Borders NHS Board

REVIEW OF THE FRANCIS, KEOGH AND BERWICK REPORTS - CONSIDERATIONS FOR NHS BORDERS

Aim

The aim of this report is to provide Borders NHS Board with an overview of the key findings contained within, and considerations for NHS Borders resulting from a review of the:

- Francis Report – Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
- Keogh Report – Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England
- Berwick Report – Improving the Safety of Patients in England

Background

In 2009, Robert Francis, QC was commissioned by the Secretary of State for Health in England to chair a non statutory inquiry in respect of the care provided at Mid Staffordshire from January 2005 to March 2009. The remit of the inquiry was principally to provide "a voice to those who had suffered and to consider what had gone wrong". When published it contained "damning criticism" of the care provided. The report also raised issues in respect of the role of external organisations that had oversight of activities at Mid Staffordshire. Following publication of the report of the first inquiry in February 2010, the decision was made to set up of a second inquiry. The inquiry chaired by Robert Francis, QC commenced in June 2010 and concluded with the publication of the Francis Report in February 2013.

In April 2013 Borders NHS Board were provided with an overview of the key themes and findings outlined in the Francis Report. The Clinical Governance and Quality Team were tasked with beginning an analysis of the recommendations to draw out learning for NHS Borders and to assess opportunities for local improvements based on current practice. As part of this process a series of discussions took place with Clinical Boards, Support Services, individual Directors and Non-Executive Directors to examine their respective areas of responsibility.

While this process was underway a second report was produced by Professor Sir Bruce Keogh in July 2013 on behalf of NHS England. The report was based on the outcome of a review into the quality of care and treatment provided by 14 hospital trusts in England. This review was commissioned by the Secretary of State in February 2013 following the publication of the Francis Report with the remit of assessing Trusts who were considered to be outliers for the previous two years on either the Summary Hospital Level Mortality Index or Hospital Standardised Mortality Rate. The rationale for commissioning the review was based on the fact that high mortality rates at Mid Staffordshire NHS Foundation Trust

were associated with failures in safety, clinical effectiveness and patient experience, as well as, in professionalism, leadership and governance.

In addition and also following the publication of the Francis Report a National Advisory Group on the Safety of Patients in England led by Dr Don Berwick was commissioned by the Prime Minister. The Group were established to study the available evidence from Mid Staffordshire and recommendations of Robert Francis and others to provide the Government and NHS with a distillation of the learning and the changes needed to improve the safety of patients in England. The Advisory Groups report was published in August 2013.

The local review of the findings from the Mid Staffordshire Public Inquiry was therefore extended to consider the findings and recommendations from the two subsequent publications from Keogh and Berwick.

Summary

While all three reports focus on the arrangements for directly provided NHS care in England it is recognised that arrangements elsewhere in the UK do vary. This does not mean that lessons and recommendations arising from the inquiry and subsequent reviews are not relevant to NHS Scotland. However the subtle differences in the model of delivery within NHS England when comparing it to NHS Scotland should be acknowledged to create a clear understanding of the baseline for improvement including:

- Existing well established focus on quality embedded at the heart of NHS Scotland's quality strategy and supporting programmes of improvement in patient safety, person centred care and other associated quality initiatives
- The supporting monitoring system of safety indicators through the Scottish Patient Safety Programme and Clinical Quality Indicators including infection rates
- The structure of NHS Boards as a single organisation as opposed to the commissioning model of Primary Care Trusts
- The presence of an active partnership structure in all NHS Boards to represent staff as equal partners at all levels in the organisation

However, NHS Borders have adopted the approach that while some of these differences should strengthen our focus on quality we believe that by thoroughly reviewing the findings of these reviews in detail against our own local practice we will find opportunities for continuous improvement in local services. This approach supports our number one organisational objective of putting patient safety at the heart of everything we do, as well as, pursuing a behavioural and culture change to promote learning, openness, transparency and candour.

Francis Report

The Francis Report in particular focuses on the roles and responsibilities of various commissioning, regulatory and supervising agencies in addition to the Hospital Trust.

Francis found that indications that things were not right in Mid Staffordshire NHS Trust were there as early as 2007, but these were not acted upon. The process of application for Foundation Trust status, which the Mid Staffordshire pursued at this time, while rigorous did not take into consideration the quality of patient care. The report questions, why the failings in patient care were not detected sooner, and identifies a number of partners and agencies that were in a position to raise concerns and take action, but did not.

There were a range of warning signs identified including:

- the Commission of Healthcare reduced the Mid Staffordshire star rating from 3 to 0 in 2004
- concerns arising from peer reviews in 2005 and 2006
- Healthcare Commission Review of children's services in 2006 stated "the Trust did not meet the requirements or reasonable expectations of patients and the public
- Auditors report for the period identified "deficiencies in the Trust's risk management and assurance systems" and "called into question the competence of senior mangers and leadership"
- Healthcare Commission annual patient and staff surveys identified Mid Staffordshire to be in the 20% worst performing in several areas
- an allegation regarding leadership in A&E was not resolved nor were issues made known to any external agency
- Royal College of Surgeons report in 2007 concluded that the operation and management of the surgical department was "dysfunctional"
- Savings in staff costs were being made despite identification of serious problems in delivery of a quality service and problems in compliance with minimum staffing levels.

