**Board meeting date:** 4th December 2013  
**Agenda Item number:** 10.11  
**Enclosure:** 11

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Formal response to the Francis Report from Dudley and Walsall Mental Health Partnership NHS Trust</th>
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<tbody>
<tr>
<td>Accountable Director</td>
<td>Wendy Pugh - Director of Operations and Nursing</td>
</tr>
<tr>
<td>Author (name and title)</td>
<td>Rosie Musson - Head of Quality, Nursing and Innovation</td>
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**Purpose of the report:** To provide a formal response to the Francis Report from the Trust

<table>
<thead>
<tr>
<th>Action required from the Board</th>
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<tr>
<td>Decision / Approval</td>
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<tr>
<td>✓</td>
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| What other Trust Committee or Group has considered the key elements of this report? |
| Committee: DONs group |
| Date reviewed: July - October 2013 |

| Key points or recommendations from Committee |
| A series of workshops held to review the recommendations |

| What other Trust Committee or Group has considered the key elements of this report? |
| MEXT |
| Date reviewed: 22nd October 2013 |

| Key points or recommendations from Committee |
| MEXT acknowledged that a lot of the areas detailed in the reports are already embedded within the Trusts visions values and culture and within the quality priorities.  
MEXT supported the themes for ongoing improvements and requested that integration was added as a further theme.  
MEXT requested that full action plans are developed and monitored. |

| What other Trust Committee or Group has considered the key elements of this report? |
| Committee: Trust Board |
| Date reviewed: 6th November 2013 |
Key points or recommendations from Committee: The Board supported the report. Further actions:
- Fully develop work plans related to themes.
- Ensure governor engagement
- To utilise as part of communication plan to staff and link with CQC inspection
- Public response from Trust to be published by end of year in line with national guidance
- Board to receive quarterly update through regular quality reports
- Audit to be completed for external view end Q1 2014

What other Trust Committee or Group has considered the key elements of this report? Committee: Governance and Quality Committee

Date reviewed: 13th November 2013

Key points or recommendations from Committee: The Committee will oversee the implementation of the action plan and report progress to the Trust Board

Strategic Objective(s) to which this paper relates:

<table>
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<tr>
<th>High quality services</th>
<th>Inclusive partnerships</th>
<th>Leadership culture</th>
<th>Responsible workforce</th>
<th>Supporting strategies</th>
<th>Effective/efficient resources</th>
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<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
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</tbody>
</table>

What impact or implications does this report have on any of the following: Please give brief details:

<table>
<thead>
<tr>
<th>Quality and standards (inc. CQC/NHSLA)</th>
<th>CQC outcomes all relevant.</th>
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<tbody>
<tr>
<td>Patient safety and experience</td>
<td>The Francis report has a key emphasis on promoting learning regarding patient safety and patient experience</td>
</tr>
<tr>
<td>Financial (income, expenditure and CIP)</td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>Effective leadership and cultural balance are required to achieve high quality person centered care,</td>
</tr>
<tr>
<td>Workforce and Leadership</td>
<td></td>
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<tr>
<td>Equality and Diversity</td>
<td></td>
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<tr>
<td>Sustainability</td>
<td></td>
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<tr>
<td>Risk Register/Board Assurance Framework</td>
<td></td>
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<tr>
<td>Patient and Public Involvement</td>
<td>Acknowledges the potential effects on patients, public confidence and the risks when organisation loses sight of the impact of their strategic decision making on the patient.</td>
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Introduction

This report provides the formal response to the Francis Report from Dudley and Walsall Mental Health Partnership NHS Trust.

Dudley and Walsall Mental Health Partnership NHS Trust have taken a balanced, proportionate, reflective, and timely approach to its response. This has involved significant Board discussion, attendance at conferences, contribution to listening events, staff workshops and seeking views of service users.

The final response has been distilled from reflecting on the key themes and recommendations from the Francis Report, the key recommendations applying to provider organisations, the Department of Health responses, the CQC strategy and Monitor’s guidance on Board Quality Governance Assurance Framework.

Summary of Key Points, Issues and Risks

This report provides a formal response to the Francis Report from Dudley and Walsall Mental Health Partnership NHS Trust.

The paper highlights the significance of the Francis Report and the implications for healthcare governance within the Trust.

It acknowledges the strategic context in terms of the effects on patients, public confidence and the risks when organisations lose sight of the impact of their strategic decision making on the patient.

