University Hospitals Coventry and Warwickshire NHS Trust

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.

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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)