The Rotherham NHS
NHS Foundation Trust

Trust Response to Francis, Keogh, Berwick – Quarter 4 2014/15

Overview:

This report forms the quarter 4, 2014/15 report to QAC, providing an update on the status of the Trust action plan developed in response to the recommendations documented in the reports of Francis, Keogh and Berwick.

The update against the plan is presented in the summary report format, showing areas of progress against the shared key themes of the three reports.

The principles presented in the paper Freedom to Speak Up have been incorporated into the action plan. This is the independent review into creating an open and honest reporting culture in the NHS carried out by Robert Francis, February 2015

1. Francis, Keogh, Berwick summary action plan

The summary table below shows progress at quarter 4 and actions taken or scheduled in response to the recommendations which run as a thread through each report. The summary is drawn from the master document action plan which has undergone review over the quarter, including allocated 'RAG' status which is reflected in figure 1 below. The table also demonstrates how the actions link to the Trust strategic priorities, CQC standards and Quality Governance Framework.

Examples of progress over Q4 are shown on the summary report (table 2). Notable additions are:

- Process commenced to identify 'freedom to speak up guardians'
- Information related to complaints now published for second consecutive month on web site
- Deputy Chief Nurse leading series of workshops on new NMC code
- The Trust has entered into a region- wide group coordinated by the improvement academy, aiming to standardise approach to mortality reviews and educate on the reduction in avoidable deaths
- Registered nurses recruited from oversees programme have commenced in post
- Strengthened response to outcome of staff survey – focus groups being established across directorates

2. Freedom to Speak Up

The review of whistleblowing in the NHS was set up in response to continuing disquiet about the manner in which NHS organisations respond when concerns are raised by staff and the way individuals have been treated if they have spoken up and expressed concerns about quality of care.

In recent years there has been an evident gap in concerns expressed by front line staff and the awareness of these issued in organisations' leadership which have been highlighted within the original 'Francis report' as well as those which followed in its wake. There are remaining concerns(nationally) that staff still do not feel willing or able to speak out about concerns, with the 2013 staff survey suggesting that only 72%of those who responded saying they were confident that it is safe to raise a concern. Robert Francis again reminds the reader that failing to speak up can cost lives.

The review therefore aimed to provide advice and recommendations to address this, raising confidence amongst NHS staff that it is safe to speak out in the knowledge that concerns will be listened to and acted upon.

It is incumbent upon the Trust therefore to revisit the recommendations related to whistleblowing and reporting concerns in the light of this report. Table 1 below sets out the 20 principles for information.

Francis made 2 specific recommendations:

- All organisations which provide NHS healthcare and regulators should implement the principles and action set out in this report in line with the good practice described
- The Secretary of State for Health should review at least annually the progress made in the implementation of these principles and actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to parliament.

Table 1 Freedom to speak up - Principles

1	**Culture of safety**: Every organisation involved in providing NHS healthcare should actively foster a culture of safety & learning in which all staff feel safe to raise concerns
2	**Culture of raising concerns**: raising concerns should be part of the normal routine business of any well-led NHS organisation
3	**Culture free from bullying**: freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours
4	**Culture of visible leadership**: all employers of NHS staff should demonstrate through visible leadership at all levels in the organisation that they welcome & encourage the raising of concerns by staff
5	**Culture of valuing staff:** employers should show that they value staff who raise concerns & celebrate the benefits for patients & the public from the improvements made in response to the issues identified.
6	**Culture of reflective practice**: there should be opportunities for all staff to engage in regular reflection of concerns in their work
7	**Raising & reporting concerns**: all NHS organisations should have structures to facilitate both formal & informal concern raising & resolution of concerns
8	**Investigations:** when a formal complaint has been raised there should be prompt proportionate fair blame –free investigation to establish the facts
9	**Mediation and dispute resolution:** consideration should be given at an early stage to the use of expert interventions to resolve conflict, rebuild trust or support staff who have raised concerns
10	**Training:** every member of staff should receive training in their organisation's approach to raising concerns & in receiving & acting on them
11	**Support:** NHS organisations should ensure there is a range of persons to whom concerns can be reported easily & without formality. They should provide staff who raise concerns with access to mentoring, advocacy, advice, counselling
12	**Support to find alternative employment in the NHS**: Where an NHS worker who has raised a concern cannot as a result continue in their current employment, NHS should fulfil its moral obligation to offer support
13	**Transparency**: all organisations should be transparent in the way they exercise their responsibility in relation to raising concerns, including use of settlement agreements