The table of recommendations contained within the report are grouped under themes. Although a number of the recommendations, such as those relating to improvements in the Foundation Trust process and changes to the English regulatory systems, are specific to the NHS in England, the recommended changes to professional regulation and the Health and Safety Executive will affect NHS Scotland. Of the other recommendations, these can be divided into five categories and grouped as follows:

- Standards of Patient Care
    - focus on putting patients first
    - nurturing a common culture supported by standards that staff and patients understand
    - professionally endorsed standards that are enforced and monitored effectively by the regulators.
- Culture
    - sharing of openness, transparency and candour throughout the system to ensure concerns regarding safety and care are brought to light
    - statutory, contractual duty of candour be introduced
    - criminalisation of attempts to obstruct candour or to dishonestly make untruthful statements to regulators
- Nursing and provision of care
    - focus on nursing but recommends accountability for all who provide care to patients
    - improvement in care through changes in improvement in recruitment, education, training and support for all healthcare professionals
    - nurse revalidation
    - greater regulation of healthcare support workers
    - more ward time for nurse managers
    - named nurse at each shift for every patient
- Leadership
    - improved leadership with greater accountability for senior managers
    - common code of ethics, standards and conduct for senior board level leaders and mangers
- Data and information
    - data, information and intelligence obtained from a range of sources

- collation and use of relevant data and information
- improved systems for storing, using and sharing data, intelligence and information
- use of data to identify areas requiring improvement and to support improvement work.

Keogh Report

The review team led by Professor Keogh acknowledging that in the 14 Trusts they reviewed there were several pockets of excellence as well as scope for improvement. The review identified a set of common themes and barriers to delivering high quality care which they believe to be relevant to all of the NHS.

These themes included a lack of understanding of the power of genuinely listening to the experience of patients, carers and staff to understand and improve services. Capability in the use of data to drive quality improvement and the complexity of using single aggregated measures such as HSMR to make judgements on quality of care provision. Several Trusts were found to be working in isolation geographically, professionally and academically leading to difficulties in recruitment and increased reliance on locums and agency staff. On the whole it was felt that not enough value is placed on the input of frontline clinicians particularly Junior Doctors and Nurses who have constant interaction with patients and who are regarded as having natural innovative tendencies. Lastly the review highlighted an imbalance between the use of transparency for the purpose of accountability and blame versus support and improvement suggesting a change in mindset is required.

The Keogh Report set out the following ambitions for the NHS in England to achieve over the coming 2 years:

- 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
- 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
- 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
- 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
- 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
- Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards
- 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
- 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

Berwick Report
The National Advisory Group on the Safety of Patients in England led by Dr Berwick gathered findings from prior reports and combined it with additional statements from patients and experts and with the research evidence. The Advisory Group highlighted seven problems which they feel can be attributed to the failures in Mid Staffordshire NHS Trust.

Firstly the Advisory Group make the important distinction that patient safety problems exist in all healthcare systems across the world. While Mid Staffordshire was an example of an extreme lapse in care there were other Trusts in England and there will be other healthcare providers elsewhere in the world who require immediate scrutiny and prompt review. But while these patient safety problems exist staff are not to blame with the vast majority wishing to do a good job, to reduce suffering and to be proud of the work they do. They suggest that a series of problems were found to contribute to what happened in Mid Staffordshire including the incorrect balance of priorities between finance and targets versus patients and quality. They highlighted that while warning signals including the voices of patients and carers were present they were not acted on and that diffused responsibilities led to a lack of ownership. A lack of any system of support to build capacity and capability of staff to deliver continuous quality improvement and a culture of fear which was toxic to safety and improvement were also documented as compounding the problems at Mid Staffordshire.

The Advisory Board concluded that while big changes are needed they *'do not believe the NHS is unsound to its core. On the contrary, its achievements are enormous and its performance in many dimensions has improved steadily over the past two decades'.*

Dr Berwick suggests that what is now required is recognition of the need for wide systematic change from any organisation making a contribution to health and care delivery. Blame should be abandoned and patients and carers should be actively engaged at all levels of the NHS. Targets should be placed within a wider context of other measures of quality and patient experience and a focus should be placed on openness and transparency in sharing information and learning from it. Staffs roles and responsibilities in relation to safety and improvement should be clear and a systematic approach to developing staff from the top to the bottom of the organisation should be deployed to enable them to master and apply modern methods for quality control, quality improvement and quality planning.

