South London and Maudsley NHS
NHS Foundation Trust

TRUST BOARD OF DIRECTORS

SUMMARY REPORT

Date of Board meeting:	24 March 2015
Name of Report:	Francis Inquiry Report
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Approved by:	Matthew Patrick, Chief Executive
Presented by:	Neil Brimblecombe, Director of Nursing & Alison Beck, Head of Psychology and Psychotherapy

Purpose of the report:

To inform the Board about the main findings from the Francis reports dated 2010, 2013 and 2015. To explore the evidence which lies behind these findings. To consider the action implications for the Board.

Action required:

The Trust Board is asked to review the paper and consider 1) any further requirements for knowledge or exploration, 2) implications for Board, 3) appointment of Speak up Guardian to champion staff concerns.

Recommendations to the Board:

Agree a review period and a method to monitor progress.

Relationship with the Assurance Framework (Risks, Controls and Assurance):

This paper contributes understanding the risks associated with not providing compassionate care.

Summary of Financial and Legal Implications:

The Trust is encouraged to identify Speak up Guardian and may want to adopt other approaches to ensure compassionate care.

Equality & Diversity and Public & Patient Involvement Implications:

The risks associated with inequalities are discussed and importance of a diverse workforce highlighted.

Service Quality Implications:

The Board need to be aware of the importance of this report when weighing the pressures of achieving financial efficiency and people focused care.

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1. EXECUTIVE SUMMARY

Robert Francis's report into the failings at the Mid Staffordshire Foundation Trust was published in 2010. It has been followed by further Inquiries and a series of Reviews which altogether require a change of culture in the NHS.

It is argued there has been a disproportionate emphasis on regulatory compliance and financial management, at the expense of high quality, patient-centred care, provided with safety and compassion. There is now general recognition that regulation cannot tackle poor quality alone. Good care requires a compassionate workforce, dedicated to the care and welfare of the people it serves, supported by professional attitudes that prioritise the primacy of the patient and those receiving care, managed by people who see good governance as an essential to be embedded in everything it does.

The responsibility for leading the culture change remains with Trust Boards and now the consequences of failures such as those at Mid-Staffs are greater for a Board and its members than any failure to meet specified targets.

The leadership required of Trust Boards is one which will support a compassionate workforce to put patients and the quality of care they receive at the centre of healthcare.

This paper summarises the Francis Inquiries and subsequent Reviews and the Trust response. It reviews the literature behind the key findings the purpose of which is to inform the Board.

The Francis Reviews support visible, effective Board leadership which prioritises cultural change to ensure compassionate and safe patient care. This will involve supporting reflective practices at all levels of the organization. It will not promote a culture of hierarchy.

This paper recommends better ways of listening to patients and staff in order to gain a granular understanding of where there are problems in the Trust as well as areas where 'we are getting it right'. Appointing a 'Speak up Guardian' to champion staff concerns will assist. A 'You said-We did' communications approach would engage staff and patients and build organizational learning. Trust-wide planning is necessary to address the concerns highlighted, for example, in the Staff Survey and to support staff more widely as well as to implement Francis' recommendation for zero tolerance for bullying.

2. INTRODUCTION

The Inquiries led by Sir Robert Francis and subsequent Reviews represent a line in the sand for a change of culture in the NHS in order to put patients and the quality of care they receive at the centre of healthcare. This paper will briefly overview the key findings of the Francis Inquiries and associated Reviews. The Board is invited to consider the implications of this work for SLaM going forward in terms of culture change.

The Kings Fund (2013) summarises the leadership requirement of Trust Boards in order to change NHS culture. This involves setting the tone for 'the way we do things around here' in their behaviour which is kind, available, empathic, fair, respectful, compassionate and empowering. Staff who feel valued and are treated well by their organisation will usually reflect this in how they treat their patients.

The Kings Fund (2013) suggests that Boards should understand the patient experience by talking to patients directly and the patient experience should be on the agenda of every Board meeting (Steward 2012), with significant time devoted to these discussions, preferably early in the meeting rather than towards the end (Ramsay and Fulop 2010).

