FRANCIS INQUIRY: REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY AND ACTION PLAN

Approved by the Trust Board: 30th September 2013

1. CONTEXT

1.1 The Mid Staffordshire NHS Foundation Trust Public Inquiry Public Inquiry chaired by Robert Francis QC (The Francis Inquiry) was published on 6 February 2013.

1.2 The Inquiry was set up under the Inquiries Act 2005 and Inquiry Rules 2006. The Inquiry examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care.

1.3 The February 2013 Inquiry builds on Mr Francis's earlier report, published in 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

1.4 This paper outlines the engagement work that has taken place within our Trust to consider the learning is transferable to the Trust and presents the high level action plan that has been developed, and is in the process of being implemented.

2. FINDINGS OF THE INDEPENDENT INQUIRIES PUBLISHED IN FEBRUARY 2010 AND FEBRUARY 2013

2.1 The initial Inquiry was set up by Right Honourable Andy Burnham MP, Secretary of State for Health in July 2009, primarily to give those most affected by poor care an opportunity to tell their stories and to ensure that the lessons to be learned from those experiences were fully taken into account in the rebuilding of confidence in the Trust. The period reviewed by the Inquiry was principally January 2005 to March 2009 and was published in February 2010.

2.2 The initial Inquiry concluded that the culture of the Mid Staffordshire Trust was not conducive to providing good care for patients or providing a supportive working environment for staff. A number of factors were identified as contributing to this:

- **attitudes of patients and staff** : patients' attitudes were characterised by a reluctance to insist on receiving basic care or medication for fear of upsetting staff.
- **bullying** : an atmosphere of fear of adverse repercussions in relation to a variety of events was described by a number of staff witnesses. Staff described

a forceful style of management (perceived by some as bullying) which was employed on occasion.

- **target-driven priorities :** a high priority was placed on the achievement of targets, and in particular the A&E waiting time target. The pressure to meet this generated a fear, whether justified or not, that failure to meet targets could lead to the sack.
- **disengagement from management :** the consultant body largely dissociated itself from management and often adopted a fatalistic approach to management issues and plans. There was also a lack of trust in management leading to a reluctance to raise concerns.
- **low staff morale** : the constant strain of financial difficulties, staff cuts and difficulties in delivering an acceptable standard of care impacted upon absence and sickness rates in particular areas.
- **isolation :** there was a sense that the Trust and its staff carried on much of its work in isolation from the wider NHS community and lacked strong associations with neighbouring organisations.
- **lack of openness** : before obtaining Foundation Trust status, the Board conducted a significant amount of business in private when it was questionable whether privacy was really required.
- **acceptance of poor standards of conduct** : there was an unwillingness to use governance and disciplinary procedures to tackle poor performance.
- **reliance on external assessments** : The Trust was more willing to rely on favourable external assessments of its performance rather than on internal assessment. On the other hand when unfavourable external information was received, such as concerning mortality statistics, there was an undue acceptance of procedural explanations.
- **denial** : there is an unfortunate tendency for some staff and management to discount the criticism of care by relying on their view that there is much good practice and that the reports are unfair.

2.3 The second Inquiry focussed upon the wider system issues on why failings in care at Trust had not been identified and acted upon sooner, to enable learning for the future of patient care. It examined the commissioning, supervisory and regulatory bodies who were involved in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009.

2.4 There were common themes on why concerns were not identified sooner:

- The Trust was an organisation that lacked insight and awareness of the care being provided to patients
- The responsibilities and accountabilities of external agencies were not well defined, operating in silos, often resulting in regulatory gaps or a failure to follow up warning signs.
- Lack of effective communication across the health care system in sharing information and concerns
- Constant reorganisation of NHS structures, often leading to a loss of corporate memory
- Systemic culture where organisations took assurance from internal or external bodies, with insufficient scrutiny of information.
- Outcomes based performance and risk based intelligence informed regulation were in their infancy.

- There was a failure to place quality of care and patients at the heart of organisations. Finances and targets were often given priority without considering the impact on the quality of care.
- Ineffective engagement with patients and the public, including a lack of priority on complaints and learning lessons.
- A failure to place clinicians and other healthcare professionals at the heart of decision making.

There are 290 recommendations within the report.

3. GAINING THE TRUST LEARNING FROM THE INQUIRIES

3.1 When the initial Independent Inquiry was published in 2010, there was a presentation to the Board on the findings by the Director of Nursing and the Medical Director.

3.2 The findings from the second Inquiry have been considered by the Trust over the past six months with significant staff engagement taking place.

3.3 Initial work

At the end of February and during March 2013, discussions took place within senior clinical and management meetings within the Trust on a summary document which outlined the 290 recommendations and how they may apply to the organisation and where there may be assurance already in place, and where further work is recommended.

