice. The wording arises in part from the fact that patients at the Mid-Staffordshire NHS Foundation Trust were found to have been deprived of such basic rights as food and drink.

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The Francis report says the NHS Constitution should be the first reference point for all NHS patients and staff. It should set out common values as well as rights, expectations and obligations.

The report states: *“The overarching value and principle of the NHS Constitution should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.”*

In response, the Government has already published a revised NHS Constitution that includes an increased emphasis on common values.

The Francis report also says the NHS Constitution should set out patient expectations as follows:

- That staff will put patients before themselves;
- That staff will do everything in their power to protect patients from avoidable harm;
- That staff will be honest and open with patients regardless of the consequences for themselves;
- That where staff are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so;
- That staff will apply the NHS values in all their work.

The report recommends that NHS staff be expressly required to abide by the NHS values and constitution, with a written commitment that can be incorporated into contracts of employment. It says this should also apply to outsourced contractors and their staff.

The Government has largely accepted these recommendations in its response document, *Patients First and Foremost*.

The Government will consult on further amendments to the *NHS Constitution* before responding in full to the Francis recommendations.

The existing framework

There are several publications that cover the importance of changing NHS culture to improve patient care and to ensure patients' voices are heard.

These include:

- The Healthy NHS Board 2013: Principles for Good Governance, NHS Leadership Academy, 2013.

This has a section on shaping culture.

- Quality in the new health system
Maintaining and improving quality from April 2013.

“An organisation that is truly putting patients first will be one that embraces and nurtures a culture of openness and learning.”

Everyone counts: Planning for Patients 2013/14

“The challenge facing the NHS is to become truly patient-centred.”

The Berwick Report from the National Advisory Group on the Safety of Patients in England is a key document containing many references to patients and their safety and examining how to improve the current system.

Checklist of practical steps

- Ensure that the NHS Constitution is prominent in your organisation and that copies are available for patients and staff;
- Run training sessions for staff on what it means practically to “put patients first” and your expectations of their behaviour;
- Decide whether you will require your staff to enter into an express contractual commitment to abide by the NHS values and the constitution and consider the consequences of this;
- Decide whether you will require contractors providing outsourced services to abide by NHS values and the constitution and include it in contracts;
- Review the culture of your organisation and decide whether changes are needed to make patients the priority in all that you do.

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How Capsticks can help

We can:

- Run a board workshop examining ways to shape your organisation's culture and identify the best methods of engagement with staff and service users. We can ensure feedback from those groups helps you shape a responsive and sustainable strategy and ensure accountability;
- Review your governance arrangements, shifting the focus beyond paper reporting towards patients' stories and experiences with emphasis on real time reporting. For example, board members could join patient safety walk-rounds and staff could take part in facilitated focus groups;
- Carry out a staff survey to see whether NHS values are embedded in your workforce and help prepare an action plan for change if necessary;
- Provide legal advice on how a commitment to abide by NHS values and the NHS Constitution could be incorporated into staff contracts and with contractors.

1.3 Fundamental standards of behaviour (Recommendations 9 – 12)

Overview

The Francis report says all of those who work in the healthcare system should be committed to fundamental standards of behaviour enshrined in the NHS Constitution (see also [1.2 Putting patients first](#)).

It says the constitution should also make clear that staff must adhere to guidance and standards produced by their own professional or regulatory bodies (see also [4.3 Professional regulation of fitness to practise](#)).

The report recommends that healthcare professionals contribute to the development of standards, and says disagreements about procedures must be resolved appropriately. Reporting of incidents should be insisted upon and staff are entitled to feedback (see also [3 Openness, transparency and candour](#)).

Francis also urges professional bodies to draw up evidence-based standard procedures for as many interventions and pathways as possible.

The existing framework

There are currently a number of codes of conduct which apply to the NHS and which could form the basis for new fundamental behavioural standards.

These include:

- The *Code of Conduct and Code of Accountability* in the NHS. This dates from 1994 (with subsequent revisions) and covers NHS boards and individuals, setting out standards on probity and openness and public service values of accountability.
- The *Professional Standards Authority* rules for members of NHS boards and clinical commissioning group governing bodies in England. This was published in 2012 and covers personal behaviour, technical competence and business practice.
- The *NHS Foundation Trust code of governance*, covering standards of behaviour for directors and governors.
- The code of conduct for NHS Managers, published by the Department of Health in 2002.
- The *Institute of Healthcare Management* code of conduct, revised in 2012.

Clearly there is much overlap between the various codes of conduct. It may be helpful to have one set of fundamental standards so there can be no doubt about what is expected from healthcare staff.

The Government's initial response to the Francis report includes support for fundamental standards and incorporates a number of ideas on how these can be achieved.

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Checklist of practical steps

- Ensure that your staff know about and follow the codes of conduct that apply to them;
- Ensure that your board members and other senior staff understand the codes of conduct which apply to them and agree on what these mean in practice;
- Encourage staff to participate in the development of standards where applicable;
- Review your system for reporting incidents and promote staff awareness of your procedures;
- Ensure that staff receive feedback about incidents they have reported, explaining what was done or why no further action was judged necessary.

How Capsticks can help

We can:

- Provide training or a seminar for board members about fundamental standards, helping to secure staff commitment to these;
- Ensure that your board induction programmes for directors are reviewed and revised in line with developments including the Francis report, the government's response, the outcome of Sir Bruce Keogh's recent inquiry into failing standards at some NHS trusts and the Berwick Report into NHS Patient Safety;
- Ensure that your induction programmes focus clearly on codes of conduct and the roles and responsibilities of directors, using relevant case study work to demonstrate how these apply in practice;
- Review the effectiveness of your incident reporting system and advise you on potential improvements, particularly in terms of fundamental standards;
- Ask staff how they view the incident reporting system and identify areas where development is required.

1.4 Common culture made real throughout the system – an integrated hierarchy of standards of service. Recommendations 13 to 18

Overview

The Francis report says: *“No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service.”*

It also states: *“Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.”*

The report recommends that standards be drawn up within:

- Fundamental standards of minimum safety and quality, in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which organisations may be prosecuted. There should be a defined set of duties to maintain and operate an effective system to ensure compliance;

- Enhanced quality standards, which set requirements higher than fundamental standards but which are discretionary matters for commissioners and subject to availability of resources;
- Developmental standards which set out longer-term goals for providers. These would aim to improve effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator.

The Francis report says that at the Mid-Staffordshire NHS Foundation Trust, *“The Board failed to get a grip on its accountability and governance structure and this clearly contributed to the extent of the failures.”*

Good governance is essential to a healthcare system that puts patients first.

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The report therefore recommends:

- A generic requirement within the regulations for a governance system designed to ensure compliance with fundamental standards;
- A single comprehensive standard setting out all the required elements of governance;
- A requirement to demonstrate that governance systems work in practice and are being used to good effect;

The report says the Government should take responsibility for setting fundamental standards after seeking a consensus with the public and professional representatives. It should define outcomes for patients that must be avoided.

NHS England and clinical commissioning groups (CCGs) should devise enhanced quality standards.

The report says it is essential that professional bodies are fully involved in the formulation of standards and in agreeing how to measure compliance.

Developing and enforcing the new standards will be the responsibility of the Care Quality Commission (CQC). *The CQC has recently completed an initial public consultation on the way it regulates inspects and monitors care.*

The CQC is proposing to categorise standards as follows:

- **Fundamentals of care**
The basics below which no provider can fall without facing serious consequences.
- **Expected standards**
Standards that patients should expect as a matter of course.
- **High-quality care**
Good practice as defined and identified by organisations such as NICE (the National Institute for Health and Care Excellence) and NHS England.

Services will be required by law to meet fundamentals of care and expected standards. They will not be granted a licence without attaining these. Providers should aspire to meet high-quality care standards and will be rated according to their achievement in this regard.

The CQC is proposing four ratings for providers. The level attained will determine how often a provider is inspected.

- **Outstanding** every 3-5 years
- **Good** every 2-3 years
- **Requires improvement** at least once a year
- **Inadequate** as necessary

The CQC is also proposing to judge providers according to whether their care is:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

The results of the CQC's initial consultation, to be published shortly, will be followed by another more detailed consultation looking at its proposed standards and ratings assessments.

(See also [4.1 Responsibility for and effectiveness of healthcare standards](#))

The existing framework

There are a number of publications that help NHS organisations to establish an effective governance system.

- *The Healthy NHS Board 2013: Principles for Good Governance, NHS Leadership Academy, 2013.*
- *Quality in the new health system Maintaining and improving quality from April 2013.*
- *The NHS Foundation Trust, Code of Governance.*
- HFMA (Healthcare Financial Management Association) *Integrated Governance: A guide to risk and joining up the NHS Reforms (2011).*

Checklist of practical steps

- Ensure you are complying with current standards and address areas that need attention;
- Review your governance arrangements and ensure that they are fit for purpose and effective;

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- Consider commissioning a governance review from an independent specialist;
- Participate in the CQC consultations to provide information to shape the new standards.

How Capsticks can help

- We have real, practical experience of NHS governance over many years;
- We can provide an independent review of your governance systems and processes, harnessing your strengths and working with you on areas that need to be improved upon. Our review will include:
 - Interviews with board directors and other senior managers
 - An assessment of your needs, challenges and risks
 - An examination of board, committee and other relevant papers
 - Debate and discussion about our recommendations
- We can provide on-going coaching and mentoring or one-off intensive support for your trust secretary to ensure he or she has a real and positive impact on the governance of your organisation;
- We are assessors for the Board Governance Assurance Framework, which reviews the effectiveness of governance arrangements. That means we can either provide an assessment for you or help you prepare for one;
- We can prepare or assess you for the Monitor Quality Governance Framework, which looks more specifically at patient safety and the quality of the care provided by your organisation;
- We can provide an effectiveness review for your board, looking at the quality of its debate, action-planning and decision-making; the adequacy of information it receives and the balance of the agenda between strategy and operational matters;
- We can carry out a skills audit of individual board members, reviewing how each one contributes to the whole board.

