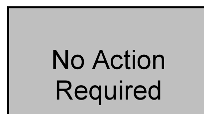
Lewisham Healthcare NHS
NHS Trust

Gap Analysis of Lewisham Healthcare NHS Trust – Mid Staffordshire NHS Foundation Trust Public Inquiry recommendations

Title of Review	**Gap Analysis of Lewisham Healthcare NHS Trust – Mid Staffordshire NHS Foundation Trust Public Inquiry recommendations**		
Date/s of Review	19th September 2013		
Lead Person			
Lead Committee	Integrated Governance and Trust Board		
Format of review (ie: written evidence / site visit, etc)	Review and gap analysis of Francis Report Recommendations undertaken by Trust Wide Francis Working Group		
Summary of conclusion of report			
Is the full report appended?	**YES**	**If NO – where may the full report be accessed?**	

Key:



Gap Analysis

Rec. no.	Theme	Recommendation	Gap Analysis	Trust Lead	Progress	Completion Date
	ORGANISATION / TRUST BOARD					
	Accountability for implementation of the recommendations **These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.**					
1	**Implementing the recommendations**	• All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of the report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;	Trust Board to receive completed Gap Analysis and proposed action plan from the Working Group and agree work programme to implement actions		Trust Wide working group established in April 2013 and meets Monthly. Group is composed of representatives from a cross section of staff. The group has agreed Terms of Reference and has assigned Leads to each applicable recommendation whose responsibility is to undertake the gap analysis, propose action plans and to lead the implementation of the action plans. The Integrated Governance Committee will receive reports from the working group. The Trust Board will need to publish an annual report on its progress.	February 2014

		• In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;				
2		• A common set of core values and standards shared throughout the system; • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; • A system which recognises and applies the values of transparency, honesty and candour; • Freely available, useful, reliable and full information on attainment of the values and standards; • A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.	The Trust has agreed its Corporate Objectives which includes the establishment of a leadership platform with strong clinical leadership. The proposed Leadership structure has been developed and will be implemented through the Integration programme for merging with Queen Elizabeth Hospital. A work programme for Organisational Development and the creation and fostering of a new organisational culture has been agreed and work is about to commence – lead by the Associate Director of Head of Workforce & Education. This will need to include all		An Organisational Development (OD) Consultancy, Loop2 has been commissioned by the Trust to assist in the production of an OD strategy and associated implementation plan, A Board awayday was held mid June aimed at • confirming the vision, mission and values of the new organisation; clarify the characteristics of the performance culture sought; consider the scale and scope of the change agenda o deliver the vision including the implications for the board and other senior leaders; • Review the scope of the change agenda to deliver the new performance	Completed Completed

			groups of staff.		culture and how OD can support the transition process • Identify what OD interventions the board wants to see and progress with the executive. An audit of organisational culture at LHT and QE is programmed to take place June – August; A diagonal slice of staff from LHT and QE have been invited to participate in group events. In addition Individual meetings with senior staff, external stakeholders and an environmental assessment will be included within the audit. An outcome report will be produced for board, including recommendations for future culture measurement, A report detailing the results of the culture audit has been produced, The Organisational Development Strategy and implementation plan has also been produced. Both documents have been approved by the October Trust board. The implementation plan content and timeline were indicative and will therefore require amendments.	Completed Completed

					A series of all staff values and behaviours workshops are being planned to run from November 2013. A 'day one' information pack for all staff which also contains the values and behaviours has been produced; Appraisal process will be amended to incorporate individual assessment against the Trust Values and behaviours. The revised process is expected to be available to all staff in April 2014. The culture audit will be undertaken again in 1 year Additional questions are being added to the 2013 National Staff Survey specific to integration and understanding of Trust vision	In Progress Completed In Progress Not started In progress
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.					

	Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
173	**Chapter 22**	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	The Trust will need to include an additional clause within the contracts of employment, following consideration of what impact it may have on staff and what staff will need to execute this duty.		Initial scoping has indicated that the Trust will need to • Ensure that reference to the NHS Constitution is included within all employment contracts • Employment contracts, in general, are also to be reviewed as part of this process. • Explore the Introduction of value based questions at the recruitment stage • Explore the Introduction of the fit and proper test in senior contracts	October 2013
174	**Chapter 22**	Candour about harm where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed	The Trust has received a proposal for this implementation from the CCG and is undertaking a review of the proposals on implementation.		Review of the Being Open policy – it will be reviewed in consultation with the 3 clinical Being Open leads in the Trust to ensure it complies with the recommendations of the	October 2013 Revised

		of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	A review of how and what skills and support staff will need to execute this duty will be required.		Francis Report. The Incident Reporting Policy and SI policy will also be reviewed to ensure Being Open process would be achieved by their operation. An update - Being Open section is on the IR forms and we will start to run extractions soon to see how many have managers reports on the moderate / severe/ death incidents where there is evidence of a Being Open process. The Being Open policy already has a letter template in the back for sending to patients / relatives when a SI occurs..... the template for documenting a BO discussion is on Nuxeo. We are adding a column to our SI spreadsheet to collect info on whether a BO letter has been sent / patient / family contacted to let them know an investigation is happening (this is also recorded within the SI report itself).	Date – December 2013 (as result of new organisations
179	**Restrictive contractual clauses**	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar	The Trust will be required to review its policies.		Gagging clauses tended to be compromise agreements – this has been reviewed via Capsticks and is no longer the practice	Completed/ Compliant

		as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care				
180	**Candour about incidents**	Candour about incident Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	As per recommendation 174. All Policies related to Risk Management and Incident Management will be reviewed in line with Being Open and CCG Guidance		See reference 174	October 2013
181	**Enforcement of the duty Statutory duties of candour in relation to harm to patients**	A statutory obligation should be imposed to observe a duty of candour: • On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonablymay request; • On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to theiremployer as soon as is	The Trust has received CCG guidance and is reviewing this guidance at present. The Trust does have a Whistleblowing Policy which will need to be reviewed and include processes for raising concerns.		The Whistleblowing policy will be reviewed to comply with current best practice and employment law legislation Marketing of this revised policy to be explored	In Progress

		reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.				
182	**Statutory duty of openness and transparency**	There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.	The Trust Board will need to consider this recommendation and decide whether or not to support this recommendation			
183	**Criminal Liability**	**It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation:** • Knowingly to obstruct another in the performance of these statutory duties; • To provide information to a patient or nearest relative intending to mislead them about such an incident; • Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are	The Trust Board will need to consider this recommendation and decide whether or not to support this recommendation			

		likely to rely on the statement in the performance of their duties.				
	Putting the patient first **The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.**					
7		All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients. The Trust is agreed that the overriding value should be to ensure that our patients take priority. Our own Trust values has as the first value putting our patients first, we will continue to review and embed our values based behaviours framework with all staff and we will ensure that all of our staff will be fully aware and understand their responsibilities as part of the new updated NHS Constitution. We will review and update		See 173	

			where appropriate our recruitment process and contracts of employment and any staff employed by us as a contractor will be expected to abide by the same requirements.			
8	Chapter 21	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	We will review and update where appropriate our recruitment processand contracts of employment and any staff employed by us as a contractor will be expected to abide by the same requirements.		To work with the procurement team to review current terms.	TBA
	Fundamental standards of behaviour **Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.**					
11		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and	The Trust does have agreed and set standards and procedures in all areas of clinical practice and non-clinical practice. The Trust assesses its compliance with all NICE clinical guidance and has agreed professional and regulation standards. Performance of staff is assessed using the Annual Performance Review process.			Completed/ Compliant

		pathways as possible.	The Trust also has an employee support system to support staff who are undergoing performance management.			
12	Chapter 2	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	Need to review Incident Reporting and management process and include proposals for staff feedback.		Incident and Serious Incident policy will be reviewed to ensure this is included.	In Progress November 2013
	A common culture made real throughout the system – an integrated hierarchy of standards of service **No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable**					
13	Nature of Standards	• Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; • Enhanced quality standards – such standards could set requirements higher than the	We support this recommendation and have in place a comprehensive programme of the development of standards, protocols and audit programmes, we encourage all clinical staff to get involved. We are currently reviewing our assurance model which monitors compliance with these standards. We support the development of a very clear, comprehensive set		This work is currently part of the integration workstream for the merger with Queen Elizabeth Hospital and will need to be completed by September 2013 November 2013 update: All Quality, Safety and Clinical Effectiveness	In progress – deadline December 2013

