Item 2

Warwickshire Shadow Health and Wellbeing Board

19 March 2013

George Eliot Hospital – Initial Response to the Francis Report

1.0 Introduction

1.1 Care at Mid Staffordshire NHS Foundation Trust between 2005- 2008 has been the subject of a previous inquiry which aimed to give a voice to those who had suffered as a result of poor care and consider how this had occurred. This second Inquiry focussed on the involvement of the wider health system- commissioning, supervisory and regulatory authorities- their actions and roles, and identify lessons that could be learnt to ensure failing and potentially failing hospitals or their services are identified as soon as is practicable.

1.2 Robert Francis QC delivered his report, with a very clear message that improvement should be driven by cultural change by putting patients first.

2.0 Key Recommendations from the report

2.1 The report emphasises the need to avoid further structural change and does not seek to scapegoat individuals. It makes a total of 290 recommendations along the following four themes.

2.2 A structure of fundamental standards and measures of compliance:

- A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue.
- These standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, with which healthcare providers must comply.
- Non compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk.
- To cause death or serious harm to a patient by non-compliance without reasonable excuse of the fundamental standards should be a criminal offence.
- Standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations.

- These fundamental standards should be policed by the Care Quality Commission (CQC)

2.3 Openness, transparency and candour throughout the system underpinned by statute. Including:

- A statutory duty to be truthful to patients where harm has been caused; The obligations embraced in the duty of candour as set out at Recommendation 181 include:
    - Full disclosure of the circumstances and provision of support where a patient is injured by the organisation.
    - Full and truthful answers to any reasonable question by a patient.
    - A requirement to disclose knowledge of unacceptable practice within the provider organisation.
- Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient
- Trusts have to be open and honest in their quality accounts describing their faults as well as their successes
- The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence
- It should be a criminal offence for the directors of Trusts to give deliberately misleading information to the public and the regulators
- The CQC should be responsible for policing these obligations

2.4 Improved support for compassionate, caring and committed nursing

- Entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients
- Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard
- Nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level
- Healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so.

2.5 Stronger healthcare leadership

- The establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct
- It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts
- A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations.

2.6 A number of these recommendations require actions from a number of other organisations, including the Government, to make necessary changes to process, structures and statute as appropriate. These changes will take time to implement.

2.7 In the interim the George Eliot Hospital Trust Directors have commenced a review of the recommendations to identify which areas could be implemented ahead of those requiring external input.

3.0 Actions

3.1 It is envisaged that these recommendations will cut across all areas of the Trusts work and therefore the engagement of all Trust staff is imperative to success.
Immediate actions undertaken to date:

- All Directors have reviewed the report and its recommendations
- Meeting held Tuesday 12 February focussed on the report and its recommendations. Led by CEO, with invites extended to Directors, Associate Medical Directors, General Managers and Heads of Nursing.
- Agreed co-ordination of GEH response by Associate Director of Governance & Transition.
- Programme of staff communications delivered pre and post report publication via email and team brief. A continuing staff communication and engagement plan in development.
- Additional risk of Non- delivery of the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry added to the Board Assurance Framework.
- Proposal for unannounced attendance by CEO and other Directors at key governance and risk meetings to increase transparency and openness within the organisation and assure Directors that robust governance processes are embedded in the organisation.
- Board away day planned to review recommendations and actions in detail.

3.2 The development of full and detailed action plan is now underway. Progress, implementation and timescales will be reported via the Board and Quality Assurance Committee on a monthly basis.

4.0 Review into the Quality of Care and treatment provided by 14 Hospital Trusts in England

4.1 The Trust has received confirmation from the Department of Health that it is one of 14 Trust's across the country that will be subject to a review of mortality rates. This review will be led by Department of Health medical director, Professor Sir Bruce Keogh.

4.2 Although the George Eliot has made significant reductions in mortality rates over the last couple of years, the Trust has been selected because of historically high mortality rates.

4.3 The Trust is working closely with stakeholders in preparation for this review that will take place before the summer.

4.4 The Trust very much welcomes this opportunity to demonstrate improvements and progress made at the George Eliot to the mortality rates to both Professor Keogh's team and the wider public. This review will also provide an opportunity to identify any further improvements that can be made and take on board best practice in order to reduce our mortality rate further.

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CHIEF EXECUTIVE