

Report to:	Trust Board - May 2013
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Enclosure 7

Title	A review of the Francis report in line with previous reviews and recommendations.
Sponsoring Executive Director	Director of Quality and Safety/ Chief Nurse
Author(s)	Director of Quality and Safety/ Chief Nurse
Purpose	To update the Board on the impact of the emerging recommendations from the second Francis report and the DH response to the Published report
Previously considered by	By the Board and Quality and Safety in May 2011, September 2011 and January 2013.

Executive Summary

In 2011 the Board considered the key themes and actions arising from a series of national reports (including the first Francis report) and the recommendations arising from these and in January 2013 updated this to include The Winterbourne view report.

Overall this provided key themes for the Boards attention and consideration with an outline of the Executive Directors who would progress these recommendations.

Since that time there have been some key changes in Chief Executive and Executive Director roles and to support the review of the Francis report (2013) and the emerging recommendations by the DH, the previous Board paper has been updated again to provide a high level overview of how we will as an organisation progress the key themes of Francis where required.

The key governance themes from the Francis report have been included in this Board update and both the Quality and Safety Committee and Workforce Committee will provide the high level formal review on progress against all recommendations relating to their Terms of reference. The quarterly review of the specific recommendations will be entered into the work programme and supporting committee's will be asked to progress the detailed action plans.

The Statement of common purpose reflected in the DH response to the Francis report is one that is core to the principles of the NHS Constitution. The Quality and Safety Committee have signed up to this statement and formally ask the Board to do the same which responds to the DH request to sign up to the Statement of common purpose.

The Quality and Safety Committee will continue to monitor overall progress against recommendations and provide an overview to the Board on a six monthly basis, with an initial report being made by the Committee in May 2013.

Related SATH Objectives	SATH Sub-Objectives
We will always provide the right care for our patients	QS1. Ensure that we learn from mistakes and embrace what works well QS2. Design care around patient needs QS3. Provide the right care, right time, right place, right professional QS4. Deliver services that offer safe, evidence-based practice to improve outcomes QS5. Meet regulatory requirements and healthcare standards QS6. Ensure our patients suffer no avoidable harm

Risk and Assurance Issues (including resilience risks)	Provide key themes of concern from national reports for Board consideration.
Equality and Diversity Issues	National reports do pick up issues of inequality and recommendations to address those.
Legal and Regulatory Issues	Supports the Equality and Health Act requirements and regulatory requirements established by CQC.

Action required by the Trust Board
<p>The Board are asked to NOTE the main report which provides a high level overview of the second Francis report and APPROVE and sign up to the Statement of Common purpose.</p> <p>The Board are also asked to NOTE the updated summary used to review the thematic aspects of all national recommendations and the lead Directors and Quality and Safety Committee assigned to progress recommendations.</p>

Public Trust Board

May 2013

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

1.0 Introduction

In order to provide the Trust Board with a high level report but a report which also ensures (with accuracy) the key issues which need to be considered and addressed by the organisation following the Mid Staffordshire Public Inquiry; The Executive summary and the Department of Health response to the Public report from Robert Francis QC have been reviewed to capture the full range of recommendations.

2.0 Background of consideration

2.1 *National to Local Context* – The first Francis Independent inquiry looked at what went wrong inside the Mid Staffordshire Trust and reported in 2010. Locally within SaTH, we have implemented many of those recommendations, taking action to strengthen the focus on the quality of care and safeguards to protect patients from harm, including forming the Quality and Safety Committee and a quality forum with Commissioners. The improved national process for Foundation Trust authorisation includes Quality and Safety criteria and builds a Quality Governance Framework for the Board to ensure that Quality remains central to the Boards business, with Quality Impact assessment processes in place to ensure that the financial constraints do not impact on quality and safety. These are all processes introduced as a direct result of the legacy from the first Francis report and recommendations.

