Board meeting date: 06/11/13
Agenda Item number: 10.5
Enclosure: 8

### Report Title:
Winterbourne, Francis, Cavendish, Keogh and Berwick Report

### Accountable Director:
Wendy Pugh - Director of Operations and Nursing

### Author (name & title):
Rosie Musson - Head of Nursing, Quality and Innovation

### Purpose of the report:
The purpose of this report is to provide the Trust Board with a formal update on the Dudley and Walsall Mental Health Partnership NHS Trust’s (the Trust) response to the recommendations of:
- Winterbourne Review ‘Transforming Care: A national response to Winterbourne View Hospital’ (December 2012)
- Francis Inquiries 2010 and 2013
- The initial Government response ‘Patients First and Foremost’ (March 2013)
- Cavendish Review ‘An Independent review into healthcare Assistants and Support Workers in the NHS and Social care Settings’. (July 2013)
- Keogh review ‘Review into the quality of care and treatment provided by 14 hospital Trusts in England’ (July 2013)
- Berwick Review ‘Improving the Safety of patients in England’ (March 2013)

### Action required from the Board

<table>
<thead>
<tr>
<th>Decision / Approval</th>
<th>Gain assurance</th>
<th>Discussion</th>
<th>Information</th>
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<td>❌</td>
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### What other Trust Committee or Group has considered the key elements of this report?
Committee: DONS
MEXT
Date reviewed: 22nd October 2013

### Key points or recommendations from Committee:
MEXT received assurance that the reports had been reviewed and themes for further actions identified. MEXT acknowledged that a lot of the areas detailed in the reports are already embedded within the Trusts visions values and culture and within the quality priorities. MEXT requested that integration was added as further theme, which has been included in this report. MEXT requested that full action plans are developed and monitored.

### Strategic Objective(s) to which this paper relates:
<table>
<thead>
<tr>
<th>High quality</th>
<th>Inclusive</th>
<th>Leadership</th>
<th>Responsible</th>
<th>Supporting</th>
<th>Effective/efficient</th>
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<tbody>
<tr>
<td>What impact or implications does this report have on any of the following:</td>
<td>Please give brief details:</td>
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<tr>
<td>Quality &amp; standards (inc. CQC/NHSLA)</td>
<td>All reports reviewed have a key message about assuring quality services and standards. The Trust has reviewed the reports to gain assurance, learn lessons and identify further themes for improvement.</td>
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<tr>
<td>Patient safety &amp; experience</td>
<td>Promotes culture of patient safety</td>
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<td>Financial (income, expenditure &amp; CIP)</td>
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<tr>
<td>Performance</td>
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<tr>
<td>Workforce &amp; Leadership</td>
<td>A key area for discussion has been the acknowledgement that culture and leadership are the key parameters which will secure the successful implementation and the sustained delivery of safe high quality patient care.</td>
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<td>Equality &amp; Diversity</td>
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<td>Sustainability</td>
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<td>Risk Register/Board Assurance Framework</td>
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<tr>
<td>Patient &amp; Public Involvement</td>
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</table>
Title | Winterbourne, Francis, Cavendish, Keogh and Berwick Report Overview Report

Introduction

The purpose of this report is to provide The Board with a formal update and gain approval on the Dudley and Walsall Mental Health Partnership NHS Trust’s response to:

- Winterbourne review ‘Transforming Care: A national response to Winterbourne View Hospital’ (December 2012)
- Francis Inquiries 2010 and 2013 and the initial Government response ‘Patients First and Foremost’ (March 2013)
- Cavendish Review ‘An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings.’ (July 2013)
- Keogh Review ‘Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England’ (July 2013)
- Berwick Review ‘Improving the Safety of Patients in England’ (March 2013)

It is anticipated that further key reports will be published in Autumn 2013 which will require consideration by the Trust

- Review of Bureaucratic Burdens
- Clwyd/Hart Complaints Reviews
- DOH Francis Report Update (Nov 2014)
- this will include a response to Francis, Cavendish, Keogh and Berwick

See Appendix 1- Report Timeline

Progress to date

The Trust has reviewed the impact of the reports from which it is evident that high levels of assurance can be drawn from the Trust’s Quality Governance evidence which is regularly reviewed by the Governance and Quality Committee and Trust Board.

Through a structured approach which involved reflecting on the recommendations it is evident that much work had already been undertaken, or in progress, through the Trust’s Quality Governance Framework and Quality Improvement Programme, however, key themes have been identified where further improvements can be made. These themes were identified by looking at how the recommendations apply to the Trust and undertaking a gap analysis.