Also strongly encouraged is that Boards actively listen. If the Board is to fulfil its core business, clinical staff and each and every member of the Board must feel comfortable about 'bringing bad news' and it might be necessary for specific arrangements to be in place for staff to bring issues of concern to the attention of the Board. Boards must also be prepared to change organisational systems that hinder high quality care, whether physical infrastructure, unnecessary bureaucracy, IT etc. Often, staff cannot initiate the necessary changes independently and need help to do so. This reinforces the message that the Board is actively listening to staff and working hard to address problems around quality.

3. THE FRANCIS INQUIRIES AND ASSOCIATED REVIEWS – SUMMARY OF FINDINGS

The **first inquiry report by Sir Robert Francis into care at Mid Staffs (published in February 2010)** identified that there had been too great a focus on processes at the expense of outcomes; and on assurance, statistics and reports at the expense of information from patient and staff experience. There was a lack of basic care across a number of areas; low morale amongst staff; lack of openness and a resignation to poor standards. Management thinking was dominated by financial pressures (and achieving FT status) to the detriment of quality of care.

The **second Francis Inquiry (February 2013)** signalled the need for significant culture change in the NHS. The Inquiry examined the involvement of numerous agencies involved with the events at Mid Staffs during 2005-2009 and the 290 recommendations were clustered into 5 key areas reflecting a common culture across the NHS that puts patients first. A culture which:

- supports compassionate care;
- is open and transparent;
- has accurate, useful and relevant information;
- is compliant with fundamental standards;
- has strong and patient centred leadership.

Six independent Reviews were also commissioned to consider key issues: 1) Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Bruce Keogh. 2) The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish. 3) A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England, by Don Berwick. 4) A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Ann Clwyd and Professor Tricia Hart. 5) Challenging Bureaucracy, led by the NHS Confederation. 6) The report by the Children and Young People's Health Outcomes Forum by Ian Lewis and Christine Lenehan.

The Government's initial response, **Patients First and Foremost**, set out a plan to prioritise care, improve transparency and ensure that where poor care is detected, there is clear action and clear accountability. The changes included a new set of fundamental standards for Care Quality Commission inspections – principles of safe, effective and compassionate care must underpin all care – and enabled the prosecution of providers in serious cases where patients have been harmed.

Hard Truths: The Journey to Putting Patients First January 2014 focused on changing culture preventing and detecting problems quickly. Among the changes, monthly reporting of ward staffing levels was introduced.

From **April 2014** all NHS Trusts were required to implement the **Friends and Family Test** (FFT). Don Berwick, in his Safety Review following the Francis Inquiry, said the NHS should be 'engaging, empowering and hearing patients and their carers all the time'. The FFT seeks to capture important information about quality of patient care by listening to staff.

In **November 2014** CQC brought two regulations for NHS bodies into force: 1) **The Fit and Proper Persons requirement (FPPR)** and 2) The Duty of Candour. The FPPR regulates the quality of Board level Trust appointments to ensure they are fit to perform their role. The CQC can remove a director where a breach is identified. During the inspection process CQC will ask: How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?

The introduction of the **Duty of Candour** arises from a recommendation in the original Francis Inquiry. It encompasses three concepts: 1) openness – enabling concerns and complaints to be raised freely and without fear; 2) transparency – sharing true information about performance and outcomes; 3) candour – informing any patient harmed by a healthcare provider and offering an appropriate remedy, regardless of whether they complain. Under the regulation the person harmed must be informed face to face as soon as reasonably practicable.

On **February 11th 2015 Sir Robert Francis published the "Freedom to Speak up – A Review of Whistleblowing in the NHS"** which highlighted the "lack of awareness by NHS leadership of the existence or scale of problems known to the frontline. In many cases staff felt unable to speak up, or were not listened to when they did. The 2013 NHS staff survey showed that only 72% of respondents were confident that it is safe to raise a concern".