3.4 Senior Clinical Event – 22nd April 2013

An event to consider the Francis Inquiry learning for senior clinicians and managers was then held on 22nd April 2013, with over 50 attendees. The group work focussed upon:

- **positive driving forces** that we have in the organisation that enable the Trust to have assurance that colleagues would not let a situation as happened at Mid Staffordshire Hospital to occur here. These included :

  a) Staff commitment – they want to make a difference and go the extra mile
  b) Clinical competence
  c) Support for training and development
  d) Service user and carer involvement
  e) Team leader management and development
  f) Use of professional standards
  g) Use of national evidence based guidelines and approaches
  h) Human Resources processes e.g. Clear job descriptions, person specifications
  i) Specifications of commissioned services
  j) Good financial management
  k) Trust vision, values and purpose.

- the identification of **restraining factors,** as areas as a Trust we need to work on reflecting the learning from the Francis Inquiry:

a) Engagement with colleagues, including communication
b) Pressure of workload on colleagues
c) Environments in which care is provided
d) Standards of care not clearly defined
e) Need to develop further leadership competencies and clarify accountability
f) Systems and processes that are constraints not enablers
g) Complicated decision making processes and a lack of clarity
h) Embedding a culture of compassion
i) Needing more support for change management
j) Role clarity
k) Determining the impact of the care we provide – outcomes

From this event it was agreed, that there should be conversations with staff across the organisation to determine their views on the themes that had emerged and what they thought the key actions were.

3.5 Staff engagement – May & June 2013

During June, 26 engagement events were held, led by the Deputy Director of Nursing, and over 230 staff attended.

There was some positive feedback on:

- The 'Kissing it Better' initiative focussing on direct patient care
- RiO champions and the support from the help desk
- How we manage the learning from the Serious Incident process
- We set ourselves high standards of care
- Mobile working is brilliant for those who have access to it
- Carers champions have been a positive development
- Participation workers in Children & Young Peoples Services in Gloucestershire have made a difference to engagement work
- The staff have some very positive ideas on what we could do differently in the future to improve services.

The staff did express concerns that we .....

- are so concerned with getting everything done in a set format, that there is a risk of losing sight of the patient.
- focus upon the negative and not the positive.
- are not letting teams get on with the job and over manage.
- are never getting on top of what we need to do, and do not have space to manage throughput.
- experience commissioner led service developments, that in the view of staff may not be always aligned with best practice.

There was noted pressure on community services, with concerns about the new configuration of teams and team managers, particularly in Gloucestershire but concerns also noted in Herefordshire in terms of the move from 4 to 3 Recovery teams.

The **key themes** that staff felt that we should work on were:

- Reducing bureaucracy
- Improving effective communication, with consistent messages and closing actions

- Reviewing the targets which are internally set, and more clarity on what specific targets apply to which services
- Improving the documentation required on the patient electronic record
- Improving the processes for managing change

3.6 Wider clinician and manager event – 1st July 2013

This event was attended by over 60 clinicians and managers, and the focus was to hear the staff engagement feedback and to develop specific actions to take forward the areas that staff had advised needed to be worked on. This was a successful approach which led to the development of multiple actions that have been owned by attendees. The specific actions were further considered by Clinical Directors, Locality Directors and Executive Directors on 22nd July 2013.

It was agreed that the monitoring of the agreed actions would be through the new formed Workforce and Organisational Development Committee structure (See Appendix 1) with 4 work streams led by Trust staff:

- Staff Engagement
- Culture
- Workforce Planning
- Training and Development

The work stream representatives have been nominated from clinicians, administration staff and managers from across the organisation.

4. THE TRUST'S FRANCIS ACTION PLAN

4.1 Through the staff engagement work over the past 6 months, the Trust is committed to ensuring that the learning from the Francis Inquiries and associated actions arising for us will make a difference to those who receive our services and the staff who deliver the services.

4.2 There are 4 detailed action plans reflecting the 4 Workforce and Organisational Development work streams. These are dynamic documents, as more feedback is gained, and actions are added and others completed. The action plans have been considered by each of the work stream groups, and they are clear about their role in overseeing the monitoring of progress made with the actions.

4.3 A high level action plan summarising the action areas has been developed and is attached at Appendix 2.

4.4 Follow up

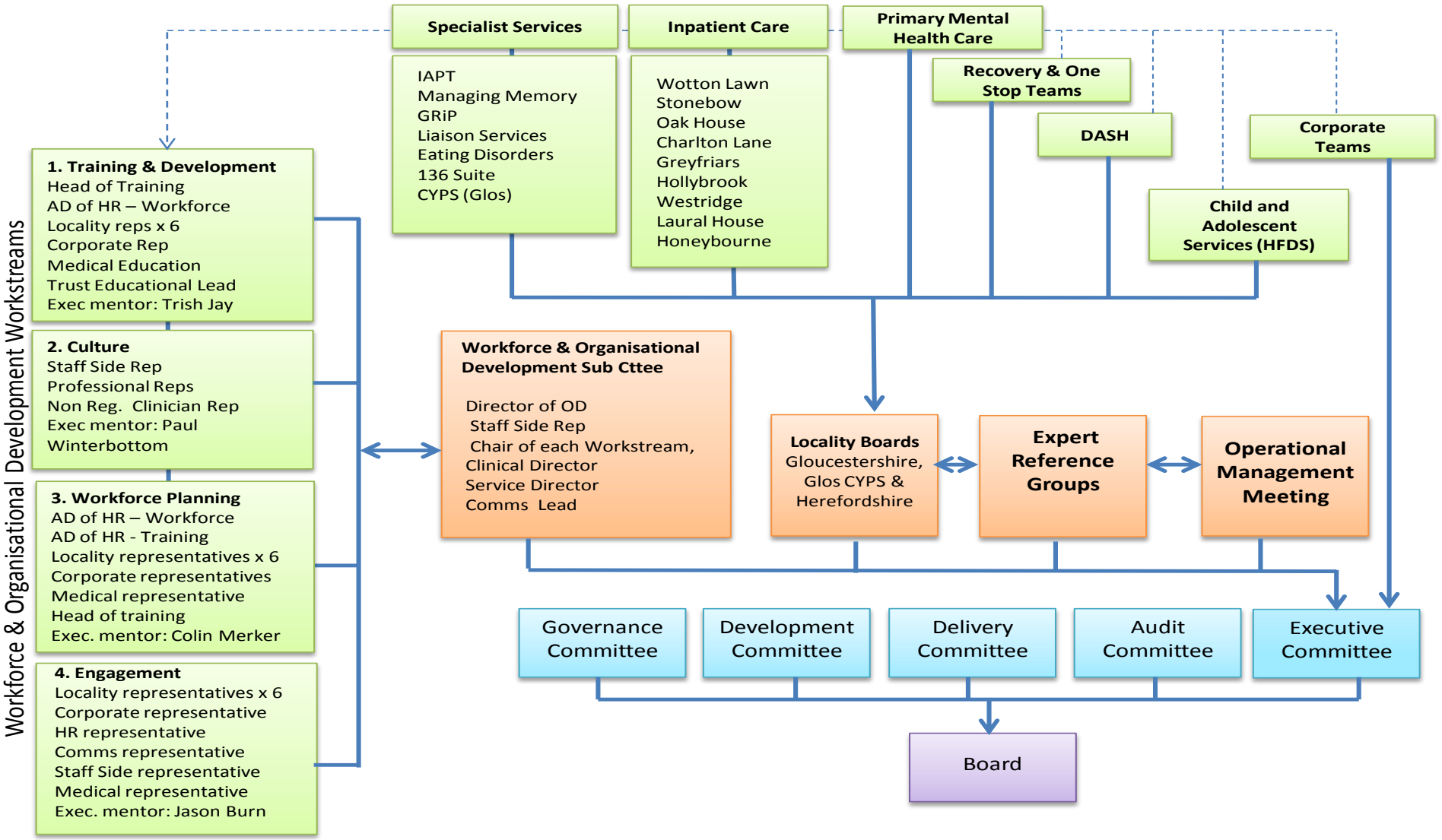
It is essential that gaining the learning from the Francis Inquiries is not seen as a one off event, but feeds into a continuous system of engagement with staff, hearing their further feedback and ideas how we can improve the services we provide and the way we provide them.

The following is planned:

- Monthly further staff engagement events during the year starting in the autumn, jointly facilitated by the Deputy Director of Nursing and Human Resources colleagues
- A follow up Francis event in the autumn for senior managers and clinicians to determine the progress made on the key areas of work
- Regular updates on the progress being made in Team Talk and News in Brief
- Oversight of all the action areas which will be the focus of the individual work streams, through quarterly updates to the Governance Committee.

Appendix 1

Workforce and Organisational Development Committee structure (September 2013)



Appendix 2

High Level Francis Action Plan

	Action:	Responsibility	Timescale
1.	**Staff Engagement –** objective is to improve staff engagement and improved communication at all levels in the organisation		
1.1	Implement the new Workforce and Organisational Development Committee structure	Director of OD	July 2013
1.2	Improve the accessibility and accuracy of information on the intranet for staff	Deputy Director of Commerce	December 2013
1.3	Improve the visibility of Board members in services	Chief Executive	September 2013
1.4	Create an online mechanism for staff to ask questions and suggest ideas	Deputy Director of Commerce	December 2013
1.5	Develop Team Talk and News in Brief on the basis of staff feedback, including updates on closing projects and initiatives	Chief Executive	September 2013
1.6	Run staff engagement events to determine impact of changes being implemented as part of this action plan	Deputy Director of Nursing/HR	November 2013
1.7	As part of change management processes, routinely test with staff (through Plan, Do, Study, Act) cycles, change before it is implemented. Build this into the Programme Management approach to projects	Executive Team	Ongoing
1.8	Outline the responsibility of team managers, matrons, community services manager and clinical directors in relation to the review of performance data and taking actions	Director of Service Delivery/Medical Director	October 2013
1.9	Outline for each team the key connections they need, and for them to regularly be updated on pathway issues	Team Leaders	November 2013
2.	**Culture –** objective is to review aspects of the culture of the organisation to determine improvements which can have a positive effect on patients and staff, including the reduction of unnecessary bureaucracy		
2.1	Review the Care Programme Approach and Risk Management policies to ensure appropriate and proportionate recording of information	Head of Quality Development and Assurance	December 2013
2.2	Review the Clinical Audit Programme for 2014/15 to reduce duplication of data collection and have a more integrated approach	Head of Quality Development and Assurance	December 2013

	Action:	Responsibility	Timescale
2.3	Review how targets are communicated to clinical teams, and whether there should be internal targets as well as the national and contractual ones	Director of Service Delivery	December 2013
2.4	Review the methodology for determining clinical efficiency rather than the use of contacts – build on the developing 'outcomes' work.	Director of Quality	March 2014
2.5	Develop a programme of work colleague shadowing	Director of OD	March 2014
2.6	Build on the work of the Service User and Carer charters, to outline the values and behaviours expected in the workplace	Director of OD	March 2014
2.7	Develop a values based interview for all recruitment of staff so that we could be reassured that we were appointing people appropriate to deliver the care	Director of OD	March 2014
2.8	Develop mechanisms to measure culture and behaviours	Director of OD	March 2014
2.9	Review the role of Super Cluster Boards – change to Expert Reference Groups	Medical Director	September 2013
2.10	Delegation of decision making within parameters – all Executive Directors to provide examples of this over the next six months	Executive Directors	November 2013
2.11	Develop the skills of staff in improvement methodologies so that they can make the small scale changes themselves.	Assistant Director of Clinical Development	March 2013
2.12	Share the development of practice through Positive Practice sharing	Deputy Director of Nursing	Ongoing
2.13	All Executive Directors to provide examples of where previous work has stopped to make time for new initiatives,	Executive Directors	December 2013
2.14	All teams to have one session of team building time each year	Director of Service Delivery	March 2014
3.	**Workforce Planning –** objective is to review workforce 'productivity' and support the development of the workforce to meet service requirements		
3.1	Review staff work plans in relation to management of workload	Assistant Chief Operating Officer	December 2013
3.2	Review the implications of the administration review on the delivery of clinical services	Locality Admin Managers	December 2013
3.3	Review the configuration of team managers in both counties	Locality Directors – Gloucestershire/ Herefordshire	December 2013
3.4	Develop the support and communication for the use of RiO (electronic patient record), through the further use of champions, approach to developments and communication	Head of Clinical Systems	December 2013

	Action:	Responsibility	Timescale
3.5	Review the time required and most effective mechanism for entry onto the patients electronic record, and protected time for this	Director of Service Delivery 2013	December 2013
3.6	Develop further mobile working for clinicians	Director of Finance	December 2013
3.7	Streamline recruitment processes to ensure timely recruitment	Director of OD	September 2013
4.	**Training and Development** - objective is to ensure training and development to meet staff and service needs		
4.1	Develop action learning sets of colleagues across the Trust to problem solve	Assistant Director of Clinical Development	December 2013
4.2	Review the elearning portal to improve use	Head of Training	March 2014
4.3	Review statutory and mandatory training profiles for appropriateness and accuracy in recording	Head of Training	March 2014
4.4	Review Health Care Assistant training in line with new national competencies	Deputy Director of Nursing	November 2013
4.5	Implement a comprehensive programme of leadership training for clinicians and managers	Head of Training	December 2013
4.6	Review staff training courses completed and how their competencies are used in practice	Head of Training/ Deputy Director of Nursing	March 2014
4.7	Pull together a management tool kit for all undertaking a management role, with specific standards	Locality Directors	March 2014
4.8	Arrange specific sessions for team managers to determine what actions/solutions would enable them to undertake their roles more effectively.	Locality Directors	October 2013