2.2 *We have built on these requirements* over the last two years building ways of reviewing Quality through a process of soft and hard intelligence, which is outlined in Appendix 3. This has created an early warning system, where the indicators have provided a view that the care on specific wards is not being provided consistently to the expected standard of care. The Trust has introduced a Quality Improvement Framework, which utilises senior nursing & patient representation to observe care in those areas, providing feedback to support improvement. This process whilst intense for wards has provided improvements in care delivery and the Trust has worked with Educational and Commissioning colleagues in the detailed reviews after the framework has been applied in order to objectively gain assurance about the improved care delivery. This process continues to be applied where it is required and as the Trust has done consistently, Commissioners, CQC and Educational colleagues are always informed where there are areas of concern.

2.3 *The Quality and Safety Committee* has overseen these systems and processes as they have been developed and have contributed to the framework by visiting clinical wards and Departments prior to the Committee meeting. This has ensured that they have an opportunity to talk to staff and patients and look at documentation of key indicators in randomly selected notes. A detailed quality and safety report has been provided monthly for the Committee to review. In addition an Integrated Performance report is now reviewed by the Board providing an opportunity to review Quality with the context of operational and financial context.

2.4 *The Board and the Quality and Safety Committee* have approved a Quality Improvement Strategy in March 2012 which established a 5 year improvement programme and under the leadership of the Centre Chiefs, Quality development plans were developed to underpin the implementation of the Strategy. Within the Governance arrangements at the Board, there have been a number of reports considering the range of external reviews and recommendations provided from National Inquiries up to and including The Winterbourne View report (December 2012) and the first Francis report (2010).

2.5 With an extensive list of recommendations, the Quality and Safety Committee themed these recommendations into 11 key work areas and this was updated in January 2013. The Committee has reviewed these themes and analysed the work currently being undertaken within the Trust to assess how these recommendations can be embedded into Governance and operational systems whilst still being tracked at Board level and this will continue to be monitored through the agreed committee's.

3.0 Current position from Francis (2013) and implementing and monitoring progress

- 3.1** The Non Executive and Executive Directors were provided with a full executive summary of the Francis report (2013) on publication and access to the full report was supported. The Executive summary was also circulated out to Centre Chief, lead clinicians and senior nursing staff across the organisation. A number of Quality news briefings and information made reference to the report.
- 3.2** The Workforce Director has reviewed each of the recommendations from the Francis report which relate to the Terms of reference for the Workforce Committee and has established a process for the detailed review and update through into main stream work and will highlight where particular work is required.
- 3.3** The overview position/ balanced score card presented as an appendix to this paper (Appendix 1) provides the ongoing accountability arrangements for tracking the work through, with an Executive lead and Trust Committee through which the recommendations will be formally considered and tracked.
- 3.4** The Quality and Safety Committee will retain the delegated Board overview on the full range of recommendations through a bi annual review.
- 3.5** It is proposed that bi-annually the Quality and Safety Chair and Workforce Committee Chair formally review the progress against recommendations made for Trust wide Governance arrangements along with the Audit Committee chair.
- 3.6** The Quality and Safety Committee reviewed and considered an initial report in April 2013 and the Board are receiving this updated report in May 2013 and thereafter on an annual basis which will be reflected through the Quality Account and contribute to the Statement of Internal Control.

4.0 Themes for Implementing the recommendations

There are 290 recommendations in the Francis report, which fall into the key headlines as described below. In undertaking a detailed review of the report, it is essential that we as an organisation do not lose the essence of all of the lessons learned from the Inquiry and therefore identifying the key Committee and lead Directors who will coordinate the detailed work streams required is essential.