In the 2014 Staff Survey the national average for mental health trusts in percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice was 69% and SLaM was 73% (with variation across CAGs 63% to 77%).

The Review requires NHS bodies to encourage openness and transparency in handling concerns. It **prioritises cultural change to improve patient safety, ensure concerns are raised, ensure freedom from bullying, value staff and promote reflective practice**. The mechanism for culture change is **effective and visible leadership** which will instil teamwork and reflective practices and not promote a culture of hierarchy.

The Review recommends the appointment of "Freedom to Speak up Guardians" who will be independent and impartial, have the authority to speak to anyone within or outside the trust, be an expert in all aspects of raising and handling concerns, have the tenacity to ensure safety issues are addressed and have dedicated time to perform the role.

The Review recommends the appointment of an Independent National Officer (INO), jointly established and resourced by the CQC, Monitor, the NHS TDA and NHS England. The INO will review the handling of concerns raised by NHS workers and/or their treatment, advise organisations on appropriate action, act as a support for Freedom to Speak up Guardians, and provide national leadership and good practice guidance

The Review notes that some staff groups are particularly vulnerable when raising concerns and require particular support to voice concerns. Additional recommendations include improvement in the handling of cases to promote their early resolution and that staff should have access to mediation, mentoring, advice and counselling.

The Review is predicated on a culture free from bullying as it is unlikely that staff will be able to voice concerns in that context. It advocates **zero tolerance to bullying**.

4. LITERATURE BEHIND FRANCIS

The literature is organised against the three of the key areas of culture change outlined in the Francis Inquiry 2013: compassionate care, openness and transparency, and leadership.

COMPASSIONATE CARE

Staff engagement has consistently been found to be a key indicator of patient satisfaction. Trusts with higher levels of staff engagement have higher patient satisfaction scores, consistently lower patient mortality rates and better financial performance (West & Dawson, 2009). Staff are more engaged when they are clear about their roles, feel involved in decision-making and are able to influence practice. In SLaM Staff Survey results 2014 indicate that staff engagement in SLaM is 'better than average' which and greater understanding of where things are working well might help improve on this further.

Borrill et al. (1999) found that staff working in **well-structured teams** had higher levels of engagement. They are not over-burdened and are able to push upwards if the demands on them become too great. They are also not asked to take responsibility for things over which they have no control.

Staff well-being is also clearly linked to improvements in organisational performance in areas such as productivity and customer satisfaction.

Communication with staff needs to take the form of listening. It is through **being listened to** staff become engaged and motivated. Staff need to feel they have been heard and attempts to listen which are not experienced as such can reduce staff engagement.

Where staff see equal opportunities for career progression and where they feel enabled to grow and develop, there are higher levels of patient satisfaction (West & Dawson, 2009). This is linked to the concept of '**psychological safety**' where staff can be 'true self' (including their ideas and beliefs) without fear of negative consequences (Edmondson, 1999; Edmondson & Lei, 2014).

Psychological safety explains why some people are more engaged at work, better able to speak out, better able to share information, better able to learn from mistakes and admit to errors, better able extend themselves in their roles, and to be more innovative than others.

Edmondson (1996, 1999) found significant differences in 'psychological safety' between groups in same organization. Singh et al (2013) found that BME staff were more vulnerable to psychologically unsafe environments and less likely to extend themselves in their roles resulting in lower performance and career achievement etc.

An ethnically and socially **diverse workforce is good for all** employees, even members of dominant group, as well as the organization because it encourages staff to explore their difference and can be open and transparent about mistakes and misunderstandings (Phillips & Loyd, 2006).

One of the most important advantages to having a sufficiently diverse workforce is that it mitigates against **organizational biases** ('groupthink', Janis, 1972), for example the tendency of groups to agree rather than explore controversial issues or alternative solutions.

Intergroup biases (in-group/out-group) play a powerful role in creation of psychological safety and effective leaders acknowledge this and mitigate the risks it can pose to the establishment of a '**Just Culture**' and to patient safety.

