Oxford University Hospitals NHS
NHS Trust

Trust Board: Wednesday 11 September 2013

TB2013.100

Title	**Response to the Francis Inquiry**

Status	For discussion
History	This paper provides an update to the Board on actions being taken to accelerate further improvement in clinical quality at Oxford University Hospitals NHS Trust in the context of the second Francis Report, the Keogh Reviews and the Berwick Report. It builds upon papers considered by Trust Board in March and May 2013.

Board Lead(s)	Professor Edward Baker, Medical Director			
Key Purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. This paper provides an update to the Trust Board on actions being taken to accelerate further improvement in clinical quality at Oxford University Hospitals NHS Trust following publication of the second Francis Report in February 2013. It has also been developed in the context of the recent publication of the Keogh Reviews into fourteen NHS Trusts with higher than average mortality rates, and the Berwick Report on patient safety.

2. These publications have had a major impact on the NHS at large. The Trust's overarching response has three key elements - the further development of a culture within the organisation in which clinical quality is the primary concern of all staff members; enhancement of systems to determine and monitor appropriate staffing levels within clinical areas in real time; and, the adoption of a programme of internal peer review and risk summits for quality assurance and improvement.

3. The paper provides an update on the priority areas identified for the Trust in Board papers received on 13 March 2013 (TB2013.39) and 8 May 2013 (TB2013.59).

4. The paper describes a number of current and potential projects which, taken together, form a comprehensive programme of work aimed at further accelerating the desired cultural change. Many of these projects were underway in advance of Francis, and these will be strengthened going forward. Others are new proposals.

5. Some of these projects are being implemented without delay whilst others are subject to consultation with the membership of TME (ongoing) and the wider Trust (anticipated).

6. Significant time and commitment that will be necessary to ensure that the projects subject to this consultation are delivered successfully and sustained. Relevant leaders and departments within the organisation will incorporate new projects relevant to their area as part of their 2014/15 work plans.

7. Systems for assessing the levels and skill mix of nursing staff are already in place such as the Safer Nursing Care Tool. This is being refined, including consistency and quality assurance of safe nursing establishments. The triangulation of acuity, dependency against Professional Judgement provides evidence based data that determines the right levels of staff by clinical area. There is also work underway to provide transparency of staff levels by ward and site in real-time in association with the electronic rostering provider.

8. A systematic programme of internal peer review of clinical services (at divisional level) and a series of risk summits is being developed in order to strengthen the Trust's assurance of clinical quality. These will be implemented from October 2013.

9. Trust Management Executive has considered the issues outlined within this paper and has requested that the proposal for a programme of peer review is rapidly worked up. A detailed plan will be considered by TME during September 2013.

Background

1. The report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Chair – Robert Francis QC) was published on 6 February 2013. Trust Board has discussed the report on a number of occasions, and received formal papers on 13 March 2013 (TB2013.39) and 8 May 2013 (TB2013.59).

2. The Keogh Reviews were published on 16 July 2013 and examined quality issues at fourteen Trusts that have had a consistently high mortality rates (HSMR or SHMI). They set eight ambitions for the NHS. Several of these ambitions mirror declared OUH priorities following the publication of the Francis Report (paragraph 11). Notable additions are the focus on the quality of data and the quality of the analysis of those data and ambition 7 of the report which highlights the potential of junior doctors as leaders for quality.

3. Central to the Keogh reviews is the introduction of a new process for assessing quality in NHS Trusts. The process is data-driven, multidisciplinary, and transparent and has a great deal of patient involvement both in providing feedback, but also as members of the review teams.

4. The Keogh review process consisted of:
    - Information gathering and analysis creating a comprehensive data pack for each trust. This was used to establish the key lines of enquiry for each review.
    - Rapid responsive review in which trained multidisciplinary inspectors visited each trust several times. The teams met with patients and staff at all levels.
    - Risk summit and action plan where the review team meets with representatives of the Trust and other stakeholders to agree action and timescale.

5. Quality issues were identified at all fourteen trusts. The key difference between these reviews and previous methods of review is the transparency of the process and engagement of different groups in the agreement of the outcomes.