14	**Accountability** : everyone should expect to be held accountable for adopting fair, honest, open behaviours & practices when raising or receiving & handling concerns with personal & organisational accountability for poor practice, victimisation, raising false concerns, acting with disrespect, inappropriate use of confidentiality clauses
15	**External review:** there should be an Independent National Officer to carry out functions described in report
16	**Co-ordinated regulatory action:** Co-ordinated action to enhance protection of NHS workers making disclosures & of the public interest in the proper handling of complaints
17	**Recognition of organisations:** CQC should recognise NHS organisations which show they have adopted & applied good practice in support/protection of workers who raise concerns
18	**Students & Trainees:** all principles of the report should apply with necessary adaptations to education and training settings for students & trainees working towards career in healthcare
19	**Primary Care: all principles to apply in primary care**
20	**Legal protection should be enhanced:**

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Action Plan Summary Table: Trust response to Francis, Keogh, Berwick: quarter $ 2014/15

(text highlighted in red added/amended over Q3)

Theme	Francis	Keogh	Berwick	Trust Response	Actions to be taken	Link to strategy/ corporate objective	CQC/ QGF regulation
Candour and transparency	Stressed the need for transparency, candour, openness **Openness** - enabling concerns and complaints to be raised freely without fear and questions asked to be answered. **Transparency** - allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. **Candour**- any patient harmed by the provider of a healthcare service is informed of the fact and an appropriate remedy offered,	Transparent reporting of issues, lessons and actions arising from complaints is an important step that the NHS can take immediately to demonstrate that it has made the necessary shift in mind set.	Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.	• Trust has Being Open Policy • Development of Datix requiring investigators to report on compliance with duty of candour • Full review of complaints process in response to Francis • FR action plan and 'Francis on a Page' published on web site • Identification of internal 'Never Events' • More quality data made public eg ward dashboards / staffing levels • Participation in Transparency Project • Whistleblowing Policy fully revised and published reflecting duty of candour regulations • Trust has pledged to support the Nursing times 'Speak out Safely' campaign • The Trust has submitted its application to 'Sign up to Safety' national campaign, making pledges for improvement against a set of agreed safety improvement metrics – outcome awaited	• Being Open Policy is undergoing full review to ensure Duty of Candour requirements included – estimated date for ratification - May 2015 • Implementation of Complaints management improvement plan - monitored via PEG – a progress in evidence • Safety improvement group to be established (sign up to safety) • Response to 'Freedom to Speak up' in progress – identification of freedom to speak up guardians • HR working with Trust solicitors to develop a template to support 'fit and proper person' test - Dir of Corp Affairs to present paper to Board	Strategic objective 1, 8	CQC Outcome 4, 17 QGF 2B, 3B, 3C

