HEALTH & WELLBEING SCRUTINY COMMITTEE

9th June 2010

MID STAFFORDSHIRE NHS HOSPITALS FOUNDATION TRUST – FRANCIS REPORT

REPORT OF CITY HOSPITALS NHS FOUNDATION TRUST

Strategic Priority : Healthy City, ClO1, C104

1. Purpose of the Report

1.1 This paper provides a brief resume into the findings of the Francis Report published in February 2010 regarding the failings of the Mid Staffordshire NHS Foundation Trust; the action and governance arrangements undertaken at City Hospitals Sunderland to ensure the Trust learns from the report.

2. Background

2.1 The Francis Report (2010) reviewed the failings of the Mid Staffordshire NHS Foundation Trust between 2005 – 2009. The report took the approach of reviewing the patient experience and heard detailed accounts of a number of specific areas of concern including:

- Continence – bowel & bladder care
- Patient Safety
- Personal and oral hygiene
- Nutrition and hydration
- Pressure area care
- Cleanliness and infection control
- Privacy and dignity
- Record keeping
- Diagnosis and treatment
- Communication
- Discharge Management

2.2 In total 18 recommendations have been made by the Francis Report for action by the Mid Staffs Trust. The recommendations focus on:

- Always putting patients first;
- Operating to the requirements of the Health Care Act (2009);
- Having partnership arrangements with other NHS organisations/HEI's to ensure high class service, training and leadership;
- Clinical audit processes;

- Complaints/incident reporting to ensure lessons are learnt and acted upon;
- Clinical supervision for doctors and nurses;
- Support for staff expressing concern over standards of care;
- Arrangements for the appointments, training, support and accountability of Executive and Non-Executive Director's positions;
- Leadership and management of nursing and standards of nursing practice;
- Clinical staff views being fully represented at all levels in the Trust in matters of standards and safety of care;
- Using standards and safety of care;
- Rebuilding confidence in the hospital.

2.3 The initial report into the standards of care at Mid Staffs was published by the Health Care Commission in March 2009. As a consequence the Board of Directors of City Hospitals Sunderland asked the Medical Director and Director of Nursing to undertake a review to give the Board assurance.

2.4 A subsequent action plan was developed which addresses any of the recommendations applicable to all organisations from the Francis Report.

2.5 The Trust's Clinical Governance Steering Group (a sub committee of the Board) which includes lay representation is monitoring progress of any actions.

3. What action is City Hospitals taking to prevent a similar situation occurring in Sunderland?

3.1 The Trust is a member of the NHS Litigation Authority (NHSLA) Risk Management Standards scheme for Acute Trusts. This requires the Trust to work to a series of standards covering the themes of:

- Governance;
- Competent and Capable Workforce;
- Safe Environment;
- Clinical Care; and
- Learning from Experience.

3.2 The NHSLA require the organisation to have robust risk management, policies and processes in place for both clinical and non-clinical activity. The Trust places significant emphasis on staff being able to report any incidents or concerns regarding patient or staff safety, including standards of care.

3.3 Working to a stratified system of risk the incidents submitted as or major/catastrophic significance are investigated using a system of Root

Cause Analysis (NPSA, 2007). The findings from the investigations are shared with the clinical teams, with action plans for improvement developed as necessary. All of the incidents in this category are discussed at the Clinical Governance Steering Group; the report is also a standing agenda item at the Trust Corporate Governance Committee and is also discussed by the Board of Directors.

3.4 The Chief Executive, Medical Director and Head of Patient Safety (a senior nurse in the Trust) review the findings of all Root Cause Analysis investigations with the clinical teams. The outcomes of these discussions are also shared with the Clinical Governance Steering Group.

3.5 In November 2009 the Chief Nursing Officer for England launched the "High Impact Actions for Nursing and Midwifery" to achieve improvements in patient care. Each action sets out the scale of the challenge and the potential opportunity in terms of improvements to quality and patient experience for the NHS.

3.6 The actions are as follows:

- Your skin matters – no avoidable pressure ulcers in NHS provided care;
- Staying safe – preventing falls;
- Keeping nourished – stop inappropriate weight loss and dehydration in NHS provided care;
- Promoting normal birth – eliminating unnecessary caesarean sections;
- Avoiding inappropriate admissions to hospital and increasing the numbers of people who are able to die in the place of their choice;
- Reducing sickness absence in the nursing and midwifery workforce to no more than 3%;
- Increase the number of patients in NHS provided care who have their discharge managed and led by a nurse or midwife where appropriate; and
- Protection from infection – reducing the rate of urinary tract infection for patients.

3.7 The Nursing and Midwifery Strategic Forum of the Trust are leading the implementation of this work across the Trust to facilitate continuous improvement in patient care.

3.8 A Trust Conference is being held in June to discuss and share good practice about the Essence of Patient Care, which is an opportunity for staff to showcase developments and learn from one another.

3.9 The Trust has an established system of listening to patients and has developed this further by offering patients the opportunity to complete a questionnaire into their recent hospital experience. The results of the

patient questionnaire are provided to the Clinical Governance Steering Group for information.

3.10 The Trust has an established system of listening to patients and has developed this further by developing a real time patient feedback questionnaire. This will be launched in June 2010 whereby volunteers and members of the Board of Governors will facilitate completion of the questionnaire by patients and their families and carers.

3.11 Results from the questionnaires will be shared with the Board of Governors and Board of Directors and associated action plans developed to address any areas of concern.

3.12 The Trust also participates in the national inpatient and outpatients surveys undertaken by the Care Quality Commission. Results are shared with both the Board of Directors and the Board of Governors.

4. Mortality Rates

4.1 The Trust participates in the CHKS Signpost report, an independent review, which benchmark organisations against peers to assist the organisation to manage clinical risk and mortality. The report published in January 2010 has identified that the Trust's mortality rate was lower than the peer groups at 1.56% compared with 1.75%. Comparison of actual deaths to the number of expected deaths using the CHKS risk adjustment methodology showed a lower than predicted number of deaths for the Trust overall.

4.2 A member of the Clinical Governance Department has been identified to interrogate the data provided by CHKS and work with clinicians to review case notes and clinical practice to promote continuous improvement.

4.3 The CHKS signpost report is also shared with the Board of Directors and the Board of Governors.

4.4 City Hospitals Sunderland has recently commenced the *Leading improvements in Patient Safety* programme, organised by the NHS Institute for Innovation and Improvement. The team from the Trust consists of a Consultant Anaesthetist; Clinical Governance Manager and Head of Patient Safety, who are all experienced clinical staff. The initial focus of the programme is a series of patient case note reviews to assess patient safety, identify hotspots and develop action plans to make further improvements with the standards of care.

5. Summary

5.1 The Trust is using the recommendations from the Francis Report to review policy, practice and operational issues across the organisation.

The report has been discussed in detail with the Board of Directors, clinical teams, the Clinical Directors and Senior Management Forum.

5.2 Staff agree that as an organisation we have an individual and organisational responsibility and are accountable for the standards of patient care we deliver.

5.3 It is important that the Trust learns lessons from the Mid Staffs report and members should have assurance that there are robust systems of governance in place within the organisation to not only highlight areas of concern but also to ensure remedial action is implemented.

6. Recommendations

6.1 That Members note the report.

References

City Hospitals Sunderland NHS Foundation Trust (2008)
Excellence in Health – Putting People First Vision 2011

Francis Report (2010)
www.midstaffinquiry.com

NHS Institute for Innovation and Improvement (2009)
High Impact Actions for Nursing and Midwifery
National Patient Safety Agency (2007)
Healthcare risk assessment made easy
www.npsa.nhs.uk

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April 2010.