To:	**Trust Board**
From:	**Chief Nurse/Medical Director**
Date:	**28/11/13**
CQC regulation:	All

Trust Board Paper P

Title:	Gap analysis of the key recommendations from Robert Francis QC, Professor Bruce Keogh and Professor Don Berwick, with the Trust's quality and safety priorities

Author/Responsible Director:
Chief Nurse/Medical Director

Purpose of the Report:

- The purpose of this report is to provide the Board (via the Quality Assurance Committee) with assurance that the three reports have been reviewed and key actions identified to address any gaps.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

- This report draws together a number of the themes around quality, culture, patient experience, openness and transparency, accountability and education and training, and provides a gap analysis against these themes.

- This report focuses on those recommendations that apply to Trust activity rather than regulation or wider healthcare issues.

- Although the reports have some common themes, in particular relating to the need for cultural change, there are however, some differences in approach. Where Francis emphasises individual and corporate accountability and recommends the use of criminal sanctions, Berwick places his emphasis on blame-free learning culture with criminal sanction as a last resort. The Keogh methodology is now being implemented nationally by Sir Mike Richards, Chief Inspector of Hospitals as part of the new inspection regime.

- Appendix 2 of this report highlights some of the key themes from the reports, together with existing assurance and potential gaps.

- These gaps include the:
    - Need to review the leadership capacity and capability across the Trust (Lead- Director of Human Resources);
    - Review of workforce to take place to ensure sufficient suitable trained/competent staff (Lead- Chief Nurse/Medical Director)
    - Need to endure there are good governance processes with the establishment of the new Clinical Management structure and introduction of the Performance, Assurance, Escalation and Response framework (Lead- Chief Nurse)

Recommendations:

- Review the gap analysis including the proposed leads and timescales.

• Note that further reports will be presented to the Executive Quality Board via the Executive Leads.	
Previously considered at another corporate UHL Committee ? QAC 28/08/13 Trust Board 25/07/13 Trust Board 26/09/13	
Strategic Risk Register **n/a**	**Performance KPIs year to date** **n/a**
Resource Implications (eg Financial, HR) **n/a**	
Assurance Implications	
Patient and Public Involvement (PPI) Implications In public domain	
Equality Impact **n/a**	
Information exempt from Disclosure **no**	
Requirement for further review ?	

REPORT TO: **Trust Board**

DATE: **28th November 2013**

REPORT BY: **Chief Nurse/ Medical Director**

SUBJECT: **Gap analysis of the key recommendations from Robert Francis QC, Professor Bruce Keogh and Professor Don Berwick, with the Trust's quality and safety priorities**

1.0 Introduction

1.1 The reports published by Robert Francis QC, Professor Bruce Keogh and Professor Don Berwick in 2013 each contain a number of key recommendations and ambitions directly pertinent to acute providers. These are summarised in Appendix I.

1.2 Reports on each have previously been presented at the Trust Board and Quality Assurance Committee.

1.3 This report draws together a number of the themes around quality, culture, patient experience, openness and transparency, accountability, education and training, and provides a gap analysis against these themes (Appendix 1).

1.4 This report focuses on those recommendations that apply to Trust activity rather than regulation or wider healthcare issues.

1.5 Although the reports have some common themes, in particular relating to the need for cultural change, there are however, some differences in approach. Where Francis emphasises individual and corporate accountability and recommends the use of criminal sanctions, Berwick places his emphasis on blame-free learning culture with criminal sanction as a last resort. The Keogh methodology is now being implemented nationally by Sir Mike Richards, Chief Inspector of Hospitals as part of the new inspection regime.

1.6 The purpose of this report is to provide the Board (via the Quality Assurance Committee) with assurance that the three reports have been thoroughly reviewed and key actions identified to address any gaps.

2.0 The Francis report

2.1 The Mid-Staffordshire NHS Foundation Trust Public Inquiry (Chair – Robert Francis QC) published on 6 February 2013 makes 290 recommendations, of which around 88 require direct or indirect action by provider organisations.

