Oxford University Hospitals NHS
NHS Trust

Title	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 – a briefing for a meeting of Oxfordshire Health Overview and Scrutiny Committee to be held on 5th September 2013
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Executive Summary

1. This paper provides a briefing to Oxfordshire HOSC on work being undertaken within Oxford University Hospitals NHS Trust (OUH) following the 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 system of internal peer review for quality assurance and improvement purposes.

3. 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. Recognising the time and commitment that will be necessary to ensure that these projects are delivered successfully and sustained, relevant leaders and departments within the organisation will be encouraged to adopt projects relevant to their area in forthcoming work plans.

4. Enhanced systems are being put in place to facilitate the real time monitoring and reporting of staffing levels against the number, acuity and dependency of patients admitted to the Trust's hospitals.

5. The immediate establishment of a programme of work of internal peer review and inspection of clinical services is envisaged to strengthen the Trust's assurance of clinical quality.

6. The input of Oxfordshire HOSC and other stakeholders would be welcomed by the Trust as we respond to these major NHS reports.

National Background

1. The report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Chair – Robert Francis QC) was published on 6th February 2013 - *'Francis 2'*. The report made 290 varied and far-reaching recommendations.

2. The Keogh Reviews were published on 16th 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 publication of *Francis 2* (paragraph 15).

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. The key difference between these reviews and others is the transparency of the process and engagement of different groups in the agreeing the outcomes.

4. Ambition 4 of the Keogh review is for improvement in CQC inspections drawing on the experience of the Keogh review process. The report specifically suggests that trusts might use the methodology of the reviews to assess and improve their own clinical quality.

5. The Berwick Report, itself a governmental response to *Francis 2*, was published on 6th 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.

Relevant actions taken within the Trust before and following publication of Francis 2

6. Several highly relevant pieces of work have been underway within the Trust over the last three years pre-dating the publication of Francis 2. These include: articulation of organisational values; a programme of work around *Delivering Compassionate Excellence*; and, the development of the Quality Strategy.

7. The Trust's Clinical Governance Committee received a presentation and discussed the *Francis 2* report at its meeting on 20 February 2013.

8. A series of open staff briefings were arranged in February and early March. Approximately 750 members of staff attended the briefings. Staff members made thoughtful and well considered contributions in the discussions that followed.

9. There was consistency in the issues highlighted by staff in the briefings. Issues raised could be divided into the following eight broad categories:

- Feedback – gathering and using information at service level
- Training – profile and priority
- Financial constraints
- Leadership and empowerment
- Nursing – changes in shift patterns
- Staff – numbers and skill mix
- Staff – valuing contribution
- Staff – agents for change.

Governmental Response to Francis

10. The Government published its initial response to the report on 26th March 2013. A full response in anticipated in due course. The Government accepted *'the essence of the Inquiry's Recommendations'*. The initial response was divided into 5 areas:

    - Preventing problems arising by putting the needs of patients first
    - Detecting problems early
    - Taking prompt action
    - Ensuring robust accountability
    - Leadership and motivation of NHS staff

11. The Government's response inevitably focused upon structural and system wide changes. The key challenge for the Trust is to make further progress in achieving and maintaining a culture in which the focus on quality and patient experience is primary and pervasive.

Key Priorities and opportunities at OUH in light of Francis 2

12. At its meetings in March and May 2013 the Board considered its response to *Francis 2*. It 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

13. In addition to these priorities the 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.

14. A small working group met to further consider the Francis report, the Government's initial

response and staff feedback from the briefings 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 group has identified 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 at OUH. Recognising the time and commitment that will be necessary to ensure that these projects are delivered successfully and sustained, relevant leaders and departments within the organisation will be encouraged to consider adopting new projects relevant to their area as part of their 2014/15 work plans.

15. The projects and interventions are divided into six broad domains of work that sit within the context of the Trust values (see figure 1 overleaf). Existing work streams have been mapped to these six domains. The further work proposed following *Francis 2* 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

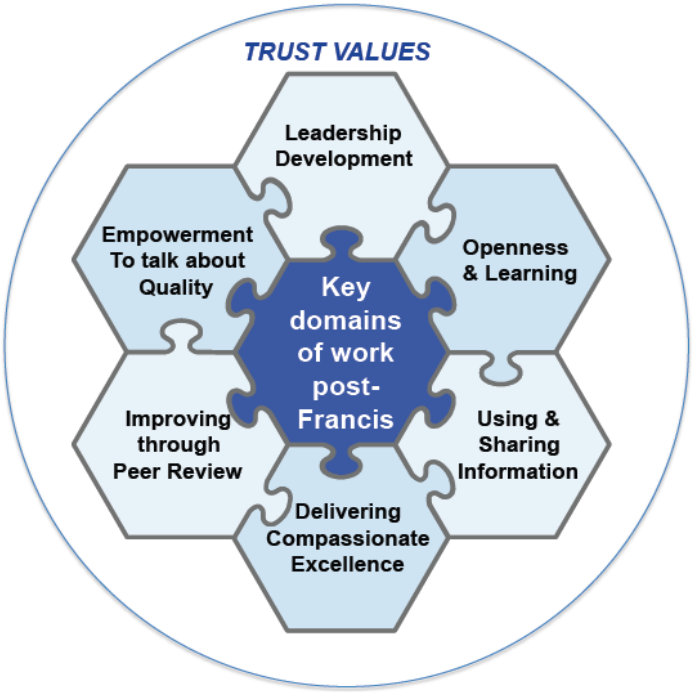
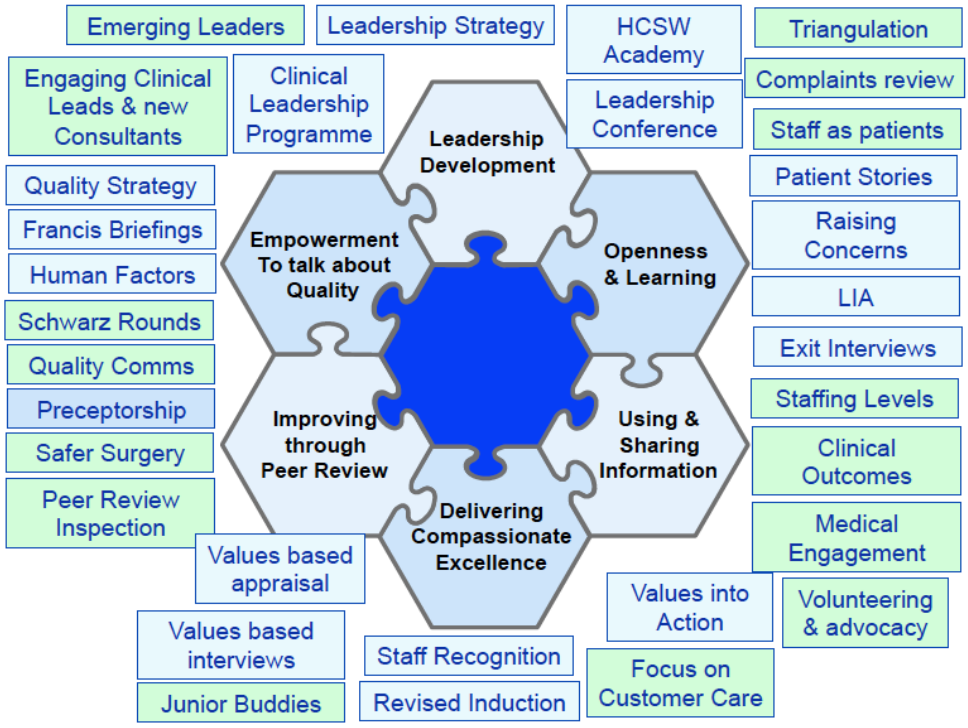


Figure 2
***Existing* work streams [blue boxes] pertinent to Francis and *proposed* projects and interventions [green boxes] (mapped to the six domains)**



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

17. In the light of the Keogh Reviews, to strengthen the Trust's assurance systems it is proposed that work on establishing an internal peer review process should be expedited.

18. The projects and interventions are set out under these six domains in Appendix 1. A comment is provided as to whether these projects represent an extension to existing pieces of work, or constitute a proposal for new work going forward into 2014/15.

19. The Trust's Management Executive is scheduled to discuss the content of this paper at its meeting on 22nd August 2013. There will then be further opportunity for consultation with staff and review at Board level. OUH will be able to update HOSC on the conclusions drawn by Trust Management Executive at the meeting on 5th September.

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22nd August 2013

Appendix 1: 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*	NEW PROPOSAL
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*	EXISTING
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