Trust Board Paper Q

To:	Trust Board
From:	Suzanne Hinchliffe, Deputy Chief Executive/Chief Nurse
Date:	28 March 2013
CQC regulation:	All Applicable

Title:	Francis Report Update

Author/Responsible Director:
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Purpose of the Report:
To provide Trust Board members with an overview of key priority areas for consideration post a UHL gap analysis.

The Report is provided to the Board for:

Decision		Discussion	x
Assurance		Endorsement	

Summary / Key Points:
The attached paper highlights:
- Six themes emerging from the report together with a summary of key areas of reported concerns for Trusts to consider.
- A summary of discussions and communications held to date.
- Six areas of particular note for Trust Board discussion.

Recommendations:
Trust Board members are asked to review the attached paper which provides a basis for discussion at the meeting.

Previously considered at another corporate UHL Committee?
Chief Executive Briefings
Extraordinary Trust Board
Stakeholder session alongside Trust Board
Joint meeting with De Montfort University
Area Team meeting alongside East Midlands Trusts
Discussions with nursing and clinician colleagues

Strategic Risk Register:	**Performance KPIs year to date:**
Where appropriate.	Linked to strategic and operational risks where appropriate.

Resource Implications (eg Financial, HR):
Currently being determined.

Assurance Implications:

Patient and Public Involvement (PPI) Implications:
Links to stakeholder discussions and feedback.

Stakeholder Engagement Implications:

Equality Impact:
Not applicable.

Information exempt from Disclosure:
No.

Requirement for further review?
Quarterly Update.

University Hospitals of Leicester NHS Trust (UHL)
The Mid Staffordshire NHS Foundation Trust Public Inquiry – Chaired by Robert Francis QC
Trust Board Meeting 28th March 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 grouped into themes identified by the inquiry.

The report recommends that all commissioning, service provision, regulatory and ancillary organisations in healthcare consider the findings of the report and share 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	• Variable involvement of bereaved families in coronial experience

• Lack of clarity regarding case referral to the coroner • Lack of Trust deployment of Rule 43	• 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.

4.0   Discussions and communications held to date

Further to the launch of the report, the Trust has:

- Provided a series of Chief Executive briefings, media interviews and staff Q&A's.
- Held an extraordinary Trust Board to highlight key findings within the report.
- Held a stakeholder session alongside Trust Board members to listen to feedback and share areas for particular note.
- Received feedback from clinicians (geriatricians in particular).
- Attended a joint meeting with De Montfort University followed by a stakeholder session.
- Participated in an Area Team meeting alongside East Midlands Trusts.
- Participated in the prioritisation of key areas of action from a nursing perspective.
- Will be represented at an LLR event drawing together key areas for action from a health-economy perspective.

Additionally, a summary gap analysis has been undertaken against key chapter outcomes and examples.

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 both key areas for discussion, with some identifying responsive actions and learning for Trust Board consideration.

5.0   Key considerations, quick wins and discussion areas for UHL

5.1   Values, Behaviours & Culture – throughout the report, there is a consistent message regarding the behaviours of staff at all levels and disregard for patients and their families.

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.

The Organisational Development Plan priorities will be led through six substantial work-streams – each theme having a series of priorities designed to build in current strengths and address gaps to improve organisational culture. These priorities have also been aligned to organisational values and support building pride in the organisation and improve staff morale. The implementation of 'Listening into Action' is also a key priority in the OD plan work stream 2, improving two way engagement to actively support listening, staff support and communications. Further considerations may also be given to expand staff feedback vis a vis Friends & Family in order to understand and 'temperature check' staff opinion and views

5.2   *Care of the Older person* – the report shares a concerning overview of how the needs of this vulnerable group were not met. The Trust has implemented a very successful care stream with a focus on frailty, multi-disciplinary older people training, dementia awareness and vulnerable adult safeguarding to name a few. However, further developments to enhance the care of the older person to be considered may include:

- The integration of a range of services both within UHL and across the health community ie continence, falls.
- Centralised information/resource for carers and families.
- Improved signposting/way-finding.
- Introduction of carers advocate support to work alongside wards and families.
- Improved means of communication with families through established models ie Patient Profile.
- Delivery of the Royal Colleges Quality Mark for older peoples care (8 ward areas currently participating).
- Expansion of volunteer mealtime assistance.

5.3   *Public and patient support* – In the development of the Quality & Safety Commitment, patient feedback was used to identify key areas for action.

Whilst in most areas there are frontline led initiatives to improve patient experience and active measures across the Trust involving patient surveys and the Friends & family test, the plethora of developments can get lost resulting in 'direction' but not 'engagement'.

Responding to this, a strategic overview of patient & public engagement and experience is to be crafted, both identifying current work-streams but most importantly, highlighting future plans aligned to goal 3 'Patient Centred Care' of the Trust Quality & Safety Commitment. Examples of these include:

- Older people and dementia.
- Discharge experience.
- Efficiency of care, ie waiting times, cancellations.

- Environment and services, ie car parking, meals.
- Pain management.
- Patient information services.
- End of Life care.

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 will 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.

5.4   *Leadership* – There can be no doubt of the Trust Board responsibility for the strategic direction of the organisation, clinical engagement, quality of service provision and, the leadership and management of staff. Supporting the staff experience 8 point action plan and the leadership and management standards developed in consultation with staff, responsibilities for transparency and candour as a Board, together with a clear Board development programme is required. Examples of further action in this area include:

- Review of complaints process (aligned to the recently announced national review) and Trust wide learning.
- Refresh of governance processes and sub-board committees.
- Portfolio review of directors.
- Response to independent evaluation of Board effectiveness and governance i.e. Deloitte, Tenon.
- Review of local escalation and assurance processes.
- Application of quality impact assessments for service developments, cost improvement initiatives.

5.5   *Clinical Quality* – The Trust has a range of measures and data from which to assess clinical quality and outcomes. These include clinical metrics, safety work-streams i.e. 5 Critical Safety Actions, infection prevention and environment surveys, clinical and patient reported outcome measures and more recently, the Trust Quality & Safety Commitment with key priorities identified for the next 3 years.

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, more granular detail regarding 'out of hours' and 'weekend' data is to be progressed coupled with a wider understanding of SHMI across the health economy on a collaborative basis.

5.6   *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 managers needs to be progressed. Further work in this area also includes the review of Health Care Assistant training modules, strengthened links with higher education, investment in nursing acuity, and continued work in values based recruitment for staff.

6.0   Next steps

The response to the public enquiry and its actions will be incremental, and priorities within this report post discussion, will need to be planned and delivered in a timely way.

Representation at the health economy discussions in response to the enquiry is due to take place in the near future, following which priorities may be re-assessed where health community focussed.

Mrs S Hinchliffe
Chief Nurse/Deputy Chief Executive