Enclosure 4

The Shrewsbury and Telford Hospital NHS Trust

TRUST BOARD – 24 FEBRUARY 2011

National Reports and Recommendations
Quality and Safety Committee - 18th February 2011

1.1 Introduction

The Board received a briefing paper and copy of the SHA tracking tool on national reports and recommendations in January 2011. The document provided a tracking methodology to identify whether these national documents and recommendations had been reviewed, considered and actions put in place.

1.2 Purpose

The purpose of this briefing document is to provide some clarity on the Trust specific recommendations that require review and action. The recommendations made for PCTs and Strategic Health Authorities have therefore been removed and a process undertaken whereby similar recommendations made in the source reports are grouped together for the Quality and Safety Committee to review in detail.

1.3 Methodology

The table (Appendix 1) identifies the source of recommendation under a key theme and does demonstrate some replication or cross over on recommendations.

1.4 Further work required within the Trust

It is recommended that a detailed analysis is undertaken on the full range of recommendations included in the Appendix and a report provided in the April Quality and Safety Committee to demonstrate which Committee or Board has considered the recommendation and how this has been implemented. Clear reference must be provided at this stage to evidence and provide assurance against each recommendation.

- Where no work has been undertaken on a recommendation then a clear action plan will need to be approved by the Quality and Safety Committee.
- Further to Quality and Safety Committee scrutiny, it is recommended that the Board sign off the final paper and tracking tool in May 2011.

1.5 Conclusion and Recommendations

The Quality and Safety Committee are asked to **NOTE** the Trust specific recommendations from the review of external recommendations and **APPROVE** the process identified for further work.

Chief Nurse / Director of Quality and Safety
February 2011

Source of recommendation	Key recommendation for internal review and action
Detecting a deteriorating patient & Mortality	
Patient Safety First Priorities NPSA 2008 (June)	Limit mortality from in-hospital cardiac arrests through earlier recognition and treatment of deteriorating patients
Ten for 2010 programme Feb 2010	Reduce harm associated with the deteriorating patient
Colin Norris Inquiry 2010 Jan 2010	Review the internal processes and practices for certification of death in line with best practice with reference to the Pathfinder Pilot established at Sheffield Teaching Hospitals NHS Foundation Trust; Review processes in place for mortality and Morbidity review; agree a consistent model for this, including reviewing all deaths and implement in all specialty areas and directorates.
Mid Staffs Review - Professor Alberti 2009 (April)	Regular, timely audits should be put in place for all patients who die in hospital
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, and independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals in using such statistics as a prompt to examine particular areas of patient care.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should standardize their procedures for morbidity and mortality meetings, including the presentation of information on trends in clinical outcome, record keeping and links with the clinical governance mechanism.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should standardise its procedure on giving families an estimate of the difficulties and the risks of prospective surgery, and should standardise its procedure for explaining to families after a death, the options for a post mortem.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should introduce systems to present information enabling trends in clinical outcome to be monitored. The most effective approach in paediatric cardiac surgery will be based on tracking surgical mortality. This should specifically include identification of individual procedures with high standardised mortality rates. It is also recommend that the Central Cardiac Audit Database makes available information on expected mortality by procedure groups in such a way that facilitates units to construct the appropriate statistical process control charts.

Colin Norris Inquiry 2010 Jan 2010	The SHA should review the training of junior doctors to improve their knowledge and understanding of Certification of Death and equip them to understand the importance of managing risk and the associated processes as a key facet of clinical practice.
Health Select Committee Report 2009(Oct)	Patient harm rates must be measured by regular reviews of samples of patients' case notes
Ten for 2010 programme	Reduce the number of suicides in community health, mental health, prisons and acute care using a suicide prevention toolkit.
Ten for 2010 programme	Reduce harm during the intrapartum stage of pregnancy through tools and resources.
Ten for 2010 programme	Reduce harm for people with learning disabilities with a focused campaign to raise awareness.
The Operating Framework for the NHS in England 2010/14 Dec 2009/10?	All patients should receive a risk assessment of venous thromboembolism (VTE) upon admission to hospital (Template published 2008, and NICE guidance Jan 2010)
The Operating Framework for the NHS in England 2010/15 Dec 2009/10?	PCTs should continue to use the national set of 'Never Events' as part of their contract agreements with providers. Never Events should be reported to the National Patient Safety Agency (NPSA) and publically reported as part of the annual reporting on quality and safety.
Ensuring best practice safety checks generally and also before Operations	
Patient Safety First Priorities NPSA 2008 (June)	Reduce preoperative harm through elective surgical site infection prevention and usage of the WHO's "Safe Surgery Checklist.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should ensure that all staff in the surgical team take part in a team brief and use the 2008 theatre checklist before surgery commended by WHO as good practice.
Ten for 2010 programme	Reduce harm during the perioperative process using the five steps of safer surgery - briefing, sign in, time out, sign out and debriefing.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Arrangements can be put in place that will create a critical mass of clinicians who, working as a single team and dealing with an adequate caseload, can maintain their expertise. This might require some mix of both expanding the Trust's service and forging robust links with another centre.
Colin Norris Inquiry 2010 (Jan 2010)	Develop and actively use evidence-based measures of the quality and safety of patient care, focusing on the Releasing Time to Care and patient safety programmes that are being implemented across the Trust.
Colin Norris Inquiry 2010 (Jan 2010)	Review and update as necessary the Trust policy on safeguarding vulnerable adults in light of the latest guidance following the "No "Secrets" consultation process.

