Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors

Date of Meeting 24th April 2013

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Our response to the Mid Staffordshire NHS Foundation Trust, public inquiry by Robert Francis QC

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NHS Foundation Trust

Board of Directors

Date of meeting 24th April 2013

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Our response to the Mid Staffordshire NHS Foundation Trust, public inquiry by Robert Francis QC

1.0 Introduction

Post the publication of the findings of the Mid Staffordshire Public Inquiry all Chairs and Chief Executives were asked to ensure their organisations considered the report in full, considered whether it accepted the 290 recommendations and to undertake a listening exercise with its staff. The outcome of which must be presented to a public board meeting. This has now been completed and this paper sets out the outcome of this exercise. The paper is presented in the following sections:

- Presents an overview of the findings of the public inquiry
- Presents the findings of our own listening exercise with staff
- A summary of the DH response to the recommendations
- Recommendations to the Board of Directors on a set of proposed actions/next steps
- Appendix 1 provides a response to the 290 recommendations

2.0 Overview of the findings of the public inquiry

2.1 The previous government ordered an independent inquiry into the failings of care at Mid Staffordshire between 2005-2009. This reported in 2010, making a number of recommendations. When the Coalition government came to power the then Health Secretary, Andrew Lansley requested Robert Francis to lead a further inquiry. The purpose of which was to establish how such failings could have been allowed to happen and to go unnoticed for such a long period of time and what were the lessons for the wider NHS. The report was published on the 6th February 2013.

2.2 The Francis report is 1782 pages long and is presented in 3 volumes, supported by an executive summary and 290 recommendations. Designed to change the culture and ensure 'patients not numbers come first,' by creating a common patient safety culture across the NHS. The essential aims of what has been suggested are to:

- Foster a common culture shared by all in the service of putting patients first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern.
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients - individuals and organisations properly accountable for what they do and to ensure that the public is protected from those not fit to provide a service.
- Provide a proper degree of accountability for senior managers and leaders to protect the interests of patients.
- Enhance the recruitment, education, training and support of all the key contributors to healthcare, in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything we do.
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

3.0 Outcome of the Trusts listening exercise

3.1 Following the publication of the report the Trust set out its plan to brief and engage its staff in the findings of the report and took the following approach:

- To hold a number of Trust wide 'drop in' briefing sessions, where all staff were welcome and they received a presentation on the findings from the Chief Nurse. In addition specific briefings were undertaken at the February private board meeting and for the Council of Governors. In total approximately 600 staff attended. In addition, the Deputy Chief Nurse for Community held three briefings for community staff.
- Local listening events were then established across the Trust led by the directorate management teams and supported by the OD team to enhance alignment with the values and behaviours framework. The purpose of which was to engage and to listen to as many staff, who were posed the following questions:

- Theme: Putting patients first all the time
  - At your best, what do you do now to put patients and their needs first?
  - What should we do to put patients and their needs first all the time?
- Theme: Speaking up safely
  - What currently enables you to speak up about any concerns you have?
  - What would enable you always to be able to speak up when you have concerns?

- Theme: Listening to our staff and patients
  - How do we know at the moment what our patients and staff think and feel?
  - What would be the most effective way of finding out what our patients and staff think and feel?

- In addition to the focus groups we also put up posters in the majority of ward staff rooms for those staff who were unable to attend a focus group but wanted to contribute.

3.2 The engagement exercise was very successful and X number of staff had the opportunity to contribute to the focus groups.

3.3 More here and in an appendix

Focus Group findings for Board report on Francis Report

Participation

3.3 Almost 1300 staff attended 90 focus groups across the Trust during March 2013. In addition data was collected via posters in wards – 24 wards took part in the process using this method.

3.4 The spread of staff involved in this exercise was fairly representative, other than from Bands 1-4 as shown in figure 1.

Staff Grade	Number	%
Band 1-4	137	11%
Band 5-6	454	35%
Band 7-8b	393	31%
Band 8c plus	43	3%
Consultants	124	10%
Training grades (ST/FY)	99	8%
Student Nurse or AHP	31	2%
Total	1281	

Figure1. Staff Attending Focus Group by grade

3.5 Across the 1300 participants there was broad representation from different staff groups – the graph in figure 2 gives the percentage breakdown of attendees by professional group