The following recommendations were made by the Advisory Group:

- The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning
- 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
- Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts
- 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

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

Considerations for NHS Borders

Following consideration of the recommendations of the Francis Report with a range of staff from across NHS Borders areas have been identified where there is considered to be scope for ongoing local improvement. These areas are outline in Appendix 1. While many of the identified areas for improvement are already now being progressed there are others areas which require further discussion in light of the Keogh and Berwick reports. These discussions will take place with the Board Executive Team, Clinical Strategy Group and Improvement Forum over the coming month to finalise an improvement plan for the organisation with clear roles and responsibilities and timeframes for delivery. A consolidated improvement plan, drawing on the learning from these three reports, will be finalised for discussion at the Clinical Governance Committee on the 6 November 2013 who will oversee from an assurance perspective the delivery of the plan reporting to the Board as required.

Recommendation

The Board is asked to:

- **Note** the work underway to finalise a consolidated improvement plan based on the learning from the Francis, Keogh and Berwick reports
- **Agree** that assurance of delivery will be sought through the Clinical Governance Committee of the Board

Policy/Strategy Implications	The content of the ongoing work outlined will be considered by the Healthcare Governance Group and implications for NHS Borders reported to the Clinical Executive Strategy Group prior to presentation to the Clinical Governance Committee of the NHS Board
Consultation	As above
Consultation with Professional Committees	As above

Risk Assessment	In compliance
Compliance with Board Policy requirements on Equality and Diversity	In compliance
Resource/Staffing Implications	Services and activities provided within agreed resource and staffing parameters

Approved by

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Evelyn Fleck	Director of Nursing and Midwifery	June Smyth	Director of Workforce and Planning

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Appendix 1

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	NHS Borders Improvement Actions
1	Develop a behavioural objective central to the core objectives of the organisation to support an ongoing cultural change
2	Embed and review the adverse event review and mortality review processes to ensure learning is collated and used to inform ongoing practice, this should be underpinned by an emphasis on openness, transparency and candour
3	Enhance the linkages between the complaints, adverse event, mortality review process and the proactive development of the local patient safety programme to improve care for patients. For the coming year applying a particular emphasis on Sepsis, Venous Thromboembolism, Patient Flow, Falls, Pressure Ulcers, Medicine Management and the Management of Dementia and Delirium, not to the exclusion of any other organisational priorities
4	Work with Clinical Boards and Support Services to ensure that improvement actions resulting from complaints, adverse events, mortality review, walkrounds, external and internal reviews are robustly tracked to conclusion
5	Enhance the existing organisational scorecard to update the quality section using measure over time and ensuring the performance indicators promote a focus not only on timeliness of service response but on improvement
6	Develop quality dashboards at service level to inform the continuous improvement of services
7	Engage NHS Borders staff in defining and articulating what its set of fundamental standards outlining accountability and monitoring arrangements to assess compliance
8	Introduce a quality awards scheme to celebrate achievements in healthcare delivery and promote a learning and development culture
9	Introduce an approach to assess team vitality across the organisation to fully listen to and engage with staff
10	Extend the existing mortality review process to include all deaths occurring out of hospital within 30 days of admission to maximise learning
11	Create time within the series of business meetings for Clinicians, Managers and Support Staff to focus on improvement challenges
12	Deploy a systematic approach to building capacity and capability in the organisation for continuous quality improvement targeted across three levels of competence general awareness, practitioner and advisor
13	Build a flexible and responsive improvement infrastructure to support staff at all levels to use the methods of continuous quality improvement in their day to day work including access to advice, support and training
14	Continue to roll out training to enable staff to draw insight from data and to use it to inform continuous quality improvement at all levels within the organisation from the Board to front line teams

15	Mirroring recent revisions to the Consultant Appraisal process introduce a reflective practice approach to supervision and appraisal of all staff groups in particular in nursing drawing in learning from complaints, incidents, observations of practice and case note review
16	Develop the involvement of patients, carers and the public at all levels in the organisation by reviewing current forums for involvement and identifying opportunities for greater participation
17	Develop proactive approaches to listening to the experiences of patients and carers both negative and positive • by building on the existing stories which are a feature of every NHS Board meeting and cascading this approach across the organisation • promoting a approach which asks every patient to feedback on their experience of care
18	Further develop digital resources to collect patient and carer feedback to be used for learning and reflective practice by clinical teams
19	Further develop the means of collecting staff feedback to inform improvements building on the existing options provided through 'Ask the Board' and the staff survey
20	Consider approaches to engaging junior staff including doctors and nurses in internal reviews of services to draw on their experiences in other healthcare organisations and to promote a focus on continuous quality improvement within their training
21	Ensure nursing and midwifery workforce and workload planning at ward level is based on the national approach using a triangulated methodology of research based tools, professional judgement and clinical quality indicators
22	Support the extended pilot of the supervisory role of the Senior Charge Nurse to enhance leadership and mentorship for ward based teams
23	Enhance NHS Borders participation in research to promote a learning and development culture and to ensure best clinical practice is adopted locally
24	Work with Scottish Borders Council to develop a joint response to the Mid Staffordshire report looking for early opportunities for shared actions and improvements across integrated services