		fundamental standards but be discretionary matters for commissioning and subject to availability of resources; • Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification.	of fundamental standards that apply consistently across the NHS.		Standards are currently being reviewed across the organisation and compliance against the standards assessed. It is aimed to achieve a Trust-wide compliance assessment in December 2013.	
14		In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publication of accurate information about compliance with the fundamental and enhanced standards	The Trust is currently reviewing its governance system for the newly proposed organisation. The Trust does have a system for monitoring its compliance with essential standards which is reported to the board and will review the process and provision of information for supporting compliance monitoring. The Trust has recently achieved NHSLA level 2, which has demonstrated compliance with the risk management standards. Maternity have recently achieved CNST level 2.		This work is currently part of the integration workstream for the merger with Queen Elizabeth Hospital and will need to be completed by September 2013	September 2013 Completed

15		All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect.	The Trust is currently undertaking a review of its Board Governance Assurance Framework and Quality Governance Framework for the new organisation which will provide a comprehensive framework for Governance standards.		This work is currently underway through the Deloitte Quality Review. November update: The Trust Governance and Divisional Governance Structures have been completed. Implementation of the Divisional Governance Structures and meetings underway.	Structure completed. Implementation in progress – deadline December 2013
	Responsibility for, and effectiveness of, healthcare standards					
19		There should be a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.	Recommendation to to Trust Board to consider supporting this recommendation			
22	Responsibility for regulating and monitoring compliance	The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on	Recommendation to Trust Board to consider supporting this recommendation			

		readily observable behaviour.				
23	Chapter 21	The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.	The role of NICE in development of standards and measures of clinical outcomes is supported. However, in relation to suitability of competence of staff and culture of organisations. Evidence based tools for establishing service requirements for staff number & skills mix is underway with Royal Colleges, research and development units and this needs to be a joint programme of work. The Trust is working with an external programme Mckinsey Improvement Programme on staffing within Nursing and Midwifery. But the recommendation is supported.			
	ORGANISATIONAL GOVERNANCE					
	Information					

244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	All information governance and health records management policies are currently under review and being updated in preparation for the merger with Queen Elizabeth Hospital.		Currently in progress and due for completion by September 2013 All new policies approved and ratified for new organisation. The Information Governance department has developed new training materials for Staff Induction	Completed 2013
245	**Board Accountability**	Each provider organisation should have a board level member with responsibility for information	The Trust has a Board level member with responsibility for information.			Completed/ Compliant

247	**Accountability for quality accounts**	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	The Trust is fully compliant with this recommendation.			Completed/ Compliant
249		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration	The Trust is fully compliant with this recommendation.			Completed/ Compliant
253	**Access to quality and risk profile**	The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.	The Quality Risk Profile needs to be significantly simplified by CQC if it is published in public domain. It also needs to reflect relevant time periods for which the publication is reflecting. Data published is frequently > 2years old. Recommendation to Trust Board to consider supporting this recommendation			
256	**Follow up of patients**	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	The DH has already required Trusts to implement the Friends and Family Test (FFT) which must be offered to all patients at the point of discharge or within		Completed	Completed/ Compliant