To date the Trust has;

- reviewed the implications and discussed in depth the Winterbourne and Francis Report at a Board Development Session
- discussed the Cavendish Review, Keogh Review and Berwick Review at Trust Board meetings
- held 3 workshops to complete a gap analysis, commissioned by the Director of Operations and Nursing for Heads of Service and Clinical Leads to identify
recommendations most pertinent to them. From this key themes have been identified for further action.

- discussed at Service Line Quality and Governance Groups
- encouraged teams to discuss reports in their services
- incorporated learning into Quality Governance Assurance Framework (QGAF) and ongoing monitoring, work plan and evidence
- MEXT have agreed the themes identified through the gap analysis and a full action plan is in development. MEXT agreed that much work had already been undertaken and that high levels of assurance can be drawn from the Trusts Quality Governance evidence which is regularly reviewed by the Governance and Quality Committee and Trust Board.

It has been necessary for the Trust to look at each report separately as they have been published over a period of time, however, to ensure a cohesive approach this has been collated into a overarching document. Please see appendix 2 for overarching themes and appendix 3 for individual report gap analysis

Each key theme where improvements can be made will have an Executive and Operational Lead to ensure leadership and accountability. Much of the work links directly through to existing Trust priorities and ongoing action, therefore, the existing quality governance fora will be the mechanism for tracking the actions to delivery. Each lead Director will have accountability to address the key priority areas.

The Trust Board will formally receive a quarterly update on progress against each action by exception.

The Executive Team and MEXT will hold the operational Executive responsibility with the Governance and Quality Committee having the accountability to report to the Trust Board on a quarterly basis.

It is worth noting that as new national guidance is published, further consideration will be given to the Trusts ongoing Quality Improvement Programme and Quality Governance Framework.

Each team will also receive a copy of the summary report and will continue to participate in the key themes identified. This will be an integral part of the Trusts ongoing Quality Improvement Programme and be reflected in the Trusts Quality Accounts.

<table>
<thead>
<tr>
<th>Summary of key points, issues and risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust has accepted the recommendations made in the reports and has taken action to assess the recommendations in the context of the services delivered.</td>
</tr>
<tr>
<td>There has been much work undertaken already as part of the Trust Quality Governance Framework and Quality Improvement Programme and through the process of reviewing the reports high levels of assurance have been gained in relation to the Trusts current position e.g. the Trust has already commenced the Healthcare Assistant development programme.</td>
</tr>
</tbody>
</table>
The Key themes where further opportunities for improvement have been identified are being delivered as part of the Trust’s Quality Improvement Programme. The key themes have been grouped into an overarching plan which will be monitored through the Trust’s Quality Governance Framework. For all themes work has progressed, however further opportunities for improvements will be driven through the Trust’s ongoing Quality Improvement Framework.

**Recommendation**

It is recommended that:

- The Board receives assurance that the reports have been reviewed and significant assurances have been provided through the trust Quality Governance Framework and the Trust’s Quality Improvement Programme.

- The Board is asked to note the progress made and accept the gap analysis and themes identified where further improvements can be made. For each theme the Board are asked to note that work has already progressed.

- It is proposed that the Board receives progress updates by exception with the Governance and Quality Committee being the designated sub-committee for overseeing delivery of the action plan.
Appendix 1

Patients First and Foremost – System Response Timeline
2013

CI role in primary care announced
Camilla Cavendish Review published
Review of Bureaucratic Burdens
Trust complete their own discussions and report

Patients and Foremost published
Funding for Schwartz rounds
Francis Response Regional Events
Francis Response update

March
April
May
June
July
Aug
Sept
Oct
Nov
Dec

Care Bill
CQC consultation
Berwick Safety Review Published

CI of Hospitals appointed
Bruce Keogh Review published
Clywd/Hart Complaints Review published
Overarching Themes

Through considering the recommendations within the reports, the following themes have been identified for incorporation into the Trusts ongoing quality improvement programmes. Much work has been completed and underway through existing workstreams, however to ensure the reports have been given full consideration by the Trust it has been integrated in an overarching plan. These will be monitored operationally by MEXT with the Governance and Quality Committee having overarching responsibility for reporting progress to Trust Board.