It acknowledges the impact of a distorted focus on the delivery of performance targets and financial myopia may tick many of the boxes yet completely miss the point.

Effective leadership and cultural balance are required to achieve high quality person centred care, excellent performance and healthy finances. This balance enables the delivery of high quality, safe, timely and effective care to the patients and public we serve. It challenges the need for the all levels of the Health and Social care system to respond in order to achieve this.

The organisation has a strong reputation as a high performing Trust, with strong values, a robust focus on quality and a valued connectivity with its local community. There has been much work undertaken already as part of the Trust Quality Governance Framework and Quality Improvement Programme and through the process of reviewing the report high levels of assurance have been gained in relation to the Trusts current position e.g. the Trust has already commenced the Healthcare Assistant development programme. However, there is learning from the Francis Report which requires the action. Through the Trusts considered approach to reviewing the report the Trust has identified the following key areas where further learning will be embedded. It is acknowledged that work has progressed in all areas.
The key themes where further opportunities for improvement have been identified are being delivered as part of the Trust's Quality Improvement Programme. The key themes have been grouped into an overarching plan which will be monitored through the Trust's Quality Governance Framework. For all themes work has progressed, however further opportunities for improvements will be driven through the Trust's ongoing quality improvement programme.

**Background**

The publication of the Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry on 6 February 2013 will have significant implications for healthcare governance across the National Health Service.

The report of 1781 pages, made 290 recommendations. The public cost of the inquiry amounted to £13 million.

The real cost was that of life, inhumane treatment, abuse, poor care and patient experience of sick and vulnerable people. Patients, their families and the public were raising their concerns but their voices went unheard for too long. There was a failure of the organisation and the wider regulatory system to intervene. Consequently this led to a lack of confidence in Mid Staffordshire NHS Foundation Trust, the wider NHS and its regulatory system.

The focus of this inquiry was on how the failings had occurred, not on what actually occurred (covered in the previous Francis Independent Inquiry Report 2010).

This paper will provide assurance that the Trust has fully considered the Francis report in conjunction with other key publications e.g. Winterbourne and Keogh Report, and also alongside the key components of the Care Quality Commission Strategy and Monitors Quality Governance Framework.

**Strategic Context**

The impact of both of the Francis Inquiries, have been significant across the whole of the National Health Service. The detail of what happened at Mid Staffordshire Hospital is truly shocking.

The response of the media, along with patient pressure/action groups has been to actively seek out other examples of poor care, experience and abuse. Whilst such occurrences are totally unacceptable, these are thankfully the extreme exceptions rather than the general experience. Most people do receive excellent / good /acceptable standards of care. It is important to recognise this and recognise the commitment and professionalism of staff who serve the patients and public.
However, one must not be complacent or assume that Mid Staffordshire cannot happen elsewhere. It is necessary to learn the lessons from what went wrong at Mid Staffordshire and ensure that at a local, regional and national level, appropriate interventions are put in place to:

- Prevent such a recurrence
- Protect the public and provide assurance that when people are at their most vulnerable
- Ensure that people can expect to receive care which is evidence based, safe, clinically effective, dignified, compassionate, personal and of the highest standard possible.

Quality and performance are key measures to provide assurance of care standards. In order to demonstrate quality, it is necessary to measure it (Department of Health, 2008). NHS targets have been controversial in respect of their impact on operational culture and delivery but equally have been significant in improving access, driving up quality and providing focus on key areas of healthcare requiring improvement.

However, there is always the risk that organisations can put so much emphasis on the delivery of the target yet miss the point of what the target was trying to achieve. There is the risk that there is too much focus on the delivery of the target and not the individual in receipt of care. It should not be about the achievement of the target to the detriment of the patient.

The requirement of course is to deliver high quality performance and achieve targets, whilst delivering good person-centred care, which is to the benefit of the patient on all counts. However, in circumstances where the performance and the finances in the organisation are challenged, then there is real risk that culturally there can become a distortion of its key raison d’etre. Too much emphasis can be placed on target/financial delivery at all costs, which can be very damaging to the morale and well-being of staff many of whom have a vocational commitment to their public service and chosen career. Most of all it can be damaging to those we care for and indeed serve in terms of the quality of care they receive. The culture and leadership are paramount in achieving high quality of care, good performance and a healthy financial situation to enable the growth and development of the organisation. This cultural and leadership balance needs to be achieved across the whole of the Health and Social Care: provider, commissioner, regulatory and national strategic and political systems.