Colin Norris Inquiry 2010 (Jan 2010)	Review the process for the timely inputting of incident data into Datix and the sharing of lessons learned from incidents.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should strengthen their approach to incident reporting, based on a just and open culture, to promote full reporting by responsible clinicians (including consultant medical staff), analysis and promulgation of lessons learned.
Colin Norris Inquiry 2010 Jan 2010	Audit compliance with the Trust's Serious Untoward Incident (SUI) policy to ensure that following incidents there is effective communication with and support to patients, their relatives and staff.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust	Trusts should act to ensure that staff can indentify serious untoward incidents, for which there is then an explicit responsibility to devise and implement an action plan, including timely notification of relevant individuals, the Trust Board and external bodies when appropriate.
Colin Norris Inquiry 2010 (Jan 2010)	Review how the central risk team is formally co-ordinated with and supports the devolved directorate structures; use wealth of experience and knowledge more effectively.
High Impact Actions - Personalised and safe care	
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.
High Impact Actions for Nursing and Midwifery Nov 2009	Your skin matters - No avoidable pressure sores in NHS provided care.
Ten for 2010 programme	Reduce patient deaths and harm associated with pressure ulcers.
High Impact Actions for Nursing and Midwifery Nov 2009	Preventing falls - demonstrate year on year reduction in the number of falls sustained by older people in the NHS provided care.
Ten for 2010 programme	Reduce patient deaths and harm associated with falls.
High Impact Actions for Nursing and Midwifery Nov 2009	Keeping nourished - Stop inappropriate weight loss and deterioration in NHS provided care.
High Impact Actions for Nursing and Midwifery Nov 2009	End of life choice - Avoid inappropriate admission to hospital and increase the numbers of people who are able to die in the place of their choice.

Infection Control recommendations	
Patient Safety First Priorities NPSA 2008 (June)	Improve critical care through more reliable application of central line and ventilator care bundles.
Health Select Committee Report 2009(Oct)	Quick implementation of proven technologies which can improve safety.
High Impact Actions for Nursing and Midwifery Nov 2009	Protection from infection - Demonstrate a dramatic reduction in the rate of Urinary Tract Infections for patients in NHS provided care.
The Operating Framework for the NHS in England 2010/11 Dec 2009	Vital Signs - Meeting National Cleaning Standards.
Ten for 2010 programme Feb 2010	Reduce bacteraemia associated with central lines.