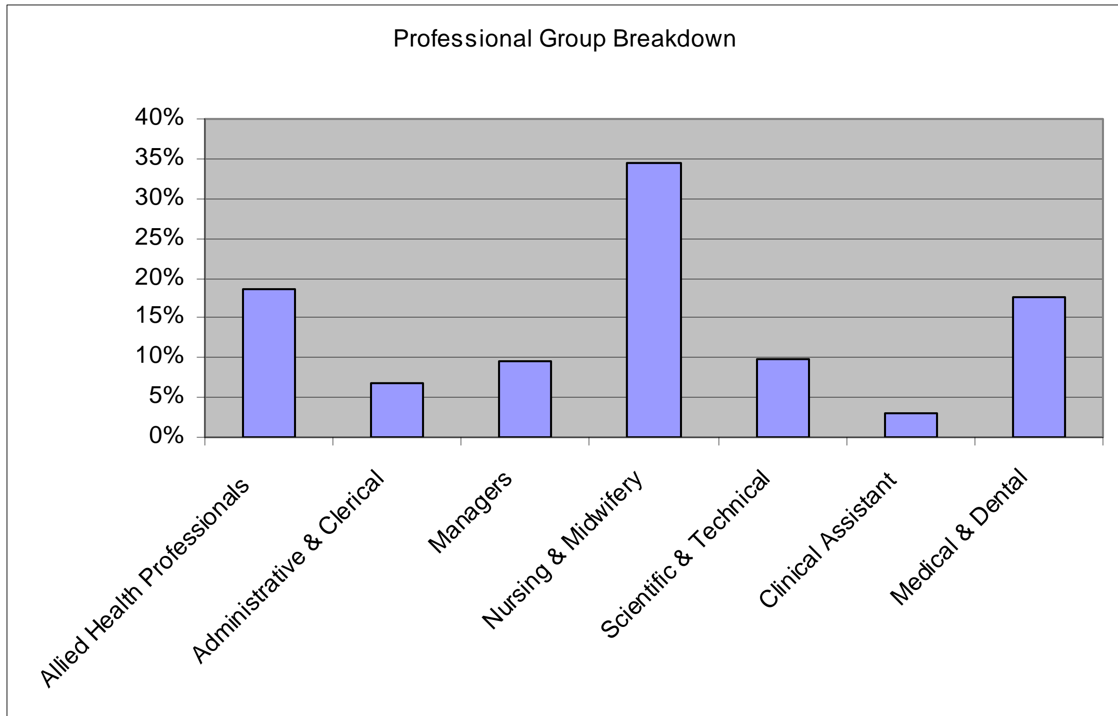

Figure 2. Staff Attending Focus Group by Profession

3.6 Staff from all clinical directorates and many corporate areas took part in focus groups. The level of participation in this process is a tribute to managers and senior staff across the Trust, both those involved in running focus groups (50 senior staff) and those enabling the process to occur through publicity, encouragement, role-modelling and giving staff time to attend. It should be recognised that the lead-time to organise this process was just two weeks.

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3.7 Finally, it should be noted that the level of participation recorded formally for this report is the *minimum level* of involvement in the Trust; many more staff contributed to this process through ward posters, informal discussions or more formal groups where attendance was not recorded.

Analysis

3.8 The Organisational Development team analysed the data under each of the headings and have identified both themes and commonly occurring terms. The commonly occurring terms are shown visually in the Wordles in Appendix X. The larger the font, the more often the word or phrase was used.

Putting patients first all the time:

1. **At your best, what do you do now to put patients and their needs first?**
2. **What should we do to put patients and their needs first all the time?**

3.9 The focus group participants and contributors to posters named dozens of ways in which they currently put patients and their needs first. This was true of frontline staff and of staff in corporate areas. The themes were:

Theme	Examples
Attend to the basics	Pay attention to dignity, safety and confidentiality and deliver evidence based care
Interactions	Listen to patients, ask how they are, be friendly and empathetic
Involvement and individualised care	Provide individualised, holistic care and involve patients and their families and give them the time they need
Prioritise patients and their needs	Manage the workload to prioritise patients, inform and advocate for them
Seeking feedback	Conduct patient surveys and act on audits
Systems that support	Appropriate care planning, training to do the job, planning convenient and flexible services and having appropriate staffing mix and levels
Effective team working	Listen and communicate with the team

3.10 It was striking that much of the language used by staff mirrored that of the Values and Behaviours Framework.

3.11 The themes were the same for both the first and second question, but the emphasis shifted from the personal responsibility for listening and communicating, to the team and Trust responsibilities for teamwork and appropriate systems and resources. This can be seen in the first two Wordles in Appendix X.