This section of the paper provides a summary of the main recommendations from the report and details of those recommendations which have specific significance for Clinical Commissioning Groups and therefore will impact on us as a provider and those recommendations which directly impact on us as an organisation. These recommendations build on the clear transferable lessons for the 2010 Francis Inquiry and the need to reduce risks to patient care, outcomes and experience that may result from failure to adequately monitor and pursue improvements in the quality, safety and patient experience of the services we provide

4.1	<p>Ensuring implementation of the inquiry's recommendations (Recommendations 1) At the heart of the report is a determination that the inquiry's recommendations and findings be implemented and not suffer the same fate as many previous inquiries. Its first recommendation sets out requirements for oversight and accountability to ensure implementation of its proposals.</p> <p>This recommendation is applicable to the Trust</p> <p>Board lead- CEO / Workforce Director</p>
4.2	<p><i>Creating the right culture (Recommendation 2)</i> The report highlights the importance of establishing a shared positive safety culture that permeates all levels of the healthcare system, which aspires to prevent harm to patients and provide where possible, excellent care and a common culture of caring, commitment and compassion. Leaders of organisations are expected to adopt the shared culture themselves, and be seen to do so. This should be supported by measures such as open board meetings, personally listening to complaints, and an open and honest admission where there is an inability to offer a service. At a system level, this should be demonstrated by constantly considering how the wellbeing of patients is protected or improved by proposed measures. As the NHS evolves into a network of increasingly autonomous units, the overall culture will define what the NHS means and does. However, a positive culture will not emerge through the good intentions of those working of those working in the system. It needs to be defined, accepted by those who are to be part of it, and continually reinforced by leadership, training, personal engagement and commitment. This will be the principal means to ensure uniformity of the standard of care and treatment.</p> <p>This recommendation is nationally led but needs to be owned locally and requires a local commitment through the Statement of common purpose.</p> <p>Board lead- CEO and Workforce Director</p>
4.3	<p>Putting the patient first (Recommendations 3-8) The report underlines the importance of making patients the main priority in all that the healthcare system does. Within available resources, patients must be expected to receive effective services from caring, compassionate and committed staff, working to a common culture. They must also be protected from avoidable harm and any deprivation of their basic rights.</p> <p>Board accountability Board lead: Workforce Director and CEO With dual work with Chief Nurse and Medical Director.</p>
4.4	<p><i>Fundamental standards of behaviour (Recommendations 9-12)</i> The report proposes that enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.</p> <p>These recommendations are applicable to those individuals within the Trust.</p>
4.5	<p>An integrated hierarchy of standards of service (Recommendations 13-18) The report proposes establishing an integrated hierarchy of service standards to promote the likelihood that a service will be delivered safely and effectively. Standards would range from mandatory fundamental service standards to discretionary developmental standards, with clear expectation of zero-tolerance towards any organisation providing services that do not comply, the fundamental standards. The standards should be evidence-based and measurable, and be clear about what needs to be done to comply. They should also be subject to regular review and modification.</p> <p>Board lead:- Chief Nurse and Medical Director through Q&S Committee and Audit Committee</p>

