Local Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry

Leeds York Partnership NHS Foundation Trust
York Teaching Hospitals NHS Foundation Trust
NHS Vale of York Clinical Commissioning Group

York Health and Wellbeing Board
10 July 2013

Introduction

Francis recommendations

Implications for quality assurance

How and where will we work differently ?

A Snapshot of the Recommendations (1)

Overall our organisations need to consider how to bring about:

A fundamental change in culture that puts patients and their safety first

We need to think about:

What needs to be done differently in future, and how we can further develop safer, committed, compassionate and caring services

How we ensure individually and collectively that patients need to be the first and foremost consideration of the system and all those who work in it

How we work collaboratively across the whole system while maintaining clear accountability

A Snapshot of the Recommendations (2)

What does that mean for commissioner and providers?

A structure of fundamental standards and measures of compliance

Openness, transparency and candour is required throughout the system, underpinned by statute

Improved support for compassionate, caring and committed nursing

Stronger patient centred healthcare leadership

Accurate, useful and relevant information to allow effective comparison of performance by patients and the public

Patients First and Foremost – The Government Response

Preventing Problems

Detecting Problems Quickly

Taking Action Promptly

Ensuring Robust Accountability

Ensuring Staff are Trained and Motivated

Implications for quality assurance (1)

Applicable to commissioner and providers

Proactive - looking for early warnings and indications of concern

Testing self-declaration through triangulation of hard and soft intelligence

Evidence of patient experience and quality assurance taking precedence

Utilising range of levers and networks available to intervene and drive improvement

Implications for quality assurance (2)

CCGs and providers have an accountability to assure themselves that their services...

...are meeting the fundamental and enhanced standards of care

…providing care that is safe, effective, and provides a positive patient experience

…are working to standards that are measurable with redress for non-compliance clearly identified

Preventing Problems

COMMISSIONER ACTIONS	PROVIDER ACTIONS
• clinical quality site visits • joint PLACE visits • tighter monitor SI monitoring systems • local meetings with regulators • regular county wide CCG quality leads meeting • assurance on plans for strengthening nursing and clinical leadership • supporting quality improvement in Primary Care • develop role of GP in quality monitoring across whole pathway • strengthen clinical input to Contract Management Boards and Quality Sub Groups	• Task and Finish Group developed to establish action required to Francis • Review of key risk management processes • Review of SI process locally • Further development of compliance review systems • Changes to senior nursing structure • IMW programme (nursing leadership) • Senior Nurse walkabouts & peer review planned • Policy development and review processes' to be revised • Refinement of audit processes • Introduction of new roles to support clinical teams

Detecting problems quickly

COMMISSIONER ACTIONS	PROVIDER ACTIONS
• Real-time access to complaints with direct intervention • Develop systems to enable themes and trends to be Identified • Strengthening information and performance analyst team • Designated GP quality leads • Effective real-time information on performance – collective and individual • Quality metrics to identify outliers and deteriorating performance – monthly, and weekly by fast track • Quarterly monitoring at deeper level on areas such as mortality and agreeing with providers what data is telling us • Quality Surveillance Groups.	• EWTT under development for ward level assurance • PURP-weekly monitoring & monthly meetings with Chief Nurse and clinical team • Dashboard being developed to look at early detection of organisational risk • Refinement of NCI's • Embedded Safety Thermometer • Weekly review of complaint (CEO, CN) • Review of mechanisms for learning from SI's and complaints • FFT – patient feedback in Real Time • Review of PPI/ Communication strategy

Taking action promptly

COMMISSIONER ACTIONS	PROVIDER ACTIONS
• Systems for end to end complaints handling including - narrative and numbers - themes and trends • Triangulation of complaints data &quality data • Process for ensuring follow up to secure improvement and learning • Direct intervention in complaint and SI management if deemed necessary • Targeted clinical quality site visits • Systems in place to review all investigation reports through the county wide CCG SI review group • Further work on whole system approach to learning and review of Serious incidents	• Weekly review of areas, trends and themes • Local resolution training to commence • Board level review of triggers • Intervention and management of robust action plans at senior level if required • further work on organisational approach to learning and review of Serious incidents begun • Senior Nurse walkabout and peer review planned (triangulated with internal and external compliance visits)

Ensuring Accountability

COMMISSIONER ACTIONS	PROVIDER ACTIONS
• CCG SI Review Group (County wide) • Development of a Quality Strategy / Assurance Framework clear Governing Body leads for quality, and supporting structures with sufficient capacity • Regular reporting on quality, performance and safeguarding at Governing Body • Public board meetings and a recognisable local identity being developed • Philosophy to ensure that high quality evidenced based care is delivered, • Strong risk management systems and processes, particularly as the new system establishes itself.	• SI review group and sharing at Executive Board level of all SI's • Strong risk management system in place, review currently being undertaken • Review of Being Open policy & audit of implementation • Monthly quality and safety report to board (being revised to ensure robust and relevant data is being captured) • Public Board meetings introduced • Promotion of Governors' role across enlarged organisation, involvement in unannounced safety walkabouts & 15 Steps etc. • Changes in Nursing management structure to ensure clear lines of accountability

Ensuring proper staff training and motivation

COMMISSIONER ACTIONS	PROVIDER ACTIONS
• Development of a mature quality and safety culture within the CCG • CCGs gearing up strategic approach to quality and safety • Commitment to quality is evidenced • Patient stories to be incorporated into quality reports • Development of process to ensure all staff are exposed to clinical settings and are in touch with patients who use our commissioned services • Strengthened appraisal system to ensure clear focus on quality and putting patients first • Development of research and evidence based approach to all service development	• Patient stories included regularly in Board and Senior meetings • Action plan in response to Staff Survey – monitored at Board Level • It's My Ward programme & promotion of engagement of clinical staff • Robust training programme available for all staff at all level's • Exploration of how we can feedback to staff more quickly, incidents, complaints etc. • New Nursing strategy with focus on safety, patient experience, staff experience and improving clinical outcomes'

Next steps

- Build upon collaborative working relationships
- Increase visibility
- Use of soft intelligence to support data

Questions?