1.5 Leadership Recommendations 214 to 221

Overview

The Francis report emphasises that what happened at the Mid Staffordshire NHS Foundation Trust was primarily caused by a failure on the part of the provider trust board.

“It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the trust’s attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.” [pg 6 of 125]

Inevitably, therefore, the report makes general and specific recommendations about leadership which will have a very real impact on the composition, conduct and performance of NHS boards.

It says that while the common culture and values of the NHS must be applied at all levels of the organisation, the example set by leaders is ‘of particular importance’.

The report recommends establishing a leadership staff college to provide common professional training in management and leadership. The college would administer an accreditation scheme to enhance eligibility for such roles and promote and research best leadership practice in healthcare.

The report regards this as a means of promoting healthcare leadership and management as a profession.

It also recommends:

- A common code of ethics, standards and conduct for boards (echoing the theme of earlier recommendations 9-12).
- An agreed list of qualities generally considered necessary for a good and effective leader.
- Greater emphasis on patient safety within the leadership framework.

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- The enforcement of leadership standards, through either:
 - disqualification from office for those who breach the code of ethics, standards and conduct
 - the establishment of a regulator

Overall, there is growing awareness that the delivery of high quality, safe, sustainable healthcare depends on the ability of boards and organisations to build effective partnerships across a complex local health and social care economy.

This is reflected in both the Francis report and the Government's initial response, which says that “[boards]... have the principal responsibility for ensuring that care in their organisations is safe and that those who use their services are treated as individuals, with dignity and compassion”.

The Government believes the Francis report's recommendations regarding leadership can be fulfilled by the NHS Leadership Academy working with a range of academic and private sector partners.

It says these organisations will work with a range of NHS staff to learn to lead their teams and provide better, more compassionate patient care.

The Government has also pledged to invest £40million in nurse leadership and is offering support to senior leaders from other sectors who want to join the NHS.

Checklist of practical steps

- Review your system of staff appraisal, particularly for senior managers, and ensure that the relevant people have a personal development plan that includes leadership training;
- Ensure you are familiar with the programmes run by the National Leadership Academy and make certain your staff have every opportunity to attend appropriate events and training sessions;
- Make certain your staff have the opportunity to develop their leadership skills and progress in the organisation.

How Capsticks can help

- We understand the crucial importance of an effective, engaged, accountable board and the strong relationship between leadership capability and performance;
- We offer a board development programme that will help your leadership team to navigate the rapidly-changing environment, enabling it to embrace change, foster innovation, encourage learning and maintain its commitment to quality and patient safety;
- Capstick's Human Resources Advisory Service in collaboration with NHS Employers offers support to NHS organisations to enhance appraisals and PDP processes for senior managers.

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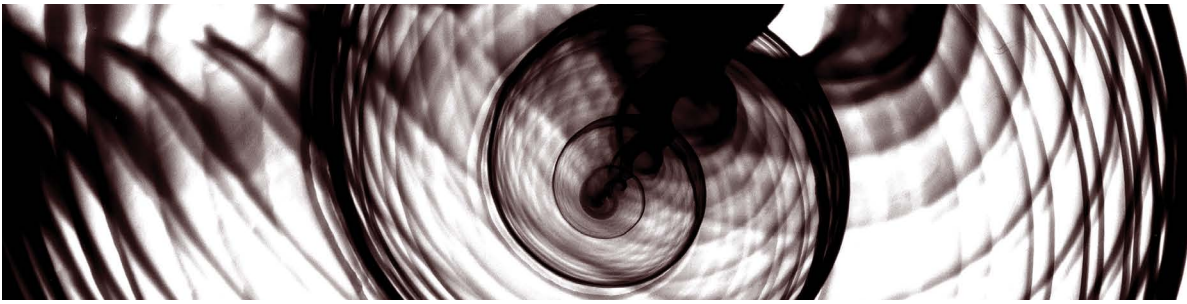
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2. Information and external reporting

2.1 Information Governance (Recommendations throughout the report)

Overview

The Francis report identifies the central importance of information in maintaining high standards.

It also recognises the difficulties inherent in balancing information-sharing against the need for patient confidentiality.

The report says that at the Mid-Staffordshire NHS Foundation Trust “... information that would have led to the much earlier appreciation of the problems of the trust was either not collated, not analysed or not disseminated...while the need for confidentiality is clear, there are exceptions to the duty to maintain it... Provided any means of identifying the patient is removed from the information, there is no public interest reason why it should not be used for the purposes of management and regulatory data.”

[Francis report, chapter 26].”

The report makes several recommendations regarding information sharing and Governance (see below).

However, even before Francis, the government had begun consulting on this subject in an attempt to reconcile patient confidentiality with effective data sharing and scrutiny. It is therefore important to understand the context in which the report makes its recommendations.

The existing framework

Key publications and developments include:

- *The Power of Information: Putting us all in control of the health and care information we need*, Department of Health, 2012, which recognises that high quality, properly accessible information is necessary to modernise the NHS and care services.
- *The Information Governance Review: to Share or Not to Share*; March 2013 (Caldicott 2)

This report, from a review chaired by Dame Fiona Caldicott, describes an urgent need for the “*re-balancing of sharing and protecting information... in the patients’ and service users’ interests.*”

However, it also says that only in the most exceptional circumstances should identifiable patient information be shared beyond those directly involved in providing care to that patient, without the patient’s consent.

There is a risk that this may deter the sharing of relevant information, particularly because of the threat of regulatory action from the Information Commissioner’s Office.

The Caldicott 2 report is clear that improper use or sharing of personal data should be taken seriously and that, as with victims of poor quality care, there should be a proper redress and accountability for information loss or misuse.

The report concludes with seven Caldicott principles for the protection of confidentiality (revised from the six originally drawn up in 1997) and 26 recommendations.

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In its response, published September 2013, the Government accepted the revised seven principles and set out its expectations for all health and social care organisations.

- *The Review into the quality of care and treatment provided by 14 hospital trusts in England* by Professor Sir Bruce Keogh (July 2013) The Keogh Review found that in trusts with high mortality statistics, *“The hospitals reviewed were often unaware of what information was reported (even if they provided the data themselves) nationally on their own organisation, and consistently challenged the validity of this. The review teams often witnessed information being used for justification to confirm a specific viewpoint the trust had on a specific issue... Information was only rarely used in an enquiring manner in order to seek out and understand the root cause of a problem area.”*
- *The Information Commissioner’s Data Sharing Code of Practice* and the *Confidentiality NHS Code of Practice*, which sets out the guidance on sharing personal data and offers practical advice to support decision-making.
- *Guidance on managing information governance incidents.*
- *The Health and Social Care Act 2012* and related guidance, which introduced changes to information sharing and governance arrangements within the NHS. These include:
 - The use where possible of de-identified data, with the aim of making the NHS number the primary identifier by 2015
 - Limits on the handling of patient-identifiable data, except by staff in “accredited safe havens” and those providing direct care
 - *Establishment of the Health and Social Care Information Centre (HSCIC)*

The main functions of the HSCIC are:

- *Managing national IT systems for collecting, analysing and presenting national health and social care data*, under direction from the Secretary of State or NHS England;
- Publishing a code of practice to set out rules on handling personal confidential information by health and care staff and organisations;
- *Establishing a library of indicators to measure the quality of health and care services;*

- *Ensuring organisations improve the quality of the data collected and submitted, by setting standards and guidelines to enable self-assessment;* and
- Creating a register of public datasets of all the information that HSCIC collects and produces.

The HSCIC has not yet published the code of practice on confidentiality. However the NHS has published a Data Flows Transition Manual.

The Francis report recommends that the HSCIC take a more active role in analysing data.

The Government’s initial response has not directly addressed this suggestion but it does envisage developing the part played by the HSCIC.

It acknowledges that, while information is key to improving quality, too great a preoccupation with information-gathering takes up staff time unnecessarily [pg 34-35 of 84].

The HSCIC will therefore be expected to ensure that *“paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third” [pg 17 of 84].*

The Government suggests that where an organisation is seeking to carry out a new information collection it should first justify this to HSCIC.

(See also [2.2 Reporting to regulators and commissioners](#))

The Francis report recommends widespread sharing of information to ensure that relevant organisations are fully aware of potential problems at a provider.

In particular, it calls for:

- A requirement by provider organisations that patient safety incidents be reported (*Recommendation 12*) (see also [3 Openness, transparency and candour](#));
- A duty to share information between regulators which goes beyond “existing concerns identified as risks” and extends to *“all intelligence which, when pieced together with that possessed by partner organisations may raise the level of concern” (Recommendation 35);*

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- A coordinated collection of accurate information about organisations' performance to be made available to providers, commissioners, regulators and the public in as near real-time as possible ([Recommendation 36](#));
- The publication and dissemination of more information than is currently available. For instance, information contained in *Reporting of Injuries, Diseases and Dangerous Occurrences* (which is currently only reported to the Health and Safety Executive) should be made available to healthcare regulators through the serious incident reporting system ([Recommendation 88](#));
- Open analysis of National Patient Safety Agency information, which is currently generally regarded as confidential ([Recommendation 102](#)).

In response, the Government has recognised a need to ensure effective joint working, including with coroners (see [5.2 Inquests](#)), and better information sharing.

