Title: The Francis, Keogh and Berwick reviews; a summary of the South Tees NHS Hospitals position

Purpose: The purpose of this report is to summarise the common themes from the Francis, Keogh and Berwick reviews and to update on the Trust’s position in relation to the recommendations

Summary: The recommendations from the three reviews have been summarised to identify the common themes and key areas of work. The Trust position is described in the report in relation to these themes and the following key work streams:
- Transparency
- Learning from patient experience
- Listening to and supporting staff
- Using measurement for quality improvement

Prepared By: Emma Carter Trust Governance Manager / Ruth James, Deputy Director for Quality Assurance

Presented By: Ruth James, Deputy Director for Quality Assurance

Recommendation: The Board of Directors is asked to approve the suggested approach and the focus in the current key areas of work.

Implications (mark with x in appropriate column(s))

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Meeting / Committee: Board of Directors
Meeting Date: 24th September 2013

This paper is for: Action/Decision Assurance Information (Only 1 column to be marked with x as appropriate)
The Francis, Keogh and Berwick reviews; a summary of the South Tees NHS Hospitals position

Introduction

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on Wednesday 6 February 2013. The Inquiry was established under the Inquiries Act 2005 and was chaired by Robert Francis QC, who made recommendations to the Secretary of State based on the lessons learnt from Mid Staffordshire. It built on the work of the earlier independent inquiry into the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009.

The 290 recommendations detailed within the Report describe the key improvement areas for a number of agencies across the NHS. As a provider organisation there are over 100 recommendations that relate specifically to activities of the trust. The trust has reviewed its position in relation to the recommendations and an action plan was presented to Integrated Governance Committee in March and updated in September.

In February the Prime Minister asked Professor Sir Bruce Keogh to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates. Keogh selected 14 trusts for his review on the basis that they had been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR).

The review identified some common challenges facing the wider HNS and Keogh identifies 8 ambitions for tackling some of the underlying causes of poor care. Improvement across these 8 areas is expected within two years.

In August 2013 the national Advisory Group on the Safety of Patients in England published the results of their review of the Francis enquiry which the government had commissioned to distil the patient safety lessons learnt and specify the changes needed. The advisory group was led by Professor Don Berwick who is an internationally recognised expert on patient safety.

The purpose of this report is to bring together the findings of these three pieces of work to identify the common issues relevant to South Tees so that we can review the actions already taken and those under development and ensure that any additional requirements are built into our strategic planning and Quality Account priorities for 2014/15.
Gap analysis

The recommendations of the three reports have been summarised within the framework shown below:

Where the recommendations for Francis, Keogh and Berwick have highlighted further work for South Tees a range of work streams have already been implemented, this work needs to be reflected in the trust strategy. The table in appendix 1 shows the findings of each of the three reviews summarised in the framework described above, lists the actions being taken by the trust and how this links to the trust's strategic objectives, where this link is not clear it is recommended that these are incorporated.

There are a number of recommendations which will be addressed by work being undertaken nationally by the regulatory organisations and professional bodies, the trust will respond to this as applicable.

Currently the main issues relating to the trust from the Francis, Keogh and Berwick reviews are:

Transparency – how we share information on safety and quality issues with patients, the public and staff. Our key actions are:

- The Trust is a pilot site for the national transparency project.
- Summary information on complaints is to be published on the website each month starting in September.
Never event data is to be published by NHS England in October, the trust is developing a section of the trust website to summarise never events and the actions taken and lessons learnt.

Ward quality dashboards are being developed and will be rolled out across the trust in October.

**Using real time patient experience feedback.** Our key actions are:

- Implementing the real-time patient experience project.
- Developing the framework for the use of the FFT feedback including the ward accreditation system.
- A patient experience sub group will be established as part of the revised governance structure

**Strengthening the processes for reviewing deaths in hospital.** Our key actions are:

- Weekly review of deaths occurring in hospital commencing in September 2013. The reviews will incorporate the ‘Hogan scale’ so we will be able to estimate how the Trust performs on the proposed new indicator measuring avoidable deaths. The finding of the review will be recoded on a data base so that we are able to immediately investigate shifts in our mortality data.