				• Complaints information now published on Trust web site 2 consecutive months • Anonymous helpline established for raising concerns • Revised whistleblowing Policy re-named 'Raising Concerns' - promoted via comms messages • Dep CN leading series of workshops on new NMC code`			
Patient experience: listening to patients and acting on what we hear	Effective and accessible complaints management process with learning and improvement demonstrated openly	Boards need to urgently review and understand what patients' views are and address key complaints themes - real time patient feedback and comment must become a normal part of provider organisations' customer service	Patient feedback should be collected as far as possible in real time and be responded to as quickly as possible. Patients and their carers should be represented throughout the governance structures of NHS funded providers All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.	• Full review of complaints policy and procedure completed • Complaints management workshops delivered across the Trust • Further complaints training delivered and one to one sessions established between governance leads and new Complaints Manager • PEG receiving complaints data and 'red' complaints actions plans for monitoring purposes • Friends & family test rolled out • Patient Experience Engagement & Involvement strategy developed – identified leads for implementation in each clinical directorate • Public governors members of QAC, PEG • Patient leaflets and posters re-designed • Complaints KPIs identified relating to quality, satisfaction survey re-designed to	Delivery of additional complaints management workshops Continuing Implementation of complaints improvement plan Improve outcome of national patient surveys – these forming work streams overseen by Patient Experience Group	Patient Experience Strategy	CQC Outcomes 1, 17 QGF 3C

				obtain information conducive to quality improvement			
Caring and compassionate Culture	Trusts must aspire to cultural assessment and change, aiming for a culture where the patient is the absolute priority	Boards are collectively responsible for quality Trusts must tap into the leadership potential of patients, members of the public, junior staff	The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning	• Established Trust core values • Revised corporate structure increasing focus on quality and quality assurance • Introduction of 'Intentional Rounding' process • Listening Into Action initiated – 10 priorities for action agreed and work underway • Safe Observation of Care and intentional rounding process introduced • Governors engagement strategy has been developed and undergoing consultation / approval over Q3 • Junior staff members, public governors invited to some corporate meetings. Student midwife a member of PAF, junior Dr a member of mortality Steering Group, Junior staff and students members of OQSEG • Competency based HCA training programme in development which will meet the recommendations of the Cave Fully implemented values based recruitment – participation in pilot ndish Report • Fully implemented values based recruitment following pilot	Post implementation audit of Intentional Rounding Publication of national cultural barometer awaited Privacy and dignity charter in development Engagement Programme for governors to be launched January 2015 Trust to 'Sign up to Safety' – NHS England objective to reduce avoidable harm by 60% over 3 years and save 6000 lives Process under consideration which enables complaints received to be mapped against core values.	Nurses and Midwives Care strategy Strategic objective 8	CQC outcome 4, 12, 14 QGF 2A, 2B
Safe Staffing Levels	Review of nurse staffing levels	Trusts need to review current staffing levels for nursing & medical	staffing levels should be consistent with the	• Staffing levels scrutinised by SWC & QAC on monthly basis	Successful recruitment to establishment	Strategic objective 7	CQC outcome

		staff and make changes required for improving quality & safety of care	scientific evidence on safe staffing, adjusted to patient acuity and the local context. Boards and leaders should take responsibility for ensuring clinical areas are adequately staffed	• Ongoing recruitment – increased levels of band 5 registered post nurses in post • Monthly report from Chief Nurse presented to QAC. • Staffing levels publically available via website and actual v rostered staffing levels provided on wards each shift. • Processes in place whereby Datix reports should be submitted where there are staffing shortfalls • Assistant Chief Nurse lead for workforce – responsible for ensuring recruitment linked to '6Cs' and values based recruitment programme • 'Recruit well' objectives of the Nurses & Midwives Care Strategy • Working to 1:8 nurse staffing ratio on wards • Successful overseas recruitment programme – 33wte RNs appointed so far, further 30 WTE due to commence. • Safer nursing tool & introduction of 'red flag' system where concerns about staffing levels.	Implementation of 'Proud to work at Rotherham' plan Reduction of use of agency staff Next focus for recruitment on return to practice, incentives to existing staff who work additional shifts with goal of decreasing agency use.	Nurses and Midwives Care strategy	13
Staff engagement – listening to and supporting staff	Engage with junior doctors and nurses to seek feedback on standards of quality and safety	All NHS organisations need to be thinking about innovative ways of engaging their staff.	leaders and managers should actively support staff by excellent human resources practices, promoting staff health and well-being, cultivating a positive	• Launch of Listening into Action – 10 priorities identified and work underway • 'Moving forward together' sessions led by CEO and Chairman – goal to engage with all staff • Annual staff survey undertaken – all	• Staff engagement & communication strategy in development • Improve feedback processes to reporters of incidents via Datix • Strengthen processes for	Strategic objective 7	CQC outcome 13 QGF 3C