4.6	<p>Responsibility for, and effectiveness of, healthcare standards (Recommendations 19- 59)</p> <p>The report highlights the importance of simplifying the regulation regime for NHS trusts to eradicate overlap and minimise the gaps between the functions of the different regulators. It proposes significant changes to the current division of regulatory responsibilities between Monitor and the Care Quality Commission (CQC), with the creation of a single regulator for all trusts, including foundation trusts. Monitor would retain its residual role as a regulator of the health economy. It suggests that these changes be implemented incrementally after thorough planning, and should not be used to justify reducing resources allocated to regulatory activity. It also stresses the importance of retaining the corporate memory of both organisations.</p> <p>Recommendations cover:</p> <ul style="list-style-type: none"> ➤ Creating a single regulator for all trusts ➤ Monitoring compliance with standards ➤ Setting standards and developing evidence-based compliance ➤ Effective assessment of compliance with standards ➤ Effective assessment of compliance and enforcement of compliance with standards ➤ CQC independence, strategy and culture <p>Medical Director and Chief Nurse through Q&S Committee and Audit Committee.</p>
4.7	<p>Responsibility for, and effectiveness of, regulating healthcare systems governance (Recommendations 60-108)</p> <p>This area of recommendations covers the following issues:</p> <ul style="list-style-type: none"> ➤ Consolidating Monitor's regulatory functions ➤ Authorisation of Foundation Trusts (FTs) ➤ Role of FT governors ➤ Accountability/training of directors ➤ Accountability of HSE ➤ Accountability of supportive agencies ➤ Effective complaints handling <p>These recommendations relate to Monitor, HSE, NHS Litigation Authority, National Patient Safety Agency and Health Protection Agency.</p>
4.8	<p>Effective complaints handling (Recommendations 109-122)</p> <p>The report recognises that there should be a uniform process for managing complaints and that the "recommendations and standards suggested in the Patients Association's peer review into complaints at the trust should be reviewed and implemented nationally".</p> <p>The Trust need to ensure recommendation 109-122 is reviewed as part of the development of the complaint process.</p> <p>Board lead: Chief Nurse and CEO</p> <p>Q&S committee to monitor</p>
4.9	<p>Commissioning for standards (Recommendations 123-138)</p> <p>The section on commissioning for standards pulls out the reflections and lessons learned by the primary care trust. The report suggests commissioning as a practice must be refocused to procure the necessary standards of a service as well as what it provides as a service (outcomes in quality as well as activity). This section should be an area of particular focus for the CCG and contains 21 recommendations specifically for commissioning organisations-with six of these specifically around the role of commissioners in performance management and oversight of quality.</p> <p>All these recommendations are applicable to the CCG but will need to be monitored by Q&S Committee and the Board through Quality schedules.</p>
4.10	<p>Performance management and strategic oversight (Recommendations 139-144)</p> <p>In relation to the work of the local Strategic Health Authority (SHA), Francis points to "a significant gap between the legislative and policy theory of the role...and their capacity to carry this role out." For example, he highlights concerns around the prioritisation of</p>

	<p>"targets not patients" and "an over-ready acceptance of action plans" from the Mid Staffordshire board, without ensuring robust scrutiny was undertaken. The importance of communication and clear information flow from performance managers to regulators was highlighted in the recommendations in this section.</p> <p>The Trust will need to work with the TDA with regard to emerging approach to strategic oversight and performance management.</p> <p>Board lead: CEO</p>
4.11	<p>Patient, public and local scrutiny (Recommendations 145-151)</p> <p>The report concludes that the standard of representation of patient and public concerns declined since the abolition of Community Health Councils (CHCs) in 2002. It suggests that Patient and Public Involvement Forums and local involvement networks (LINKs) failed to offer a route through which patients and members of the public could link into health services and hold them properly to account. It makes several recommendations in relation to how this should be addressed moving forward into the new quality architecture.</p> <p>The Trust need to work with Health Watch and PEIP and Quality and Safety Committee to review the recommendations and how they should change and support public and patient involvement and support to hold the Trust to account.</p> <p>Board lead- Chief Nurse/ Director of Quality and Safety</p>
4.12	<p>Medical training and education and professional regulation of fitness to practice (Recommendations 152-172 and fitness to practice 222-225)</p> <p>A brief summary of the workforce-related recommendations, including those relating to medical training and education and professional regulation of fitness to practice, can be found on the NHS Employers website.</p> <p>These recommendations need to be reviewed by the Medical Director in relation to Medical Staff employed by the Trust.</p> <p>Board lead: Medical Director</p>
4.13	<p>Openness, transparency and candour (Recommendations 173-184)</p> <p>The report concludes that "insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns, and cause regulation and commissioning to be undertaken on inaccurate information and understanding".</p> <p>These recommendations relate to us as a provider organisation and the principles of the Duty of candour are included into the Quality schedule with Commissioners.</p> <p>Board lead :- Chief Nurse through Q&S committee</p>
4.14	<p>Nursing (Recommendations 185-213 and Fitness to practice 226-235)</p> <p>The report recognises that, "much high-quality, committed and compassionate nursing is carried out day in and day out, often with inadequate recognition." However it states, "it is clear that the nursing issues found in Stafford are not confined to that hospital but are found throughout the country' and argues the NHS needs to give the highest priority to 'reversing the scandalous decline in standards." The report focuses on the culture of caring requiring more focus on delivering compassionate care at the point of recruitment, in training and through annual appraisal. The report also examines and makes recommendations in relation to the role of nursing leadership and that of healthcare support workers.</p> <p>These recommendations are applicable to the Trust</p> <p>Board lead: Chief Nurse & Workforce Director</p> <p>Workforce Committee</p>
4.15	<p>Leadership (Recommendations 214-221)</p> <p>The report focuses on the leadership and development of a staff college or training system to:</p> <ul style="list-style-type: none"> ➤ provide common professional training on leadership and management ➤ promote healthcare leadership and management as a profession ➤ administer an accreditation scheme ➤ promote and research best leadership practice. <p>A code of ethics to be produced and enforced by employers. Serious non-compliance will disqualify board directors and managers from holding such positions in the future.</p>