2.2 The inquiry examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It considered why serious problems at the Trust were not identified sooner and highlighted import lessons to be learnt for the future of patient care in the NHS.

2.3 The government also indicated that all NHS hospitals should set out how they intend to respond to the inquiry's conclusion before the end of 2013.

2.4 Francis sets out his aspirations:

- No tolerance of non-compliance with fundamental standards
- Openness and transparency, duty of candour to patients
- Strong and patient centred healthcare leadership
- Stronger regulation
- Compassionate, caring and committed nursing service
- Accurate, useful and relevant information about services

Throughout the report Francis refers to culture and listening to patients and acting on what they are telling us.

3.0 Government Response to the Francis Report

3.1 The government published its initial response to the report in March 2013 entitled 'Patients First and Foremost', and highlighted a 5 point plan for improvement:

- Preventing Problems
- Detecting Problems Quickly
- Taking Action Promptly
- Ensuring Robust Accountability
- Ensuring staff are trained and motivated

4.0 Keogh Report

4.1 The Keogh Report was published on 16 July 2013 after the review of quality of care and treatment provided by 14 hospital Trusts.

4.2 Keogh had already identified 5 key themes in the design of the review process, these are seen as the core foundations of high quality care:

- Patient experience
- Safety
- Workforce
- Clinical and operational effectiveness
- Governance and leadership.

4.3 Key quality findings from the reviews were:

- Poor engagement of patients and staff;

- Poor implementation of early warning scoring, particularly with reference to hospital acquired pneumonia;
- Weak workforce data that did not reflect the reality of the situation in clinical areas with over reliance on temporary staff;
- Lack of clear approaches to quality improvement;
- A disconnect between the leaderships view of the clinical risks and the frontline reality.

4.4 Having completed the reviews, Keogh sets eight ambitions for the NHS. The methodology used by Keogh has now been adopted by Mike Richardson for the new style Care Quality Commission inspections which the Trust will be participating in the first quarter of 2014.

5.0 Berwick report

5.1 The Berwick Report, commissioned by the Government in response to the Francis report was published on 6 August 2013. It focuses on creating an effective safety culture within the NHS. The risk management culture Berwick advocates is one of transparency, learning and improvement. Like Keogh he emphasises the importance of safe staffing levels for all clinical areas and the real-time monitoring of actual staffing against this standard. Berwick's report centres on patient safety. He argues that quality and safety cannot be separated. Berwick states that "the most important single change in the NHS: to become a system devoted to continual learning and improvement in patient care – top to bottom, end to end". To achieve this he highlights the following as fundamental to understanding and achieving the necessary cultural changes:

- Patient safety problems exist in all health systems
- Staff are not to blame
- Central focus must always be on patients
- Clear warning signals are missed
- Clarity of ownership and leadership needed
- A culture of fear is toxic to safety and improvement
- There should be a driven and resourced agenda to build the capability for improvement

6.0 Assurance and Gap Analysis

6.1 Appendix 2 highlights some of the key themes from the reports, together with existing assurance and potential gaps.

6.2 These gaps include the:

- Need to review the leadership capacity and capability across the Trust (Lead- Director of Human Resources);
- Review of workforce to take place to ensure sufficient suitable trained/competent staff (Lead- Chief Nurse/Medical Director)
- Need to endure there are good governance processes with the establishment of the new Clinical Management structure and

introduction of the Performance, Assurance, Escalation and Response framework (Lead- Chief Nurse).

7.0 Recommendation

7.1 The Trust Board are asked to:

- Review the gap analysis including the proposed leads and timescales.
- Note that further reports will be presented to the Executive Quality Board via the Executive Leads.

The reports of Robert Francis QC, Professor Sir Bruce Keogh and Professor Don Berwick - Main findings

Francis
The overarching conclusion is that 'a fundamental culture change is needed' to put patients first, 'which can largely be implemented within the system that has now been created by the new reforms'.