Monitor and the Care Quality Commission have reviewed their arrangements to ensure that they share information more effectively about the performance of foundation trusts.

Some of the Francis report's recommendations in relation to information – such as the suggestion that patients be granted greater access to their records and the ability to enter comments in 'real time' ([Recommendation 244](#)) require technological change and may take some time to achieve.

Others require changes to organisational and national policy.

These include:

- Board level responsibility for information ([Recommendation 245](#));
- Standardisation of audited, more accessible quality accounts across organisations ([Recommendations 246 - 250](#));
- Criminal sanctions for any individual director who signs a statement which he or she does not have reason to believe is true;
- A regulatory right to require corrections to inaccurate accounts ([Recommendation 251](#));
- The contribution by healthcare professionals to routine publishing of statistics for the efficacy of treatments for performance oversight and revalidation ([Recommendations 262-266](#)).

The Government has already said that outcomes data will be published in cardiology, vascular surgery, upper gastro intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery, head and neck surgery and thyroid and endocrine surgery.

The Francis report also calls for hospital mortality statistics to be recognised as "national statistics". Although this has not yet been implemented, Professor Sir Bruce Keogh's review of 14 providers with higher-than-average death rates has been completed: 11 providers were put in "special measures" as a result and reports were published.

Checklist of practical steps

- Ensure there is board level responsibility for information and information governance;
- Make sure your organisation is familiar with, and ready for, the new guidance being published by HSCIC;
- Understand the existing rules;
- Ensure that "data protection" is not used as a blanket excuse for failing to share information where appropriate;
- Make sure staff receive clear guidance on the legal framework, the handling and disclosure of confidential information and the possible sanctions for breaches of confidentiality or data loss;
- Ensure you have systems and processes to protect personal information and set out who to approach for advice;
- Update your privacy notices explaining to the individuals from whom you collect data how their information is used and with whom it is shared. Make sure your registration with the Information Commissioner reflects your practice;
- Conduct formal information security risk assessments;
- Report information governance incidents in line with requirements.

QUICK LINKS:

Governance and internal reporting
Professional regulation and workforce

Information and external reporting
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How Capsticks can help

We can:

- Prepare data-sharing and data-processing agreements and protocols;
- Advise on the lawfulness of information-sharing proposals and requests;
- Draft fair processing notices and data protection policies;
- Advise on responses to data subject access requests and requests made under the Freedom of Information Act 2000;

- Advise on dealing with information security breaches and liaising with the Information Commissioner's Office.

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2.2 Reporting to regulators and commissioners (Recommendations throughout the report)

Overview

Under current arrangements, NHS trusts and foundation trusts are required to report to a range of regulatory, public and government bodies.

The Francis report recommends that more information should be shared – and in new ways – both between providers and regulators and between the different regulatory bodies.

This would facilitate earlier identification of risks and deficiencies.

It also recommends a merger of the functions of the two key regulatory bodies – Monitor and the Care Quality Commission (see below) – although this has been rejected by the Government.

The report suggests that all of those involved in NHS commissioning, provision and regulation become more proactive in seeking out information regarding standards and quality. This includes the General Medical Council and the Nursing and Midwifery Council (see also [4.3 Professional regulation of fitness to practise](#)).

The report emphasises the role of individual directors and trust boards in ensuring honest and accurate reporting to regulators and says each provider organisation should have a board level member with responsibility for information (see [1.5 Leadership](#)).

The existing framework

The bodies and organisations with a role in regulation and information-gathering include:

- The **Care Quality Commission (CQC)**, the quality and safety regulator for all health and adult social care services in England.

Under Section 64 of the Health and Social Care Act 2008, the CQC may require NHS trusts to provide it with documents, records or other items which CQC considers necessary or expedient to have for the purposes of any of its regulatory functions.

In addition, the Care Quality Commission (Registration) Regulations 2009 include (for example) *the requirement to notify the CQC of the death of a service user or of allegations of patient injury or abuse*.

There is also an obligation on every NHS trust to send to the CQC, if requested, a summary of complaints made against the trust and the responses given.

(See also [4.1 Responsibility for and effectiveness of health services](#) and [5.1 Effective complaints handling](#))

- **Monitor**, which regulates the entire health services sector in England and grants licences to provider organisations.

Under Section 104 of the Health and Social Care Act 2012, Monitor may require any NHS healthcare provider to submit information it considers necessary for its regulatory functions.

QUICK LINKS:

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The conditions under which Monitor issues providers with licences contain two general conditions governing the provision and publication of information by licensees. (General Conditions 1 and 2).

(See also [4.1 Responsibility for and effectiveness of health services](#))

- **The NHS Trust Development Authority (NTDA)**, which assists NHS trusts towards foundation status and supports them on matters including quality and governance.

The NTDA has the power to direct NHS trusts as to the exercise of any of their functions by the National Health Service Trust Development Authority Directions 2013 at direction 4(a), and is obliged by direction 4(m) to request any information from NHS trusts that it requires to carry out its functions.

In addition, NHS trusts may be contractually obliged to report to the NTDA (as a Regulatory or Supervisory Body) under service condition 2 (regulatory requirements) of the standard NHS contract [pg 4].

- **The Secretary of State for Health and the public**, through the publication of annual quality accounts.

Under section 8 of the Health Act 2009 individuals or bodies who provide, or make arrangements for others to provide, NHS services must publish a document each year which sets out information relating to the quality of those services. This is called a quality account, and there are some exemptions to the obligation available for a limited number of providers.

More detail on the Quality Accounts is set out in the [National Health Service \(Quality Accounts\) Regulations 2010](#).

■ Commissioners

Under the standard NHS contract between providers and commissioners, providers must meet requirements relating to the provision of information both to commissioners themselves and to the relevant regulatory body or bodies.

Specifically, under service condition 28 (Information Requirements) of the contract [pg 17], providers must supply to the relevant commissioner information set out in schedule 6 part C of the standard contract, which includes both nationally and locally set requirements. [pg 68]

They must also provide any additional information which the relevant commissioner reasonably requires in relation to the contract.

Under these requirements, providers are obliged regularly to submit information to commissioners regarding:

- Their performance against an agreed service development and improvement plan;
- Their performance against standards set out under schedule 4 ([quality requirements](#)) [pg 37];
- Any breached thresholds and “never events” (as defined in the standard contract);
- Any serious incidents reportable patient safety incidents (those which involve moderate or severe harm or a death), or other patient safety incident as defined in the standard contract and as set out in the incidents requiring reporting procedure ([schedule 6 part E](#)) [pg 75];
- Any relevant incident described in [service condition 33](#) (Incidents Requiring Reporting) [pg 29];
- *Any safeguarding concerns and the way they are being addressed [pg 28].*

The Francis report calls for a shift in the way information is gathered and reported.

It recommends:

- The coordinated collection of near-to-real-time, accurate performance information - including statistical outcome measures and all safety-related incidents – which it says should be made available to providers, commissioners, regulators and the public (Recommendation 36);
- The introduction of a standard format for annual quality accounts, ensuring “full and accurate information” is given about trusts’ performance against every relevant standard, so that reports may no longer give prominence to successes at the expense of areas where a trust has not achieved compliance (Recommendation 37).

In its initial response, the Government says that the Health and Social Care Information Centre (created by the Health and Social Care Act 2012) will become the single national information-collection hub. It also says the same data sets will be used to judge standards throughout the healthcare system. [pg 16, paragraph 9 and pg 17, paragraph 14]. (See also [2.1 Information governance](#))

The report makes several recommendations about the role of the Care Quality Commission in gathering information.

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It says the CQC should:

- Actively seek out information about all useful complaints information that is relevant to the assessment of compliance with fundamental standards (recommendation 38) (see also [5.1 Effective complaints handling](#));
- Require providers to submit information about patterns of complaints, how they were dealt with, and outcomes (Recommendation 39);
- Investigate media reports of any serious incident or avoidable harm, examining how it was addressed by the provider and requiring the trust to demonstrate how it implemented the lessons learned (Recommendation 44);
- Write to every newly-appointed foundation trust governor inviting him or her to submit to the Care Quality Commission any concerns he or she may have (Recommendation 48);
- Take over from Monitor the role of assessing trusts' applications for foundation status.

(See also [4.1 Responsibility for and effectiveness of healthcare standards](#))

The Government's initial response to the report contains a declaration signed by key healthcare organisations pledging that they will "seek out and act on feedback, both positive and negative" [pg 11, paragraph 10]

The Francis report emphasises the need for those who provide and disseminate data and information to ensure its accuracy, recommending that: "Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission." (Recommendation 176)

Currently, the standard NHS contract between providers and commissioners includes a duty of candour which means that providers must let service users (or a person acting lawfully on their behalf) know about any reportable patient safety incident [pg 30, Service Condition 35];

The report recommends the introduction of a statutory duty of candour, with criminal sanctions against organisations or individuals who fail to disclose what they should (see also [3 Transparency, Openness and Candour](#));

See also [4.3 Professional regulation of fitness to practise](#) for the role of the professional regulatory bodies in gathering and sharing information.

Checklist of practical steps

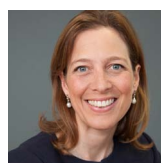
- Compile a checklist of information required for the different regulators to ensure information is submitted as necessary, including internal gateways and reviews to ensure accuracy;
- Analyse themes across the information submitted to regulators to ensure that lessons are learned early and that risks are mitigated;
- Run sessions with your boards and governors to update them on the reporting recommendations of the Francis Report and ensure their compliance;
- Run a campaign within your organisation to reiterate the importance of candour, transparency and reporting errors;
- Undertake an audit of reporting structures in place in your organisation, identifying deficiencies and putting in place teams to rectify them if necessary.

