Trust Board Paper O

To:	**Trust Board**
From:	**Chief Nurse/Deputy Chief Executive**
Date:	**28 February 2013**
CQC regulation:	**All applicable**

Title:	**The Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Robert Francis QC**

Author/Responsible Director: Chief Nurse/Deputy Chief Executive

Purpose of the Report: To provide assurance on the preliminary review of UHL's response to the recommendations arising from the Public Inquiry report.

The Report is provided to the Board for:

Decision		Discussion	✓
Assurance	✓	Endorsement	

Summary / Key Points:
The report details key areas for focus and Trust Board discussion.

Recommendations:
Communications and next steps as detailed in section 5 of the report.

Previously considered at another corporate UHL Committee?
Trust Board development session on 15 February 2013.

Strategic Risk Register: **Yes**	**Performance KPIs year to date:** **Yes**

Resource Implications (eg Financial, HR):
Yes

Assurance Implications:
Yes

Patient and Public Involvement (PPI) Implications:
Yes

Stakeholder Engagement Implications:
Initial stakeholder engagement event to be held on 28 February 2013.

Equality Impact:
Yes

Information exempt from Disclosure:
N/A

Requirement for further review?
Yes

University Hospitals of Leicester NHS Trust (UHL)
The Mid Staffordshire NHS Foundation Trust Public Inquiry – Chaired by Robert Francis QC
Trust Board Meeting 28th February 2013

1.0 Introduction

The publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was released on the 6th February 2013. This report ran to 1776 pages in 3 volumes covering:

- Warning Signs
- Governance and Culture
- Roles of scrutiny, patient and public involvement groups, commissioners, the Strategic Health Authority and regulators
- Themes for the present and future
- 290 recommendations

Recommendations within the report are, where possible, grouped into themes identified by the inquiry (previously circulated to Trust Board members as part of the Executive Summary), together with the organisation suggested to take them forward.

The report recommends that all commissioning, service provision, regulatory and ancillary organisations in healthcare consider the findings of the report and announce its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted.

2.0 Report Overview

The Francis report painted a shocking picture of appalling standards of patient care.

It highlighted poor management practices, an organisational focus on national financial and performance imperatives to the detriment of the quality of patient care.

It also challenged the effectiveness of the regulatory and oversight mechanisms in identifying and tackling poor quality patient care proactively and systematically leading to attention on who is responsible for ensuring patients receive high-quality care, and, for acting if appropriate standards are not met. It has also particularly highlighted how the decisions and actions of staff at all levels can affect the quality of care patients receive.

More specifically, chapter contents include an array of examples which led to the report recommendations. For the purpose of this report summary, a provider focus has been given which includes the following:

2.1 Warning Signs – within the report there is a chronological analysis showing numerous causes for concern about the Trust's standards of service, governance, finances and staffing, and, that these were not addressed. These include:

• Negative peer review reports • Lack of engagement of clinicians • Lack of engagement with the wider health economy • Increasing staff sickness • Low morale • A belief (below corporate level) that finances took priority over clinical governance	• Staff attitude • Poor standards of cleanliness • Lack of clinical strategy • CRES (Cash Releasing Efficiency Savings) with a key focus on staff reduction • Regulatory concerns • Concerns about basic nursing care • Hospital acquired infections

2.2 Trust Leadership

• Whistleblowing and staff concern to raise issues • Staff survey results and evidence of action taken • Incidence of staff appraisal • Patient survey outcomes and actions	• Absence of analysis and learning from complaints • Compliance with safety alerts • Lack of openness relating to complaints • Tolerance of poor standards • Relationships and senior post turnover

2.3 Complaints

• Lack of transparency • Failure to investigate properly • Dissatisfaction by complainant of all levels of the complaints system	• Inadequate staff to support Patient Advice and Liaison Service • Absence of sharing of information • Lack of learning

2.4 Mortality

• Too much focus on coding at the expense of mortality ratios indicating concerns about care • Lack of mortality data disclosure	• Over reassurance of mortality data • Widespread lack of understanding regarding significance of figures

2.5 Patient and public local involvement and scrutiny

• Ineffective routes to engage patients and members of the public • Lack of follow-up by MP's • Lack of clarity regarding involvement forums and roles	• Ineffective challenge and follow up of local scrutiny • Dysfunctional relationships of patient involvement structures • Public reticence in raising concerns and acceptance of poor care

2.6 Certification and inquests relating to hospital deaths

• Ineffective certification of the cause of death • Lack of clarity regarding case referral to the coroner • Lack of trust deployment of Rule 43	• Variable involvement of bereaved families in coronial experience • Lack of provision of evidence and information to coroners

2.7 Culture

• Bullying • Target driven priorities • Disengagement from management • Low staff morale	• Acceptance of poor behaviours • Denial • Reliance on external assessments

2.8 Values, standards, openness and candour

• Lack of compliance to values and principles • Lack of clarity regarding standards expected	• Lack of ownership regarding values expected • Insufficient openness, transparency and candour

2.9 Nursing

• Unacceptable standards of nursing care • Inadequate staffing levels and skill • Ineffective leadership • Lack of specialist skills to care for the elderly	• Poor recruitment processes • Deficiencies in initial and continuing training • Lack of role clarity • High staff sickness