The recommendations with the Francis report are wide ranging, but taken together the aims are to:

- Foster a common culture shared by all in the service of putting the patient first
- Develop a set of fundamental standards the breach of which should not be tolerated
- Ensure openness, transparency and candour throughout the system about matters of concern
- Make individuals and organisations properly accountable for what they do and ensure protection of the public
- Provide a proper degree of accountability for senior managers and leaders
- Enhance recruitment education and training
- Develop and share ever improving means of measuring and understanding the performance of individual professionals and teams.

Keogh.

The following were identified as being core foundations of high quality care:

Patient experience – understanding how the views of patients and related patient experience data is used and acted upon (such as how effectively complaints are dealt with and the visibility of feedback themes reviewed at board level).

Safety – understanding issues around the trust's safety record and ability to manage these (such as compliance with safety procedures or trust policies that enhance trust, training to improve safety performance, the effectiveness of reporting issues of safety compliance or use of equipment that enhances safety);

Workforce – understanding issues around the trust's workforce and its strategy to deal with issues within the workforce (for instance staffing ratios, sickness rates, use of agency staff, appraisal rates and current vacancies) as well as listening to the views of staff;

Clinical and operational effectiveness – understanding issues around the trust's clinical and operational performance (such as the management of capacity and the quality – or presence - of trust wide policies, how the trust addresses clinical and operational performance) and in particular how trusts use mortality data to analyse and improve quality of care;

Governance and leadership – understanding the trust's leadership and governance of quality (such as how the board is assured of the performance of the trust to ensure that it is safe and how it uses information to drive quality improvements).

Berwick recommendations:

1. The NHS should continually and forever reduce patient harm by embracing Whole heartedly an ethic of learning

2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support

3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts

4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives

6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS

7. Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment

Integrated action plan for themes from Keogh, Berwick and Francis reports **Appendix II**

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Keogh Ambition 1 We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing. **Berwick Report Recommendation 5** Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals including managers and executives. **Patients First and Foremost** - Theme of preventing problems **Francis Report** - Themes around information and quality of data and openness, transparency and candour	• The Trust monitors mortality rates and reports in the public domain. The Medical Director meets regularly with the Head of Outcomes and Effectiveness to look at our performance. • The Trust takes data from Dr. Foster, HED and other, national sources so that we can compare how well we are doing. • Integrated dashboard presented to the Trust Board each month. • Particular areas of interest which impact on mortality rates are used to inform the priorities (respiratory pathway is a workstream for the Quality Commitment Programme in 2013- 2014). • Trust has participated in LLR mortality review (initial response to QPMG 13/11/13). • All services have Mortality and Morbidity meetings.	• Need to strengthen governance arrangements within the newly formed CMGs and agree assurance and escalation response framework. • Need to establish overarching Mortality Review Group • Action request that view Innovation Improvement Science Unit. Request the new IISU to consider QI methodology and report back to EQB. • Audit quality of M&M meetings.	Chief Nurse Medical Director Medical Director/ Associate Director of Quality Improvement Medical Director	November 2013 November 2013 December 2013

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Keogh Ambition 2 The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level. **Berwick Report Recommendation 2** All leaders concerned with NHS Healthcare should place quality of care and patient safety at the top of their priorities **Berwick Report Recommendation 7** Transparency should be complete, timely and unequivocal. All nonpersonal data on quality and safety should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public. **Patients First and Foremost** – Theme of detecting problems early **Francis Report** – Theme of openness, transparency and	• The Quality and Performance report details mortality information (monthly update) at Trust Board, Quality Assurance Committee and Quality and Performance Management Group. • The Trust Board has received a Board development session in relation to mortality and a detailed report at October Trust Board. • Staff are encouraged to report incidents. • 3636 anonymous staff concern reporting line. • Staff are encouraged to record incidents onto the Datix system. • Ward boards display information about quality and safety for the public using safety crosses to make the information clear and accessible. • Full and routine disclosure of all	• There is a national and local requirement to present data in a meaningful way to the public. Further consideration required. • Review of the Quality and Performance report. • There is a shortfall in skills of data analysis and interpretation (particularly statistical analysis). Establishment of the Business Strategy Support Team will concentrate the skills available to support the Board and management teams (scoping required). • Ward quality dashboards need to be implemented to make ward level data accessible to support ward sisters, matrons and clinical leads to understand their data and to take appropriate actions. The dashboards will also enable Trust to be aware of any areas of underperformance	Director of Strategy Director of Strategy Chief Nurse	TBC TBC November 2013