3.12 As a contributor said, we all need to do more of what we do on a good day.

Speaking up safely

1. **What currently enables you to speak up about any concerns you have?**
2. **What would enable you always to be able to speak up when you have concerns?**

Theme	Examples
Approachable/visible manager	A supportive and visible manager who listens
Clear standards	Being clear about the appropriate standards of care
Completing the action/ feedback loop	Knowing that your concern will be acted on
Culture	Feeling safe and an open and honest culture with no fear of repercussions
Guidance & Process	Knowing what the policy and processes are and who to raise concerns with
Personal qualities	Self confidence, passion for patient care and professional responsibility
Space and time	Individual and team meetings
Support	A supportive team

3.13 By far most important single factor enabling staff currently to speak up was a supportive and visible manager. The single most important factor that would encourage more speaking up was the knowledge that there would be action taken and feedback given, whether through managers or through formal mechanisms such as Datix. This was followed by the need for an open and supportive culture where staff felt safe to raise concerns.

Listening to our patients

1. **How do we know at the moment what our patients think and feel?**
2. **What would be the most effective way of finding out what our patients think and feel?**

Theme	Examples
Create the right culture through behaviours	Talk to patients (speak to/ask/listen/discuss), create a culture of listening, look at patient's body language, have friendly body language, make time for this
Formal feedback	Surveys, complaints, PITS/PALS, patient fora, review survey questions
Informal feedback	Compliments, thank you cards, asking for feedback after an interaction/intervention, follow up phone calls
Completing the feedback loop	Discussing and displaying findings, giving feedback on comments, using Datix/SUI information

3.14 The strongest theme in this question was feedback through formal mechanisms, particularly noting what we do now using surveys, complaints data, PALS/PITs, closely followed up by informal feedback we receive now such as compliments and cards. The theme identified around ‘closing the loop’ occurred again, as under ‘speaking up safely’. This shows how important it is not only to gather information, but to feedback to staff. The other strong theme here was around behaving in a way that enable patients to be heard and creating the right culture for this.

Listening to our staff

1. How do we know at the moment what our staff think and feel?

2. What would be the most effective way of finding out what our staff think and feel?

Theme	Examples
Relationship with manager	Appraisals, 1:1s, feeling listened to and valued, getting feedback, being approachable, clinical supervision
Meetings and fora	Team meetings, MDTs, joint managerial and clinical fora, open fora
Metrics	Staff survey, attendance, employee relations & turnover data, incident forms

3.15 The majority (2/3) of the comments from staff on this question were on what is good now including appraisal, team meetings and being listened to. The main areas which staff thought could be more effective was in the approachability of managers, getting feedback and in having regular 1:1s. Staff also listed a wide range of metrics used to listen to and gauge staff views, notably the staff survey. The weight of appreciative data on what is good now aligns with our excellent staff survey results.

Recommendations

Celebrate the current good practice

This exercise was designed to help staff think about what we currently do well under the three themes identified. However, an overwhelming amount of data was generated on our current good practice (on all questions there was more data about ‘good now’ than ’better if’) with high levels of consistency across the Trust. This needs to be recognised and celebrated; the process modelled this but the Board should acknowledge it.

Spread the good practice

A large amount of data collected in this exercise is repeated in the ‘good now’ and ‘better if’ questions, suggesting we have the organisational capacity for great practice (congruent with our patient safety record, patient feedback and staff survey) but do not practice it in all areas of the Trust. What this process

highlights are the areas staff think we should focus on in making improvements. Spreading good practice is a perennial issue for the Trust but a message from the top on what is valued in the organisation and role modelling of what is valued by staff will help managers be clear on what is expected to create areas of best practice.

Closing Feedback Loops
In questions on both speaking up safely and on listening to patients, staff valued feedback on issues that have been raised or on feedback such as survey data and were keen for this to be done consistently.

There is a specific action to be considered in how Trust level and Directorate data is fed back to staff in a way that is useful and meaningful. In addition, there is an opportunity to use this process as a way of modelling closing the feedback loop (as one participant suggested). Plans have begun to use the Trust-wide Fit for the Future launch to feed back on this process, and consideration needs to be given to other ways to thank and acknowledge staff contribution as well as demonstrate actions taken.

Don't take our eyes off some of the basics
There is clear message from staff in this process that basics of caring for patients safely and kindly, having clear processes to follow, regular meetings/appraisals and feedback are all valued and needed to do the best that they can for patients.

Support managers to support their staff
Staff clearly value visible, approachable and accessible managers at the line and at more senior levels. The success of this process has shown how well staff respond to effective management action. However, managers often feel squeezed between helping staff deliver front-line services and meeting organisational targets. We recommend that the Board and other senior layers of management acknowledge the importance of managers in providing a safe and supportive environment for patients and staff.