6. Key quality findings were:
    - Poor engagement of patients and staff;
    - Poor implementation of early warning scoring, particularly with reference to hospital acquired pneumonia;
    - Weak workforce data that did not reflect the reality of the situation in clinical areas with over reliance on temporary staff;
    - Lack of clear approaches to quality improvement;

- A disconnect between the leaderships view of the clinical risks and the frontline reality.

7. Ambition 4 of the Keogh review is for improvement in Care Quality Commission (CQC) inspections drawing on the experience of the Keogh review process. The CQC will undertake the first reviews using a methodology based on the Keogh process later this month. The report also suggests that trusts might use the methodology of the reviews to assess and improve their own clinical quality.

8. The Berwick Report, itself a governmental response to *Francis 2*, was published on 6 August 2013. It focuses on creating an effective safety culture within the NHS. The risk management culture Berwick advocates is one of transparency, learning and improvement. Like Keogh he emphasises the importance of defining safe staffing levels for all clinical areas based on the clinical burden and the real-time monitoring of actual staffing against this standard.

9. Berwick's report centres on patient safety. He argues that quality and safety cannot be separated. Safety can never be absolute, but it is the first requirement for clinical quality. He identifies three necessary elements for effective quality management:
   - Quality control
   - Quality improvement
   - Quality planning

Work within the Trust relevant to Francis, Keogh and Berwick

10. Several highly relevant pieces of work have been underway within the Trust over the last three years pre-dating the publication of the Francis Report. These include: articulation of organisational values; a programme of work around *Delivering Compassionate Excellence*; and, the development of the Quality Strategy.

11. At its meetings in March and May 2013 the Trust Board agreed that the priorities for action were:

    - **Culture** - The Trust should consider whether the work already underway is sufficient
    - **Complaints** - The Trust should review its complaints handling process
    - **Risk management** - There should be a review of the Trust's approach to clinical risk management
    - **Mortality** - The systematic review of patient deaths already underway should be made a priority
    - **Response to quality concerns** - The Trust should make sure quality concerns are addressed rapidly and effectively

12. In addition to these priorities the Trust Board agreed that there should be a review of clinical staffing in all services to ensure it was at a level necessary to provide a safe high quality service.

13. Encouragingly these priorities have been supported in the subsequent reports. An additional issue that was not specifically identified in the Trust's priorities, but did emerge from the Keogh report was the need for much improved data quality and data analysis on clinical quality. This needs to be added to the Trust's priorities.

14. A more fundamental issue is a radical change in the approach to the assessment and assurance of quality signalled by the Keogh report and now adopted by the CQC. Regulatory hospital inspections up till now have been heavily reliant on the self-reporting of evidence of compliance tested by a relatively generic physical inspection process, often itself focusing on documentation rather than practice.

15. The Keogh approach is one of multidisciplinary, expert peer review with emphasis on taking evidence from staff and patients rather than trust managerial reports. More time is spent in clinical areas and more clinical areas are visited.

16. Progress against the Trust's priorities for action is identified in Table 1 below:

Progress to date on priority actions for OUH following Francis	
Area	**Update**
Culture	Multifaceted work continues including leadership development strategy, values based interviews and the *listening into action* programme.
Complaints	A review of complaint management is in progress. Revised reporting with enhanced triangulation across information sources on the experience of patients and additional granularity is being provided to Quality Committee including the learning that can be derived more widely from all aspects of patient feedback and complaints.
Risk Management	Further work ongoing in relation to local ownership and action in response to clinical incidents. A programme of risk summits has been initiated. The patient safety function within the Trust will move into the Quality and Risk Directorate to create a single management structure for quality with immediate effect.
Mortality	Development of Clinical Outcomes Review Group. Further work to embed standardised mortality review across all clinical services. Mortality Review Group to be established.
Response to Quality Concerns	Renewed effort has been made to ensure that quality concerns that are raised are shared and collated, and that actions are rapid and proportionate. This is applicable to concerns raised both under the 'Raising Concerns' (whistleblowing) policy and via other routes.

	Enhanced reporting of concerns raised and actions taken via Clinical Governance Committee and the monthly Quality Report to the Board.
Clinical Staffing Review	This is an ongoing process that is being refined in alignment with national data, to provide more sophisticated information related to safe levels of nursing establishments. Additionally, the Trust is working with the electronic rostering software provider, to facilitate and view real-time staff levels by clinical area and site.