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
candour	RCA and complaint responses to patients and/or relatives. • Monitoring of quarterly safety metric internally and with Commissioners. • Strong quality, safety and experience component at Annual Public Meeting.	in a timely way and where necessary take remedial action. • Further work to be undertaken to provide quality data for the public • Review of complaints process and policy required following publication of Report of handling of complaints by NHS hospitals in England by Ann Clwyd MP. • Strengthen quarterly Patient Safety report to include rates of incidents by CMG's.	Lead Director TBC Director of Safety and Risk Director of Safety and Risk	December 2013 December 2013
Keogh Ambition 3 Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.	• The Quality Commitment Programme identified need to improve patient experience and work stream identified for elderly and dementia patients. • Regular events with prospective governors.	• There needs to be closer links between all aspects of patient experience to include complaints, patient surveys and social media. • Increase story telling at CMGs and corporately.	Chief Nurse	December 2013

Integrated action plan for themes from Keogh, Berwick and Francis reports **Appendix II**

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Berwick Report Recommendation 3 Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts. **Berwick Report Recommendation 8** All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care. **Patient First and Foremost** – Theme of preventing problems **Francis Report** – Theme of fostering a common culture shared by all and developing a set of fundamental standards.	• Regular patient stories at Trust Board meetings. • Friends and Family Test – substantial patient feedback now available to be used to make service improvement. • Patient advisors sit on Trust Committees and undertake quality walkabouts. • Overview and Scrutiny Committee conduct quality visits and formally report so they can seek the views of member and the public. • Daily reviews of patients by the duty Matrons/Site team are being undertaken to ensure that the patients care needs to continue to be met and if this is not possible that they are moved to an appropriate area. This is monitored at the daily site meetings. • Patients/Carers involved in new build solutions e.g. NNU	• Establish complaints review panel and invite membership from Healthwatch and Pt Advisors. • Patient Experience Group to be established. • Need to invite the patients and relative or carer to join RCA investigation teams. • Need to share outcomes and learning of complaints and SUIs more widely with patients and the public via forums, newsletters and website. • Need for greater analysis and triangulation of patient feedback • Further development of matrons and senior sisters about standards and responding to concerns required. • Large scale public Listening	Director of Safety and Risk Director of Nursing Director of Safety and Risk Director of Communications Chief Nurse Chief Nurse Director of Communications	January 2014 December 2013 February 2014 TBC TBC TBC December 2013

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
		events planned.		
Keogh Ambition 4 Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections. **Berwick Report Recommendation 10** We support responsive regulation of organisations. **Patient First and Foremost** – Theme of ensuring robust accountability **Francis Report** – Theme of ensuring that relentless focus of the healthcare regulator is on policing compliance with the fundamental standards of care.	• The Chief Operating Officer and the Associate Medical Director were part of the Keogh Review Inspection Team and are part of the first wave of CQC inspections. • The Trust has offered the CQC the services of its relevant staff to be part of the new CQC regime.	• Work needs to be undertaken to ensure that the Trust learns from the CQC's inspection process which will help when undertaking its own robust assessments and in formulating action plans to address areas requiring improvement. • Need to introduce a programme of internal 'mock' inspections to provide assurance about the standards of care being delivered.	Director of Clinical Quality/ Chief Nurse Director of Clinical Quality/ Chief Nurse	December 2013 TBC
Keogh Ambition 5 No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past. **Berwick Report Recommendation 1** The NHS should continually and forever reduce patient harm by embracing	• The Learning from Experience Group promotes organisational learning. • Patient safety now featuring in undergraduate medical training.	• Strengthen governance arrangements within the clinical specialities and the CMGs through agreeing Performance Assurance, Escalation and Response framework. • Gap: Increase the use of quality improvement	Chief Nurse/ Chief Operating Officer Head of Service Improvement	December 2013 February 2014