Set aside further time
Undertaking this process has sent a clear message from the Trust's senior leadership regarding the importance of the Francis report and of putting patients at the centre of what we do. It is suggested that the Board of Directors continue by setting aside further time to consider the specific themes and actions from this research and the implications on the Board itself. This could be combined with the previously agreed session on Trust Values and Behaviours.

4.0 Summary of the DH response to the Francis Inquiry

4.1 The DH response was published on the 26th March, the title of which is 'Patients First and Foremost'. The document sets out an initial overarching response on behalf of the whole health system. It details key actions to ensure that patients are ***'the first and foremost consideration of the***

system and everyone who works within it' and to restore the NHS to its core humanitarian values. It sets out a collective and commitment and plan to eradicate harm and to aspire to excellence. This is a call to action for every clinician and everyone working within health care. The DH sets out a 5 point plan to end the failure and issuing a call for excellent.

A. Preventing problems
B. Detecting problems quickly
C. Taking action promptly
D. Ensuring robust accountability
E. Ensuring staff are trained and motivated

4.2 Preventing Problems

The need to secure a consistent culture of compassionate care. With both commissioners working with Trusts to tackle poor care and the appointment of a Chief Inspector of Hospitals, who will shine a powerful light on the culture of hospitals. To do this however leaders need time to lead and staff need time to care. Therefore there will be a review of the paperwork and 'box ticking' and duplicatory regulation. In addition the NHS Commissioning Board has appointed Don Berwick to advise them on how to create a safety culture and a zero tolerance of avoidable harm and that this becomes embedded within the DNA of the NHS.

4.3 Detecting Problems Quickly

4.3.1 The Care Quality Commission will appoint a Chief Inspector of Hospitals, who will be supported by an expert group of inspectors who will have walked the wards, spoken to patients and staff and looked the board in the eye. The Chief inspector will make an assessment of every NHS hospitals performance.

4.3.2 Generalist inspectors will be replaced by experts who will get to the heart of how hospitals are serving their patients and a 'comply or explain' approach will be used in inspections.

4.3.3 There will be a new ratings system established for the CQC to apply and they are currently working with the Nuffield Trust. In addition the CQC will appoint a Chief Inspector of Social care.

4.4.4 To support the new spirit of candour and transparency, hospitals will not be subject to just aggregate ratings but you will be able to drill down to individual specialities. Mortality data must be accurate but interpreted with care so that members of the public and patients can trust that what they are hearing is a fair and honest account. There will be tough penalties and potential legal sanctions on Boards who re found to be 'massaging' figures or concealing the truth about their performance. In addition their will be a statutory duty of candour on all providers to inform people if they believe treatment of care has

caused death or serious injury, and to provide and explanation even if they have not asked for one.

Contractual clauses to prevent NHS staff speaking out on patient safety issues will immediately stop and the final are of action in this section is the commencement of a national review of best practice in handling complaints.

4.4 Taking Action Promptly

4.4.1 The CQC, working with NICE, commissioners and professionals, patients and the public will draw up a new set of simpler fundamental standards, which make explicit the basic standards beneath which care should never fall. These are likely to include:

- Patients getting their correct medicines at the right time
- Patients getting food and water and assistance to eat and drink when they need it
- Patients being assisted to go to the lavatory when they need to go to prevent any patient having to soil their clothes or their bed
- Patients being asked to consent to treatment and all staff to communicate with patients effectively about their care

4.4.2 The Chief Inspector of Hospitals will develop a new 'time limited 3 stage failure regime' for quality as well as finance. The first stage setting out the responsibilities of the Board to work with commissioners to resolve the failings, the second stage would require the CQC to call in Monitor and the final stage if the failings had still not been addressed would lead to the Chief Inspector initiating a failure regime in which the Board could be suspended or the hospital put into administration, whilst ensuring continuity of care.

4.5 Ensuring Robust Accountability

4.5.1 At a national level the proposals within this section will resolve the confusion of roles and responsibilities in the system so it is absolutely clear where the 'buck' stops. The Chief Inspector will identify failing standards in the NHS Trusts and Foundation Trusts.

4.5.2 Where the Chief Inspector identifies criminal negligent practice the CQC will refer the matter to the Health and Safety Executive to consider whether a criminal prosecution should be considered for either providers or individuals. The DH will ensure there is sufficient resource for the H&S Executive to fulfil this remit.

4.5.3 Urgently the GMC and NMC and other health care regulators are hampered by outdated legislative frameworks. As part of the Law Commissions review the DH will seek to legislate at the earliest opportunity the possible opportunity to overhaul radically 150 years of complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.