How Capsticks can help

We can:

- Provide training sessions for your board and governors to update them on the outcome of the Francis Report, and advise them how the report will affect their roles in future;
- Assist with applications for foundation trust status which will require increased emphasis on patient safety and quality considerations;
- Help prepare checklists of information required to be reported to regulators and commissioners;
- Assist with internal governance to ensure quality and high standards of information in your preparation and submission to regulators and commissioners.

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3. Transparency, openness and candour

Recommendations 173 to 184

Overview

Candour is important to maintain trust in the service, properly involve patients in their own care and identify concerns early.

It helps to facilitate patient choice and to ensure that remedies are available and lessons learnt from mistakes.

NHS staff must understand the duty of candour as well as the existing framework of obligations.

The Francis report proposes a statutory duty of candour, which the Government is considering.

This would require that 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, the patient (or any lawfully entitled personal representative or authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, *whether or not the patient or their representative has asked for this information.*

Crucially, under the report's proposals, individual health professionals as well as organisations could face criminal sanctions should they wilfully obstruct anyone in the performance of this statutory duty.

The existing framework

The current requirements in relation to openness, transparency and candour are set out in various documents.

- *The NHS Constitution makes clear that when mistakes happen they should be acknowledged and an explanation provided, along with an apology.*

- The GMC's *Good Medical Practice* as well as the NMC's *Code of Conduct* both place an ethical duty on the health professionals to be open and honest with patients if things go wrong and to offer full explanations promptly when a patient has suffered harm.
- *The NHS Litigation Authority Risk Management Standards 2012-13* require organisations to have "an appropriate documented process for open and honest communications following an incident, complaint or claim".

Level 1 requires this process to include how staff "acknowledge, apologise and explain when things go wrong". This is in line with previous guidance from the NHSLA to Trusts in 2009.

- *NPSA (National Patient Safety Agency) guidance* requires "acknowledging, apologising and explaining when things go wrong."
- *Service condition 35 of the NHS Standard Contract contains contractual obligations of candour (pages 30-31):*

Providers must tell a patient (in writing, with all facts and an appropriate apology) about any unintended or unexpected incident that could have led, or did lead, to moderate or severe harm or death to a patient. This contractual obligation requires an apology in relation to any "reportable patient safety incident" – that is, a near miss and not just an incident that results in serious harm or death as proposed under the statutory duty of candour.

Unlike the ethical duty to keep patients informed, the contractual duty of candour applies only to incidents that result in moderate or severe harm or death. In assessing the level of harm, *Seven Steps to Patient Safety* grades patient safety incidents.

QUICK LINKS:

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Providers must ensure that if they enter into sub-contracts with other providers or with individuals, that the sub-contracting arrangements include equivalent obligations of candour and appropriate reporting provisions so that the provider can comply with its own obligations.

The Francis report concludes that existing arrangements regarding candour are insufficient and that a statutory duty with criminal sanctions would act as a better deterrent to wilfully withholding information.

As an example of the culture which the report seeks to address, Francis cites the case of John Moore-Robinson, in which it was felt that the trust's in-house solicitors were "simply at the wrong starting point" with their intention of withholding information which it was not in the best interests of the trust to disclose.

In its initial response, the Government has accepted the need for a statutory duty of candour.

However, it has reserved its position in relation to criminal sanctions against individuals because of concerns this might "unintentionally create a culture of fear" and "prevent lessons being learned".

It has also, made clear that "there can be no excuse for boards who knowingly supply wrong information about key indicators such as mortality rates or deliberately withhold information from patients or families about serious harm or death".

Under the Government's proposed statutory duty, health and care providers must inform patients if they believe treatment has caused "death or serious injury".

The Government will confirm its position in its final report but in the meantime the Berwick Report does not recommend a statutory duty of candour with criminal sanctions enforceable against individuals working in healthcare as it says this would undermine the development of a learning culture.

Prohibition on gagging clauses

Closely aligned to the duty of candour is the recommended prohibition in the Francis Report on so-called "gagging clauses" which seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care. This has already resulted in the Secretary of State for Health writing to all NHS chairs reminding them of the need to ensure that

contracts of employment and compromise agreements with departing staff do not prevent them from raising such concerns.

The challenge for employers is to achieve the right balance between permitting and fostering a culture of openness and transparency and protecting their legitimate business interests, particularly when employees leave their organisation.

The Public Interest Disclosure Act 1998 (PIDA) sets out various types of disclosure that may qualify for protection under the Act. The categories that are most relevant to healthcare bodies are failure to comply with a legal obligation or endangering health and safety. PIDA expressly forbids any attempt by employers in contracts or other agreements to prevent employees from making protected disclosures provisions in a compromise or other agreement.

The Government acknowledges that the use of confidentiality clauses within compromise agreements can help both parties end the employment with a clean break.

However, it emphasises that such clauses should never go further than is necessary to protect matters such as patient confidentiality and commercial interest. It makes clear that gagging clauses are strictly prohibited and unenforceable in law.

Checklist of practical steps

- Undertake a full review of your *Being Open* policy to ensure it is accessible, up to date and unambiguous. Ensure that staff at all levels have appropriate training in the policy and that they know what to report and when;
- Ensure staff check with senior colleagues that documents they disclose do not breach confidentiality, that discussions and explanations are documented in patient records and internal paperwork is completed;
- Ensure you have an established system for reporting incidents and collating data in line with the trust's contractual obligation;
- Ensure that incidents leading to serious harm or death can be identified and information passed to the board or external regulator as necessary;

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- Review all information from complaints to identify possible patterns of poor care;
- Review your handling of complaints, litigation and inquests. Ensure that staff working in these areas are clear about their legal obligations and process matters promptly and thoroughly, with sensitive, responsive and accurate communication;
- Ensure that staff preparing documents for the purpose of complaints, internal incident investigations and risk management are aware of the context in which their view is sought and that they provide clear and factual accounts. They should remember there is no legal privilege attaching to such documents;
- *If a request is made to the trust for disclosure of records in contemplation of litigation, consider the pre-action protocol*; arguably all disclosable documents should be sent out rather than only the medical records;
- Review contracts of employment, codes of conduct and disciplinary procedures. These should include specific provisions requiring staff to be honest, open and truthful in all their dealings with patients and the public;
- Consider your response if members of staff do not meet the standards of candour expected of them, now or in the future under a possible statutory duty. Any decision to adopt a ‘zero tolerance’ approach by treating such instances as grounds for dismissal would demonstrate a commitment to the principles underlying the Francis report but would work only if applied consistently to all staff, irrespective of their seniority or profession;
- Include in any new contracts of employment and compromise agreements an express provision permitting disclosures that are in the public interest;
- Ensure you differentiate between confidentiality provisions which aim to protect the legitimate interests of the employer and those which seek to prevent a public interest disclosure. In determining whether a clause might be viewed to be a gagging clause, consider whether it appears to limit the scope of employees to make protected disclosures.

(See also [5 The Patient Interface](#))

How Capsticks can help

We can offer support and advice on:

- Policy review, drafting and implementation;
- Training and education at board and directorate level;
- Standard contract obligations, as well as the candour and related obligations to be included in any sub-contracts;
- “Training the trainer” packages, with the provision of core material to assist in the implementation of trust-wide policies;
- Employment contracts, compromise agreements and disciplinary issues relating to duty of candour;
- Handling complaints, inquests and issues around disclosure of information.

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4. Professional regulation and workforce

4.1 Responsibility for and effectiveness of healthcare standards (Recommendations 19 to 59)

Overview

The Francis report concludes that *“at the heart of the failure to detect or prevent the appalling events at Stafford sooner was the concept of the core standards and the means of assessing compliance: the annual health check (AHC). The core standards suffered from a number of deficiencies.”*

He therefore recommends that *“the standards to be enforced by the regulator should be a clear fundamental set of standards, driven by the interests of patients, and devised by clinicians; a “bottom up” as opposed to a “top down” system.”*

Francis judges the regulatory landscape confusing and in need of simplification. He therefore recommends that the Care Quality Commission (CQC) should monitor not only compliance with fundamental standards but also providers' governance and financial sustainability to ensure they can deliver compliant services on a sustainable basis.

This would entail the CQC taking over functions currently performed by Monitor, which regulates the entire health services sector in England.

However, the Government has rejected this recommendation and is proposing to retain both organisations, each with a distinct function.

The existing framework

The Care Quality Commission

The CQC was established by the Health and Social Care Act 2008 as the healthcare regulator responsible for the registration, inspection and review of health and care providers.

All providers of health and care that carry out regulated activities are required to register with the CQC. As a condition of registration, they must meet the CQC's essential standards of quality and safety:

All CQC-registered providers are inspected regularly to monitor their compliance with the essential standards of quality and safety. The CQC inspects most hospitals, care homes and home care agencies at least once a year. All inspections are unannounced unless there is a very good reason for CQC to give notice. There are three types of inspection:

- Scheduled – these are inspections carried out on a rolling programme. Providers are not told the date of a scheduled inspection;
- Responsive – these are carried out when concerns are raised over a provider's compliance with the standards;
- Themed – these are carried out when the CQC reviews a particular type of service (for example, learning disability services) or a specific set of standards (such as those covering dignity and nutrition).

If the CQC finds that regulations have been breached, a report will be required from the provider explaining what is being done to address the problem and how it plans to ensure compliance.

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In the case of a serious breach, or if compliance action has not been effective, the CQC may take enforcement action.