**Improving the way we engage with patients and the public on planning and developing services:** Our key actions are:

- To continue to consult with the public on major service reconfigurations
- To build on the use of patient forums as a source of feedback on service development.
- To work with the developing Healthwatch on mechanisms to seek feedback from the public on planning and service development.

**Conclusions**

Work to address the recommendations for the Francis, Keogh and Berwick reviews has commenced. Most of the actions needed are already reflected the Trust’s strategic objectives, where there are gaps the relevant strategic theme should be updated.

It is requested that Board of Directors approve the suggested approach and focus in the current key areas of work.

**Ruth James**  
Deputy Director Quality Assurance  
September 2013
### Agenda item: 8.3

#### Appendix 1 – Summary of the Francis, Keogh and Berwick recommendations

<table>
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<tr>
<th>Francis report</th>
<th>Keogh report</th>
<th>Berwick report</th>
<th>Trust Response</th>
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<td><strong>Demonstrate great leadership</strong></td>
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| The need for a culture of caring and compassion in which the patient is priority. | Board must take collective responsibility for quality within their organisation. Leadership potential of patients and members of the public. | The best way to reduce harm is for the NHS to embrace wholeheartedly a culture of learning. Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours. Leadership - quality of care, in particular patient safety at top of priority list. Patients & carers should be represented through the governance structure. | 1. The national cultural barometer will be implemented when approved nationally.  
2. Membership of the groups within the governance structure will be reviewed when the structure is approved to identify opportunities for greater involvement of patients and carers  
3. In respect of a culture of caring a number of work streams are present in the organisation. These streams focus on creating a compassionate organisation and staff and therefore compassionate care. They include Schwartz rounds, psychodynamic supervision for groups and teams for the emotional labour of caring, mindfulness stress reduction which includes self-compassion training and team effective training using psychodynamic models. | Quality is at the forefront of the Trust’s strategy. Need to include the work relating to the cultural barometer |

| The need for transparency and honesty - being open | Transparent reporting of complaints reporting of issues, lessons & actions arising from complaints | Transparency should be complete, timely and unequivocal. All non-personal data on quality & safety should be shared in a timely fashion with all including the public | 1. The Trust has a being open policy.  
2. Changes made on Datix system to prompt for relevant information.  
3. Trust taking part in phase 2 of the Transparency project for reporting Falls & Pressure Ulcers.  
4. Work underway to publish complaints and the results of never event investigations on the Trust website | Not explicitly reflected in the Trust strategy. Links with 1.2 Patient safety and 1.3 Patient experience |
### Listen to patients

| Sharing complaint information and demonstrating learning and improvement | Feedback, concerns & complaints to used as a source of improvement. Transparent reporting of complaints reporting of issues, lessons & actions arising from complaints | Complaints provide vital information and should be gathered and responded to in a timely way. | 1. 36% of patients in 2011 National Inpatient survey saw posters/leaflets explaining how to complain.  
2. How to complain posters have been updated and have been distributed to all wards and departments. Leaflets need further updates due ICAS changes. Information is also available on trust website informing patients how to complain.  
3. Friends and family test is being implemented and all adult patients are asked to complete and comment on discharge from A&E and in patient areas.  
4. Quarterly patient surveys are also undertaken sampling approximately 660 patients views each quarter. Many clinical areas also have their own comments/ suggestions boxes and many actively survey their patient group for ideas regarding service improvements.  
5. Review of the complaints process has commenced PR are working with the PRD team to publish complaints information on the website, once up and running this will be refreshed monthly. | Not explicitly reflected in the Trust strategy |