2.10 Care of the Elderly

• Lack of named consultant • Absence of clear handover responsibilities • Inadequate food and nutrition • Lack of teamwork	• Poor information sharing • Lack of involvement of families • Lack of hygiene and cleanliness • Poor discharge arrangements

3.0 High Performing Organisations

In identifying key areas for focus and Trust Board discussion, consideration needs to be given to what constitutes high performing organisations. These include:

- Create a positive, open and transparent culture
- Embed desired values and behaviours across the organisation
- Prioritise delivery of high quality patient care, setting quality objectives

- Have appropriate, integrated governance systems, processes and procedures, including robust clinical and financial governance arrangements, and implement them
- Identify key risks early and work to mitigate them
- Encourage, value and act on feedback from patients and staff
- Understand and track performance, including learning from complaints, concerned and serious incidents to improve the quality of care
- Know their limitations and understand other organisations may be better equipped to provide some services

There can be no doubt however who has the primary responsibility for delivering high quality care which clearly lies with the organisation providing care, and its board.

Although many external bodies support this with regulatory or oversight powers, the board's responsibilities are clear.

Evidence from high-quality healthcare organisations across the world demonstrates the importance of organisational culture in ensuring the delivery of high-quality, patient-centred care, regularly reviewing and examining their performance, creating a positive organisational culture, the right environment to support staff and to do the 'right' thing for patients.

In considering the context for discussion and potential quick wins, the following areas have been highlighted, that, irrespective of further external review of the recommendations, are proposed to be key considerations in providing responsive actions and learning from the report.

4.0 Key considerations and discussion areas for UHL

4.1 Values, Behaviours& Culture(a)– throughout the report, there is a consistent message regarding the behaviours of staff at all levels and disregard for patients and their families. Whilst UHL has established values (2009) which are included in job descriptions, reflected in values based recruitment processes and part of the mandatory refresh equality course, further development is proposed to expand this area of work relating to management standards and behaviours.

4.2 Values, Behaviours & Culture(b) – consider utilising 'Learning into Action' as a key driver to communicate and engage around the Public Inquiry outcomes and local actions and expectations

4.3 Values, Behaviours & Culture(c) – consider expansion of staff feedback vis a vis Friends & Family in order to understand and 'temperature check' staff opinion and views

4.4 Care of the Older person – the report shares a concerning overview of how the needs of this vulnerable group were not met. Whilst there are very successful developments in the trust regarding this i.e. Frailty service, further consideration should be given to how UHL could be a leader in this field going forward, through the integration of a range of services both within UHL i.e.; continence, falls,

frailty, and across the health economy. This could also take the form of an 'Older Persons pledge' with designated lead older persons nurse.

4.5 Public and patient support – responding to public and patient concerns in a responsive way through visible rather than remote services has been highlighted as a developing need within UHL. Whilst the advent of the facilities management partnership arrangements will go some way in responding to this, more immediate and visible action could be taken utilising the main entrance of the Leicester Royal Infirmary site in partnership with our stakeholders together with a patient advice service for immediate concerns to be shared.

4.6 Patient information/communication &visibility of care - whilst there are many examples of patient information i.e.bedside information packs, speciality condition leaflets and a degree of benchmarked information available, more prominence to be placed on:

- 4.6.1 Consistent patient information on admission and discharge
- 4.6.2 Transparency of clinician performance comparisons
- 4.6.3 Expanded metrics with a focus on hydration and nutrition
- 4.6.4 Local complaints management and visibility with partner agencies
- 4.6.5 Incident reporting and feedback

4.7 Mortality–the widespread lack of understanding relating to the significance of mortality figures cannot be underestimated, more recently clarified through the shift to Summary Hospital-Level Mortality Indicators (SHMI's). Through the 'Saving Lives' Goal of the Trust Quality & Safety Commitment where work is being supported by Boston Consulting Group (BCG), commitment to a wider understanding of SHMI across the health economy is required.

4.8 Nursing standards –the shocking examples of poorly governed and delivered care within the report provides leverage for a greater focus on the leadership roles of ward managers and clinicians. To this extent, whilst providing greater clarity on the prominence of clinical presence on ward rounds, supported resource for continuing professional development and the introduction of supervisory status of ward managerswill be considered.

4.9 Stakeholder discussion – engaging with our stakeholders to share respective priorities is a valued opportunity to work collaboratively. Proposals for early discussions are planned for immediately before the February 2013 public Trust Board.

5.0 Communications and next steps

Further to pre-planned communications on the launch date of the public inquiry, a series of Chief Executive Briefings, media interviews and Q&A's were provided to staff.

Pre-arranged teleconferences have been held with the Clinical Commissioning Groups (CCG's) and Local Area Team (LAT) colleagues regarding both the sharing but also co-ordination of key areas post respective Board deliberations. Furthermore, discussions with De Montfort University have been held regarding the impact of the report on education and training of all staff – this has resulted in a planned summit to be held with invites to all partner organisations including the deanery.

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For our staff, further briefings regarding key areas of action, engagement sessions and individual responsibilities will be progressed.

The Chief Nurse/Deputy Chief Executive will report further at the Trust Board meeting on the Trust's response to the Public Inquiry.

Mrs S Hinchliffe
Chief Nurse/Deputy Chief Executive