			48 hours of discharge. The Trust has fully implemented the FFT in accordance with DH guidance and is reporting the results on a monthly basis internally and externally to the DH. Patients therefore have the opportunity to provide feedback on their care and we receive a very wide range of responses.			
262	**Enhancing the use, analysis and dissemination of healthcare information**	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such	The Trust has a system of reviewing clinical outcomes, benchmarking, mortality reviews and patient satisfaction. National Audit data on outcomes and mortality is also being published at Consultant level. Revalidation of Medical Staff will include their Quality Improvement Activity and audit of performance. The Trust is reviewing its systems at present through the integration programme and will ensure documented processes will be agreed and approved.		All process are under review as part of the integration workstream and in preparation for the new organisation. November 2013 update: New organisational performance scorecards have been developed which will be used for the process of Performance Review of the Trust and it's Divisions. A new structure and procedure for the Mortality and Morbidity Reviews across the organisation is in the process of being developed with the Deputy Medical Director and this should be completed by mid December 2013. Through our CQC Steering Group, Trust performance information will	In progress 2013

		systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.			be published via information for staff briefings.	
268	**Resources**	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	The Trust provides provision for significant data to be collected across the organisation and also funds the subscription to national registries. The Trust will include this in the work programme for the agreed procedures.		A review is currently underway with the scoping and mapping of requirement of resources for information and data collection for the relevant central registries for the newly proposed organisation.	Completed 2013
270		There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public.	Recommendation to Trust Board to consider supporting this recommendation			
271		To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards establishing such status for	Recommendation to Trust Board to consider supporting this recommendation			

		them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail				
37	**Use of information about compliance by regulator from:** • **Quality Accounts**	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence	The Trust is compliant with this recommendation and obtains both an internal and external audit report on the compliance with national guidance and accuracy of data reported.			Completed
45	• Inquests	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.	The Process will need to be agreed with CQC and rolled out across the organisation. We await the information on the process from the CQC.			

49	**Enhancement of monitoring and the importance of inspection**	Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential. The Care Quality Commission should consider its monitoring in relation to the value to be obtained from: • The Quality and Risk Profile; • Quality Accounts; • Reports from Local Healthwatch; • New or existing peer review schemes; • Themed inspections.	Recommendation to Trust Board to consider supporting this recommendation			
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings					
87	**Ensuring the utility of a health and safety function in a clinical setting**	The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare. Either the Care Quality Commission should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has power to launch a prosecution.	Recommendation to Trust Board to consider supporting this recommendation			
88		Information sharing The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare	This should be the work programme of the CQC but information on process should			

		regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	be shared with Trusts. Recommendation to Trust Board to consider supporting this recommendation			
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	This should be the work programme of NHS Commissioning Board but information on process should be shared with Trusts Recommendation to Trust Board to consider supporting this recommendation			
	Enhancement of the role of supportive agencies					
91	**NHS Litigation Authority Improvement of risk management**	The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority	Recommendation to Trust Board to consider supporting this recommendation			
92		The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3.	Recommendation to Trust Board to consider supporting this			

			recommendation			
93		The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiences in risk management, such as occurred at the Trust.	Recommendation to Trust Board to consider supporting this recommendation			
98	National Patient Safety Agency functions	Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	Reporting to the NRLS - we already upload to NRLS in a timely manner. We have some assurance that we are within the 'average' band of rate of reported incidents to NRLS compared with peer group Trusts, however we still need to encourage greater reporting, especially when harm has arisen. We continue to monitor the number / percentage of claims that have previously been reported as incidents (as one measure of our safety culture)		In preparation for the merger with Queen Elizabeth Hospital, additional resource has been put into the structure for Patient Safety.– Roles within this resource will be tasked with compiling more feedback to front line staff (know to be a factor in encouraging a robust safety culture; and work on being invited to attend various Directorate morbidity / discrepancy meetings to encourage incident reporting	

	Effective complaints handling **Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.**					
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	The current PALS, compliments, concerns and complaints leaflet contains details of how to raise a concern and make a formal complaint. The leaflet also details a description of ICAS' function and contact details.		Action –include para on AVMA and their contact details to the leaflet	Completed June 2013
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	Trust Complaints policy addresses that litigation and a formal complaint can run in tandem.			Completed June 2013
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and	PALS leaflet is distributed to all wards and departments. Posters are situated around the site along with some banners. PALS website contains		Action – Further banners and posters to be ordered. There will be a banner in each lift lobby on each floor of Riverside, along with outpatients.	Completed

		collectively, to share their comments and criticisms with the organisation.	information on making a complaint.			
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such	PALS would currently log these as feedback or a potential complaint and forward them to a directorate. Action – this will continue, however the PALS unit will firm up the procedures to ensure that they are made aware of the outcome of the investigation and that this can be logged along with actions, learning's and service improvements.			Completed June 2013
113		Complaints handling The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	Recommendation to Trust Board to Accept Recommendation		Complaints policy now incorporates recommendations made in the Francis report	Completed June 2013
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation	The PALS team currently advises directorates when a complaint comes in and it is felt that an incident should be logged or SI declared.			Completed June 2013