| Acting on real time patient feedback and making the results available to all stakeholders | Real time patient feedback & comment must become normal part of customer service and reach beyond Friends & Family Test. | Pt feedback should be collected as far as possible in real time and responded to as quickly as possible | 1. Development of real time patient experience project - due for completion in March 14.  
2. A Patient experience Sub Group will be established as part of a revision to the current governance structure. | This work is described within the supporting initiatives which underpin objective 1.3 Improving Patient |
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<th><strong>Experience</strong></th>
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| **The imperative to have a positive incident reporting culture and to provide feedback to staff who report incidents on the action taken** | **1. Data shows the organisation is in the middle 50% of trusts for reporting of incidents.**  
**2. Datix has been modified to email feedback to the reporter of incidents.**  
**3. Checklists have been developed to encourage investigators and approvers of incidents to feed back. Lessons learnt are disseminated through staff meetings and trust briefings.** |
| **Where an incident qualifying as a Serious Incident (as defined by NHS England) occurs, CQC regulations should require that the patient or carers affected by the incident be notified and supported.** | **Links with 1.2 reducing patient safety incidents resulting in serious harm and 4.1 staff engagement.** |
| **Reviewing nurse staffing levels** | **1. Build on the recommendation of the recently reported review of nursing in the trust.**  
**2. The senior corporate nursing structure will include a lead nurse for workforce.** |
| **Nursing staffing levels & skill mix will appropriately reflect the case load & severity of illness. This will be transparently reported to the board.** | **Not specifically reflect in the trust strategy.** |
| **Seek feedback from junior doctors and nurses on standards of quality and safety** | **1. The annual national NHS Staff Survey provides both a measure of staff engagement and a basis for divisional / directorate action plans with staff to address the themes emerging from the results.**  
**2. Staff are actively engaged in service improvement workshops, with recent examples including 16 wards being involved in the improvement of patient discharge processes and a ‘front of house’ rapid improvement workshop to address acute admissions. The wider adoption of the VMPS methodologies will engage staff in decision making across the** |
| **Positive impact that happy & engaged staff have on patient outcomes - Need to think about innovative ways to engage staff** | **Described within 4.1 improving staff engagement and the supporting initiatives** |
3. Commitment to personal development & training with opportunities locally and through linkage to regional and national leadership programmes. The development of a robust talent management framework linked to staff appraisals will enhance this.
4. Recognition of staff achievements via the annual ‘Star Awards’ plus the nursing ‘Nightingale Awards’.
5. Staff communication through for example CEO ‘blog’ & ‘discussions over coffee’, monthly briefing, bulletins.
6. Adoption of the national Health Promoting Hospitals framework aimed at improving and promoting a health and wellbeing of the staff and the wider community.
7. Junior doctors & Student nurses are included in the CEO and Chair coffee mornings with staff. Further work to be included.

**Measurement for quality improvement**

| The need to monitor quality and safety at ward level and to follow standard procedures and take corrective action when necessary | Confidently & competently use data and other intelligence. Rapid access to accurate, insightful and easy to use data at service line level | Active interrogation of information for learning Need to seek out variation within the organisation Patient & carer voice essential in monitoring safety & quality of care | 1. Development of ward level dashboards linking in with pre-existing directorate and divisional dashboards. 2. Use of SPC charts and funnel charts to identify variation within the organisations. 3. Use of Friends & Family test information and complaints/PALS/complaints to triangulate data at ward level 4. Development of real time patient feedback 5. Governance framework restructure includes the intention to establish a patient experience sub group of IGC | 1. Links with overall objectives to improve quality safety and patient experience, operational excellence and organisational capability. |
| Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio. | We will have made demonstrable progress towards reducing avoidable deaths in our hospital | Unless and until a better metric is developed, the NHS should use mortality rate indicators like the Hospital Standardised Mortality Rate or suitable alternatives as one of its ways to detect potentially severe performance defects worth investigating further. Mortality measurement should be used as a ‘smoke detector’ in a spirit of supportive and genuine inquiry, not used to generate league tables or similar comparisons. | 1. STHFT first introduced an early warning system in 2005. This was superseded by the NEWs in July 2013. A graded response strategy is in place that guides all staff on the clinical response required dependant on the patients’ acuity of illness. The NEWS has been incorporated into the existing H@N system which ranks the priority of the call dependant on the patients NEWS score. The introduction of Comprehensive Critical Care Outreach will significantly contribute to a standardised response strategy in a more consistent manner.  
2. We are introducing a weekly review of deaths occurring in hospital in September 2013. The reviews will incorporate the ‘Hogan scale’ so we will be able to estimate how the Trust performs on the proposed new indicator measuring avoidable deaths. The findings of these reviews will be reported through the committee structure via CSSG to Board. They will also be held on a database so that future alerts generated by mortality figures can be immediately investigated. | Clearly reflected in objective 1.1 – reducing mortality and the supporting initiatives described in the annual plan |