	<p>Regulation of managers is also to be considered after reviewing the impact of a licensing provision for managers. Consideration to be given to regulatory oversight of the competence and compliance of appropriate standards by non-foundation trust boards of similar rigour to foundation trusts.</p> <p>These recommendations are applicable to the Trust Board lead CEO and Workforce Director through Workforce Committee</p>
4.16	<p>Caring for older people (Recommendations 236-243) The report concludes that "the true measure of the NHS's effectiveness in delivering hospital care can be found in how well the elderly are looked after" and makes several recommendations in relation to this area in relation to the role of the senior clinician, named nurses, the importance of team working, regular ward rounds, private areas for patients and families, appropriate discharges well planned and timed, and other recommendations.</p> <p>These recommendations relate to us as a provider Board lead: Chief Nurse through Q&S committee</p>
4.17	<p>Information (Recommendations 244-272) The report is clear about the positive role that information can play, encompassing issues such as: highlighting inadequate performance; accountability; informing the public; and supporting patient choice. Francis advocates an integrated system with common information practices, while acknowledging that the Government's information strategy "appears to contain most if not all" of his suggested elements.</p> <p>A number of these recommendations are applicable to the Trust Board lead Medical Director and Director of Finance Through Information Board</p>
4.18	<p>Enhancement of the role of supportive agencies (Recommendations 236-243) National Patient Safety Agency (NPSA) The resources of the NPSA need to be well protected and defined. The report recommends that consideration should be given to transferring the resource provided by the National Reporting and Learning system from the NHS Commissioning Board to a semi-independent system regulator. The CQC should be enabled to exploit the potential of the safety information obtained by the NPSA or its successor to assist it in identifying areas for focussing attention. There needs to be a better dialogue between the two organisations concerning how they can assist each other.</p> <p>Health Protection Agency (HPA) The report concludes that more robust arrangements for sharing infection control concerns with regulators and performance managers are needed. It calls on the HPA and its successor to work with the Health and Social Care Information Centre to coordinate the collection, analysis and publication of provider data, relating to healthcare associated infections. Where HPA or its successor is concerned that a provider is not adequately managing healthcare associated infections to protect the public and patients, they should immediately inform commissioners, the CQC and, where relevant, Monitor of their concerns.</p> <p><i>These recommendations relate to external national organisations.</i></p>
4.19	<p>Coroners and inquests (Recommendations 273-285) Terms of registration/authorisation should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function.</p> <p>These recommendations relate directly to the Trust. Board lead: Medical Director Monitored by Quality and Safety</p>
4.20	<p>Department of Health leadership (Recommendations 286-290) The report argues that the DH lacks a sufficient unifying theme and direction with regard to patients' safety. It also says that the DH has struggled to get the balance right between "light touch" regulation and the need to protect service users from harm. In</p>

<p>addition, the report argues that while the DH asserted the importance of quality of care and patient safety, it failed to recognise that the structural reorganisations have on occasion made such a focus very difficult in practice, it also found that at times DH officials were too far removed from the reality of the service they oversee. The report sets out recommendations to address these issues.</p> <p><i>These recommendations do not relate to the Trust.</i></p>

5.0 Summary

The Department of Health published their response to the Francis report through a document called Patients First and foremost (March 2013). In the report it invites organisations to sign the pledge made within the document “A Statement of common purpose”. By signing up to the statement the Organisation would make the commitments to renew and reaffirm our personal commitment to the values of the NHS, set out in the Constitution. A draft Statement of Common Purpose is outlined in Appendix 2 which has been adapted from the national document. Quality and Safety Committee have signed up to the pledge and ask the Board to take a lead in this commitment and sign up to that pledge on behalf of the organisation.