Diversity needs to be grounded in a sense amongst staff of **fairness and equality** which presents a significant challenge in the NHS. For example, the NHS recruitment processes has been shown to disproportionately favour white applicants (Kline, 2014). Staff who describe being bullied or harassed and staff who perceive unfair career opportunities are less likely to be engaged.

In SLaM HR data indicates that whilst Black staff make up 25% workforce they are disproportionately in lower paid jobs (eg 50% unqualified nursing staff). In recruitment white applicants are significantly more likely to be appointed; white staff are significantly more likely to be promoted; black Africans significantly less likely to be promoted than other black groups and the total. Black staff are more likely to be involved in disciplinary process, formal sickness review and to be redeployed.

Staff Survey results 2014 indicate that SLaM is in the lowest 20% of Trusts in terms of bullying, harassment and discrimination at work. SLaM is also in the worst 20% of Trusts in terms of the percentage of staff who experience physical violence (from patients/relatives/public and from other staff) and staff who perceive inequalities in terms of career progression. The latter has deteriorated since last staff survey and both are worse for BME staff compared to white staff.

OPENNESS AND TRANSPARENCY

The principle of a Just Culture lies behind the Francis Inquiries and other Reviews. This represents a shift from blaming individuals for errors and towards understanding the systems factors which contribute to the error occurring. Frontline staff often trigger the error by actively failing but this failure is generally the consequence of prior conditions more deeply embedded in the system such as understaffing, unworkable procedures or inadequate training. In this context blaming staff is unlikely to prevent further harm occurring and is likely to leave them (and their colleagues) feeling psychologically unsafe, less likely to explore the contribution of different factors and work towards building a safe culture (Vincent et al., 2013). Senior leaders can review the design of the system to correct obvious deficiencies and vulnerabilities in the system (Reason, 1990).

Sir Robert Francis's report highlights the value of reflective practice so that staff have "time to explore issues, analyse systems and share good practice". Human error is pervasive, even among skilled practitioners, and complex systems also generate errors. In order to learn and improve, staff need to know that it is safe to discuss mistakes and near misses.

LEADERSHIP

Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental (Kings Fund, 2013).

The leadership qualities required are those which support the findings of the Francis Reviews. Leaders need to be kind, available, empathic, fair, respectful, compassionate and empowering. They listen to patient voices as the most important source of feedback on

organizational performance. They listen to staff about how to support them to deliver safe, effective and compassionate services. They show that they have acted on what they heard. They create a strong sense of team identity whilst simultaneously being committed to collaborative cross-team and cross boundary working (a key element of collective leadership).

Collective leadership does not assume that organizations are safe (i.e. "It couldn't happen here") but instead actively seeks out the stories about harm to patients that has occurred to drive improvement (Leonard & Frankel, 2012). It provides psychological safety that ensures speaking up is not associated with being perceived as ignorant, incompetent, critical or disruptive. Leaders must create an environment where no one is hesitant to voice a concern and staff know that they will be treated with respect when they do.

Leaders must ensure organisational fairness, where staff know that they are accountable for not engaging in unsafe behaviour, but are not held accountable for system failures. Engaged leaders hear patients and front-line staff concerns regarding defects that interfere with the delivery of safe care, and address them.

5. THE TRUST RESPONSE

In **July 2013 a group of Senior Managers and Heads of Professions in SLaM formed a Francis Working Group**, to lead the development of an organisational response to the Francis Report. The group proposed four essential work-streams:

1. Creating the right culture for positive challenge and positive action (Francis themes of leadership, openness and transparency, values and standards)
2. Working with service users in a spirit of co-production and co-creation
3. Looking after staff, each other and ourselves
4. Assuring quality of care in every corner of the Trust (information)

An action plan followed (February 2014) and became the responsibility of the Forward Planning Delivery Group receiving regular updates from CAGs every month and reporting to Board Quality Sub-Committee.

