Agenda Item No: **7**

Health Scrutiny Panel

19 December 2013

Report title	The Royal Wolverhampton NHS Trust (RWH) response to the Government report 'Patients First and Foremost'	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being	
Wards affected	ALL	
Accountable director	Sarah Norman, Community	
Originating organisation	The Royal Wolverhampton NHS Trust	
Accountable person	David Loughton Tel Email	Chief Executive 01902 307999 david.loughton@nhs.net
Report has been considered by	RWH Trust Board RWH Trust Compliance Committee RWH Trust Board	May 2013 August 2013 September 2013

Recommendation for action or decision:

The Panel is recommended to review the progress by RWH in implementing recommendations arising from the report 'Patients First and Foremost'. This report was prepared in response to the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Sir Robert Francis QC.

1.0 Purpose

1.1 This report provides an overview of The Royal Wolverhampton NHS Trust's (RWH) response to the recommendations in 'Patients First and Foremost' report published by the Government in March 2013.

1.2 The report was the Government's response to the findings of the Public Inquiry chaired by Sir Robert Francis QC into the quality of care provided at Mid Staffordshire NHS Foundation Trust.

1.3 Following a review of the 290 recommendations in the 'Francis Report', 102 were considered applicable to the RWH and have been reviewed in regard to existing actions and assurances; and where necessary further action has been undertaken.

2.0 Background

2.1 A full gap analysis and action plan has been formally reviewed by the RWH Trust Board and by its delegated committee, where monitoring will continue quarterly.

2.2 The overarching and significant themes from the report are outlined in the table in section 3 below.

2.3 RWH has in place a number of programmes of work which drive the ambition within Francis to improve patient safety, experience and quality. There are some programmes of work that directly link to the recommendations in the Francis report. However, there is also other related work being undertaken by RWH to demonstrate mitigation against a re-occurrence of the issues experienced at Mid Staffordshire NHS Foundation Trust

2.4 The Trust has assigned leads to progress actions and where appropriate work is aligned to existing work areas to embed improvements into mainstream work.

3.0 Progress

3.1 Status of progress against recommendations:

Total recommendations	**Red**	**Amber**	**Green**	**Grey (national actions)**	**Actions in development**
102	0	28 (27%)	58 (57%)	14 (14%)	2 (2%)

Grading key:

- Red = major gaps in assurance/significant risk/work not yet commenced to manage risk.
- Amber = moderate gaps in assurance/moderate risk/ work in progress to deadline to manage risk.
- Green = no or minor gap in assurance/minimal risk/ work complete or majority complete to deadline.

3.2 The table below provides a headline summary of work in place or in development at RWH to address the themes falling from the Francis report.

Theme	Work in place or in development
Openness transparency and candour	• Favourable results for 2012/13 being open policy audit – passed level 3 NHS Litigation Authority being open criteria. • Maintained a healthy reporter status by the National Patient Safety Agency reporting benchmark. • Contractual target agreed with Commissioner taking effect from 1st April 2013. • Internal systems and processes for monitoring the Duty of Candour [1]for incidents and complaints. • The Trust will consider any further indicators to measure or evaluate progress.
Nursing, Care of the Elderly and Putting patient first	• Priority work streams - care of the older person and urgent and unscheduled care. • Work programme and group in place with a focus on care of the older person. • A Creating Best Practice programme is in place to drive improvements across clinical care and safety areas. This work covers documentation, nutrition and hydration, ward rounds, pressure ulcer management and prevention, infection prevention, patient satisfaction, workforce and staff satisfaction. • Dementia care developments. • Nursing and midwifery workforce – skill mix review • Nursing Midwifery Programme aligned to the 6C's (care, compassion, competence, communication, courage and commitment), the NHS Constitution, The Nursing and Midwifery Council Code, and the Royal College of Nursing Fundamentals of Nursing Practice • Quality impact assessments on all Cost Improvement Programme projects

[1] 'Duty of Candour' is defined in Robert Francis' report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

Leadership, Fundamental standards of behaviour	• Organisational Development plan in place to address issues reporting, information flows, RWT Trust Board development and assurance. • 2013 Culture survey in progress and will inform culture, leadership, values and behaviours. • Review and new developments in leadership training and competencies in progress. • Values based recruitment commenced to include interview assessment aligned to 6C's.
A common culture made real through the organisation, Fundamental standards of behaviour	• Review in progress of the organisation safety culture survey – benchmark against 2010 results. • Further requirements considered following the 2013 survey report. • Strengthening of accountability through the divisional and committee reporting structure.
Effectiveness of healthcare standards, Effectiveness of regulating healthcare systems governance	• Executive safety walk-around • Using technology to keep patients safe - Safe Hands electronic tagging, VitalPAC[2] to identify deteriorating patients. • Project group initiated to review quality and performance indicators, strengthen internal assurance and develop internal early warning alert systems. • Quality assurance framework to include internal quality indicators, new Care Quality Care inspection domains, Keogh(Keogh mortality review) lines of inquiry. • expansion in the scope of obtaining patient feedback or experience.

4.0 Financial implications

4.1 There are no financial implications arising from the recommendations in this report.

5.0 Legal implications

5.1 There are no legal implications arising from the recommendations in this report.

[2] VitalPAC is a computer software system for detecting deteriorating patients in hospital and improving patient safety and outcome

References

- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013)
- Patients First and Foremost - The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf