Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Culture change in the NHS - Applying the Lessons of the Francis Inquiries

Item 16j

Governing Body meeting

2 April 2015

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Is your report for Approval / Consideration / Noting

For noting.

The paper sets out the actions taken nationally since the Francis Public Inquiry report in 2013 to improve quality and safety of NHS care.

Are there any Resource Implications (including Financial, Staffing etc)?

No

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
2. To improve the quality and equality of healthcare in Sheffield

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No

PPE Activity

How does your paper support involving patients, carers and the public?
The national improvements support more patient involvement and better patient experience.

Recommendations

The Governing Body is asked to note this paper

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1. Background

The above report, published by the Department of Health (DH) in February 2015 sets out progress made in applying lessons learned from the Francis Public Inquiry report into Mid Staffordshire Hospital in 2013. It highlights that a significant number of improvements have been achieved, however these must be sustained, embedded for the future and applied equally and rigorously across all sectors of the health system. Each chapter sets out key areas where further action is needed to ensure that safe, effective and compassionate care is the norm. The annex to the report sets out the progress made against the 290 recommendations of the Francis report.

2. Chapter 1 – Preventing problems

2.1 Chapter 1 describes how the health and care system has made a fundamental shift in the way in which it prevents the occurrence and recurrence of poor or unsafe care, through: the creation of a much more open and transparent healthcare system and the launch of a new national drive to improve safety in the NHS.

2.2 The Public Inquiry described how the misalignment of goals, actions and behaviours led to failures of patient safety. In response, the review into patient safety led by Professor Berwick called for the NHS to embrace a culture of learning.

2.3 The Public Inquiry highlighted the failure of the regulatory system to notice or act on the poor standards of care which persisted at Mid Staffordshire. Francis found that the Commission's culture needed to be transformed and significant work has been done to re-establishing the credibility, authority, independence of the Care Quality Commission (CQC) to enable effective action to be taken.

The CQC has a new Chair, a Chief Executive and board. Three independent Chief Inspectors have been appointed, covering hospitals, general practice and adult social care. The organisation's independence has been strengthened in legislation and the inspection model completely overhauled, moving to a thorough approach, informed by experts, patients and staff, and drawing on a rich set of data.

2.4 At the same time, there has been a drive to ensure that the NHS is open and transparent. A new legal duty from November 2014 - the Duty of Candour - will ensure that when something goes wrong, patients and their relatives are told about it promptly and mistakes are learned from. To reinforce this, the NHSLA will work to ensure that there are stronger incentives to financially reward organisations to comply with the Duty of Candour and are consulting on compensation costs for patients for those who don't.

The GMC and the NMC are also introducing consistent responsibilities of individual health professionals to ensure that action can be taken when they are not candid about errors. This is being reinforced through the introduction of the role of the 'responsible clinician' and already two thirds of Trusts are now participating in the 'Name Above the Bed initiative'.

In relation to whistleblowing, the Secretary of State commissioned Sir Francis QC to conduct an independent review on how this could be achieved. The outcome of the independent review was published on the 11 February 2015. There needs to be a more strengthened voice of 'whistle-blowers' and the NHS has yet to turn the cultural corner.

2.5 The introduction of the 'MyNHS' website will increase transparency of the NHS. It allows comparison between organisations on measures that matter to patients, including outcomes of individual surgical consultants, with plans to extend this to other specialities. In July 2014 NICE guidelines were published on nursing staff requirements for patients on adult inpatient wards in acute hospitals and the NHS Choices website now provides ward-level nurse staffing data on a monthly basis for every hospital in England.

2.6 Although levels of avoidable harm are still too high, more than 94 per cent of patients receive harm-free care. To increase this further, the Sign up to Safety campaign has been introduced in which organisations and individuals work to halve avoidable harm by 2017. More than 200 organisations have signed up already and work is now under way to recruit and connect up to 5,000 safety champions. The campaign is underpinned by 15 new Patient Safety Collaboratives – local networks of hospitals, commissioners and other key stakeholders covering the whole of England. NHS England is also piloting Safety Action for England team (SAFE), with the expertise and flexibility to support organisations that are struggling to address critical safety issues.