It may:

- Impose or change a condition of registration;
- Suspend registration;
- Cancel registration;
- Issue a fixed penalty notice;
- Offer a caution;
- Prosecute.

(See also [2.2 Reporting to regulators and commissioners](#))

Monitor

Monitor was established under the Health and Social Care (Community Health and Standards) Act 2003, as the independent regulator of foundation trusts. Its functions initially included:

- Establishment and maintenance of a register of NHS FTs.
- Assessment of applications for FT status.
- Authorisation of NHS trusts as NHS FTs.

Monitor now has responsibility for the licensing of all NHS providers. The Health and Social Care Act (2012) requires everyone who provides an NHS health care service to hold a licence unless they are exempt under regulations made by the Department of Health. Foundation trusts are licensed from 1 April 2013. All other providers will be required to apply for a licence from April 2014.

The licence allows Monitor to:

- Set prices for NHS-funded care in partnership with the NHS England;
- Enable integrated care;
- Safeguard choice and prevent anti-competitive behaviour which is against the interests of patients;
- Support commissioners in protecting essential health services for patients if a provider encounters financial difficulties;
- Oversee the way that NHS foundation trusts are governed.

Monitor's standard licence conditions are grouped into sections. Some of these sections apply to all licence holders and some sections only apply to certain types of licence holder, for example, foundation trusts.

Monitor has a range of powers to ensure that providers comply with their licence conditions. These include being able to ask providers to set out how they will go about addressing areas that did not comply, and taking enforcement action when providers fail to meet their licence conditions.

(See also [2.2 Reporting to regulators and commissioners](#))

The Francis report recommends (in summary):

- The CQC should become the single regulator of corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts (Recommendations 60 and 61);
- The CQC should be responsible for policing fundamental standards, through the development of its core outcomes, by specifying the indicators by which it intends to monitor compliance with those standards. It should not be directly responsible for policing compliance with any enhanced standards but it should regulate the accuracy of information about compliance with them (Recommendation 20);
- A service incapable of meeting fundamental standards should not be permitted to continue. Breaches of those standards should result in regulatory consequences for either an organisation (in the case of a system failure) or in individual accountability where appropriate. Where such breaches lead to serious harm or the death of a patient, criminal liability should follow. Failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches that do not cause actual harm but which have exposed patients to a continuing risk of harm should also be regarded as unacceptable (Recommendation 28);
- It should be an offence for death or serious injury to be caused to a patient if a warning notice has been issued about a breach of these regulatory requirements (or any other breach) but the notice has not been complied with. However, a provider could use the defence that all reasonably practicable steps had been taken to prevent a breach, including the existence of any prescribed system to prevent such a breach (Recommendation 29);

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- The CQC should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed (Recommendation 38);
- The CQC should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes. Greater attention should be paid to the narrative contained in complaints data as well as to the numbers (Recommendations 39 and 40);

(See also [2.2 Reporting to regulators and commissioners](#))

- The CQC should be notified directly of upcoming healthcare-related inquests, either by trusts or coroners (Recommendation 45).

(See also [5.2 Inquests](#))

The Government position

The CQC, working with the National Institute for Health and Care Excellence (NICE), commissioners, patients and the public, will draw up a new set of simpler fundamental standards making explicit the basic standards beneath which care should never fall.

These fundamental standards will be incorporated into the CQC registration system.

The CQC will be given the power to conduct ratings inspections based on providers' overall performance. In its initial response to the Francis report, the Government compares these aggregated ratings to Ofsted's inspections of schools and says they will offer "a single balanced version of the truth" about providers.

The Government has already appointed a chief inspector of hospitals, Professor Sir Mike Richards, as "the focal point for honest and independent assessment about how well or badly hospitals are doing".

The Government believes that the Care Quality Commission and Monitor should remain as separate organisations fulfilling distinctly different functions. Rather than merging the responsibilities of the regulators, a single failure regime will be established that will place the same emphasis on addressing failures in quality of care as there is on financial failure.

The Care Quality Commission will work with Monitor, the NHS Trust Development Authority and the NHS England to agree an overall approach to provider assessment, which will aim to minimise duplication, reduce burdens and join-up intelligence (see also [2.1 Information governance](#) and [2.2 Reporting to regulators and commissioners](#)).

Checklist of practical steps

- Review your compliance with current quality standards (and with forthcoming fundamental and expected standards as soon as they become available) to identify and correct any weaknesses;
- Ensure that your procedures allow frontline professionals, both clinical and managerial, to speak up safely and without fear of reprisals about any failings in care;
- Ensure your board has confidence in its ability to monitor the quality of care, take action to resolve issues, and create a culture of openness that supports staff to identify and solve problems;
- Regularly review your complaints process, including how well it is resourced and whether you comply with deadlines;
- Review your complaints data and extrapolate themes and lessons learned and provide these in an easily understandable format to the board.

How Capsticks can help

We can:

- Provide a review of your complaints and report on compliance, themes and actions to rectify weaknesses;
- Provide training in how to investigate complaints properly and draft responses;
- Provide board training in examining complaints reviews and effectively assessing assurances that the complaints system is working as it should;
- Undertake a clinical governance review to ensure that your organisation has systems in place to ensure that as far as possible the board has timely sight of risks that may otherwise result in a breach of the fundamental standards;

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- Provide a framework of clear roles and responsibilities that make accountability for the quality of care from ward to board explicit and which build on current actions already in place within your organisation.

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4.2 Training, education and development (Recommendations 152 to 172 and 185 to 190)

Overview

The Francis report identifies a number of key themes in relation to medical education and training.

It says the system of regulation and oversight of medical training and education in place between 2005 and 2009 failed to detect any concerns relating to the Mid-Staffordshire NHS Foundation Trust “other than matters regarded as of no exceptional significance”.

Factors contributing to this included:

- *Insufficient recognition of the role medical education and training can play in safeguarding patients;*
- *Insufficient consideration of the relevance of training taking place in a setting which complied with minimum safety and quality standards;*
- *The lack of any requirement for medical practitioners from within the EEA (European Economic Area) to be able to communicate proficiently in English, such that they could assume professional responsibility for an English-speaking patient;*
- *The deficient approach taken by the General Medical Council (GMC) in relation to the Approved Practice Setting (APS) status of the Trust.*

The Berwick review into patient safety, published in July 2013, recommends that:

- *The Government, Health Education England (HEE) and NHS England should ensure sufficient staff are available to meet the NHS’s needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well supported (Recommendation 4);*
- *Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all healthcare professionals, including managers and executives (Recommendation 5);*
- *The NHS should become a learning organisation (Recommendation 6).*

Training and the training establishments’ role in patient safety

The Francis report concludes that the following principles need to be incorporated into the medical education and training system:

- The system must keep as its first priority the safety of patients;
- No provider of clinical placements should be permitted to receive or employ students and trainees in areas or services not complying with minimum patient safety and quality standards;

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- The regulators and deaneries should, as part of their monitoring of the standards of education and training provision, assess and exercise an independent judgement on whether providers comply with the above principle;
- If, in the course of any quality assurance or management process, concerns relating to patient safety are raised or become apparent, whether or not directly relevant to the well-being of students or trainees, appropriate action must be taken to ensure that the concerns are properly addressed and the health regulator informed.

The GMC is reviewing the way it assures the quality of medical education and training.

The review takes in:

- *The GMC's standards for medical education and training;*
- *Its approach to visits and inspections of training programmes and facilities;*
- *The way it measures and reports performance (including the transparency of such reporting);*
- *The case for GMC approval of educational environments;*
- *Its response to concerns raised;*
- *The role of medical royal colleges;*
- *The need for consistency in the way the GMC approves against standards.*

In its response to the Francis report, the GMC has also stated that it:

- *Is planning a major programme of work to engage doctors and medical students in discussions about professional standards;*
- *Will continue to work with other regulators and organisations to improve sharing of information.*
- *Supports a requirement on healthcare organisations to release healthcare professionals to support statutory inspections and visits;*
- *Has introduced a specific patient safety question in its annual survey of doctors in training which has enabled it to identify and follow up on patient safety risks;*

- *Will review the issue of a suitable ratio of trainers to trainees as part of its education review;*
- *Is reviewing the APS scheme and will report in late summer 2013.*

The Nursing and Midwifery Council (NMC) has stated in its response to Francis that it is

- *Reviewing its standards, including a particular focus on the issue of fundamental standards, complaints, candour, communication, older people and delegation to healthcare workers;*
- *Evaluating its pre-registration education standards;*
- *Improving its joint working and intelligence sharing arrangements with other professional and systems regulators;*
- *Developing proposals for a proportionate revalidation process for all registered nurses and midwives, the first phase of which is planned to be in place by the end of 2015.*

Proficiency in the English language

The GMC's current powers allow it to test the language skills of doctors who qualified outside the EEA (European Economic Area).

However, in February 2013 the Government announced plans to extend that to doctors who qualified from within the EEA. There is already a mandatory duty on responsible officers to ensure that the doctors they recruit and appoint are able to communicate effectively before they take up a post.

Staffing levels

The DOH recognises that adequate staffing levels are essential to delivering high quality care. The new chief inspector of hospitals will have a clear remit to inspect staffing levels, although it is the responsibility of providers to assess the skills mix of their workforce according to local need.

Values-based recruitment (Recommendation 191)

Values-based recruitment uses interview techniques and assessments which aim to identify a job applicant's values and attitudes alongside his or her competencies and experience.

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Health Education England (HEE) will introduce values-based recruitment for all students entering NHS-funded clinical education programmes, including scenario-testing to assess candidate's attitudes towards caring, compassion and other necessary professional values.