4.5.4 The DH will implement a national barring list for unfit managers based on the barring scheme for teachers.

4.6 Ensuring Staff are Trained and Motivated

4.6.1 Starting with a pilot, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant. To enable them to gain experience in front line care and also the role of the HCA and their future management of them. The scheme will need to be tested and carefully implemented and managed.

4.6.2 Building on the historic introduction of medical revalidation the DH wish to work with the NMC to introduce an affordable and proportionate national scheme to ensure all practising nurses are up to date and it to practice.

4.6.3 There is a national review underway to ensure that healthcare assistants can provide safe and compassionate care and that every organisation will have to demonstrate that all HCA's are properly trained and inducted. This will be supported by a national code of conduct, but there will be no national statutory regulation framework or a separate barring scheme for HCA's.

4.6.4 Each organisation should have a clear aspiration to treat its staff well, with robust recruitment, induction and appraisal programmes in place, and all organisations will have to ensure it has the right staffing profile to be able to provide the right level of care. Therefore there will be no mandated minimum nurse staffing levels, as this does not provide for local flexibility. But the expectation will be that all Trusts will have to have in place an accredited tool to assess the workforce requirements and as a minimum these are presented to the Boards on a six monthly cycle.

4.6.5 All Trusts will be expected to make progress with the implementation of the national nursing vision 'Compassion in Practice – 6C's' and as part of this those wards across the country who do not have intentional hourly rounding in place will be expected to do so as well as give due consideration to ensuring Ward sisters/Charge Nurses are in a supervisory role.

4.6.6 The Francis inquiry recommended the creation of a separate registered older persons nurse. However given that many of older people are cared for in many parts of the NHS the DH recommends that they will strengthen the training on the care of the frail older person throughout all programmes. So that all adult trained nurses have the right set of skills to care for our most vulnerable patients.

4.6.7 To ensure that the NHS creates the cultural change it needs, it requires leaders who have the skills and abilities to do this therefore the NHS leadership Academy which has already been established will programmes that support the development of leadership skills from Board to Ward. Building the capacity and ability of our top leaders.

4.6.8 The final recommendation in this section is aimed at Ministers and Civil Servants who will be expected to have front line clinical experience. GSTT has been asked to support those based in London by offering them volunteering and work shadowing placements.

Appendix

Put Patients First – Good Now

Put Patients First – Even Better If

Speak up – Good Now

Speak up – Even Better If

Seeing action/getting feedback

Better analysis of incident forms

One-to-ones

Team meetings

Managers regularly asking

Overhaul of DATIX

Knowing standards

Confidence to approach the right person

Knowing you will be listened to

Confidence in process

Accessible manager

Knowing something will be done

No fear of repercussions

Confidentiality is assured

Supportive & visible manager

Feeling supported to resolve problems

No blame culture

Self confidence

Clear about policy and process

Team working

Open and honest culture

Less hierarchy

Anonymity of whistle blowers

Clear point of contact for each area

Open forum for staff and managers

Open door to senior managers

Listening to Patients – Good Now

Listening
Compliments
Thank you cards
Complaints
Surveys
Make a point of asking
Patients tell you
Patient's body language
Near point patient feedback
Discuss survey findings
Comment cards
Family and friends test
Dialogue/discussion
Engage with families
Culture of listening to patients
Follow up phone calls
Managers ask about experience
Datix/SUI info
Patient support groups
Friendly body language
Speak/ask
PIT/PALS

Listening to Patients – Even Better If

Surveys

Speak/ask

Family and friends test

Listening

Understanding diverse needs

Computerise feedback

Ask GPs/CCGs

Deliberate decision to make time

Datix/SUI info

Value the patient

Confidence

Going the extra mile

Make a point of asking

Patient's body language

Ask for feedback afterwards

Follow up phone calls

Patient forum

Get the frontline staff involved

Feedback on comments

Anonymised feedback

More accessible PALS

Ask at discharge

Allow feedback without a complaint

Engage with families

Mystery shopper

Review survey questions

Getting more formal feedback

Listening to Staff – Good Now

Staff survey
Incident forms
Team meetings
MDT meetings
360 feedback
Email contact
Listening
Feeling valued by manager
Morale
Educational supervision
Mentoring
Give and receive feedback
Open door policy
Staff turnover
Clinical supervision
Team building
Sickness rate
One-to-ones
Staff fora
Debriefing
Appraisals

Listening to Staff – Even Better If

Staff survey
Approachable managers
Clinical and managerial joint meetings
Give and receive feedback
Exit interviews
Anonymous comments box
Mentoring
Staff fora
One-to-ones
Clinical supervision
Manager role modelling
Appraisals
Feeling valued by manager
360 feedback
Team meetings