2.7 A new emphasis will be placed on tackling sepsis and plans include having this as a new diagnosis with treatment goals for hospitals to help raise standards.

3. Chapter 2 – Detecting problems quickly

To improve the communication systems for raising and listening to concerns, this chapter sets out the action that has been taken to ensure that complaints about such care are properly heard and learned from, and to ensure that the voice of patients is a strengthened.

3.2 In response to the Clwyd Hart review of complaints the DH and NHSE issued a new feedback and complaints guide for patients. The Parliamentary and Health Service Ombudsmen (PHSO), the Local Government Ombudsman and Healthwatch England have jointly published a new 'vision' or set of expectations which captures what good complaints handling should look like. The CQC is now routinely examining how well organisations handle complaints and those that fall short will have this reflected in their inspection findings.

3.3 The Friends and Family Test has been introduced at ward level to hear directly what patients think. More than five million FFT responses have been collected and 85 per cent of Trusts are using it to improve patient experience and 78 per cent report that it has increased the emphasis placed on patient experience in their Trusts.

3.4 To increase communication between the DOH, the Secretary of State and over 500 DOH staff, has been spending time on the front line of health and social care. This has reinvigorated their values and improved their understanding of local practice.

3.5 The PHSO service has been made more responsive and faster in the way it handles complaints, and will ensure patient and public confidence in its work. In particular, the Government has agreed that a review of NHS complaints advocacy services should be completed by the spring of 2015. The Government also intends to fund local authorities to provide advocacy services.

4. Chapter 3 – Taking action promptly and ensuring robust accountability

This Chapter sets out how the Government has put in place a new system with clear accountability, standards and a fixed timetable.

4.1 The CQC was established as 'the nation's whistle-blower', with the independence and expertise to speak up when services are poor. Failure is now being identified quickly- 19 Trusts have been put into special measures over the past 18 months as a result.

4.2 That process of identifying poor care has been strengthened by setting out the fundamental standards – covering essentials such as cleanliness, eating and drinking and consent. CQC ratings are now also used to make decisions over which NHS Trusts should be given Foundation Trust status.

4.3 The process of recovery from special measures has also been more clearly specified, so that hospitals with complex problems aren't ignored, whilst patients suffer. Already six hospitals have left special measures. Trusts in special measures have employed extra staff and in Trusts subject to regulatory action relating to care, a change may be required to the leadership.

4.4 Where required, new measures allow for stronger sanctions and criminal prosecutions of both individuals and institutions. A new offence of 'Wilful Neglect' will ensure that individuals can be prosecuted and the fundamental standards will allow the CQC to prosecute organisations. A new Fit and Proper Persons Test, enforceable from November 2014, enables the CQC to take action against organisations that employ directors, complicit in poor care.

5. Chapter 4 – Ensuring staff are trained and motivated

5.1 In his Public Inquiry, Francis found the relentless focus on access targets at Mid Staffordshire led to a bullying culture in which patients' welfare took second priority. Ensuring excellent leadership in the NHS has been a key component of the Government's response and in the CQC's new inspection regime 'well led' is one of the five key criteria.

5.2 The NHS Leadership Academy's Executive Fast Track Programme started last June, preparing talent to bolster the top leadership.

5.3. The introduction of the FFT for Staff has been important and shows that 77 per cent would recommend their organisation to friends or family in need of treatment. However a quarter of NHS staff are still demanding improvements to care.

5.4 While the right leaders are critical to shaping culture, the Public Inquiry highlighted the need to ensure that the right people are recruited to the health professions. Health Education England recently published guidance to help to ensure that the education providers take account of the values as well as the A Levels, of the next generation of health professionals.

6. Recommendation

The Governing Body is asked to note this report and the actions taken nationally to improve quality and safety.

Kevin Clifford, Chief Nurse
19 March 2015