### Transforming Care: Winterbourne View Hospital

- Improve triangulation of safeguarding trends
- Further develop processes to take into account views of family’s and carer’s
- Improve triangulation of trends identified through the use of the Mental Health Act
- Improve compliance with MCA and DOLS Training
- Improve incident reporting system to capture further detail regarding restraint

### Francis Inquiry

- Pledge – Values in Action
- Increase staff engagement in quality improvement
- Improve communication
- Duty of Candour – continue to develop culture of openness
- Nursing Strategy incorporating learning from Francis
- Values based recruitment
- Integration

### The Cavendish Review

- To introduce bespoke Healthcare Assistant development programme

### The Keogh Mortality Review

- To ensure the principles identified in the report are incorporated into the themed action plan
  - Values in action (individual accountability and leadership)
  - Duty of Candour (transparency of data)
  - To note the Keogh inspection framework is likely to underpin further quality inspections.

### Berwick Review

- To further review recommendations following publication of national overarching quality improvement framework
- To review staffing levels following publication of national work
**Winterbourne Review Trust gap analysis** – Table 1 provides an overview of the gap analysis undertaken by the Trust in relation to Winterbourne review. It included an analysis of the overarching recommendations and themes that were discussed in more detail and then further actions to be taken. Themes have been incorporated into the overarching plan.

**Table 1**

<table>
<thead>
<tr>
<th>Winterbourne Review (December 2012)</th>
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<tbody>
<tr>
<td>The Government published its final report in response to criminal abuse by staff at Winterbourne View Hospital revealed through an undercover investigation by the BBC’s Panorama programme in May 2011.</td>
</tr>
<tr>
<td>This report set out a range of national actions which the Department of Health and its partners will deliver to lead a redesign in care and support for people with learning disabilities or autism and mental health conditions or behaviours viewed as challenging</td>
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</tbody>
</table>

**Outcome of Trust Review**

The analysis of the recommendations in the Winterbourne report suggested:

- that a number of the recommendations required consideration across the health economies and would be considered as part of the multi agency partnership working that is driven through the safeguarding boards.

- it was noted in the workshops that there are already a number of comprehensive work streams underway in the Trust that can provide ongoing against some of the recommendations e.g. safeguarding annual work plan, incident reporting processes

- there were a number of recommendations/areas requiring assurance that required consideration by the Trust which are detailed below. These have been considered through the workshops which mapped what the Trust was already achieving and also areas for improvement. It is proposed that the areas identified for improvement will be driven through DONs with assurance on progress provided to the Quality and Governance Committee
<table>
<thead>
<tr>
<th>Overall Theme</th>
<th>Where We Can Improve</th>
<th>What We Have Done</th>
<th>What We Intend To Do</th>
</tr>
</thead>
</table>
| Systems in place to identify patterns of safeguarding issues linked to services | Whilst the trust has systems in place to identify patterns of safeguarding issues, it was considered that further to ensure greater triangulation of information would be beneficial. | • Safeguarding Policies and Procedures  
• Incident Reporting  
• Safeguarding database  
• Monthly governance reports  
• Patient safety co-coordinators  
• Safeguarding lead  
• Safeguarding Strategic Group  
• Exception reporting the Governance and Quality Committee  
• Training  
• Embedding lessons | • Further work required to improve the triangulation of trends including incident reporting, complaints, disciplinary investigations, Positions of Trust, serious incidents.  
• Improve embedding lessons process to ensure information is incorporated from new Trust safeguarding database and serious case reviews  
• Safeguarding dashboard to be revised following introduction of new safeguarding database and requirements of safeguarding boards. This will include service line reporting. |
| Systems and processes in services to take into account the views of service users, their families and other visitors | Carer and family engagement is currently a Trust quality improvement priority for 2013/14. It was considered that this should continue to be a priority and incorporate the learning from Winterbourne | • Triangle of Care  
• Care Planning Process  
• SED  
• Service User Engagement Strategy  
• EBE ward visits  
• CQuin – Friends and Family Test  
• Community Survey  
• Inpatient survey  
• Advocacy  
• Care planning processes (CPA) | • To improve ‘real time’ service user feedback opportunities  
• To incorporate new CQC ‘5 Questions’ into service user feedback processes  
• To incorporate outcome measures from Trust PBR quality model  
• To utilise feedback from STEPs service user feedback |
<table>
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</table>
| Methods in place of identifying competences required and achieved by staff in inpatient services | No further actions identified however once published to review the implications of the proposed nurse revalidation process | • Safeguarding competency framework  
• Medicines management framework  
• HCA training programme  
• MAPA live register and training  
• Mandatory training  
• Suicide prevention training  
• Supervision and PDR process  
• Clinical audit  
• Medical revalidation |  |
| In the use of the MHA are trends identified and monitored in relation to complex cases | Whist systems are in place within the Trust to identify trends, it was considered that further triangulation of trends was required. | • Mental Health Act Co-ordinator  
• Incident reporting  
• Mental health Act Scrutiny Committee  
• CQC compliance visits  
• MHA audit | • To revisit CQC themed inspection action plan and provide assurances on actions taken  
• Further work required to improve the triangulation of trends including incident reporting, complaints, disciplinary investigations, Positions of Trust, serious incidents. |
| Are staff ‘DOLs’ aware and how is compliance monitored | Whilst considerable progress has been made in relation to raising awareness of DOLs further work was identified in relation to compliance with training | • The Trust provides essential training for MCA and DOLs  
• Raised awareness with all staff though staff leaflet  
• Full time MHA Manager  
• Mental Health Act Scrutiny Committee  
• Best Interest Assessors | • To address compliance with MCA and DOLs training |
<table>
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</table>
| Are there systems and processes in place to record and monitor the use of restraint | Whilst systems are in place to monitor the use of restraint, further work was identified in terms of improving the incident reporting system to gather more specific information. | • Restraint currently monitored through electronic incident reporting system  
• MAPA is build accredited and has national recognition –license to practice  
• MAPA policy  
• Governance trend analysis and reports | • To improve the incident reporting system to include further detail of restraint used e.g position, area of body  
• To incorporate best interest planned interventions into lower level of MAPA. |
| Are there training standards for healthcare support workers                    | No further actions identified                                                        | • Healthcare Assistant training programme  
• Mandatory training  
• Supervision  
• PDRs  
• Trust induction  
• Local induction programme  
• Customer Care training |                                                                                   |
| Are there systems and processes are in place to provide assurance that essential standards are being met and that there are governance systems in place to ensure they deliver high quality and appropriate care. | No further actions identified                                                        | • CQC workbooks  
• Clinical Governance processes  
• Trust Quality governance framework  
• CQC visits  
• Hear and Now Quality reviews  
• AIMs accreditations  
• CQR meetings  
• Quarterly performance  
• Clinical audit  
• QGAF  
• TDA  
• Integrated dashboard |                                                                                   |
Francis Inquiry gap analysis Table 2 provides an overview of the gap analysis undertaken by the Trust in relation to Winterbourne review. It included an analysis of the overarching recommendations and themes that were discussed in more detail and then further actions to be taken. Themes have been incorporated into the overarching plan.

