The Rotherham NHS
NHS Foundation Trust

Francis, Keogh, Berwick Recommendations: How has the Trust responded? Quarter 2

Previously you received a 2 page paper summarising the actions the Trust has taken in response to the Francis report, and also to the Keogh and Berwick reports, published in the wake of Francis. This paper provides a further update on the position at the end of quarter 2, 2014/15. Some of the introductory information warrants repeating from the previous paper:

Background

A key message we should take from the messages of all of these reports is that we must not be complacent. Events at Mid Staffordshire were exceptional and most people reading the report were shocked by the picture that unfolded. It is important though that we don't see this as so extreme or unique it could not happen here. Acting upon the recommendations is how we are making sure such events could not happen at our own organisation. Berwick and Keogh made significant contributions to addressing the problems identified by Francis.

What is the Berwick Report?

Don Berwick led the National Patient Safety Advisory Group, commissioned by the government to undertake a review of safety in the NHS

key messages?

- Place quality and safety above all other aims in the NHS
- Engage, empower, listen to patients
- Foster the growth and development of staff
- Insist upon transparency and model it in your work

Don Berwick's message to front line staff

- *Be a quality inspector, never knowingly passing on a defect, error or risk to a colleague or patient, putting things right where you can, and reporting everything, especially when you need help to put something right.*
- *Appreciate that your responsibility is n**o**t only to your patients but also to help continuously improve the healthcare system in collaboration with others*
- *Treat your colleagues with respect and courtesy and seek to create supportive teams with common goals*
- *Commit to learning about patient safety as a core professional responsibility and develop your ability to detect problems*
- *Be willing to speak up to leaders when you believes that a lack of skills, knowledge or resources places patients at risk of harm and be willing to listen to others when they identify these risks*
- *Celebrate and take pride in improvements to patient care*
- *Be willing to be open and acknowledge when something as gone wrong and make timely apologies and reparation where appropriate*

The report includes 10 recommendations – which condense the 290 recommendations made by Francis

What is the Keogh Report?

Sir Bruce Keogh led the review into quality of care and treatment provided by 14 NHS hospitals in England. These Trusts were identified because of consistently high mortality rates, which triggered a need for a quality review wider than mortality statistics alone. He used a methodology which can be adopted by Trusts to review and improve quality of care.

Key messages?

Keogh set out 8 ambitions for improving patient safety based on the principle that mortality rates can be a warning sign or 'smoke alarm' for potential quality problems. Trusts need to review their performance across 6 areas:

- Mortality
- Patient experience
- Safety
- Workforce
- Clinical and operational effectiveness
- Leadership and governance

Link to Keogh report
http://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf

Link to Berwick report
https://www.gov.uk/government/publications/berwick-review-into-patient-safety

Link to Francis report
http://www.midstaffspublicinquiry.com/

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What action has the Trust taken?
(examples)
Greater executive visibility

Introduction of bed boards and 'Intentional Rounding' process

Datix investigation template requires confirmation that patient/relatives have been informed of incidents, in line with duty of candour requirements

Incident Review Group established to improve learning following complaints, incidents, claims

Complaints policy and processes fully revised and complaints management workshops delivered across the Trust

Friends and Family Test rolled out

Listening Into Action initiated - 'top 10' priorities for change to be identified shortly

Development of values based PDR

Junior staff and public governors invited to attend a number of corporate meetings

Staffing levels and plans to address shortfall scrutinised on a monthly basis at QAC and Workforce Committee - comprehensive recruitment plan in place

Minimum AHP shift levels agreed

Nurses and Midwives Care Strategy launched with key themes which link to those of Francis, Keogh, Berwick

Improving staff communication processes

Breach of fundamental standards classed as internal 'Never Events'

REPORT SHARED THEMES

- **Candour and Transparency**
- **Patient Experience: listening and acting**
- **Safe staffing levels**
- **Staff engagement: listening and supporting**
- **Effective use of metrics to improve quality**

Robert Francis said:

'The vast majority of front line staff who are consistently hard working, conscientious and compassionate have to understand that criticism of poor and unacceptable practice is not aimed at them but is part of a struggle to support everything they stand for'

Keogh reported that involving staff and patients was the single most powerful aspect of the review process. There is much work still to be done. If you would like to get involved or find out more, please contact Hilary Fawcett, Quality Governance Lead: hilary.fawcett@rothgen.nhs.uk