The response by the DH through the above document sets out a five point plan to revolutionise the care that people receive from the NHS putting an end to failure and issuing a call for excellence

- A. Preventing problems
- B. Detecting problems quickly
- C. Taking action promptly
- D. Ensuring robust accountability
- E. Ensuring staff are trained and motivated

5.1 Each Committee assigned a range of recommendations will need to review these within the key themed areas for the local context rather than the national context and map their current terms of reference to those themes as well as the detailed work required behind each recommendation.

6.0 Current appraisal of Trust progress in each domain area with the “Francis” overall themed recommendations.

The Committee and the Board received an update on each of the themed areas for all previous reviews and recommendations in January 2013. In this report Board members are asked to note that the additional recommendations made by the second Francis report and the DH response can be linked with the previous themes presented to the Committee and Board to some degree but this will be reviewed in more detail by each of the Committee’s. ie

A: Preventing problems

Area 1 - Detecting a Deteriorating Patient and Mortality- Executive lead- Medical Director

Area 2 - Patient Safety Recommendations- Executive Director lead- Director of Quality and Safety / Chief Nurse.

- **Francis (2013) Caring for the Elderly (4.17)**

B: Detecting problems quickly

Area 3 - High Impact Actions- Executive lead- Director of Quality and Safety/ Chief Nurse

Area 4 - Infection Control Recommendations- Executive Lead- Director of Quality and Safety/ Chief Nurse

- **Francis (2013) Information Governance processes relating to Quality (4.18)**

C: Taking action promptly

Area 5 - Drugs and Therapeutics Committee- Executive lead- Medical Director

Area 6 - Quality Review Processes- Executive leads- Chief Nurse & Medical Director

- **Francis (2013) Commissioning for standards and local scrutiny (4.9)**
- **Francis (2013) Performance management and strategic oversight (4.10)**

Area 10 - Patient Experience- Executive Lead- Director of Quality and Safety/ Chief Nurse

- **Francis (2013) Recommendations relating to Complaint handling (4.8)**
- **Francis (2013) Patient, public and local scrutiny (4.11)**

Area 7 - Managing Emergency Flows of Patients- Executive Lead- Chief Operating Officer

Area 8 - Management of Medical Patient Flows- Executive Lead- Chief Operating Officer

- **Francis (2013) Coroners and Inquests (4.19)**

D: Ensuring robust accountability

Area 11 - Trust Wide Governance Arrangements – CEO Lead

- **Francis (2013) - Board responsibility for and effectiveness of healthcare standards**
- **(CQC, Monitor, HSE, HPA, NPSA)- (4.5, 4.6, 4.7)**
- **Medical training and Education (4.12)**
- **Openness, transparency and Candour (4.13)**
- **Professional regulation of fitness to practice (GMC/ NMC) (4.16)**

E: Ensuring staff are trained and motivated

Area 9 - Staffing recommendations – Executive Lead -Chief Operating Officer with support from Workforce Director

- **Recommendation requirements of healthcare workers**
- **Putting the patient first**
- **Fundamental standards of behaviour**
- **A common culture made real throughout the system.**
- **Sitting with the Workforce Committee and Workforce Director(4.1, 4.2, 4.3, 4.4)**
- **Q&S and Workforce Committee- Nursing focus on caring, training and experience (4.14)**
- **Leadership (4.15)**

6.1 The two sub Board Committees who are leading this review of the Francis Report are the Workforce Committee and the Quality and Safety Committee. The high level reports from these Committee's to the Board will provide assurance across these key themes. It is suggested; but subject to both Chairs agreeing, that the Committee should hold a joint workshop to review and align work streams and agree sub Committee (operational /clinical performance) work programmes to achieve changes/ supporting programmes where required.