**Dudley & Walsall Mental Health Partnership NHS Trust Response**

The Trust recognises that the Francis Report will have significant implications for healthcare governance across the National Health Service, Social Care and private providers.

A balanced, reflective and proportionate response has been taken. Significant engagement and discussion has taken place across the organisation to inform the implications for the Trust and this response to it. This has included:

- Reviewing the implications and discussed in depth the Francis Report at a Board Development Session
- Discussing the Winterbourne Report, Cavendish Review, Keogh Review and Berwick Review at Trust Board meetings
- Held 3 workshops to complete a gap analysis, commissioned by the Director of Operations and Nursing for Heads of Service and Clinical Leads to identify recommendations most pertinent to them. From this key themes have been identified for further action. (see appendix 1)
- Discussed at Service Line Quality and Governance Groups
- Discussed at the Trust Service User engagement forum
- Encouraged teams to discuss reports in their services
Incorporated learning into Quality Governance Assurance Framework (QGAF) and ongoing monitoring, work plan and evidence.

The Management Executive Team (MEXT) and the Trust Board have agreed the themes identified through the gap analysis and a full action plan is in development. It was agreed that much work had already been undertaken and that high levels of assurance can be drawn from the Trusts Quality Governance evidence which is regularly reviewed by the Governance and Quality Committee and Trust Board.

Presented a report to the Trust Board on the outcome of the Trust wide review of the recommendations which the Board have signed up to.

The formulation of the response has been undertaken by reviewing the Francis Report and its recommendations, developing these into the main themes. The key recommendations which were directly relevant or had indirect implications for provider organisations were identified. The Department of Health response to the Francis Report and the Care Quality Commission’s publication of its Strategy for 2013-16 were considered. Monitor’s publication regarding Board Governance to assure on quality has also been incorporated into the response. Consequently, the Trust response has sought to be as reflective, proportionate, and well Informed.

There is a clear view that the response and appropriate actions will not sit as a separate entity but be absolutely embedded and mainstreamed across the organisation and existing quality governance structures and processes within the Trust.

The Trust seeks to be a transparent, open organisation with a duty of candour, and are committed to delivering care which is safe, timely and effective. The patient, their family/carers are at the heart of all that we do.

The Trust expects high standards of care which are patient focused and deliver against performance targets. However, these will not be delivered at the expense of patient safety.

The Trust always aim to be caring and compassionate and staff will be recruited against and be monitored against core NHS values.

The Trust are committed to and embrace the NHS Constitution.

Staff are encouraged to share any concerns, report any safety incidents and be supported in order to inform a clear sequence and clarity of events.

The organisation always seeks to learn from near misses, adverse events, feedback, complaints and serious incidents (whilst obviously seeking to avoid these wherever possible) yet improving our care and processes going forward to prevent recurrence.

Every member of staff needs to reflect and consider their own contribution and response for our patients and public whom we serve.
The Board

The Board will continue to:

- Focus on the strategic development/leadership of the organisation and the delivery of high quality care which puts the patient first.
- Ensure the necessary high quality leadership and strategic direction is given to organisation, maintaining and shaping its culture.
- Monitor and strive to enhance the highest standards of patient experience, safety and effectiveness.
- Be appropriately transparent and seek to do as much of its business in public wherever possible.
- Maintain a duty of candour, ensure public confidence, act with integrity, genuineness and honesty.
- Have public accountability in respect of public statements, signed declarations and transparency with regulators.
- Seek robust assurance via Governance and Quality Committee, ensuring these are triangulated to provide a rich, informative horizon scanning of organisational performance, ensuring relevant corrective actions have been established where indicated.
- Be committed to the continual leadership development of all board members.

Quality & Safety

There will continue to be a focus on quality (patient experience, safety and effectiveness) across the organisation, with quality metrics providing the necessary assurance at all levels and to identify and provide the required intervention early if required.

The Trust Quality Account will continue to be constructed as a full, accurate statement of compliance against relevant standards and in the nationally mandated format. It will signed off by all the board and published on the Trust website. (It will be subject to independent audit).

The Trust uses a range of intelligence and feedback to inform the quality of its services, proactively intervening and investigating, rather than reactively waiting for a formal traditional trigger.