17. A small working group met to further consider the Francis report, the Government's initial response and staff feedback from the briefings held in February / March 2013 in order to inform and develop the Trust's response. The group was mindful of the many work streams that are already underway within the Trust. The output of this group has been to identify a set of projects and interventions, some in progress and others new, which together form a coherent and substantial programme of work to accelerate further improvement in clinical quality.

18. The projects and interventions are divided into six broad domains of work that sit within the context of the Trust's values (see figure 1 overleaf). Existing work streams have been mapped to these six domains. The new work proposed does not alter the direction that the organisation seeks to take but acts as a catalyst in moving forward (see figure 2 for existing work streams and proposed projects and interventions, mapped against the six domains).

Figure 1

Six key domains of work following Francis sit within the context of Trust Values

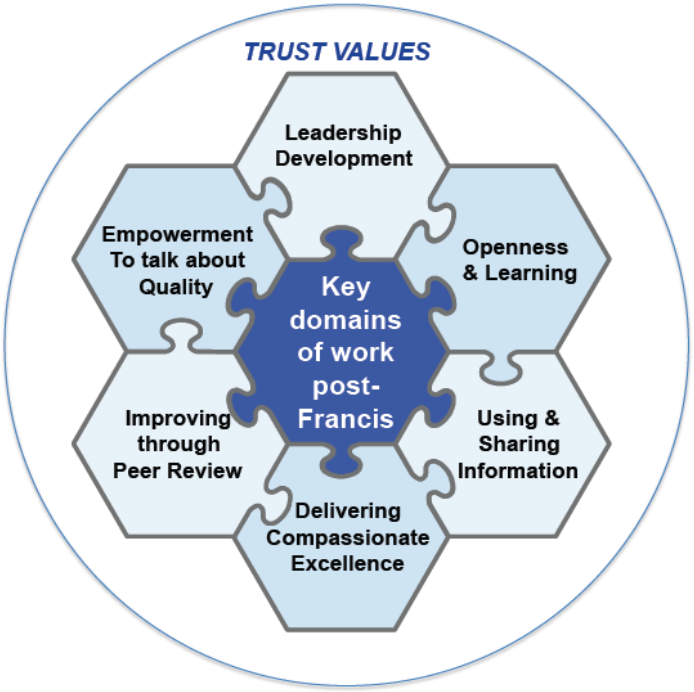
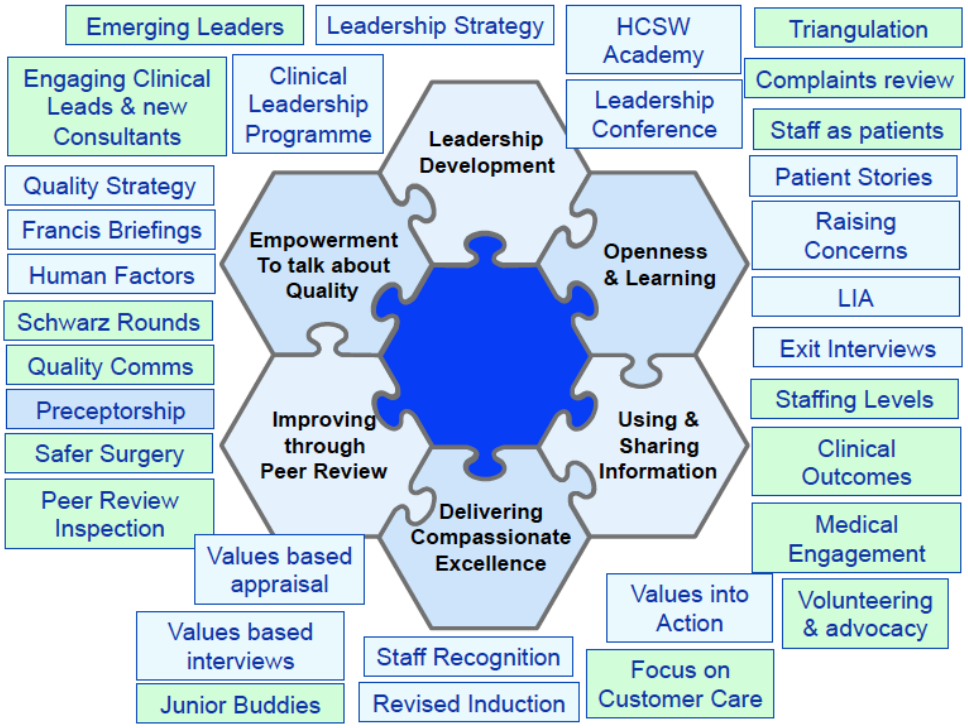


Figure 2
***Existing* work streams [blue boxes] pertinent to Francis and *proposed* projects and interventions [green boxes] (mapped to the six domains)**



19. The group has identified 21 projects and interventions that should be considered with a view to adoption or – where already in place – further developed and reinforced.

