Coventry City Council

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To all Members of the Health and Social Care Scrutiny Board (5)

23rd September, 2013
Our ref: C/LMK

Dear Member,

Supplementary Agenda – Meeting of the Health and Social Care Scrutiny Board (5) - Wednesday, 25th September, 2013

The papers for the above meeting were circulated on 17th September, 2013. At the time of publication, there were a number of documents which were not available. These documents have now been received and are attached to this letter. Please include them with your papers for the meeting.

- **Agenda Item 4.** **MEETING THE CHALLENGES OF THE FRANCIS REPORT** (Pages 3 - 20)

  The Scrutiny Co-ordinator will report at the meeting

  The following organisations have been invited to attend the meeting for the consideration of this item:

  University Hospital Coventry and Warwickshire
  Coventry and Warwickshire Partnership Trust
  Coventry and Rugby Clinical Commissioning Group
  NHS England The Local Area Team
  West Midlands Ambulance Service

If you have any queries, please do not hesitate to contact me.

Yours sincerely

Liz Knight
Governance Services Officer

Membership: Councillors M Ali, J Clifford, C Fletcher, P Hetherton, J Mutton, H Noonan, H S Sehmi, S Thomas (Chair) and A Williams
By invitation: Councillors K Caan, A Gingell and D Spurgeon

Coventry City Council

Briefing note

To: **Health and Social Care Scrutiny Board** **Date: 25th September 2013.**

Subject: The Francis Inquiry into Mid-Staffordshire NHS Foundation Trust – response of local providers.

1 Purpose of the Note

1.1 The Scrutiny Board has been invited by the Health and Wellbeing Board to investigate the local response to the Report of the Francis Inquiry and to satisfy itself that recommendations are being taken on board by local providers and where appropriate other agencies. Senior managers from the three provider Trusts serving Coventry will be present at the meeting to discuss the implications of this Report. They are:

(i) Coventry and Warwickshire Partnership Trust
(ii) University Hospitals Coventry and Warwickshire
(iii) West Midlands Ambulance Service

2 Recommendations

2.1 To note the Briefing Note and appendices provided by local organisations, and consider any further Scrutiny work the Board might like to conduct around the Francis Inquiry.

3 Information/Background

3.1 The Francis Inquiry report attributes accountability for the appalling and systematic failures in care at Stafford Hospital to the Trust Board. The report also identifies to a network of failures by national and local organisations to respond to concerns about the hospitals services.

3.2 The report's 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'. Importantly the report acknowledges regular organisational change as a factor in the background to the events leading to the Inquiry.

3.3 Whilst the report focuses on the events surrounding Stafford hospital between January 2005 and March 2009 the repercussions of the recommendations of the report are seen to be far wider than one Trust, given a wide range of smaller scale but similarly alarming failures in patient care across the health and social care environment.

3.4 The report is critical of many of the organisations which surround NHS provider Trusts, including commissioners, regulators, strategic health authorities and the various organisations involved in patient and public involvement in the health service. This criticism extended to the local authority Overview and Scrutiny Committees which covered the Stafford area.

Francis Inquiry Recommendations

3.5 In total 290 recommendations are made covering all affected parties from the Department of Health through NHS providers, commissioners, regulators and professional bodies through to local authority scrutiny committees and patient and public involvement mechanisms.

3.6 The theme of the report's recommendations is to promote greater cohesion and a more common culture across the health system. The Report makes clear that 'This will not be brought about by yet further "top down" pronouncements, but by the engagement of every single person serving patients'.

3.7 The report identifies the importance of compassionate caring and committed nursing.

3.8 Recommendations include proposals to create a single regulator for provider Trusts (amalgamating the Care Quality Commission [CQC] and Monitor). This would promote consistent regulation of corporate governance, financial competence, viability and compliance with patients' safety and quality standards.

3.9 The report recommends zero tolerance of a failure to reach fundamental standards. Criminal liability could follow should serious harm or death result from a breach.