115		Investigations Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	Recommendation to Trust Board to accept Recommendation		Complaints policy re-to incorporate recommendations made in the Francis report.	Completed June 2013
116		Support for complainants Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	Action – PALS will amend the meeting invitation letter to include the details of ICAS and that an advocate may accompany them.			Completed April 2013
118	Learning from Complaints	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, ifdifferent, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint	Action – PALS will amend the standard para at the bottom of the upheld complaint responses to request permission to anonymously use a summary of their complaint and the Trust response on the Trust's website.			September 2013

		is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.				
119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	Action – Complaints reports will be circulated to OSC's and Healthwatch			Completed 2013
120		Commissioners should require access to all complaints information as and when complaints are made, and shouldreceive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	. Recommendation to Trust Board to consider supporting this recommendation Awaiting Commissioner process			
121		The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.	Recommendation to Trust Board to consider supporting this recommendation			
122	Handling Large Scale Complaints	Large-scale failures of clinical service are likely to have in common a need for: • Provision of prompt advice, counselling and support to very distressed and anxious members of	Action – Complaints policy will be re-written to incorporate recommendations made in the Francis report.			Completed June 2013

		the public; • Swift identification of persons of independence, authority and expertise to lead investigations and reviews; • A procedure for the recruitment of clinical and other experts to review cases; • A communications strategy to inform and reassure the public of the processes being adopted; • Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.				
133	**Role of Commissioners in Complaints**	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	The Trust will work with Commissioners to agree an approved process for the implementation of this recommendation. Recommendation to Trust Board to consider supporting this recommendation			

137	**Intervention and sanctions for substandard or unsafe services**	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service	The Trust will proactively work with Commissioners should they have any concerns with any aspect of care or provision of services to patients. Recommendation to Trust Board to consider supporting this recommendation			
	Coroners and Inquests					
274	**Information to and from Coroners**	There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest	Recommendation to Trust Board to consider supporting this recommendation			
277	**Death Certification**	Death certification National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.	Recommendation to Trust Board to consider supporting this recommendation			

279		So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	The Trust will work to provide guidance on this recommendation.		At induction all junior doctors have been issued with guidance on death certification including consulting with consultant prior to completion. This document to be used in all subsequent inductions	completed
280	**Appropriate and sensitive contact with bereaved families**	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	Although the Trust supports this recommendation we need to give careful thought as to whether this is appropriate for all patient deaths, the skills our staff will need to ensure this is undertaken appropriately and sensitively.			TBA
	Medical Education and Training					
152	**Medical Training**	Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.	Recommendation to Trust Board to consider supporting this recommendation but would also want to ensure that the organisation raising its concerns had also raised them promptly with us.			

158	**Training and training establishments as a source of safety information**	The General Medical Council should amend its standards for undergraduate medical education to include a Requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.	Although this recommendation is for the GMC we support the need for seeking feedback from both are nursing and medical students. This is already in place within nursing but needs to be developed within medicine further. Recommendation to Trust Board to consider supporting this recommendation			
159		Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.	Trust need to be included in development work. Recommendation to Trust Board to consider supporting this recommendation			
163	**Safe staff numbers and skills**	The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.	Recommendation to Trust Board to consider supporting this recommendation			