Medications recommendations	
Patient Safety First Priorities NPSA 2008 (June)	Reduce harm from high-risk medicines (e.g. anticoagulants, injectable sedatives, opiates and insulin).
Ten for 2010 programme Feb 2010	Reduce patient harm associated with the use of anticoagulants.
Ten for 2010 programme Feb 2010	Reduce patient harm associated with the use of insulin.
The Airedale Inquiry	The Trust should consider whether doctors should be required to review prescription charts and clinical records when examining patients and to review the content of the doctors and nurses induction courses to ensure scope of professional practice is covered.
Colin Norris Inquiry 2010 Jan 2010	Complete review of pain management guidelines, including the assessment and management of “irregular pain” Review specific pharmacy procedures: “Scheduled visits by pharmacists to wards” and “Policy on clinical pharmacy practice”, ensure the role of the ward based visiting pharmacist is reviewed in this to include monitoring compliance with the Trust’s Medicines Code as a key component of the visit.
Colin Norris Inquiry 2010 Jan 2010	Review Terms of Reference and membership for the Trust Drugs & Therapeutics Risk Management sub-committee; clarify reporting arrangements within the Trust’s clinical governance and committee structure.
Colin Norris Inquiry 2010 Jan 2010	Review clinical pharmacy support to the wards and ensure that provision is sufficient to meet ward needs.
Colin Norris Inquiry 2010 Jan 2010	Review and place a higher priority on the implementation of technological solutions in medicines management to improve the audit trail of drug use and reduce patient risk of harm from medicines, to consider: automated dispensing system for access to drugs out of hours; automated dispensing in pharmacy; swipe card technology for access to drug cupboards instead of keys; electronic prescribing and administration of drugs; interim arrangements for 'out of hours' drug storage.
Colin Norris Inquiry 2010 Jan 2010	Undertake an audit of the omission of prescribed drugs in conjunction with the introduction of the new drug treatment chart: address specifically the reasons why the drug has been omitted, what actions were taken to obtain the drug and who authorised the non administration.
Colin Norris Inquiry 2010 Jan 2010	Review the current controlled drugs checking procedures and ensure audits are up to date, including the specific aspects covered in the 3 monthly checking procedures (to broaden to include receipt signature monitoring). The content of the CD Accountable Officer report presented to the Trust Drugs & Therapeutics Risk Management Sub-Committee to be reviewed, and consideration given to a process which can highlight actions agreed in those areas where audits are not undertaken or where audit identifies concern; including this on Trust risk register. CD audits should include an audit of compliance of the receipt section of the CD order book bearing a signature to verify receipt has occurred and by whom.

Colin Norris Inquiry 2010 Jan 2010	Raise the profile of the need to sign the receipt section of the controlled drug order book possibly by emphasising this as part of the three monthly audit of controlled drug Records.

Quality review processes	
Mid Staffs Review – Professor Alberti 2009(April)	The PCT should build quality and outcome measures into their commissioning and performance management arrangements with the Trust.
Mid Staffs Review – Dr David Colin Thomé 2009 (April)	All hospital providers including Foundation Trusts must allow PCTs ready access to review their services.
Mid Staffs Review – Professor Alberti 2009 (April)	In the medium term the needs of the local population should be clearly enumerated by the PCT and the Acute Trust and these should be reflected in the 5-year strategy for the Foundation Trust. The focus should be on what can be done safely and well by the Trust and what should be left for other Trusts to do.
The Operating Framework for the NHS in England 2010/12 Dec 2009	Vital Signs - Improving Health and Reducing Health Related Inequalities.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Trust, together with the Primary Care Trust, should promote the development of links with other NHS Trusts and Foundation Trusts to enhance its ability to delivery up-to-date and high-class standards of service provision and professional leadership.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust.

Managing Emergency flows of patients	
Mid Staffs Review – Professor Alberti 2009(April)	An Urgent and Emergency Care Board should be established forthwith to ensure appropriate care and services for all those with an urgent or emergency need. This should be a joint enterprise involving the PCT, Acute Trust, Ambulance Trust, patients/public and other relevant partners.
Mid Staffs Review – Professor Alberti 2009 (April)	An emergency care directorate should be established in the Trust encompassing all acute specialties with responsibility for the rapid, effective delivery of care from the patient's admission throughout the whole of the patient's care pathway to discharge.
Mid Staffs Review – Professor Alberti 2009 (April)	The number of emergency physicians should be reviewed to ensure sufficient cover is achieved.
Mid Staffs Review – Professor Alberti 2009(April)	Protocols for common conditions should be introduced in A&E.
Mid Staffs Review – Professor Alberti 2009(April)	Equipment deficiencies in the Emergency Admissions Unit and on the medical wards should be reviewed and appropriate purchases made.
Mid Staffs Review – Professor Alberti 2009(April)	The Trust should allow direct admission of suitable patients to the Emergency Admissions Unit, once patient flows have been improved.
Mid Staffs Review – Professor Alberti	Lengths of stay on the Emergency Admissions Unit should be limited to 48 hours. The institution of a short-stay ward should be considered.

Management of medical patient flows	
Mid Staffs Review – Professor Alberti 2009(April)	A new model of care for medical patients who are admitted should be implemented which provides for much earlier consultant contact.
Mid Staffs Review – Professor Alberti 2009 (April)	The Trust should not pursue the development of a hyper-acute stroke service.
Mid Staffs Review – Professor Alberti 2009(April)	Care of the elderly services should be enhanced and a care of the elderly network established across primary, secondary and community care.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.
Mid Staffs Review – Professor Alberti 2009(April)	The intermediate care capacity in the community should be reviewed with the PCT and increased if necessary.
High Impact Actions for Nursing and Midwifery Nov 2009	Managed Discharge - Increase the number of patients in NHS provided care who have their discharges managed and led by a nurse or midwife where appropriate.