3.10 Complaints handling should be improved by introducing sensitive but responsive, accurate and transparent communication and learning (for example with Scrutiny Committees and Local Healthwatch).

3.11 Commissioners are given clear guidance about greater involvement with patients and the public in commissioning; promoting alternative sources of provision (and choice); and for GPs (in their roles in Clinical Commissioning Groups) to take a monitoring role on behalf of patients.

3.12 Perhaps amongst the most significant recommendations for providers are around the so called 'Duty of Candour'. Providers will be placed under a legal responsibility to be more open, transparent to report failings in the services delivered. Criminal proceeding can be brought against any officials behaving dishonestly with regulators, commissioners or the public regarding their services.

3.13 Also of importance is the emphasis placed on strong patient centred healthcare leadership, and for the voices of patients to be significantly louder for decision-makers than appeared to be the case in Mid Staffordshire NHS Foundation Trust during the period covered by the two Francis Inquiry Reports.

Overview and Scrutiny / Local Healthwatch / Health and Wellbeing Boards

3.14 The report is far from complimentary about the role of scrutiny committees and patient and public engagement structures in challenging poor standards at Stafford hospital.

3.15 To improve this for the future the report makes a number of recommendations related to the City Council and its role in public and patient involvement in health services. These include:

- Closer collaboration between overview and scrutiny committees and the Care Quality Commission – perhaps including 'sounding board events'(Recommendation no 47).

- That scrutiny committees and Local Healthwatch should have better access to detailed information about complaints (whilst being mindful of patient confidentiality) (119).

- That guidance should be given to promote the co-ordination and co-operation between Local Healthwatch, Health and Wellbeing Boards and scrutiny committees (147).

- Scrutiny committees to be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks (149).

- Scrutiny committees should have powers to inspect providers, rather than relying on local patient and public involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action (150).

- Department of Health / NHS Commissioning Board / CQC etc. should publish quality accounts or other reports in a common format to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees and Local Healthwatch.

More Recent Developments.

3.16 In March of this year the Government published 'Patients First and Foremost – the Initial Response of the Government to Report of the Mid Staffordshire Foundation Trust Public Inquiry. The Government accepted the Report in general terms and gave a commitment to establish the 'Duty of Candour' and other recommendations requiring legislation at the next opportunity. The Government said that "This is a watershed moment for the NHS and a call to action for every clinician, everyone working in health and care, and every organisation."

3.17 The Government also outlined plans for significant changes to regulation of NHS provider Trusts. In June CQC produced its key document 'A New Start' which was the subject of a recent report and City Council consultation response. This included realising the Government ambition of establishing 'Chief Inspector of Hospitals' plus a further series of appointments to produce improved inspection outcomes.

Local Responses

3.18 Attached are briefing notes prepared by the three NHS provider Trusts serving patients in Coventry. Officers from these Trusts will be present at the meeting to discuss the implications of the Francis Report for them and to answer Members questions.

For more information about the Public Inquiry Report into the Mid-Staffordshire NHS Foundation Trust please see:
http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

To view the Government's initial response to the Inquiry Report:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

All of these documents (above include Executive Summaries).

For the CQC document 'A New Start':
http://www.cqc.org.uk/media/cqc-launches-consultation-future-inspection-and-regulation

Finally the Centre for Public Scrutiny has produced 'Safety, Quality, Trust' a guide into the Francis Report which Members may find to be of interest:

Briefing Note Author:
Peter Barnett
Head of Health Overview and Wellbeing
People Directorate
Tel: 02476 831145.

September 18th 2013.