Table 2

<table>
<thead>
<tr>
<th>Francis Inquiry 2010/13 and the initial Government response Patients First and Foremost (March 2013)</th>
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<tbody>
<tr>
<td>The second Francis Inquiry, published on the 6 February 2013, signals a need for significant change in the NHS. The Inquiry examines the involvement of numerous agencies involved in the events at Mid Staff during 2005 - 2009. The conclusions and the 290 recommendations are drawn from some 300 witness statements and further consideration of the first report.</td>
</tr>
<tr>
<td>Following the publication of Patients First and Foremost, the Secretary of State wrote to Trust Chairs calling to action every individual and organisation within the Health and Care system, to reflect on our behaviours and priorities. In order to support staff to bring about the cultural change, the Government revised the NHS constitution to take into account the lessons from the Public Inquiry. It makes it clear to staff the importance of common values, and in particular the fundamental value “working together for patients”. In addition, it is requested that all NHS hospital should set out publicly how they intend to respond to the inquiries conclusions before the end of 2013.</td>
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<tr>
<th>Outcome of Trust Review</th>
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<tr>
<td>The initial findings from the Francis Report have been considered as part of the Trust’s journey to develop robust quality governance. This is evidenced in the Trusts Quality memorandum and also in the evidence attached to the QGAF. The QGAF is monitored quarterly through the Governance and Quality Committee and the Trust Board. Examples of areas of improvement include e.g. Trust escalation process for raising concerns, Hear and Now Reviews, Staff nurse development programme, Service line performance reporting, Quality improvement programme, MEXT work shadowing, NED alignment to service lines, Expert by Experience visits, Clinical Directors</td>
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<tr>
<td>Following the publication of the second Francis report the Trust Board discussed in depth and reviewed the implications and the Francis Report at a Board Development Session</td>
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<td>The Trust has also participated in the regional listening events regarding the Francis Inquiry which has provided an opportunity to share insights, ideas and inspirations.</td>
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<tr>
<td>The Trust then held several workshops led by the Executive Director of Operations and Nursing and facilitated by Learning and Development to undertake the gap analysis explore lessons that can be leaned and actions required.</td>
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The analysis of the 290 recommendations in the Francis report suggested:

- that approximately 50% of the recommendations are for consideration by regulators and commissioners although it is acknowledged in the longer term they will impact e.g. changes to CQC.