HEE is also leading a cross-NHS set of programmes to ensure values-based recruitment at all levels of the NHS.

The Department of Health has announced a pilot project to ensure every student who seeks NHS funding for a nursing degree should first serve up to a year as a healthcare assistant, in order to promote frontline caring experience and values as well as academic strength.

Staff development

The Berwick report states that training and education regulators, providers and the HEE should ensure that all healthcare professionals receive initial and ongoing education on the principles and practices of patient safety.

The Berwick report states that providers will also need to:

- *Foster good teamwork in care, in part by asking teams to set challenging and measurable objectives and encouraging them to take time out for performance review;*
- *Actively support staff through excellent human resource practices, recognising good performance and addressing systems problems;*
- *Work with professional regulators to create systems for supportively assessing the performance of all clinical staff;*
- *Listen to staff, for example through department and ward level cultural and teamwork safety surveys.*

NHS leaders

The Berwick report states that NHS England and its partners should encourage and expand structured programmes to equip NHS leaders with an in-depth understanding of safety and improvement.

(See also 1.5 Leadership)

Checklist of practical steps

- Ensure that all staff are trained in the principles and practices of patient safety;
- Ensure the trust is following best practice in human resources;

- Ensure that objectives are set, annual appraisals are being undertaken and that adequate supervision is provided;
- Ensure sufficient time is provided for teams to review their performance and discuss how it can be improved;
- Listen to and act on the concerns of staff and patients, in part by establishing cultural and teamwork safety surveys for staff and patients;
- Ensure that staff levels have been assessed and that the skill mix is appropriate to needs;
- Ensure staff have the right communication skills to deliver safe care;
- Ensure values-based recruitment at all levels.

How Capsticks can help

We can:

- Advise on the development and implementation of human resources practices;
- Ensure that the recruitment and employment practices comply with both UK and European equality legislation, including review of standard documents, application forms and eligibility criteria and handling ad hoc queries in respect of individual applicants;
- Assist with reviewing, drafting and implementing your training and development policies;
- Offer training and education at board and directorate level;
- Advise on Learning and Development Agreements;
- Draft “customised” contracts relating to the provision of education and training by external providers.

For further information on training, education and development, please contact:



Mark Whiting
Partner

020 8780 4892
mark.whiting@capsticks.com

QUICK LINKS:

Governance and internal reporting
Professional regulation and workforce

Information and external reporting
The patient Interface

Openness, transparency and candour
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4.3 Professional regulation of fitness to practise

Overview

The Francis inquiry's review of professional regulation of fitness to practise identifies a number of key issues both specifically at the Mid-Staffordshire NHS Foundation Trust and more generally.

These include:

- *The largely reactive approach of the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to individual complaints against identifiable individuals.*
- *The absence of referrals to either body by professionals themselves at the Mid-Staffordshire NHS Foundation Trust.*
- *The lack of complaints by patients at Mid-Staffordshire NHS Foundation Trust to the two professional regulatory bodies.*
- *The absence of a trust policy at the Mid-Staffordshire NHS Foundation Trust for referring clinicians to their professional regulators.*
- *The need to improve information sharing between regulators.*
- *The reluctance of doctors to accept standard processes and to engage with team and management roles.*

Among the recommendations of the Berwick report are that the professional regulators assure the capacity and involvement of professionals in the continual improvement of the systems of care in which they work.

It also says providers will be expected to identify fitness to practise concerns at an early stage and report these to the regulators.

Investigating generic complaints

Professional regulators can only investigate where there has been a complaint against an individual healthcare professional.

The Francis report recommends that to be effective in protecting patients, regulation needs to be more proactive (see also 2.2 *Reporting to regulators and commissioners*).

It says generic and systemic concerns need to be identified at an earlier stage to address issues before they impact on

patient care. The report encourages the GMC and the NMC to investigate systemic failures and then take proceedings against individuals it identifies as being professionally responsible.

The GMC recognises the need for it to contribute to the identification and, in some cases, the investigation of generic concerns but it wants to discuss with the Department of Health how best this could be done.

It recognises that it has a role in supporting professionals, promoting professionalism and promoting and protecting standards.

The GMC has developed new roles for employer liaison advisers and regional liaison advisers to facilitate engagement with healthcare providers, the professions and patients.

Trusts' medical directors and responsible officers should meet regularly with employer liaison advisers, who will support and offer advice in managing doctors.

The aim is to encourage the provider to identify fitness to practise concerns at an early stage.

Regional liaison advisers will work with patient groups, the profession and those in training to provide a better understanding of what is happening at the clinical frontline.

The NMC does not agree with the Francis report recommendation that it should investigate systemic issues.

The NMC believes its steps towards closer working with the CQC and other regulators to address serious patient safety issues will provide a better solution.

The NMC is scoping the introduction of new regional advisers who will perform a function similar to the GMC's employer liaison advisers and is due to pilot this in 2014.

Raising the regulator's profile and improving fitness to practise processes

The Francis report considers that the lack of complaints from the public may have been due to the GMC's and NMC's lack of profile. It recommends that both regulators need to ensure patients and other service users are made aware at the point of service provision of their existence, role and contact details. The report also says that both the public and professionals may be deterred from referring cases by the apparent complexity of the fitness to practise processes and the time taken to resolve cases. It recommends that complainants be fully supported.

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In May 2013 new rules designed to speed up and simplify fitness to practise hearings before the Medical Practitioners Tribunal Service (MPTS) were implemented. Longer term, following the Law Commission's consultation on the Regulation of Health and Social Care Professionals, a bill is likely to be introduced to Parliament in the 2014/15 session. This is expected to lead to a simplification of the current statutory regime into a single act, enabling faster and more proactive action on individual professional failings.

Both the NMC and GMC are reviewing and revising the information for patients on their websites. The NMC is planning to put in place new witness support arrangements and introduce new public and employer guidance documents by April 2014.

The GMC is considering whether patients need information about the GMC when they visit hospitals.

In addition to the steps the professional regulators are taking, providers should also consider the need to raise the profile of the professional regulators at the point of provision.

Healthcare professionals raising and reporting concerns

The GMC:

- *Has launched a confidential helpline for doctors concerned about patient safety, aimed at those who want advice and support about GMC guidance or who feel they cannot raise a concern locally;*
- *Has produced an online tool for doctors to guide them through the process raising concerns as well as new guidance on *Raising and acting on concerns about patient safety*;*
- *Is planning a major programme of work to engage doctors and students in discussion about professional standards and guidance;*
- *Is working with other health professions regulators to support the NHS Employers Whistleblowing Charter.*

The NMC published revised guidance *Raising and escalating concerns* in 2010.

The NMC's planned review of its standards will include a particular focus on the issue of fundamental standards, complaints, candour, communication, older people and delegation to healthcare workers.

The Berwick review says providers should consider putting in place appropriate policies to encourage and support staff to raise concerns about any patient safety issues.

And it recommends that where scarcity of resources threatens to compromise safety, *"all NHS staff should raise concerns to their colleagues and superiors and be welcomed in so doing"*.

Information sharing

Both the GMC and the NMC agree with the Francis report's recommendations in relation to information sharing both with each other, the Royal Colleges and the CQC.

The Berwick review recommends that systems and professional regulators should streamline requests for information from providers so that they have to provide information only once and in unified formats (the same applies to inspections).

The GMC has already agreed a joint operating model with CQC and has published a protocol for routine information-sharing, local liaison meetings, joint inspections, referrals to the GMC and risk summits to review urgent concerns at a healthcare provider.

The NMC plans to finalise a new operational protocol and data sharing agreement with the CQC by December 2013.

The CQC has joint working agreements in place with a number of regulators.

(See also 2.1 Information governance and 2.2 Reporting to regulators and commissioners)

Healthcare workers

The Government has rejected the Francis report's call for the regulation of all healthcare workers. However, the chief inspector of hospitals will ensure that all healthcare assistants are properly trained and inducted.

Standards of conduct and training for all care assistants were published in March 2013 and providers will need to ensure that they comply with these standards.

The Cavendish review

This has made further recommendations, including new common training standards and a requirement that all healthcare workers achieve a certificate of fundamental care before working unsupervised.

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Joint proceedings

The Francis report recommends that the Professional Standards Authority for Health and Social Care (PSA) should consider forming a common independent tribunal to deal with cases that arise from the same events but involve different individuals who are regulated by different bodies to avoid the risk of inconsistent outcomes.

Both the NMC and the GMC have agreed to discuss this with the PSA.

Checklist of practical steps

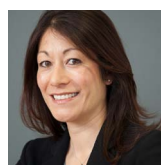
- Ensure you have appropriate policies to encourage and support staff to raise concerns about patient safety issues;
- Engage with the GMC and, when in place, NMC liaison advisers;
- Implement a policy on reporting fitness to practise concerns to professional regulators;
- Review employment disciplinary procedures to make clear the trust is entitled to proceed even when there are pending fitness to practise proceedings;
- Ensure that, at the point of provision, patients are made aware of the existence of the professional regulators should they need to make a complaint concerning a healthcare professional's fitness to practise;
- Ensure that standards of conduct and training for all healthcare assistants are being complied with;
- Implement policies to ensure clinical staff engage with standard processes and team and management roles;
- Facilitate investigation by the regulators;
- Encourage the regulators to coordinate their requests for information;
- Support and facilitate peer reviews.