172	**Proficiency in the English language**	The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.	Recommendation to Trust Board to consider supporting this recommendation			
	NURSING					
185	Focus on culture of caring	**There should be an increased focus in nurse training, education and professional development on the Practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires:** • Selection of recruits to the profession who evidence the: • Possession of the appropriate values, attitudes and behaviours; • Ability and motivation to enable them to put the welfare of others above their own interests; • Drive to maintain, develop and improve their own standards and abilities; • Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery	The Trust through its organisational development work programme will include elements of these recommendations within the programme. The recommendations listed on the left must be done in active partnership between the universities and ourselves. We already have good working relationships in place with our Universities and are very clear what standards we expect from our students but we know we		This work will be part of the implementation of the OD strategy. Working in partnership with our universities the 6C's Compassion in Practice is being taught. Student nurses have the importance of giving high quality care with compassion reinforced during their introduction to the Trust and our expectations are clearly stated. Similarly, these principles are emphasised and included within the Band 5 induction programme Matrons undertake monthly Quality Ward Rounds and HON's and Governance leads are developing a	In progress

		of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: • Recognition of achievement; • Regular, comprehensive feedback on performance and concerns; • Encouraging them to report concerns and to give priority to patient well-being.	can still continue to improve. Investment in required to support an increase in clinical educators to bridge the gap between the university and the clinical environment.		peer review programme to assess and audit practice and patient experience in all ward areas. Feedback from ward walkabouts by Patient Welfare Forum members, results from patient satisfaction surveys/ questionnaires and complaints are investigated, analysed and reviewed and lessons learnt are reflected upon and actions implemented to improve patient care, services and the patients experience Patient stories are shared and reflected upon during governance meetings	
187		There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An	Careful consideration is required of this recommendation for the development of a minimum period of time being implemented for all students to undertake a period of clinical practice as an HCA. This would be require considerable resource, including clinical supervisors but it may also act as a barrier to encouraging students to enter the profession.		The Trust aims to facilitate this recommendation in association with the universities and will accommodate in accordance with nationwide changes in nurse training	Awaiting progress report from NMC

		alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.				
188	**Aptitude test for compassion and caring**	The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	Recommendation to Trust Board to consider supporting this recommendation			
193	**Standards for appraisal and support**	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis	The Trust would support the concept of this development but this requires a change to the legal framework in which the NMC operates at present. Recommendation to Trust Board to consider supporting this recommendation			
194		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this	The Trust accepts the recommendation for an annual appraisal, and will ensure that it is focussed on care/attitude via the values based framework and quality assurance process to		Some Competency documents already in place these will be tied to appraisal in the next year. . A pilot for band 8s will be implemented 13/14 for roll out later in the year.	March 2014

		should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process.	ensure that the appraisal is not just a 'tick box' exercise. In relation to revalidation we will wait for guidance from the NMC We also need to consider how best we would test compassion but also strongly believe this should be for all clinicians within our trust and not just for nurses.		Annual PDR's are undertaken for all nurses. Matrons are ensuring that all areas are fully compliant. PDR process is under review with the aim of improving the existing PDR format to ensure it meets this recommendation	
195	**Nurse Leadership**	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plansrelating to every patient on his or her ward. They should make themselves visible to patients and staff alike, andbe available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a rolemodel and mentor, developing clinical competencies and leadership skills within the team. As a corollary, theywould monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	Whilst the Trust supports the recommendation of Ward Sisters being in a supervisory role We need to recognise the importance of this role and ensure that they have the right level of resource and infrastructure to execute their duties. The Trust is working with McKinseys Improvement Programme and staffing and skill mix is part of this work programme, the outputs of the programme will feed into the action plans for this report.		Ward managers have an allocated number of non-clinical shifts and the Trust must risk assess extending this allocation and consider the quality and financial impact of additional non-clinical time. HON's are exploring different ways of working for Ward Managers to release them to provide additional non-clinical time for supervision and to maximise their time Leadership programmes are available and additional clinical supervision is being accessed As part of the Nursing Strategy review the Nurse's Responsibility Matrix will be updated to clarify the	