In **September 2014 the Department of Health requested an update on Trust progress** in response to Francis. This was presented to Board Quality Sub-Committee In January 2015 in the form of a gap or 'next steps' analysis. Both CAGs and Corporate Functions had put considerable effort into work to improve compassionate and safe patient care. This cannot be described fully here; however an example will be provided for each area:

	Example of CAG work	Example of Corporate work
Culture for positive challenge and action	Scheduled patient safety Walk Rounds	Value based recruitment Revalidation of doctors and nurses
Working with service users in a spirit of co-production and co-creation.	PPI meetings are established Examples of excellent practice in co-production in areas around the Trust including winners of national awards	The Recovery College EPIC is established to develop governance around service user and carer involvement.
Looking after staff, each other and ourselves	Reflective Practice groups	Coaching and workshops from SLaM partners Schwartz Rounds® planned Arts Strategy
Assuring quality of care in every corner of the Trust	Work with teams to prepare for CQC visits to new standards	Trust Quality Strategy Care Delivery System

The learning from this exercise includes:

1. Some approaches are only within individual CAGs but could work well more widely effectively work across CAGs
2. Adopting a consistent approach to actively listening to staff and patient feedback and to being transparent about 'what you said and what we did' would be helpful.
3. Cross-cutting themes, such as the impact on staff from a range of diverse backgrounds, require exploration to develop granular understanding eg. why is SLaM in the lowest 20% on Staff Survey results 2014 on 'bullying, harassment and discrimination at work' and why is this worse for BME staff?
4. We need to evidence that we are closing gaps in relation to quality priorities.

6. GOOD PRACTICE EXAMPLES

Active listening to staff good practice examples:

- Helena Donnelly was a whistleblower at Stafford Hospital and gave evidence at the first Francis Inquiry. She took up a role as Ambassador for Cultural Change at Staffordshire and Stoke on Trent Partnership Trust with a remit from the Trust Board and CEO "to act freely and with complete autonomy from the management team as another route for issues of concern to be raised at the highest level … to visit teams and services across the organisation … gathering feedback about how staff feel, if they feel listened to and what might prevent staff from raising concerns".
  http://www.staffordshireandstokeontrent.nhs.uk/About-Us/ambassador-for-cultural-change.htm

- Oxleas NHS Foundation Trust have achieved excellent staff survey results by creating a Head of Partnership Engagement reporting to CEO. She actively engages staff across the Trust and has an understanding of local issues. She is able to challenge on behalf of staff and to ensure that the executive team responds.

Listening to Patients about Quality of Care good practice example:

- Nottinghamshire Healthcare 'Positive about Change' collects web based patient and carer feedback in co-operation with Patient Opinion. The site is monitored to ensure staff respond in a timely fashion and to gather evidence around common areas of concern. The site constructs reports by theme and service area. It also provides transparent feedback about 'what we've done'.
  http://feedback.nottinghamshirehealthcare.nhs.uk/

7. RECOMMENDATIONS

1) The Board to consider how to best meet the expectation that Boards provide visible, effective leadership which prioritises cultural change to ensure compassionate and safe patient care. Also how to ensure non-hierarchical reflective space at all levels of the organization.

2) To continue to develop new and improved ways of hearing the patient voice, for example to have 'Patient Stories' regularly at the Board and to review processes as recently recommended by the Quality Sub Committee.

3) Demonstrate visible leadership by actively encouraging staff to voice concerns, actively listening to staff and acting on what is heard. Utilise a "You said - We did" approach to communications so that staff and public can consistently hear how the Board has acted on staff and patient advice and concerns.

4) Appoint a Speak up Guardian to champion staff concerns. To develop a model of this informed by the Board's views.

5) Further exploration of issues of staff experience that we do not always currently understand fully. For example a zero tolerance policy for bullying will require a wider understanding of the issues involved and why bullying and harassment are worse for BME groups. A staff support policy will require deeper understanding of factors affecting different staff groups feeling support and where there are gaps.