- there are already a number of comprehensive work streams underway in the Trust that can provide ongoing reassurance against some of the recommendations e.g leadership events, 2013/14 quality improvement, priorities, staff nurse development programme. This is detailed in the QGAF evidence.

- the Francis recommendations are already reflected in the Trust core values and should continue to be a fundamental part within Trust work programmes.

- alongside existing work streams the following themes were identified in the DONs workshops as key areas for further development were identified through the workshops. The themes have been endorsed by MEXT which added a further theme of integration.

<table>
<thead>
<tr>
<th>Overall Theme</th>
<th>Where We Can Improve</th>
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<tbody>
<tr>
<td>Pledge – Values in Action</td>
<td>Evidence that all staff have reflected on their behaviors and priorities to ensure the fundamental value of ‘working together for patients’ (NHS Constitution) and staff understand their accountability for attitude and behaviors.</td>
<td>Customer care training, Appraisals PDRs, Professional codes of Conduct, Trust vision and Values, Trust policies and procedures, Health and wellbeing strategy, Supervision Policy, HCA components cover various aspects, Leadership events</td>
<td>Improve links with KSFs with values, Ensure the Trust contracts reflect the values of the organisation, Revisit processes for reflective practice – ensure they reflect Trust values</td>
</tr>
<tr>
<td>Overall Theme</td>
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| Increased staff engagement in quality improvement | To develop further opportunities to engage and listen to staff for the purpose of quality improvement | • Quality Improvement Strategy  
• Bright ideas  
• Ask Gary  
• Service line quality groups  
• Team meetings  
• Governance and Quality road shows  
• Clinical audit  
• Hear and Now Quality reviews – peer involvement  
• MEXT work shadowing  
• Trust escalation framework | • 4 events a year to present an idea to improve patient care. ‘Quarterly Innovation Sessions’ lead by DONS  
• Quarterly newsletter feeding back to staff – You said, We did  
• Undertake further Quality and Governance Road shows  
• Identify further training opportunities for staff regarding quality improvement e.g clinical audit  
• To further develop opportunities for sharing best practice and learning. |
| Improving communication                           | To further develop the effectiveness of communication within service areas – ‘making messages as clear and simple’ | • Team brief  
• Wednesday wire  
• Ask Gary  
• Bright ideas innovation scheme  
• Active desktop  
• Intranet  
• Team meetings  
• DONs  
• Leadership events | • You said, We did” type format“  
• Need to look at how different management styles encourage discussions or stifle – incorporate into leadership development  
• Review intranet and include staff views and service users views on how improvements can be made to layout  
• Look at ways to make information clear and concise  
• Encourage managers to have free discussion time in team/business meeting  
• Communications audits |
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</table>
| Duty of Candour       | To continue to develop a culture of openness and transparency across the organisation | • Serious Incidents  
                        |                        | • Contracts  
                        |                        | • Service Users and Carers Involvement  
                        |                        | • Data quality improvement plan  
                        |                        | • Whistleblowing  
                        |                        | • Ask Gary  
                        |                        | • Meetings with families following serious incident  |
|                       |                                                                                     | • Need to encourage staff to speak out  
                        |                        | • Encourage openness and transparency in team meeting etc..  |
| Nursing Strategy      | To refresh the strategy for nursing to ensure it fully includes learning from the Francis Report and reflects Trusts strategic direction | • Staff nurse development programme  
                        |                        | • HCA development programme  
                        |                        | • Learning and development strategy  
                        |                        | • Dignity champions  
                        |                        | • PRIDE  |
|                       |                                                                                     | • To re-launch Nursing Strategy ensuring it encompasses learning from Francis report and Trust strategic direction.  |
| Values based          | To revisit recruitment processes with a view to introducing values based component to recruitment process | • Staff nurse recruitment  |
| recruitment           |                                                                                     | • To introduce values based recruitment  
                        |                        | • Looking at ‘market place’ recruitment  
                        |                        | • To participate in recruitment fairs  |
| Improve Integration   | To ensure an integrated approach to the delivery of Trust business to promote positive outcome for service users. | • Service transformation  
                        |                        | • Embedding lessons processes  
                        |                        | • Leadership events  
                        |                        | • Trust visions and values  |
|                       |                                                                                     | • To ensure all professional bodies policies need to work together not against each other to promote greater integration.  
                        |                        | • To ensure services are working in an integrated way to enable greater triangulation of information and promote early intervention and trend analysis.  |
Cavendish Review Table 3 provides an overview of the gap analysis undertaken by the Trust in relation to the Cavendish review. The key recommendation relevant to the Trust is in relation the health Care Support Workers.