How Capsticks can help

We can:

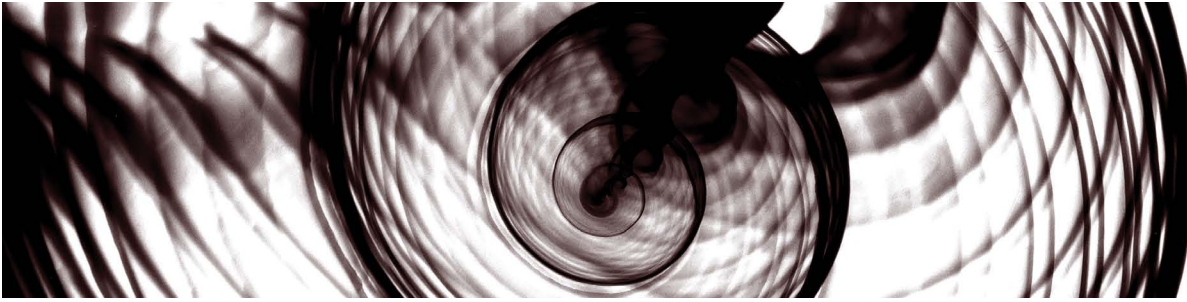
- Assist with reviewing, drafting and implementing policy;
- Review and advise on employment disciplinary procedures.

For further information on professional regulation of fitness to practise, please contact:



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5. The patient interface

5.1 Effective complaints handling (Recommendations 109 to 122)

Overview

“A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public’s trust in the service.” Francis Report, Chapter 3, Paragraphs 3.1-3.2

The Francis report notes that many people did not complain about their experience of poor care at Mid-Staffordshire. It suggests this may be due to a perceived imbalance of power between organisations and individuals, and a desire on the part of patients and families to put an episode of poor care behind them.

The report says if patients and their families do not complain when things go wrong, trusts will have less information with which to identify poor care and take remedial action.

It makes several recommendations aimed at making it easier to complain and at improving trusts’ response to complaints.

The existing framework

Complaints to NHS bodies must be managed in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. These can be found [here](#).

The guide to good complaints handling by clinical commissioning groups (CCGs) and commissioning support units (CSUs) sets out how they can effectively manage complaints.

The NHS Constitution sets out the rights of patients in relation to complaints [here](#).

The Francis report includes an [entire chapter on complaints](#) and how they should be managed.

The report says:

- It should be easier to make complaints;
- The threat of litigation should be no barrier to dealing with a complaint;
- Trusts should promote their willingness to receive complaints;
- All complaints, even informal feedback, should be investigated;
- If a complaint concerns what would be defined as a serious untoward incident, it should be investigated as such and recorded;
- Investigations must be effective and prompt;
- PALS (the patient advice and liaison service) should be more obviously separate from the complaints department.

It also recommends:

- An advocacy service for all complainants who want it or need it;
- The provision by trusts in their general literature of details about independent complaint advocacy services – for example ICAS (the Independent Complaints Advocacy Service) and AVMA (Action against Medical Accidents). This information should also be offered to complainants;

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- A summary of each complaint upheld regarding patient care should be published on the trust's website (subject to the protection of patient confidentiality – see also [2.1 Information governance](#)).

Intractable complaints may now be handled by the independent advocacy charity POHWER.

External scrutiny of complaints

The Francis report says commissioners in Mid Staffordshire were not sufficiently informed about complaints.

It recommends that:

- Commissioners should have as near to real-time access to complaints and information on their outcomes as possible (see also [2.2 Reporting to regulators and commissioners](#));
- CCGs should be required by NHS England to monitor this information about complaints and, where appropriate, to engage with complainants - either to support them in the pursuit of the complaint or assist in mediating a resolution;
- Commissioners should undertake the support and oversight role of GPs in this area, and be given the resources to do so;
- Complaints of sufficient gravity or an obvious pattern of complaints should trigger commissioners' own investigations;
- Information about complaints should be provided to overview and scrutiny committees and to local healthwatch organisations (subject to the protection of patient confidentiality, see also [2.1 Information governance](#)).

The Francis report says external review should be available in cases where the complaint:

- Is treated as a serious incident requiring investigation (SIRI);
- Requires an expert clinical opinion;
- Raises substantive issues of professional misconduct/performance of senior managers;
- Relates to the nature or extent of services commissioned.

Using information from complaints

The Francis report finds that at the Mid-Staffordshire NHS Foundation Trust, only limited information from complaints was collected and analysed and this did not reach the trust board. It says information sent to the Department of Health was not sufficiently detailed and the large number of complaints was thought to be a positive indication of openness and increased reporting.

With regard to large-scale failures of clinical services, the Francis report says, there is a need for:

- Prompt advice, counselling and support;
- Swift identification of independent investigators and reviewers;
- A procedure to recruit clinical and other experts;
- A communication strategy to inform/reassure the public of the process adopted;
- Clear lines of accountability for setting up the review and for oversight.

Parliamentary and Health Service Ombudsman (PHSO)

The PHSO has agreed a protocol under which it will notify the CQC if it is alerted to, or becomes aware of, particular concerns.

The ombudsman has also pledged to begin investigations more promptly and complete them more quickly.

The PHSO will publish summaries of investigations to show good and bad practice. It will focus on identifying systemic issues from individual complaints and publish thematic reports.

It will make it easier for people to complain to the PHSO and work with regulators to drive better information sharing (see also [2.1 Information governance](#) and [2.2 Reporting to regulators and commissioners](#))

A report for the [PHSO, NHS Governance of Complaints Handling](#), explores how complaints are managed across the NHS.

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Complaints review

Following on from the Francis report, the Department of Health established a review of the NHS complaints process led by Labour MP Ann Clwyd and Professor Trisha Hart, CEO of South Tees Hospital NHS Trust. The closing date for sending the views and evidence was 31 May 2013 and the review is expected to report to the Health Secretary later this year.

The terms of reference are as follows:

- To consider how to align more closely the handling of concerns and complaints about patient care;
- To identify where good practice exists, how it is shared and the factors that help or hinder its adoption;
- To consider what standards might best be applied to the handling of complaints;
- To consider how intelligence from concerns and complaints can be used to improve service delivery, and how this information might best be made more widely available to service users and commissioners;
- To consider the role of the Trust board and senior managers in developing a culture that takes the concerns of individuals seriously and acts on them;
- To identify the skills and behaviours that staff, including clinical staff, need to ensure that concerns of the individuals are at the heart of their work;
- To consider how complainants might more appropriately be supported during the complaints process through, for example, advice, mediation and advocacy;
- To consider the handling of concerns raised by staff and the support available for whistleblowers.

The review will be encouraged to make recommendations relating to:

- Any aspect of the NHS complaints arrangement and other means by which patients make concerns known;
- The way that organisations receive and act on concerns and complaints;

- The way boards and managers carry out their functions;
- The process by which individual organisations are held to account for the way they handle concerns and complaints;
- The recommendations about complaints made by the Francis report.

Checklist of practical steps

You should ensure that:

- Your organisation displays clear and accessible information about how service users can complain;
- Staff in the complaints handling team have clearly defined roles and responsibilities;
- Each complaint has a lead investigator;
- You respond adequately to the complainant and those who are the subject of the complaint;
- Complainants have a single point of contact in your organisation;
- You have robust governance arrangements for complaints handling;
- Your complaints investigation process is impartial and fair;
- Complaints documentation is accurate and complete;
- Complaints information is recorded, analysed and disseminated throughout your organisation and to external audiences;
- Lessons from complaints are learned across your organisation.

All of these standards are set out in the Patients Association good practice guide for NHS complaints.

The guidance was highlighted by the Francis report as a valuable tool for trusts.

(See also 3 *Openness, Transparency and Candour*)

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How Capsticks can help

Our legal team includes a number of former NHS complaints managers. We understand the challenges involved in dealing with complaints and we will always aim to help you resolve matters locally, avoiding referrals to the ombudsman.

Capsticks can assist you with all your complaints through our dedicated and bespoke complaints handling process.

We can:

- Review your complaints policies and procedures;
- Assess your processes in reporting on complaints trends;
- Assist with specific, complex complaints and responses;
- Advise you on managing complaints meetings and information sharing, especially in light of the new duty of candour;

- Assist you with complaints when there are other legal processes ongoing;
- Ensure you have in place a robust process to keep the board up to date with trends in complaints received;
- Help manage your complaints through our Complaints Handling Service.

For further information on effective complaints handling, please contact:



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Partner

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5.2 Inquests (Recommendations 273 to 285)

Overview

Inquests and the rules that govern them were under scrutiny even before publication of the Francis report.

Indeed, the report highlights many concerns expressed previously as well as recommending that ongoing reforms be extended or supplemented.

It focuses particularly on the duty to disclose information to the coroner and the certification of hospital deaths.

Overall, its recommendations are aimed at “*making more of the coronial process in healthcare related deaths*”.

Disclosure

Prior to the Francis report, it was widely accepted that NHS trusts were only required to respond to specific requests for information from the coroner.

In some cases, this meant critical witness statements and internal investigation reports which had not been requested by the coroner were not disclosed.

Crucially, however, this has now changed - partly as a result of the report but also because of the new coronial law which means trusts must actively identify and disclose any information which is likely to be relevant, with the threat of criminal sanctions if they fail to do so.

The Francis report says in recommendation 273 that all healthcare providers should be obliged (via the terms of their registration) 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.

In fact *The Coroner's and Justice Act 2009* goes further and it is now a criminal offence (under schedule 6 of the Act) for a person to:

- Do anything that is intended, or is likely, to have the effect of distorting, altering or preventing any evidence or document that is given for the purposes of a coroner's investigation;
- Intentionally suppress or conceal, alter or destroy a relevant document. A document is relevant if it is likely that a coroner conducting an investigation would (if aware of its existence) wish to be provided with it.