The Francis Report and related documents: Report for Coventry Council Health and Social Care Scrutiny Board held on 25 September 2013

PURPOSE OF THE REPORT / PRESENTATION:

1. To update the HSCSB regarding the Trust's response to the Francis Report (published on 6 February 2013) and subsequent reports by Cavendish, Keogh and Berwick commissioned by the Secretary of State.
2. To share the Trust's analysis of Francis et al recommendations and the actions arising.
3. Discussion: To consider how changes in practice and the new model of regulation and inspection can create new opportunities for collaboration and learning

SUMMARY OF KEY ISSUES:

1. Taken together the reports represent a significant cultural shift for Trusts; the changes may be summarised as
    - meeting a 'duty of candour' by being open, truthful and transparent
    - Listening to and acting upon the patient's experience
    - engaging patients in all aspects of the Trust's 'daily business'
2. Gap analysis shows that the Trust does not presently meet all the recommendations
3. To fully comply with the recommendations continuing action at Board, Corporate and Clinical Speciality levels is required.
4. The Trust response to Francis should be aligned and integrated with other change processes either already underway or projected to ensure a coherent and effective response
5. Major changes in the process of inspection and regulation of Trusts are also underway; further guidance is anticipated in the autumn.
6. The Department of Health is yet to publish a final response to Francis; the Trust has acted on the assumption that the main themes will be accepted.

Report prepared by:
Peter Short, Project Manager

On behalf of:
Andrew Hardy, Chief Executive Officer
Paul Martin, Director of Governance
Jenny Gardiner, Associate Director of Governance

1 Introduction

Following publication of the **Francis** inquiry report into Mid-Staffordshire Hospital in February 2013, the Secretary of State commissioned four additional reports to further explore some key themes. Three were published in July 2013: **Keogh** looked at 14 Trusts identified as having higher than expected mortality ratios; **Cavendish** considered the position of non-registered clinical staff in health and social care; **Berwick,** published in August**,** was asked to consider the measures required to consolidate learning and development across the health sector; and **Clwyd and Hart** were tasked with reviewing the NHS complaints system. Their report is expected in the next few weeks.

The recommendations from these reports will help shape the context in which the Trust provides services. They place patient safety at the centre of our thinking and activity and propose a very wide range of changes for the NHS to consider. The Chief Executive Officer has undertaken a programme of briefings for staff and the Patient Council and briefings have been presented to public Trust Board sessions in April, July and for September 2013.

For those recommendations that are directly relevant to the Trust, Executive and Corporate leads have assessed the level of assurance available to ensure the Trust adopts both the ethos and the specific requirements to meet each recommendation. The Trust has developed an integrated action plan and agreed that a steering group be established to ensure the programme of change is delivered in an effective and timely manner. The Trust will need to continue being mindful of the emerging national debate regarding the detailed implementation of recommendations.

All of the reports stressed that engaging with, listening to, and learning from patients is an essential component of a safe NHS. Berwick describes this as involving patients in the 'daily business' of the NHS.

2 What we have learned

Each of the published reports has been subject to a gap analysis from which an integrated action plan has been developed. These actions are being incorporated into existing or planned change programmes and progress will be reported to the Board and its sub-committees.

The actions have been grouped into four broad themes:

- **Leadership and accountability:** ensuring that the Trust has competent, trained and supported leaders at every level capable of delivering high quality care through openness and partnership with patients and staff.
- **Cultural Change: values, behaviours, relationships**: Listening to and acting upon the Patients voice is at the heart of the Francis report and we shall expect to demonstrate how we achieve this to deliver a learning organisation that consistently delivers safe care. The Trust will review the relationships across all stakeholders – the Board, staff, patients, carers and partner organisations.
- **Data, Information, Knowledge** Using the rich data and intelligence gathered by the Trust and our partners to optimise learning, create change where appropriate and provide assurance to regulators, commissioners and public that our services are safe and effective.
- **Redesign of the complaints process** consistent with the proposals of Francis et al and the forthcoming Clwyd/Hart report. Any such system must provide independent assurance that complaints management is open, fair and thorough. The Trust will begin a review of its complaints management once the Clwyd/Hart report is available.