Table 3

**Cavendish Review – An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings**

Camilla Cavendish was asked by the Prime Minister to undertake a review of the key issues of how healthcare assistants and social care assistants are valued and supported. This ‘Cavendish Review’ was launched in May 2013 with a report published in July 2013. The recommendations included:

**Outcome of Trust Review**

In response to the recommendation regarding Healthcare Assistants (HCA), the Trust has taken a proactive approach and commenced a comprehensive development programme for all Healthcare Assistants. The HCA development commenced in October 2013.

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<thead>
<tr>
<th>Overall Theme</th>
<th>Where We Can Improve</th>
<th>What We Have Done</th>
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<tbody>
<tr>
<td>HCA development</td>
<td>Provide a comprehensive development programme for</td>
<td>Developed a bespoke HCA development programme which has commenced in October 2013</td>
<td>Evaluate development programme Review following publication of national programme</td>
</tr>
</tbody>
</table>

The Keogh Report Table 4 provides an overview of the gap analysis undertaken by the Trust in relation to the The Keogh Report

Table 4

**The Keogh Report – Review into the quality of care and treatment provided by 14 hospital Trusts in England July 2013**

**Background/ National Context**

The Keogh Review focuses on the quality of care and treatment provided by 14 hospital Trusts in England. Professor Sir Bruce Keogh published his report into 14 hospitals with high mortality rates on 16 July 2013.

The review highlighted concerns in the 14 hospitals and as a result required urgent action to be taken to improve quality and safety of some of the services they provided.
Outcome of Trust Review
Trust initial response

In October 2013 a document outlining the roles and responsibilities of the national oversight bodies around improvement work with the Keogh Trusts was published. This document is relevant to the Trust as it is a blueprint for the wider system on how it should respond to future challenges where quality of care comes under the spotlight. The document also includes some key messages for Trusts which will require further consideration, however on first impressions the work undertaken within DONs in relation to the Francis report has focused on ‘values in action’ which will take on board the key messages within Keogh.

- Individual health and care professionals, their roles and behaviours as actions, are the first line of defence in maintaining quality
- The leadership within provider organisations is ultimately responsible for the quality of care being provided by the organisation
- Trust Boards are responsible for quality in their organisation, including making data transparently available on their results;
The Berwick Report Table 5 provides an initial position statement undertaken by the Trust in relation to The Berwick Report

Table 5
Berwick review ‘Improving the Safety of patients in England’

<table>
<thead>
<tr>
<th>Background/national context</th>
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<tbody>
<tr>
<td>The Berwick report was published in August 2013. The Berwick Report sets out a transparent framework for the continuous improvement of quality within the NHS and also acknowledges the enormous importance of the Patient and Service User voice being heard and heeded at all times.</td>
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<table>
<thead>
<tr>
<th>Outcome of Trust Review</th>
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<tbody>
<tr>
<td>Trust response - first Impressions:</td>
</tr>
<tr>
<td>At the time of writing this report further work is required to consider fully the implications of the Berwick review in the context of the Trust however first impressions are</td>
</tr>
</tbody>
</table>

- The Berwick Report condenses the 290 Francis recommendations into 10 principle based recommendations.
- The Berwick Report does not soften the Francis Inquiry in any way but is more progressive on how you really embed a culture of self-regulation and continued learning with a powerful criminal sanction for individuals who mistreat or neglect patients.
- The report really does highlight the need for the NHS to fully commit to an open, transparent culture with a continual drive for Zero harm with continual improvement being the key.
- The Berwick report provides a strong platform for the Trust Board to discuss and consider any amendments that need to be made to the Trusts current Quality Improvement Framework and strategy. This should be in the context of pending DOH publications.
- it is anticipated that the Berwick report and its recommendations will form part of the Governments response to Francis due later this year and it appears likely that there will be a case made for NHS providers to adopt a single over-arching Quality Improvement Framework. The Trust should further review the recommendations following the publication of national overarching quality improvement framework
- Since the publication of the report there has been media coverage in relation to minimum staffing levels which are being looked at nationally. There is an opportunity for the Trust to involve in this work and utilise as part of service transformation