					purpose of non-clinical time and supervision	
198	**Measuring cultural health**	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer".	The Trust supports the need for monitoring how staff, feel, and we will explore the use of the cultural barometer. However we should implement something for our whole workforce and not just for nurses, using the tools we currently have including the staff survey.		See 2 above re culture audit and OD strategy and implementation plan	Audit Completed
199	**Key nurses**	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present atevery interaction between a doctor and an allocated patient	The Trust will need to review this recommendation with the Ward managers before accepting this, to understand how different it would be to the current process of patient allocation which is in place.		A named nurse process is already in place but it is acknowledged that it is not systematic across all areas. HON's aim to develop this as part of the current review of the handover process. A handover checklist has been devised and, once piloted, is planned to be rolled out as best practice across the Trust.	
200		Consideration should be given to the creation of a status of Registered Older Person's Nurse.	The DH recommends that they will strengthen the training on the care of the frail older person throughout all programmes. So that all adult trained nurses have the right set of skills to care for our most vulnerable patients.			
207	**Strengthening identification of healthcare support workers and nurses**	There should be a uniform description of healthcare support workers, with the relationship with currently registered	Recommendation to Trust Board to consider supporting this recommendation		The Trust is currently awaiting the guidance from the NMC on the description and regulation of HC	

		nurses made clear by the title.			support workers. The NMC have published the Health Care Support Worker new code of conduct.	
	Caring for the elderly **Approaches applicable to all patients but requiring special attention for the elderly**					
236	**Identification of who is responsible for the patient**	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of apatient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	This is supported and is already in place the named Consultant is the responsible officer until the patient is either discharged or transferred under the care of another named Consultant.			Completed
237	**Teamwork**	There needs to be effective teamwork between all the different disciplines and services that together provide the ollective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued	The Trust supports this recommendation and can demonstrate effective MDT working in many areas of the Trust. We need to develop an assurance model that effectively ensures this is in place across the Trust			
238	**Communication with and about patients**	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors	The Trust supports this with the 2 hourly rounds across wards. Further work is required on the remaining recommendations and this will be undertaken as part of the working group		Promotion of the "No decision about me, Without me" campaign is being developed within the revised Nursing Strategy Through governance structures, including Directorate Governance meetings, Outcomes with Learning, Patient Safety and Clinical Quality Committees, complaints, risks,	

		• Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.			incidents and audits are analysed and reviewed monthly Learning from incidents and complaints are feedback to staff in ward/departmental meetings and in Grand Rounds EIDO patient information leaflets have been commissioned and are available for nursing and medical staff to assist with informed consent and to enhance communication Quiet rooms are available for confidential patient/ family use in all ward areas Dementia pathways are in place and a Lead Nurse is being recruited to increase and support the pathway implementation across the Trust	
240	**Hygiene**	Hygiene All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	The Trust supports this recommendation and does encourage compliance with standards. The Infection and Ward Teams conduct monthly audits on compliance.			completed
241	**Provision of food and drink**	The arrangements and best practice for providing food and drink to elderly patients require	The Trust has a quality and contract monitoring group which regularly reviews the		Initial Catering team work closely with the Matrons and Trust audit and Monitoring team to ensure best	completed

		constant review, monitoring and implementation.	arrangements for provision of food and drink. This is reported via the Trust Governance Processes.		practise is adhered too.	
242	**Medicines administration**	Medicines administration In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	The Trust does have a process in place for monitoring and auditing this. A workstream is underway through the Trust working groups to address issues which arise.			
243	**Recording of routine observations**	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	The Trust is currently developing a Ward Contract for Ward Managers which will include the responsibility of Ward Leaders for the safety of their patients and the requirement for ensuring routine observations are carried out. The Trust also has in place an Early Warning Scoring system which is audited each month and		The Nurse's Responsibility Matrix is being revisited as part of the Nursing Strategy review. Documentation and observation audits are completed monthly within the Nursing Metrics and a Synbiotix Lead Nurse post is being developed to oversee compliance against the completion of Synbiotix in the integration process. Also an electronic record keeping system is being researched and will be	

			results are feedback to Ward Managers.		commissioned and implemented following integration. The Early Warning Scoring system continues to be monitored and is audited monthly.	

Date signed off as completed by Trust Board / sub committee…………………… Signature of Chairperson: ……………………………

To be completed by review 'lead officer' and submitted to the Trust Board / sub committee following report from external agency.