Each of these themes will be influenced by further national, regional and local discussion arising from the Francis Report. The detail required to operationalise many of the recommendations will be subject to emergent national guidance. Whilst initiating a programme of change we also need to

avoid making significant change to systems and processes in advance of anticipated national guidance unless there is a concern regarding patient safety. The Board has agreed to create a steering group with the task of supporting delivery and avoiding duplication of effort.

3 **Duty of candour:** Francis identified openness, honesty and transparency as the key to avoiding a repeat of the mid-Staffordshire crisis. Francis makes these specific recommendations relating to NHS Trusts:

Francis: 173	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful. *The Trust places as much information as possible into the public domain: the website, Board minutes, the Quality Account, Annual Report and information for the media and public.*
Francis: 174	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information. *The Trust will audit practice against this recommendation as part of the annual audit cycle*
Francis: 175	Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative). *The Trust is considering how it might best demonstrate compliance for all such interactions; data from patient feedback and complaints Is evaluated to identify specific concerns.* *Neither the Trusts 'Impressions' survey nor the national in-patient survey specifically ask this question, but the latter does ask about 'mixed messages'.*
Francis: 176	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission. *Key Trust documents and reports are externally audited to validate accuracy of content*
Francis: 177	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission *The Trust is committed to maintaining open and honest communication with all stakeholders. Performance data is subject to external scrutiny and validation.*
Francis: 178	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations. *The Trust is presently reviewing and revising all its HR policies and procedures to ensure compliance with Francis' principle. There is no timetable as yet for publication of a revised NHS Constitution.*
Francis: 179	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

	The Trust has reviewed the phrasing of contracts to ensure compliance
Francis: 180	Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency. *The Trust's 'Being Open' policy is under review; This will be completed when the CCG has finalised its agreement on information sharing across the local health economy.*

There is continuing debate about how Trusts can best demonstrate compliance with transparency. For example, the CQC has proposed a range of indicators for assessing the quality of service (117 to date) but none directly reflect the duty of candour. However, recognising the importance of cultural change a comprehensive whole organisation improvement programme will be launched later in the year, including the re-launch and embedding of a revised set of *Trust Values and Behaviours* that will emphasise the duty of candour, honesty, openness and integrity.

4 Other significant recommendations identified by gap analysis

Amongst the detailed recommendations the Trust has identified areas for further development:

- Directors will be assessed as 'fit and proper persons' who can demonstrate compliance with a prescribed code of conduct
- The training and continued development of Directors, individually and collectively
- Nominate an executive lead for Information
- Place the patient voice at the heart of our safety and quality agenda our 'daily business'
- Recruitment practice should explicitly assess candidates values, attitudes and behaviours towards the well-being of patients
- Engaging with staff in innovative ways to improve safety, enhance patient experience and increase clinical effectiveness
- Listening to, and learning from patient and staff feedback through *Impressions* and the Friends and Family Test.
- The 12 standards on complaints management proposed by the Patient Association should be adopted by Trusts. In addition any new system of complaints management should facilitate easier access to expert support; anonymised summaries of upheld complaints should be published or shared confidentially with key stakeholders.
- Publish and review a speciality level statistical dataset on efficacy of treatment, to be available online and shared with partner organisations and regulators.

5 Enforcement: Inspection and legal accountability

There will be statutory accountability and enforcement to support compliance and punish breaches. Francis suggests legal sanctions for named individuals shown to have breached fundamental standards or the duty of candour (recommendation 28); Berwick is more nuanced suggesting that criminal sanctions 'should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment' (recommendation 10). The initial DH response (Patients First and Foremost) supported the idea of criminal sanctions; a definitive response from DH is awaited.

A prosecution has now been instigated by the HSE against Mid-Staffordshire NHS Trust in one case, but as yet no criminal proceedings have been taken against individual officers or staff.