			organisational climate, involving staff in decision making and innovation, providing staff with helpful feedback and recognising good performance , addressing systems problems and making sure staff feel safe, supported respected and valued at work	staff have opportunity to submit response • Regular staff briefing meetings scheduled and regular electronic comms messages in corporate format 'Dear Louise' process • Junior staff & students invited to corporate meetings • Nursing & Midwifery strategy launched • 'Train & Develop well' & 'Care Well' themes of above strategy • Chief Nurse meets with all student nurses • Keogh principle applied of involving junior staff and students in corporate meetings - student nurse members of OQSEG / AMD seeking junior Dr to attend mortality review group • Clinical colleagues invited to present their work to board • COO & ADPSR working with junior Drs - patient safety • Use of 'staff stories' at Strategic Workforce Committee (SWC) • Revision of HR strategy placing patients at the heart of all we do • Proud awards and long service awards revised/refreshed	sharing learning from incidents across the Trust (led via Incident Review Group (IRG) • Review and action plan associated with 2014 staff survey • Strengthened response /action plan following staff survey in development – focus groups in all directorates – staff invited to provide feedback and ideas for improvement. Action plan to SWC / Board		

				• Twice monthly inductions scheduled – MAST will be completed prior to commencing in post from April 2015 • Senior leadership programmes underway • HR medical staffing team to be introduced with links to PGME & Med. Director office			
Effective use of data and use of metrics to improve quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed	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 . Trusts should make demonstrable progress towards reducing avoidable deaths Trusts should have clear, formally agreed pathways for the recognition and	organisations should routinely collect, analyse and respond to local measures that serve as early warning systems of quality and safety problems such as the voice of the patients and staff, staffing levels, reliability of critical processes and other quality metrics The NHS should use mortality rate indicators like HSMR or suitable alternatives as one of its ways of detecting potentially severe performance defects worth investigating	• 'Perform and Report Well' theme of Nurses and Midwives Care Strategy • Implementation of ward dashboards • Corporate mortality review process developed and launched, led by Mortality Steering Group • Harm free Care data is displayed in clinical areas on dashboards(includes pressure ulcers, falls, complaints rates, FFT feedback) • key number of KPIs/Metrics have been monitored through the Trust Board. These will be aligned and agreed with each Directorate and areas of concern regarding performance addressed at these meetings • Data quality reports readily available audit plan in place for 2014/15 • Mortality Review Group established – Keogh methodology to be applied, informing review process, including	Mortality Steering Group re-established – to review and incorporate recommendations of Keogh into work plan Death certification process review and SOP completion Further development of Board scorecard COO developing suite of consistent, data validated reports for use at performance meetings Introducing set of nursing metrics	Strategic objective 1	QGF 4A, 4B, 4C CQC outcome 4

		management of acutely ill and deteriorating patients, particularly in areas where there is higher mortality such as pneumonia & acute renal failure	further. Mortality measures should be used as a 'smoke detector' in a spirit of supportive and genuine enquiry, not used to generate league tables or similar comparison	review of junior doctor involvement • The Trust has entered into a region-wide group coordinated by the improvement academy aiming to standardise approach to mortality reviews and educate on the reduction in avoidable deaths. • By the review of data produced by business intelligence the HMSG responds to “outliers” by the commissioning of a team to review the care determining where improvements need to be made to reduce avoidable deaths in the future. • The mortality process aims to review deaths in the hospital and escalate cases where avoidable death or substandard level of care has taken place. • The process has been agreed with all consultant grade clinicians with the involvement of all permanent senior medical staff. • integrated quality report reinstated			