Staffing recommendations	
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	The Trust should ensure that all new members of staff receive appropriate induction on joining the Trust. The nature of the induction will depend on the nature of the post, but for consultant staff must include relevant clinical governance and multidisciplinary team working systems.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	The Trust should ensure that all newly appointed consultant staff have access to an appropriate mentoring arrangement. The nature of this will vary according to the nature of clinical practice, but for technically demanding specialties such as paediatric cardiac surgery must include arrangements that facilitate joint operating.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	The Trust should ensure that the effect of appointing a new consultant on clinical practice is identified before arrival, together with any consequences for equipment provision and potential impact on other members of the multidisciplinary team. Expectations of how the new consultant will work with other consultant members of the team must be explicit and agreed from the outset.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should implement clinical governance systems that set out explicit responsibilities service by service with a single line of accountability to the Trust Board.
Mid Staffs Review – Professor Alberti 2009(April)	Minimum staffing levels policy must be considered to ensure skill mix is achieved which meets patient dependency.
Colin Norris Inquiry 2010 Jan 2010	Review the effectiveness of the current model for the supervision of nursing and other clinical staff.
Colin Norris Inquiry 2010 Jan 2010	Raise awareness as part of patient safety training amongst staff of the potential for malicious action against patients by healthcare professionals.
The Airedale Inquiry June 2010	Ensure that the developments of the Scope of Professional Practice includes clear lines of accountability, training and development plans are fit for purpose, evaluation of the role and that there is effective dialogue with patients, carers and the public.
Review of the early warning systems in the NHS Feb 2010	Professional bodies must encourage openness and transparency amongst all healthcare professionals, including supporting them in raising concerns early.
The Airedale Inquiry June 2010	The guidance should alert organisations to the need to give effective support to those who are giving witness statements.

Mid Staffs Review – Professor Alberti 2009(April)	The complement of nurses in the Trust who provide care to patients in the emergency care pathway should be adequate according to need and the training of nurses and other ward workers enhanced.
The Airedale Inquiry June 2010	The Trust Board should ensure that Human Resource policies and procedures are followed including staff appraisal, development planning and HR department resources to deliver the organisational development programme.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.
Colin Norris Inquiry 2010 Jan 2010	Introduce a policy statement and standards for multidisciplinary working throughout the Trust and audit practice against these.
High Impact Actions for Nursing and Midwifery Nov 2009	Fit and well in care - Reduce sickness absence in the nursing and midwifery workforce to no more than 3%.
Colin Norris Inquiry 2010 Jan 2010	Establish a process for auditing personal files in order to ensure that ; (a) Trust recruitment processes are complied with; (b) performance of staff is assessed effectively through appraisal; (c) individual and collective training needs are identified from the appraisal process.
Colin Norris Inquiry 2010 Jan 2010	Develop a co-ordinated education and training programme for staff to respond to the training needs identified through staff appraisal; development of clinical supervision.
Colin Norris Inquiry 2010 Jan 2010	Establish effective workforce information, including ward establishments, vacancies and sickness and absence levels and actively use this to support management at both Trust and divisional level.
In -Patient flow (Bed Management)	
Mid Staffs Review – Professor Alberti 2009(April)	Plans should be put in place forthwith to improve bed management with a bed management team and early review of all patients in the hospital on a daily (7 days) basis.

Patient experience	
Mid Staffs Review – Professor Alberti 2009(April)	A member of the Board should be given responsibility as patients' champion and (s)he or another Board member should have the same role specifically for older people.
Mid Staffs Review – Professor Alberti 2009(April)	More use should be made of real-time patient questionnaires.
Mid Staffs Review – Professor Alberti 2009(April)	Patient/public representatives should be included on all Board committees and sub-committees.
Review of the early warning systems in the NHS Feb 2010	National Quality Board are to undertake a review of patient engagement and feedback mechanisms to understand how their outputs are connecting with Trust Boards and the decision making process.
Health Select Committee Report 2009(October)	Ensuring harmed patients and their families always receive full and frank information about incidents of harm
The Operating Framework for the NHS in England 2010/13 2009(Dec)	Vital Signs - Reputation, Satisfaction and Confidence in the NHS.
Colin Norris Inquiry 2010 Jan 2010	Clarify the roles and responsibilities of Matrons in relation to communicating with Patient Relations Department to ensure clarity regarding responding to patients concerns.
Colin Norris Inquiry 2010 Jan 2010	Review the Trust complaints process and handling, to ensure that there is sufficient independence in investigations and that action is taken in response to issues raised.
Colin Norris Inquiry 2010 Jan 2010	Raise awareness of the Trust complaints policy; review the process for ensuring that staff listen to and formally record information and concerns expressed by relatives and carers so that they are included as part of the care planning process and review.