The CQC consultation on its strategy for regulation, encompassing a review of the scope and process of Inspection is already underway in 18 Acute Trusts. The new Inspection regime will be implemented from October 2013 with larger teams (perhaps 15-20) including clinicians and 'experts by experience' staying on site for up to 15 days. They will investigate against key lines of enquiry identified in advance by considering all relevant intelligence regarding quality and safety. There will be public

listening events and focus groups for staff as part of the programme and a summative 'Quality Summit' after the inspection to consider the report and actions arising. All stakeholders can expect to be invited to actively participate in these comprehensive inspections.

6 Work in progress

- The Clwyd/Hart report on NHS complaints systems is due to be delivered to the Secretary of State in September/October. It is likely to embrace the Patients Association (PA) standards for complaints management but also to make a wider range of recommendations than those from the PA.
- The DH Consultation *Strengthening Corporate Accountability in Health and Social Care* will inform their detailed response to Francis; this is expected in the autumn.
- The National Trust Development authority (NTDA) is developing its own strategic thinking about quality improvement and performance, adopting a range of measures for assessing Trusts.
- Monitor have recently published a new Risk Assessment Framework that the Trust will have to comply with as a pre-condition for attaining Foundation Trust status
- Significant changes to the Quality Account can be expected for 2014/15; Guidance should be available later this year.

In responding to this complex agenda the Trust has decided to:

- Begin the process of change wherever practicable.
- Use existing and proposed change processes as much as possible.
- Engage with stakeholders and partner organisations in achieving the changes we need.
- Actively engage patients in all aspects of the programme
- Build in a process of reflection and review – we are unlikely to get to the best solutions at once.
- Keep abreast of national and regional initiatives; learn from others.

Bibliography:

A promise to learn– a commitment to act Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England Chaired by Don Berwick (DH, London, August 2013)

The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings Cavendish, C. (DH London July 2013)

Good practice standards for NHS Complaints Handling – a summary (Patient Association July 2013)

Patients First and Foremost: The Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (DH March 2013)

Review into the quality of care and treatment provided by 14 hospital Trusts in England: overview report by Professor Sir Bruce Keogh KBE (NHS England, 16 July 2013)

Review of the NHS Complaints System: Clwyd and Hart: (DH London NYP)

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Sir Robert Francis (HC 898-I) (London: The Stationery Office, 6 February 2013)

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Report to Coventry Health Overview and Scrutiny Committee

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – Trust Response Report

1. Purpose of Report

To provide a report to the Health Overview and Scrutiny Committee (HOSC) on the work undertaken by the Trust to date in response to the report on the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC.

2. Background

Robert Francis QC published the report on the Mid Staffordshire NHS Foundation Trust Public Inquiry on February 6th 2013. This final report, building on the initial independent report published in February 2010, is extensive and provides a systematic analysis into how the Trust and the wider healthcare and regulatory systems contributed to the failures in care. The report makes 290 recommendations focussing on creating a learning and patient centric culture, openness and transparency and a more cohesive system.

3. Current Position

In February 2013, the Trust Board of Coventry and Warwickshire Partnership Trust began considering its response to the final inquiry report and have developed an action plan in response to the provider related recommendations. The Trust Board has had four dedicated development sessions that have further matured its response and it has also received regular reports updating on progress on initial actions and also introducing any new national developments. The update report is due at the end of September.

Very importantly, the Trust Board is committed to genuine learning based on the key learning themes, particularly those relating to a culture that listens to patients, service users and carers and its staff, and that promotes safe and high quality care. In order to do this it has commenced engagement both within the Trust and with patients, service users and carers in the key learning theme of culture and values.

Our Engagement Work

Our engagement work to consider the learning from the inquiry using our Equal Active Partners programme approach was led by the Interim Chief Executive, David Allcock, and Director of Nursing and Quality, Tracey Wrench, and was undertaken between March and end of May 2013, with seven sessions including one with the Trust Leadership Team. Over 500 staff took part. Participants were asked to consider and feedback on how the Trust could promote compassionate practice and how to bring alive the NHS values alive, reflecting the Trust Board's focus on the culture within the organisation.