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This is a major change and extension of the ‘duty of candour’ relevant to all involved in inquests, including clinicians and managers. To avoid the risk of criminal sanction it will be necessary to provide comprehensive witness evidence and to ensure that all relevant documents are provided, especially if they contain critical comment.

(See also [3 Openness, Transparency and Candour](#))

Elsewhere Francis has recommended that the CQC are informed about any healthcare-related inquest.

As an example of why the new rules were deemed necessary, the Francis report highlights the John Moore-Robinson inquest.

Mr Moore-Robinson died from a ruptured spleen in April 2006 after being told by a junior doctor at Stafford hospital that he had bruised his ribs in a mountain bike accident.

A statement written for the coroner by an A&E consultant at the hospital, which was critical of Mr Moore-Robinson’s treatment, was not given to the coroner on the advice of the trust’s in-house solicitor, who wanted to avoid adverse publicity.

The Francis report acknowledges that the actions of the trust in failing to pass on the consultant’s statement were not unlawful; there was at that time no legal duty to disclose it.

It is also the case that coroners’ courts by law do not concern themselves with “matters of blame”, which has made it difficult in some cases to identify what information should be passed on to an inquest.

However, the report says that *‘the way in which the Trust handled the matter can be viewed as an object lesson in how the tragedy of an avoidable death can be exacerbated by inappropriate handling of the case’*, and that *“for all the fine words printed and spoken about candour, and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism”*.

The inquest verdict in the case of Mr Moore-Robinson has since been overturned and a new inquest will have to be heard.

The Francis report does not suggest that statements cannot be appropriately amended or re-considered if, for example, the content is wrong.

It is critical of amendments or redactions required only if the opinion or content is adverse to the Trust.

If an opinion is provided by a doctor who has not considered all of the relevant medical records or witness statements, he or she should be advised to consider all of these documents to ensure the accuracy of his or her opinion.

Certification of hospital deaths

In 2005, Dame Janet Smith’s report into the killing of some 250 patients by GP Harold Shipman identified flaws in the death certification process.

As a result the *Coroners and Justice Act 2009* was introduced to modernise the coronial system and provide a greater degree of scrutiny in healthcare deaths through the appointment of independent medical examiners (IMEs)

IMEs will consider medical records, investigate and decide which deaths should be reported to the coroner.

However, they are not yet in place nationally and the Francis report makes several recommendations about their role.

It says:

- They should be independent of the organisation whose patient deaths are being scrutinised ([Recommendation 275](#));
- Their number and resources must be sufficient ([Recommendation 276](#));
- They should seek out and consider any serious untoward incident or adverse incident report relating to the deceased patient ([Recommendation 278](#));
- They should have training in how to approach families to minimise distress ([Recommendation 281](#)).

It was initially intended that the NHS would appoint IMEs but the responsibility has since been transferred to local authorities, who also appoint coroners ([section 54](#)).

A pilot study using independent scrutiny of certifiable deaths in five areas increased the number of deaths that were reported to the coroner and may mean there are more healthcare inquests if and when IMEs are appointed nationwide. The likely start date of the scheme has been delayed from April 2014, probably until October 2014.

The Francis inquiry heard that currently, the job of completing a medical certificate as to the cause of death (MCCD) is often delegated to junior doctors who feel under pressure to ensure there is no need for a post mortem examination.

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Many MCCDs that are reviewed contain errors and the guidance available is not easy to understand.

The Francis report recommends that, as far as is practicable, death certificates should be completed by a consultant or another senior and fully-qualified clinician in charge of the patient's case or treatment.

Consultants should also understand their duty to identify any concerns about actions which may have contributed to a death.

The report says new national guidance should be produced in relation to death certification.

Checklist of practical steps

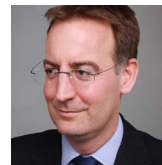
- Ensure deaths are certified only by consultants or senior doctors;
- Train all staff in their obligation to volunteer information to the trust's legal department and coroner, if it may be relevant to how a patient died;
- Provide all staff with guidance on certifying deaths, reporting deaths and writing witness statements, to ensure that they are all aware of their obligations proactively to identify concerns about matters which may have contributed to the death;
- Create a standard checklist for every inquest case, to ensure that each issue is proactively considered and to ensure all relevant documents are disclosed;
- Do not suggest the removal of any part of a statement for an inquest only on the basis that it is critical of, or adverse to, the trust;
- Consider each case carefully before the inquest to identify whether there is any information or documentation which the coroner is likely to believe is relevant;
- Remember that only a director can approve non-disclosure and this should not be done without legal advice given the new criminal sanction.

How Capsticks can help

We can:

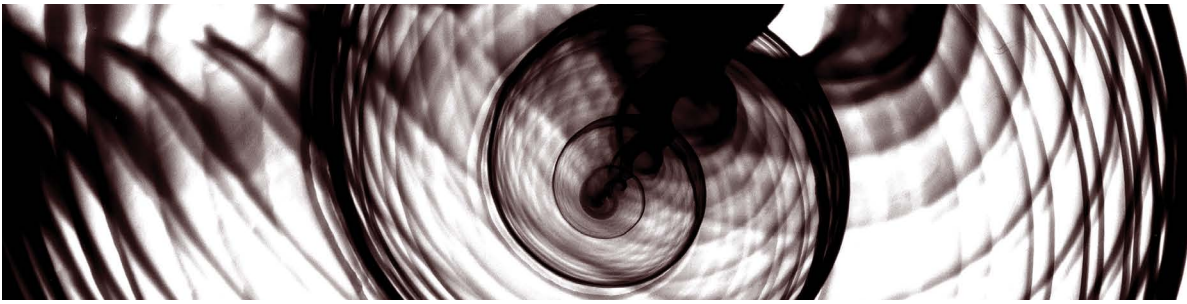
- Draft standard guides to death certification, reporting of deaths to the coroner and providing witness statements;
- Train senior medical staff in certifying and reporting deaths;
- Advise on draft witness statements or suggested amendments;
- Advise on disclosure;
- Prepare witnesses for inquests;
- Represent you in court.

For further information on inquests, please contact:



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Partner

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6. Resources list

General

Berwick Report: Improving the safety of patients in England

Mid Staffs Public Inquiry Final Report

Mid Staffs Public Inquiry Executive Summary

Patients First and Foremost: Initial Government Response to the Mid Staffs Public Inquiry

1. Governance and internal reporting

A new start: consultation on changes to the way CQC regulates, inspects and monitors care

Berwick Report: Improving the safety of patients in England

Code of conduct and code of accountability in the NHS

Code of Conduct for NHS Managers

Everyone counts: Planning for Patients 2013/14

Integrated governance: a guide to risk and joining up the NHS reforms

Management Advisory Service: the Manager's Code

Mid Staffs Public Inquiry Executive Summary

NHS Constitution for England

Patients First and Foremost: Initial Government Response to the Mid Staffs Public Inquiry

Quality in the new health system – maintaining and improving quality from April 2013

Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

The Healthy NHS Board 2013: Principles for good governance

The NHS Foundation Trust Code of Governance

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2. Information and external reporting

Care Quality Commission (Registration) Regulations 2009

Checklist Guidance for reporting, managing and investigating information governance serious incidents requiring investigation

Confidentiality: NHS Code of Practice

Data sharing Code of Practice

Health and Social Care Act 2012

HSCIC Collecting Data

HSCIC Data Flows Transition

HSCIC Data Quality

HSCIC Indicator Assurance Service

HSCIC Reviews of Central Returns

HSCIC Systems

Information: to share or not to share? The Information Governance Review

Mid Staffs Public Inquiry Final Report

NHS Standard Contract 2013/14: Particulars

NHS Standard Contract 2013/14: Service Conditions

Patients First and Foremost: Initial Government Response to the Mid Staffs Public Inquiry

Review into the quality of care and treatment provided by 14 hospital Trusts in England: overview report (The Keogh Review)

The new NHS provider licence

The NHS Trust Development Authority Directions 2013

The power of information: putting all of us in control of the health and care information we need

3. Openness, transparency and candour

Berwick Report: Improving the safety of patients in England

GMC Good Medical Practice

Mid Staffs Public Inquiry Final Report

NHSLA Risk Management Standards 2012-13

NHS Standard Contract 2013/14: Service Conditions

NMC: The Code: Standards of conduct, performance and ethics for nurses and midwives

NPSA Being Open framework

NPSA seven steps to patient safety: full reference guide

Patients First and Foremost: Initial Government Response to the Mid Staffs Public Inquiry

Pre action protocol for the resolution of clinical disputes

The NHS Constitution

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Berwick Report: Improving the safety of patients in England

CQC Joint Working Agreements

CQC Standards

GMC launches confidential helpline for doctors to raise concerns about patient safety

GMC operational protocol: a practical guide for staff

GMC: raising and acting on concerns about patient safety (2012)

GMC response to the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry

GMC: reviewing our approach to the quality assurance of medical education and training

Health and Social Care Act 2008

HEE: collaboration delivered successful values based recruitment events

Law Commission: regulation of health and social care professionals

Mid Staffs Public Inquiry Executive Summary

Mid Staffs Public Inquiry Final Report

NHS Employers: The Speaking Up Charter

NMC: Raising Concerns: guidance for nurses and midwives

NMC response to the Francis report

Patients First and Foremost: Initial Government Response to the Mid Staffs Public Inquiry

Skills for Health: code of conduct and national minimum training standards for healthcare support workers

The Cavendish Review

The new NHS provider licence

5. The patient interface

Coroners and Justice Act 2009

Department of Health: Death Certification Reforms

Health and Social Care Act 2012

Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

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Proposed terms of reference for the new NHS complaints system review


The NHS Constitution

October 2013

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