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
wholeheartedly an ethic of learning. **Berwick Report Recommendation 6** NHS should become a learning organisation. Its leaders should create and support the capability for learning and therefore change within the NHS. **Patients First and Foremost** – Theme of preventing problems **Francis Report** – Theme of fostering a common culture	• The Trust hosts the Academic Science Health Network. • Members of the Trust participate in a number of regional and national fora to share and disseminate good practice and to learn from others. • Patient safety report monthly (QPMG and QAC) • Integrated Board performance dashboard (Quality and Performance Report).	methodologies at UHL; within specialities, the CMGs and Corporately. The Innovation Improvement Science Unit. Request the new IISU to consider QI methodology and report back to EQB. • Need to develop RCA competence and expertise amongst the Executive Team. • Develop RCA and complaints training and incident investigation master classes internally. • Improvement and Innovation framework scope organisational improvement skills and training requirements. • Need to strengthen the patient's voice in RCA and complaint responses.	Director of Safety and Risk Director of Safety and Risk Director of Safety and Risk	March 2014 March 2014 March 2014
Keogh Ambition 6 Nurse staffing levels and skill mix	• Nurse staffing review completed and presented to Executive	• Need further work to link compassion into the	Chief Nurse/ Director of Human Resources	TBC

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards. **Berwick Report Recommendation 4** Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well supported. **Patients First and Foremost** – Theme of ensuring staff are trained and motivated **Francis Report** – Theme of compassion linked to reward	Team 27/08/13. Priority areas identified for investment including supervisory time for ward sisters. Sickness absence monitored in Q+P report. • Temporary staff (bank and in some cases locum) used in some areas but carefully monitored and skill mix considered. Expectation is that temporary staff are appropriately inducted. • There are a few recruitment hot spots areas/areas for medical staff of high vacancies reflecting national shortages, for example E.D. This is closely monitored and locums are inducted appropriately. • Detailed nursing workforce report developed with monthly reporting at QPMG and QAC. • Twice daily process overseen by senior nurses to ensure safe staffing on a shift by shift basis, with an escalation process if safety issues arise.	appraisal process • Need to implement plans for twice daily review of staffing • Difficulties with national recruitment. Recruitment plan to be implemented. • Need to have greater transparency re: nurses available each shift and display at ward level for public. • Need to implement the national nursing strategy and 6Cs • Need to review clinical skills training and monitoring of competence.	Chief Nurse Chief Nurse/ Director of Human Resources Chief Nurse Chief Nurse Chief Nurse	TBC Commenced Commenced 25/11/13 TBC TBC

Themes from Keogh Review Ambitions, Berwick Report Recommendations and Francis Report	Assurance/Existing Workstreams	Any gaps or Further Actions Required?	Lead	By When
Keogh Ambition 7 Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors. **Patients First and Foremost** – Theme of ensuring staff are trained and motivated **Francis Report** – Theme of leadership	• All F1 and F2 doctors receive quality and safety training as part of a structured training programme. • Doctors in Training forum chaired by Dipti Samani (Specialist Registrar).	• Need to ensure ideas and projects developed by junior doctors are supported and incorporated into working patterns across the Trust.	Medical Director	TBC
Keogh Ambition 8 All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy. **Patients First and Foremost** – ensuring staff are trained and motivated **Francis Report** – Themes of developing fundamental standards of care and compassion.	• Listening in Action staff engagement programme. • Explicit behaviours and core values identified by the Trust. • Values and behaviours incorporated into appraisals and application forms. • Reward strategy recognises required behaviours.	• Leadership and OD strategies to be reviewed in the context of Francis, Keogh and Berwick reports.	Director of Human Resources	December 2013