20. In the light of the Keogh Reviews, the development of a systematic programme of internal peer review of clinical services (initially at divisional level) and a series of risk summits is a clear priority amongst these projects and interventions.

21. The Trust's response to Francis was considered by Trust Management Executive (TME) on 22 August 2013. Plans will be presented to TME the on 12 September to begin the peer review programme from October 2013, with the intention of completing an initial review of all divisions by the end of January 2014. TME has agreed with the plans for risk summits into pneumonia and inpatient diabetes care and will provide a view on the other projects and interventions that have been proposed after further consultation.

22. For clarity, the projects and interventions are set out under the six domains in table 2 below. A comment is provided as to whether these projects represent an extension to existing pieces of work, constitute a proposal for new work going forward into 2014/15, or represent new work upon of which urgent adoption is required.

Table 2
Projects proposed to accelerate further improvement in clinical quality at OUH

Domain: Delivering Compassionate Excellence		
Value Based Interview	*Incorporating Trust values into everyday processes starting with recruitment*	EXISTING
Focus on Customer Care	*Customer service training and heightened profile for 'Friends and Family' feedback*	EXISTING
Patient Stories	*Establishing a catalogue of patient stories - positive, negative and mixed - for use in training*	EXISTING
Physical frailty and cognitive impairment - volunteering and advocacy	*Focus on the contribution of volunteers and formal advocacy services*	NEW PROPOSAL
Junior Buddies	*Enhanced communication and understanding between junior staff from different professional backgrounds*	NEW PROPOSAL
Domain: Improving through Peer Review		
Peer review inspection	*A comprehensive programme of internal peer review, involving patients and carers, based on Keogh / CQC model*	ACTIVE DEVELOPMENT
Domain: Leadership Development		
Clinical Leadership Programme – *Safe in our hands*	*Leadership development programme for ward managers (sisters and charge nurses) and equivalent*	EXISTING
Healthcare Support Workers' Academy	*Induction and training for healthcare support workers*	EXISTING
Engaging with Clinical Leads and new Consultants	*Programmes aimed at supporting and developing these two important groups of medical staff to support cultural change*	NEW PROPOSAL
Emerging Leaders	*Programme aimed at developing service improvement skills of emerging leaders in a multi-professional setting*	NEW PROPOSAL
Domain: Empowering Staff to talk about Quality		
Schwarz Rounds	*Adoption of a standardised approach to debriefing and learning following adverse clinical events*	NEW PROPOSAL
Quality Comms – the interface between clinicians and corporate teams / functions	*Improving the accessibility of corporate level expertise for clinical services*	NEW PROPOSAL
Preceptorship for newly qualified nurses	*Assist new staff in making transition from student to qualified professional*	EXISTING

Safer Care associated with Surgery – Quality Account	*A programme of work aimed at improving the safety of surgery*	EXISTING
Domain: Using and sharing information		
Raising the profile of Clinical Outcomes including avoidable mortality	*Development of clinical outcome review group and enhanced focus upon the review of deaths to identify opportunities for improvement (including the appropriate use of risk summits)*	ACTIVE DEVELOPMENT
Raising the profile of staffing establishment levels	*Development of a system in order that information on the number of clinical staff are held in an agreed and format and shared openly within the organisation*	NEW PROPOSAL
Measuring Medical Engagement	*Use of the Medical Engagement Scale for assessment and monitoring*	NEW PROPOSAL
Domain: Openness and learning when things go wrong		
Transforming Complaints	*Review the way in which complaints and complainants are handled and valued*	EXISTING
Clinical Risk Management and Local Triangulation	*More effective learning through collation of the findings of patient feedback and clinical risk investigations at service level*	EXISTING
Staff experiences as patients	*Facilitate staff in giving feedback to colleagues as to their own experiences of healthcare in a supportive environment*	NEW PROPOSAL
Exit Interviews	*Consolidate work being undertaken to perform and learn from exit interviews*	EXISTING

23. Figure 3 below illustrates the relationship between the proposed divisional peer reviews and crosscutting pan-Trust risk summits. Table 3 below provides further information on the key features of each.