These sessions provided a rich feedback that has been analysed into themes and recommended responses that were presented to The Leadership Team in early June

and the Trust Board in a development session in June 2013, where the next steps to respond were agreed.

An Equal Partners Newsletter feeding back the themes and next steps was subsequently developed and sent to participants, and circulated widely in the Trust (attached).

A comparable approach was taken to engage patients, service users and carers during our Quality Event in April 2013. Some similar themes were gathered during feedback, with a particular focus on values and compassionate behaviours, including staff working in partnership and empowering patients and service users.

As a result of both pieces of engagement work, the Trust is currently refreshing its values, and very importantly, the behaviours that reflect these values as the foundation in which other work streams will be implement i.e. value-based recruitment. There are three sessions that commenced in September and are due to complete in October 2013; these are being led by Chief Executive, Rachel Newson, and Director of Nursing and Quality, Tracey Wrench. The work is being co-produced by a group of patients, service users and carers, staff and governors, with opportunity for wider feedback in October, and it is anticipated that the refresh will be ratified by Trust Board at the end of October.

Duty of Candour

The Trust is exploring its application of the duty of candour which will be routinely monitored through the contract monitoring meeting with the Clinical Commissioning Group (CCG).

The Health Act 2009 and standard NHS contact previously required NHS organisations to “have regard” to the NHS Constitution. The Constitution places an expectation on staff to acknowledge mistakes, apologise, explain what happened and put matters right.

Arrangements around candour apply for incidents where a patient safety incident causes a patient to suffer actual moderate or severe harm or death (as defined by the National Patient Safety Agency) and are currently contained within the Trust’s Being Open policy.

The Francis report has recommended the Duty of Candour be “enshrined in statute” and the Trust is expecting further national publications to influence direction further. The Berwick Report (A Promise to Learn – A Commitment to Act, August 2013) recommended that a Duty of Candour be applied to only the most serious of incidents. The Trust awaits the Governments response to both the Francis Report and the Berwick Report.

While awaiting further national guidance the Trust is progressing and implementing the Duty through the current contract terms which include the following key points following a relevant patient safety incident:

- There should be a full investigation as soon as possible
- Within 10 working days there should be:
- A verbal notification to the patient/appropriate other (unless they refuse)
- Provision of all facts known as at the notification date
- Include an appropriate apology (guidance from the NHS Litigation Authority refers to an “expression of regret”)
- As soon as practicable offer a step-by-step explanation of what happened, to be updated during the investigation

- Provide a copy of the investigation report within 10 working days of sign off (this is locally supported by a best interests assessment and reference to the Data Protection Act).

Complaints about failures must be notified to Commissioners. Sanctions from Commissioners for failing to comply with obligations include:

- Notification to the CQC and/or
- Formal written apology signed by the Chief Executive
- Publication of the failure on the Trust website
- Financial consequences

There has been a significant amount of work to raise awareness of the new requirements across the Trust (development sessions with the Trust Leadership Team in June 2013 and to the Operational Management Team in August 2013, discussions with directorates, and included in Learning Alerts in June and July 2013). An approach to implement the new requirements, building on existing Serious Incidents Requiring Investigation (SIRI) processes is currently being piloted within the community mental health teams.

Through the work undertaken to implement the contract requirements a number of key work streams have been identified, each of which presents discrete challenges:

- Implementation for moderate (i.e. non SIRI) actual harm incidents
- Implementation for secondary care/specialist services incidents
- Implementation for pressure ulcer SIRI incidents
- Policy/procedure/process issues
- Monitoring systems

The Trust has developed an implementation plan for the Duty and is working with its commissioners to ensure that the arrangements are and remain robust.

