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The Francis Report – implications for community pharmacy

In late March 2013 the Department of Health (DH) published 'Patients First and Foremost' the initial Government response to the report of the Mid Staffordshire NHS Foundation Trust Public Enquiry.

In an accompanying letter to Chairs of NHS Trusts, Jeremy Hunt, Secretary of State for Health said:

'This is a call to action for every individual and organisation within the health and care system, to reflect on our behaviours and priorities. I know that many of you are delivering outstanding care, and this should not be taken as a negative reflection on the hard work that many in your organisations are doing to respond to the many pressures facing the NHS. However there are lessons for all of us to learn from the appalling events at Stafford Hospital, and it is important that we do so.'

The response is divided into five areas, designed to improve the care that people receive from the NHS:

1. Preventing problems;
2. Detecting problems quickly;
3. Taking action promptly;
4. Ensuring robust accountability; and
5. Ensuring staff are trained and motivated

The recommendations of the Inquiry focussed on acute hospitals and so too does the response to the Inquiry, however, DH states that many of the messages from the Inquiry are equally relevant to other health and care settings. Issues such as the culture of care and the vital importance of listening to and being open with patients, their families and advocates apply across the health and care system.

A summary of the main points in the documents and the actions listed by DH are set out below:

1. Preventing Problems

- A Chief Inspector of Hospitals will be appointed by CQC to lead inspection and highlight where standards are not being met.
- Time to Care – DH will ensure that paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third.
- The Health and Social Care Information Centre will act as a single national hub for collecting information, and it will have a duty to seek to reduce the information burden on the service year on year.
- The Berwick Review - Prof Don Berwick, former adviser to President Obama, is working with NHS England to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

2. Detecting Problems Quickly

- The CQC Chief Inspector of Hospitals will make assessments based on judgement as well as data. The Chief Inspector will be supported by expert inspectors (rather than generalists) who have ‘walked the wards, spoken to patients and staff, and looked the board in the eye’.
- The Chief Inspector will become the nation’s whistle-blower – naming poor care without fear or favour from politicians, institutional vested interests or through loyalty to the system rather than the patients that it serves.
- A ‘comply or explain’ approach to known good practices will be used in inspections. So, where there are well-established practices that benefit patients, inspectors will expect to see these being used across hospitals or a valid explanation given if this is not the case.
- The CQC will be given the power to conduct ratings at the earliest opportunity and will work with the Nuffield Trust to develop these proposals further. This will ensure that there is a single version of the truth about how hospitals are performing, not just on finance and targets, but on a single assessment that fully reflects what matters to patients.
- A Chief Inspector of Social Care will be appointed who will adopt a similar approach to social care and will be charged with rating care homes and other local care services, promoting excellence and identifying problems.
- Publication of information at a department, specialty, care group and condition-specific level. Initially this will see an extension of the transparency on surgical outcomes from heart surgery, to cardiology, vascular surgery, upper gastro intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery, head and neck surgery and thyroid and endocrine surgery.
- Implementation of penalties and possibly additional legal sanctions at corporate level for organisations that are found to be massaging figures or concealing the truth about their performance.
- Create a statutory duty of candour on providers to inform people if they believe treatment or care has caused death or serious injury, and to provide an explanation.
- A ban on clauses intended to prevent public interest disclosures.
- Complaints Review - a review of best practice on complaints to ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement rather than irritations to be managed defensively.

3. Taking Action Promptly

- CQC, working with NICE, commissioners, professionals, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall.
- Introduction of a time limited hospital failure regime for quality as well as finance.

4. Ensuring Robust Accountability

- The Health and Safety Executive to be able to apply criminal sanctions where the Chief Inspector identifies criminally negligent practice in hospitals.
- Faster and more proactive professional regulation - as part of the implementation of the Law Commission’s review, DH will seek to legislate at the earliest possible opportunity to overhaul 150 years of complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.
- Introduction of a national barring list for unfit NHS managers.

5. Ensuring Staff are Trained and Motivated

- Healthcare Assistant training and practice for up to a year to be undertaken before people undertake NHS funded nursing degrees.
- Introduction of revalidation for nurses.
- Publication of a Code of Conduct and minimum training for Healthcare Assistants.
- Introduction of a barring system for Healthcare Assistants
- The NHS Leadership Academy will initiate a major programme to encourage new talent from clinical professionals and from outside the NHS into top leadership positions.
- Frontline experience for D staff - within four years, every civil servant in the Department will have sustained and meaningful experience of the frontline with Senior Civil Service and Ministers leading the way.

Implications for community pharmacy

Some of the actions and issues raised in the Government response and the Francis report that could be applied to community pharmacy are detailed below. Some of the points are areas where action has already been taken by community pharmacy, but where additional effort may be required to meet the vision included in the Francis report.

PSNC undertook an initial review of the Francis Inquiry report and the initial DH response to the inquiry's recommendations at its meeting in May 2013. A further discussion on the topic and in particular its relevance to quality standards in community pharmacy will be undertaken at the July 2013 meeting of the Committee. PSNC plans to work with the other pharmacy bodies over the next few months to consider the actions community pharmacy needs to take in response to the report.

1. Development of (quality) standards for services (fundamental, enhanced and developmental standards).
2. Development of evidence based standard procedures, e.g. for provision of medicines optimisation services.
3. Increased patient safety incident reporting and appropriate feedback following reporting.
4. Development of outcome measures for services.
5. Development of risk management standards.
6. Improving complaints handling processes and learning from complaints.
7. Being alert to concerns raised by patients about other services, and taking necessary action to raise these concerns on behalf of patients.
8. Embedding a culture within community pharmacy that supports the raising of concerns and open discussion about care and system failures in order to improve future patient care.
9. Implementing the duty of candour and ensuring that is part of the culture of community pharmacy practice (but recognising the need to tackle decriminalisation of dispensing errors).
10. Enhancing the caring culture within community pharmacies.
11. Enhancing team working in primary care and between primary care and secondary care, in particular to support transfer of care for individual patients, when they move from one care environment to another, e.g. living in their own home to a care home.
12. Access to shared clinical records to facilitate improved patient care.
13. Building robust follow up of patients into community pharmacy services.
14. Creation of system to support collation of real-time performance information on community pharmacy services.

As previously stated, many of the recommendations within the Francis report focus on secondary care services, but some of these 'hospital specific issues' may map across to support community pharmacies provide to care homes.