Figure 3 Relationship between Peer Review and crosscutting pan-Trust Risk Summits

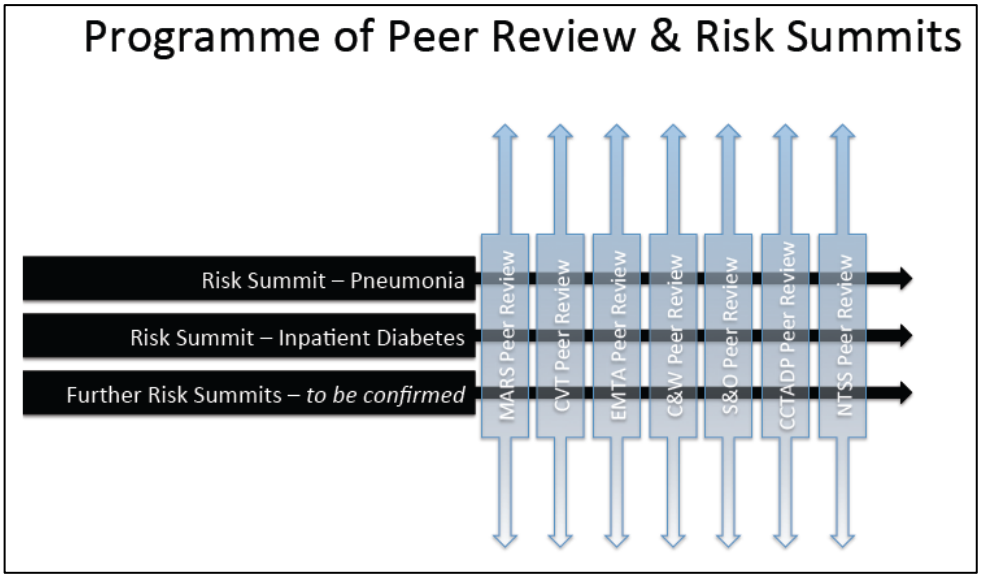


Table 3
Key features of proposed Peer Review and Risk Summits

Peer Review and Risk Summits	
Peer Review	**Risk Summits**
• Clinical services operated within each of the seven divisions will be reviewed by peers from elsewhere within the Trust (divisional and corporate) • Focus on generic aspects of care, patient experience and service delivery as opposed to highly specialist service reviews • Review driven by, and focused through, data (for example – Divisional Health Assure profiles, benchmarked outcomes from national audits or Dr Foster; information drawn from clinical incidents, staff and patient experience; and, routine divisional quality reports including divisional risk register) • Trained multi-professional review teams with senior leadership (executive director or deputy?), lay representation, GP representation, and the input of junior / trainee professionals • Team divided into sub-groups such that review at service level is unobtrusive • Systematic review process over a number of days, including out of hours over evenings and weekends • Structured feedback both informally at service level and formally to TME at the end of the process – emphasis on the formative and developmental	• Topics for risk summits relate to clinical conditions and patient pathways that span divisional boundaries and / or issues that may impact upon quality and are ubiquitous (for example, out of hours working, booking of appointments, communication with primary care) • Clinical conditions will be chosen following analysis of data from benchmarked outcomes, local intelligence (for example patterns of clinical incidents) and national priority areas (for example, dementia) • Key stakeholders will be identified including a lead clinician • Data packs will be assembled as pre-reading for summit participants who will come from clinical services (via Director of Clinical Services), from corporate topic lead roles, and from a public / patient and commissioner perspective • Summits will address data packs, identify and agree upon gaps in practice and agree rapid programmes of work to improve deficiencies in service provision where identified • Summits will report to TME and CGC in parallel
Executive Lead: Director of Assurance	Executive Lead: Medical Director

Conclusion

24. Trust Board is asked to note the content of this paper;
    - 24.1. To note the plans to implement a process of internal peer review;
    - 24.2. To note the note the plans for risk summits;
    - 24.3. To consider the additional proposals in the context of previous discussions on this topic.

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September 2013