Responding to the Recommendations

Following initial consideration of all the recommendations, the ones directly relevant to the Trust have been allocated a lead director or directors who are responsible for their progression. It is managing the balance between those actions that can be taken by the Trust proactively now whilst also acknowledging that many recommendations require definitive strategy statements and actions from other bodies, particularly regulatory bodies, or from reviews set out in train by NHS England. Where progress in these areas is known they have been incorporated in the action plan.

Tracey Wrench - Director of Nursing and Quality
September 2013

Back to the Floor

Visibility of our senior managers. Our Trust Board, both Directors and Non-Executive Directors have been going "back to the floor" and working with teams across the organisation to gain a wider understanding of the roles and services we provide. Just a few photos are shown below:

Roisin Fallon-Williams, Director of Strategy and Business Support spending time on Quinton Ward at the Caludon Centre

Rachel Newson, Chief Executive spending time with Community Physiotherapy/Falls Team

Sharon Binyon, Medical Director, spending time with Physiotherapy Team, City of Coventry Health Centre

Stewart Bell, Non-Executive Director spending time with the MAPA team

Alan Dodds, Non-Executive Director spending time with the Dental Team

Gale Hart, interim Director of Finance and Performance with our Smoking Cessation Team

Mike Williams, Non-Executive Director with staff on Sherbourne Ward at the Caludon Centre

Contact us...

The next issue of EAP news will be distributed in September.

If you have any questions about Equal Active Partners or you would like to feedback on the process so far, please contact us: **equalactivepartners@covwarkpt.nhs.uk** or call **024 7632 4358.**

Special Issue Francis Report

Tracey Wrench, Director of Nursing & Quality - headed the Big Conversation Francis Report Events

The final report into the care provided by Mid Staffordshire NHS Foundation Trust has been published. Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care.

Robert Francis QC has made 290 recommendations for all organisations in the health system and Government. His final report is based on evidence from over 900 patients and families who contacted the Inquiry with their views.

During March and April CWPT planned five sessions to present some of the key findings of the Francis Report to staff. The sessions were not only about presenting the findings, but also to give staff an opportunity to reflect and respond to some of these key findings. The response to the Big Conversation – Francis Reports were so popular that an additional event was offered. Over 500 staff attended one of the six Big Conversations which took place at locations around Coventry and Warwickshire. All written comments and feedback have been captured and themed in a way to enable us to respond and report back on the events.

Staff were asked to think about two main questions around compassionate care and the values within the NHS Constitution.

Compassionate care – What is compassion and compassionate practice?

Some of the themes which came from this question included:

- Communicate what it is and what behaviours represent it and what behaviours do not represent it
- We should adopt a zero tolerance of non-compassionate behaviour
- Patients/service users should always be at the centre of all we do
- Compassionate care should be applied to both patients/ service users and staff
- We should have Compassionate Care Champions in the Trust
- Showcase good/excellent practice

- Patient involvement and experiences (positive and negative) used to define compassionate practice
- Real time patient experience feedback given as part of 360 for staff as individuals
- Real time patient experience feedback given in relation to a culture of compassion at ward/team level
- Visibility of senior staff including Trust Board and role modelling
- Supervision including peer/team supervision should be across the organisation
- Team working and time for group reflection should be encouraged
- Student practice education placements
- Competent managers with focus on leading and managing
- Effective and regular communication across the whole Trust
- Safe place to raise concerns

Investing in People – Protected Learning Time

- Training – not just Statutory and Mandatory but also external training
- Quality supervision and annual appraisals
- Focus on compassionate behaviours/ skills
- 360 Feedback including that from patients/service users
- Develop staff to have the right skills
- Supervision including peer/team supervision
- Team working and time for group reflection
- Time to be practice educators/mentors/supervisors

How can we incorporate the NHS Constitution into our everyday work?