Trust wide Governance arrangements	
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	All NHS Trusts and Foundation Trusts responsible for the provision of hospital services should review their standards, governance and performance in the light of this report.
The Airedale Inquiry June 2010	Periodic reviews should take place of corporate governance arrangements should take place at Trust Board level.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support, and accountability of executive and non-executive directors of NHS Trusts and NHS Foundation Trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.
Mid Staffs Review – Professor Alberti 2009(April)	Clinical governance arrangements should be enhanced with strong Board level support.
The Airedale Inquiry June 2010	The Trust Chief Executive should ensure the management structure is under review to respond to changing organisational needs.
The Airedale Inquiry June 2010	Governance systems in NHS provider organisations needs to be designed to reflect the Board's 24 hour a day responsibility for all areas of service delivery.
Review of the early warning systems in the NHS Feb 2010	Provider – Trust Board is given further guidance on how best to govern for quality. The NQB will lead a piece of work during 2010 which will help boards to develop robust governance for quality.
Review of the early warning systems in the NHS Feb 2010	Develop closer alignment of compliance frameworks for different types of provider (e.g. Monitor's Compliance Framework for FT's and NHS Performance Framework for NHS Trusts).
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	Trusts should ensure that there is a written protocol setting out those procedures which should not normally be carried out in their Trust, but for which patients should be transferred for surgery elsewhere, taking into account the outcome data for procedures carried out less often. It is recognised that there will be exceptions in practice, but it is considered important that there is an explicit norm against which exceptions may be individually justified.

Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	The Trust should ensure that management decisions about clinical services are subject to a proportionate appraisal of relevant facts and information, and include a risk assessment that takes clinical risks into account.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust	Trusts should ensure that there is effective clinical and managerial leadership at each level to deliver an organisational culture that promotes openness, cooperation and high standards of service.
Review of paediatric cardiac services at Oxford Radcliffe Hospitals NHS Trust July 2010	The Trust should ensure that there is effective operational planning for clinical service changes that takes account of the expected impact on the capacity and capability of the relevant clinical teams, the level of support services required and the provision and utilisation of facilities such as theatres and intensive care.
The Airedale Inquiry	Develop a communication plan for patients and families should events as identified in the Airedale report occur at any Trust in future.
Health Select Committee Report 2009(October)	Boards and senior management make patient safety the top priority.
Colin Norris Inquiry 2010 Jan 2010	Review the effectiveness of the Trust's Assurance Framework and other mechanisms for the Board to evaluate Trust performance in relation to clinical quality.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard of safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.
Colin Norris Inquiry 2010 Jan 2010	Embed the new approach to governance across the Trust, ensuring that this is effective in meeting the needs of both the Trust as a whole, and individual clinical areas such as the ortho-geriatric service.
Colin Norris Inquiry 2010 Jan 2010	Address the gap between the development of policies and their implementation, ensuring that policies are regularly reviewed and that they are audited to check that they are working in practice.
Colin Norris Inquiry 2010 Jan 2010	Establish an effective, standardised system of audit where directorates feed into a coherent Trust audit programme, resulting in consistent collection of information, action in response to recommendations and assurance mechanisms. The audit programme should include a specific audit of clinical records to assure the Board that the quality of record keeping meets clinical and legal requirements.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.

Colin Norris Inquiry 2010 Jan 2010	Actively promote the new whistle blowing policy through communication and training, supporting a culture of openness.
Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 - March 2009 (Robert Francis QC)	The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.
Health Select Committee Report 2009(0ctober)	Commissioning, performance management and regulation arrangements must be clarified and rationalised to become more effective.
Health Select Committee Report 2009(Oct)	Better and more explicit patient safety education for healthcare workers.
Health Select Committee Report 2009(Oct)	The introduction without delay of the NHS Redress Scheme.