The Complaints Policy and associated practice will be reviewed and updated following the publication of the national review of complaints processes in the NHS, recently conducted by Ann Clywdd MP and Professor Tricia Hart.

The learning from complaints will be better embedded and evidenced by the operational teams as well as triangulation with serious incidents, claims and litigation.

The Trust will continue to encourage its staff in reporting concerns and adverse events. These will be appropriately investigated and the learning shared as relevant to prevent recurrence.

Transparency, openness and candour should prevail in respect of appropriately informing patients/families/regulators/coroner in relation to complaints and incidents.
Regulatory Assurance

The Trust will strategically work closely with the Clinical Commissioning Group Quality and Safety Team to provide assurance regarding the quality of care for our mutual population served. This will also enhance and provide trusting relationships supporting the reporting, investigation, outcomes, learning and actions from serious incidents.

Full co-operation, honesty and transparency will continue to be provided across all levels of the organisation to support the regulatory function.

All relevant regulatory inspection reports which are in the public interest will be available on the Trust website.

Nursing

All Nurses and Health Care Support Workers will be recruited and appraised for values, care and compassion.

The Code of Conduct for Health Care Support Workers will be incorporated into the Job Descriptions of all Health Care Support Workers, along with a requirement to complete the National Minimum Training Standards for Health Care Support Workers (Department of Health, 2013). The Trust has already commenced a robust Health Care Support Worker programme.

Continual professional development is required of all Nurses and Healthcare Support Workers. This will is evidenced at appraisal and linked to the proposed revalidation process for nurses.

Patients (and their families) of all ages should be cared for with respect, dignity, compassion and kindness at all times. Information should be given in a timely and appropriate manner.

The Trust’s Nursing Strategy is being reviewed to ensure lessons from the Francis Report are fully incorporated.

Implementation

The Trust response will be posted on our website and be shared widely with staff.

The response will be woven into the organisation at all levels via discussion, implementation and behaviour throughout the Trust.

It has been agreed that the Trust will have an action plan for the key themes identified for further work, this will be an integral part of the Trust’s Quality Improvement strategy and woven into ongoing service delivery.
Conclusion

The events at Mid Staffordshire NHS Foundation Trust have been a watershed moment for the NHS, which has significantly affected public confidence. This has tarnished the reputation of the National Health Service and those who work within it.

It has resulted in the need a significant evaluation and enhancement of healthcare governance at every level.

Dudley and Walsall Mental Health Partnership NHS Trust has set out its response. The Trust has a strong reputation as a high performing Trust, with strong values, a robust focus on quality (patient experience, safety and effectiveness) and a valued connectivity with its local

However, the Trust must also seek to learn the lessons from the Francis Reports and not be complacent.

The response is proportionate and balanced. It seeks to focus on the areas relevant for the organisation to take forward, enhance and embed.

It is imperative that the response is implemented at both an organisational and personal level.

Recommendation

The Board is asked to receive, accept and ratify the Trust response to the Francis Report.
Overarching Themes

Through considering the recommendations within the reports, the following themes have been identified for incorporation into the Trusts ongoing quality improvement programmes. **Much work has been completed and underway through existing workstreams, however to ensure the reports have been given full consideration by the Trust it has been integrated in an overarching plan.** These will be monitored operationally by MEXT with the Governance and Quality Committee having overarching responsibility for reporting progress to Trust Board.

Transforming Care: Winterbourne View Hospital

- Improve triangulation of safeguarding trends
- Further develop processes to take into account views of family’s and carer’s
- Improve triangulation of trends identified through the use of the Mental Health Act
- Improve compliance with MCA and DOLS Training
- Improve incident reporting system to capture further detail regarding restraint

Francis Inquiry

- Pledge – Values in Action
- Increase staff engagement in quality improvement
- Improve communication
- Duty of Candour – continue to develop culture of openness
- Nursing Strategy incorporating learning from Francis
- Values based recruitment
- Integration

The Cavendish Review

- To introduce bespoke Healthcare Assistant development programme

The Keogh Mortality Review

- To ensure the principles identified in the report are incorporated into the themed action plan
  - Values in action (individual accountability and leadership)
  - Duty of Candour (transparency of data)
  - To note the Keogh inspection framework is likely to underpin further quality inspections.

Berwick Review

- To further review recommendations following publication of national overarching quality improvement framework
- To review staffing levels following publication of national work