7.0 Conclusion and recommendations

7.1 The Trust Board are asked to **Note** the high level review of the second Francis report (2013) and **sign up to** the Statement of Common Purpose.

7.2 Further work will now be required for each specific Committee to review the recommendations in relation to the current practice, systems and processes and to identify the formal gap analysis. The Workforce team are already undertaking this gap analysis which is being reported to the Workforce Committee and a further report by the Chief Nurse/ Medical Director of the supporting Committee's roles in the Quality and Governance recommendations will be undertaken and reported in June 2013. It is recommended that a

joint workshop is held in July 2013 which will demonstrate the full work programme for each part of our Governance structure.

- 7.3 The Quality and Safety Committee will ensure that the work plan for 2013/14 plans regular updates to identify gap analysis and tracks the implementation of any required recommendations.

Director of Quality and Safety/ Chief Nurse
May 2013

Table 1; National reports and recommendations

Area 1	Area 2
Detecting a deteriorating Patient & Mortality	Patient Safety Recommendations
Medical Director	Chief Nurse
Trust wide Mortality Committee and Clinical Governance Committee	Clinical Governance Committee (CGC) & Quality and Safety Committee
Trusts Safety Plan	Trusts Safety Plan
Area 5	Area 6
Medications Recommendations	Quality review process recommendations
Medical Director	Medical Director and Chief Nurse
Trusts Drugs and Therapeutics Committee	Monthly Quality review (Internal and PCT)
Clinical Governance Committee (CGC)	Clinical Governance Committee and Quality and Safety Committee
Area 9	Area 10
Staffing recommendations	Patient Experience
Chief Operating Officer/ Workforce Director	Chief Nurse
Hospital Executive Committee/ Clinical Governance Committee/Workforce Committee	Patient Experience and involvement Panel and Quality and Safety Committee
Staffing reviews / HR Policy Framework	Quality Improvement Strategy

Appendix 1

Area 3	Area 4
High Impact recommendations	Infection Control Recommendations
Chief Nurse	Chief Nurse
CGC & Nursing and Midwifery Forum	Infection Prevention and Control Committee & Q&S
Quality Improvement Strategy/ Quality Account	Infection Control Annual Plan
Area 7	Area 8
Managing Emergency Flow Patients	Management of Medical Patient Flow
Chief Operating Officer	Chief Operating Officer
Hospital Executive Committee	Hospital Executive Committee
Value Stream work on Unscheduled Care	Value Stream on Unscheduled Care
Area 11	
Trust wide Governance arrangements	
Chief Executive	
Trust Board / Audit Committee	
Board Assurance report	

Statement of Common Purpose

Quality and Safety Committee

In the light of the findings of the report into the Mid Staffordshire NHS Foundation Trust Public Inquiry, we the undersigned make the following commitments.

1. We renew and reaffirm our personal commitment and our organisations' commitment to the values of the NHS, set out in the NHS Constitution:

- **Working together for patients¹**. Patients come first in everything we do. We fully involve patients, staff, families, carers', communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.
- **Respect and dignity**. We value every person – whether patients, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.
- **Commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.
- **Compassion**. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.
- **Improving lives**. We strive to improve health and well-being and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.
- **Everyone counts**. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

2. We apologise to any individual affected by an incident whilst under our care and concerns relating to how we deliver care. We find the Mid Staffordshire report deeply disturbing and what happened in Mid Staffordshire NHS Foundation Trust was, and is, unacceptable and collectively we take responsibility for putting things right in our Trust accepting that we do not get it right all of the time. We recognise that SaTH is responsible for care that is poor as well as care that is good or excellent. Our commitment to the NHS and our pride in the good that we do every day will not blind us to our failings. It compels us to resolve them.