Effectiveness and Time to Care

- Focus on quality and not just targets
- Focus on 'time to care'
- Too much paperwork/data collection
- Get IT systems right
- Appropriate clinical and staff spaces/environments

Workload pressures

- Not always enough staff
- Capacity issues
- Skill mix
- Impact of vacancies/sickness/ absence

Change Management

- Making the NHS Constitution Values 'our own'
- Re-aligning our Trust Values
- Develop clear, simple language 'owned' by all staff/patients/public
- Create a framework that allows individual services to communicate how their service will meet it
- Communication and dissemination of the NHS Constitution
- Recruitment/Selection and on-going Staff Responsibilities
- Recruit using our Values
- Our Values and the required behaviours
- Staff Induction/ Training
- Supervision and Appraisal
- Empower staff to promote values/zero tolerance of poor behaviours – use of disciplinary procedures
- Demonstrate we value our staff

These are just some of the key themes which emerged from our Big Conversation, Francis Report sessions. The findings have now been presented to our Trust Board and one of the big outcomes will be to consult on our Trust values. Our values are:

Giving Hope
Breaking down Barriers
Respect for Everyone
Seeking Excellence.

We want to ensure that these values remain relevant, continue to be meaningful and represent who we are as an organisation. We will therefore be going out to service user/patient groups, as well as stakeholders and staff to test this out with them.

Other actions are already in place which will look at:

Our Recruitment and Selection process, how we can appoint staff not only based on skills and knowledge, but also on our values.

At our further Big Conversations for managers, we have asked staff to put themselves forward to join groups. One group to look at "keeping and developing our staff" and a second to review how we communicate in the Trust. Another key theme which has been echoed at all the Big Conversations was around Protected Learning Time. Again, this is a piece of work, captured in one of our Quality Goals which is a priority for us as an organisation.

Further information on progress will be available on the Intranet.

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DUTY OF CANDOUR

Following the Mid Staffordshire Hospital review and Robert Francis' subsequent report there has been an ever increasing focus on NHS Trust's and their commitment to openness and honesty relating to when things go wrong.

West Midlands Ambulance Service NHS Foundation Trust (the Trust) prides itself on its approach to being open when things go wrong and ensuring that learning takes place to prevent further harm.

Quality Account

The Trust's Quality Account available via www.wmas.nhs.uk provides an assessment of the quality of care delivered during 2012/13 and presents the plans for improvement during 2013/14.

Being Open

The Trust set itself a priority within the 2012/13 Quality Account to achieve 100% compliance with the Trust's Being Open Policy.

The Trust committed to making contact with all patients or their relatives following incidents where things went wrong and harm occurred. The definition of harm includes all harm regardless of severity.

The Trust achieved 100% compliance and continues to monitor and report on 'Being Open' compliance through the Board of Directors Quality report.

Complaints

The number and type of complaints and subsequent learning is contained within the Trust's Quality Account, the Patient Experience Annual Report and Board of Director papers.

The Trust is considering how best to publish upheld complaint summaries as recommended in Robert Francis' report. Consideration is being given to themes (ie PTS delays) and examples of responses (with the complainant's permission) being published in a 'Quality Zone' on the Trust website.

Learning Review

The Trust has a group that meets at least 10 times each year to review high risk/serious incidents and emerging themes identified through incident reporting, staff and patient feedback, complaints, claims and clinical audit.

This group is responsible for ensuring learning is shared and appropriate actions are taken to reduce the likelihood of harm occurring.

The Learning Review and Serious Incident reports are published as part of the Board of Director's papers and are used to inform the Trust's Quality Account.

Patient Stories

The Trust encourages patients and relatives involved in incidents where things have gone wrong to attend the Board of Director's meeting to have the opportunity to discuss their experience and hear what has or could be done to reduce the likelihood of errors occurring again.

Patient Stories are also shared within internal Trust publications to ensure learning is shared with all staff.

Going Forward

The Trust will bring together all of the above into the 'Quality Zone' area currently being developed on the Trust website.

Sue Green
Deputy Director of Nursing & Quality