What further action will be taken?
(Examples)
Trust Mortality Steering Group to establish and implement effective corporate process for carrying mortality reviews, in keeping with Keogh principles

Full revision of Trust Being Open and Whistleblowing Policies underway to ensure 'duty of candour' legislation is reflected

Implementation of complaints management improvement plan, including - anonymised complaints information to be published on the Trust web site

Strengthening of Clinical Directorate patient experience development plans

Successfully recruit staff and reduce agency usage

Fully implement values-based recruitment

Improve feedback processes to reporters of incidents and sharing learning across the Trust

Improve the outcome of national in patient surveys

Review the Trust code of conduct to incorporate national Fit and Proper Person legislation

Integrate quality walk round process and CQC self-assessment to create a clinical accreditation system

Complete the implementation of action plans designed to improve the outcome of National In Patient Surveys

Trust response to Francis, Keogh, Berwick: Quarter 2 2014/15

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– plan in development to publish anonymised complaints information on internet • 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 • Participation in Transparency Project	• Being Open Policy is undergoing full review to ensure Duty of Candour requirements included • Whistleblowing Policy undergoing full review • Implementation of Complaints management improvement plan • Complaints data to be published in Trust web site • Review of code of conduct (incorporate fit and proper person requirements)	Strategic objective 1, 8	CQC Outcome 4, 17 QGF 2B, 3B, 3C
Patient experience:	Effective and accessible complaints management	Boards need to urgently review and understand	Patient feedback should be collected as far as	• Full review of complaints policy and	Delivery of additional complaints management	Patient Experience	CQC Outcomes 1, 17

listening to patients and acting on what we hear	process with learning and improvement demonstrated openly	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	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.	procedure • Complaints management workshops delivered across the Trust • PEG receiving complaints data 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	workshops Submission to PEG of all Clinical Directorate development plans linked to Patient Experience strategy Implementation of complaints improvement plan Improve outcome of national patient surveys Investigate means of building further on use of real time patient feedback	Strategy	QGF 3C
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' • Development of values based PDR and	Fully implemented values based recruitment, with plan for evaluation Post implementation audit of Intentional Rounding	Nurses and Midwives Care strategy Strategic objective 8	CQC outcome 4, 12, 14 QGF 2A, 2B

				recruitment • Listening Into Action initiated • Publication of national cultural barometer awaited • Junior staff members, public governors invited to some corporate meetings – this to be extended			
Safe Staffing Levels	Review of nurse staffing levels	Trusts need to review current staffing levels for nursing & medical staff and make changes required for improving quality & safety of care	staffing levels should be consistent with the 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	• Staffing levels scrutinised by QAC on monthly basis • Monthly report from Chief Nurse presented to QAC. • 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	Successful recruitment to establishment Implementation of 'Proud to work at Rotherham' plan Reduction of use of agency staff	Strategic objective 7 Nurses and Midwives Care strategy	CQC outcome 13

				• Ongoing recruitment • Working to 1:8 nurse staffing ratio on wards			
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 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	• Launch of Listening into Action • Staff engagement & communication strategy being drafted • Annual staff survey undertaken – all staff have opportunity to submit response • 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	• Improve feedback processes to reporters of incidents via Datix • Strengthen processes for sharing learning from incidents across the Trust (led via Incident Review Group (IRG) • Review and action plan associated with 2014 staff survey	Strategic objective 7	CQC outcome 13 QGF 3C

				corporate meetings - student nurse members of OQSEG / AMD seeking junior Dr to attend mortality review group			
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 further. Mortality measures should be used as a 'smoke detector' in a spirit of supportive and	• 'Perform and Report Well' theme of Nurses and Midwives Care Strategy • Implementation of ward dashboards • key number of KPIs/Metrics that have been monitored through the Trust Board . These will be aligned and agreed with each Directorate and areas of concern regarding performance etc will be addressed at these meetings • There is a plan to roll out Dr Foster to the Clinical Directors so that they are able to monitor mortality. • Data quality reports readily available audit plan in place for	Mortality Steering Group re-established – to review and incorporate recommendations of Keogh into work plan Death certification process needs review and SOP completing Introduce mortality review process	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	genuine enquiry, not used to generate league tables or similar comparison	2014/15 • Mortality Review Group established – Keogh methodology to be applied, informing review process, including review of junior doctor involvement			