3. We will put patients first, not the interests of our organisation or the system. **We will listen to patients**, striving to ensure the quality of care that we would want for ourselves, our own families and our friends.

4. **We will listen most carefully to those whose voices are weakest and find it hardest to speak for themselves.** We will care most carefully for the most vulnerable people – the very old and the very young, people with learning disabilities and people with severe mental illness.
5. **We will work together**, collaborating on behalf of patients, combining and coordinating our strengths on their behalf, sharing what we know and taking collective responsibility for the quality of care that people experience. **Together, we will be unfailing in rooting out poor care and unflinching in promoting what is excellent.**
6. Whilst the poor care in the Francis report was in a hospital, poor care can occur anywhere across the health and social care system. Whether in a care home, at the family doctor, in a community pharmacy, in mental health services, or with personal care in vulnerable people's homes, **we will work with our Local Health Economy and multi agency partners to ensure that the fundamental standards of care that people have a right to expect are met consistently, whatever the settings.**
7. **Every one of us commits to ensuring a direct connection to patients and to the staff who care for them.** We will ensure that our organisation and our staff look outwards to the people they serve, taking decisions with patients and local communities at the forefront of their minds. **We will shape care in equal partnership with the people who depend on it.** We will do the business of the patient, before that of our organisation or the system.
8. **We will work together to minimise bureaucracy, enabling time to care and time to lead, freeing up the expertise of NHS staff and the values and professionalism that called them to serve.** Caring is demanding as well as rewarding, and depends on the personal and professional values of everyone who works in the NHS. We know well-treated staff treat patients well, so as the NHS become busier we need to ensure time to care and time to recover from caring. We will recruit, appraise and reward staff for their care, as well as their skills and their knowledge.
9. Healthcare is complex and we are part of a complicated system. Building on a foundation of fundamental and inviolable standards, **we will build a single set of nationally agreed and locally owned measures of success, focused on what matters most to patients.** They must be credible and independently assessed so that patients, the public, Parliament and those who work for NHS patients have a single version of the truth about local services and organisations and their staff have a single set of standards of care to which they aspire.
- Blind adherence to targets or finance must never again be allowed to come before the quality of care.** We need to use public money well and we need to be efficient and productive, but these are a means to an end – safe, effective and respectful care, compassionately given. We will be balanced in what we do and what we expect, with the patient interest at the heart of it. We must all do our best to maintain and raise quality within the resources we have.
10. We believe that patients are best served and our values nurtured by a spirit of candour and a culture of humility, openness, honesty and acceptance of challenge. Things do go wrong, but when they do we must learn from mistakes, not conceal them. **We will seek out and act on feedback, both positive and negative.** We will listen to patients who raise concerns, respond to them and learn from them. We will listen to staff who are worried about the quality of care, praising them for speaking up, even if a concern was misplaced. **We have a duty to challenge ourselves and each other on behalf of patients and we will do so.**
11. Signing up to principles is relatively easy. **Changing ourselves, our behaviour, individually and institutionally, is difficult, but we pledge to do so.** Health and care is not like any other job. It touches the hearts of people's lives, can do immense good but also immense harm – it is a matter of life or death. This is both a privilege and a great responsibility. Together, we will make ourselves accountable and responsible for what we do, not what we say, in striving to make real, for every patient, the values to which we recommit ourselves today. Over the coming months, SaTH will set out our plans for making these commitments a reality. In delivering those plans, we will be judged by the difference that they make to the people whom we serve.

12. All of the organisations signing this pledge have different responsibilities within our healthcare system, but as a acute healthcare provider we pledge to learn the lessons from Mid Staffordshire NHS Foundation Trust, help to build better care for every patient and do everything in our power to ensure it does not happen again. We invite all wards and Departments in the SaTH to join us in signing up to this statement of common purpose.

Director of Quality and Safety/ Chief Nurse

Chair of the Quality and Safety Committee

Medical Director

Non Executive member of Quality and Safety

Deputy Chief Nurse

Deputy Medical Director

