Bay Governance Blog

University Hospitals of Morecambe Bay NHS Foundation Trust

Improving the Quality of Healthcare for our Patients

Issue 4

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Good Governance in Today's NHS

I want to start this month's blog by saying that there are exciting times ahead for Governance, especially as we are going to develop a **CQC Assurance Framework** – to enable the Trust to move to a position of sustainability and continuous improvement to achieve a CQC rating of 'Outstanding'.

The Framework will be created to continually assess ourselves and identify any potential weak areas for development. We will utilise NHS Improvement's Well-led Framework: 10 high level questions and principles of good practice aligned with the CQC'S characteristics of 'good' under their Well-led domain Key Lines of Enquiry (KLOE), which is now reflected in the CQC's assessments and ratings.

I hope that all staff will strive forward and contribute to achieving this rating and I look forward to working with you.

Mary

The Governance Hub

The Governance Hub is a supportive unit assisting in many areas across the division.

Most recently, the Hub has been assisting Fliss Swift, Patient Experience Manager. A major aspect within Patient Experience is promoting, collating and analysing the feedback from the Friends and Family Test (FFT). In recent years, the Trust's FFT has been hosted by 'I want Great Care' (iWGC). However, following a recent tendering process, this will, from the 1st April, be hosted by HealthCare Communications. The 'switch over' will happen on the 1st April, although you shouldn't initially see any major differences. There are, however, some changes planned with the swap from paper feedback forms to electronic on all in-patient wards and to use tablets for local survey work too – the majority of outpatient and ED feedback will continue to be captured using SMS and Interactive Voice Recordings (IVR). So, 'keep an eye' out for electronic tablets being used.

Look forward

NHS England have recently updated their guidance around a structured judgement review for mortality and the Hub will be undertaking some work with Ulysses to see how this can be incorporated into the Ulysses Safeguard System.

Louise, Joe, and the Team

An Effective Board

At the Trust, we have spent time to develop the roles and behaviours of the Board to make them as effective as possible.

This focus on the behaviours, roles, relationships and competences all affect the dynamics of the board, differs from much of the existing guidance, which focuses on the role and purpose of the board and on governance processes. We are seeing how behaviour in the boardroom is key to the effective management of quality.

So how does our Board encourage effective management of quality?

Firstly, by learning to listen; boards that don't listen to patients, governors, commissioners and staff lose the opportunity to put things right. A failure to listen can be prompted by many things, including a fear of challenging one another and of conflict – even the healthy kind – or a lack of trust. The board handles difficult news well, and clinical staff, as well as NEDs and Executives are comfortable with bringing bad news to the board when necessary. This is all part of keeping the board honest about its core business, and one reason why working with behaviours is so rewarding. It's no coincidence that the qualities of openness, integrity and honesty are at the centre of the values and behaviours required by boards.

Mature boards are able to combine the disciplines of formal board behaviour with the ability to respond in a 'human' way to painful scenarios: boards should be able to show an emotional response and not hide behind 'performance management speak'. If they're not capable of a strong response to bad news, where will the energy come from to change the situation? Like all teams, this Board does not seek to be guilty of avoidance, but instead tackles problems head on.

The competence of individual board members lies at the heart of the performance of whole boards –their ability to deal with difficult issues or to avoid them, to raise the tone of the debate or to reduce it to operational levels, and their skills in getting to the heart of things without ruffling feathers. These are important qualities in board members that need development or coaching.

Quality is the responsibility of the whole board, and the work of the Quality Committee is important to the Trust. The relationship between the Quality Committee and the main board is key and, here again, behaviours and culture are important: on an effective board, the chair will think about how to bring the energy and flavour of the Committee into the whole board to keep everyone engaged on quality.

Pollution and Learning

The BBC reported this week (http://www.bbc.co.uk/news/world-europe-39115829) about pollution in the Chamonix Valley, which has become the most air polluted area in the French Alps. This follows recent reports in the press about "dirty diesel" cars and small particulates.

Air pollution caused around 7 million premature deaths in 2012, according to the World Health Organization. Tens of thousands of people are dying early in the UK every year because of toxic fumes. Furthermore, air pollution is linked to terrible health effects, including asthma and impaired lung development in children. If left unaddressed, by 2050 it will overtake poor sanitation and polluted drinking water to become the leading environmental cause of death worldwide.

There is history……

When Britain was the workshop of the world its coal consumption increased from around 10 million tons per annum in 1800 to almost 200 million tons in 1950. A permanent smoke haze enveloped cities like Glasgow, Leeds, London and Manchester. It blocked out the sun, blackening buildings, increasing the severity of fog episodes and damaging people's health. Coal smoke was linked to very high death rates from respiratory diseases such as bronchitis, killing between 800,000 and 1.4 million people in the period 1840-1900.

Lack of exposure to sunlight meant that rickets – a disease that affects healthy bone development in children – was endemic in industrial towns.

The 1952 London smog disaster – now thought to have claimed as many as 12,000 lives – was the catalyst for the development of comprehensive air pollution controls in Britain. Following this tragedy, the government passed the **Clean Air Act of 1956**, which for the first time regulated both domestic and industrial smoke emissions. Historians widely considered it to be an important milestone in environmental protection. The legislation included powers to establish smokeless zones, and provided generous subsidies to householders to convert to cleaner fuels (smokeless solid fuel, gas and electricity).

This energy transition did not happen overnight. It took around three decades, and another **Clean Air Act in 1968** (to deal with slow-moving local authorities), before smoke control programmes were finally completed. By the 1980s, the skies had cleared, improving health and quality of life in the cities of the first industrial nation (although the problem is not yet eradicated).

Whilst the initial reaction to the Chamonix valley pollution may be to blame transport, a study has shown that 60-80% of the fine particle pollution is caused by traditional wood burning stoves and fires used in the area.

What's this got to do with patient safety…..

Well it is perhaps a good example of failure to learn from events. If there are any lessons to be learned from Britain's Age of Smoke, they are:

- Stronger political leadership is required on environmental issues (tough legislation on smoke was long overdue in 1956)
- Overcoming cultural obstacles to environmental change will not be an easy task
- Energy transitions can take a long time to complete
- Organising and legislating to mitigate or adapt to slow onset disasters such as climate change – whose effects are not as obvious to the public – will be challenging.

In the case of Chamonix, the second point is why the lessons may not have been "learned". The key is that the information to improve air quality has been around for a long time. Information is often available and we provide it in various forms and through training – but it is not always assimilated and put into practice. **Learning is changing and sustaining - not information giving!**

Geoff and the Patient Safety Team

An Introduction to the Legal Services Department

What do we do?

We deal with claims and inquests and are the first point of contact for legal advice for the Trust.

Where can you find us?

We are based at Westmorland General Hospital on level 4.

Who are we?

Ranu Rowan is Head of Legal Services. Gareth Dodds and Claire Rawlinson are Legal Services Officers and deal with clinical claims and inquests. Claire joined the team in January and is providing maternity cover for Emma Brough. Rachel Breakell and Natalie Hartley are part time Legal Services Assistants and deal with employer's liability claims. Joelle Boyd is a part time secondee from Hill Dickinson solicitors and deals with inquests.

Tell me more about clinical claims...

A clinical negligence claim can be made by any patient who believes that they have endured suffering or loss as a result of negligent clinical practice. The procedure for making a claim is set out in the *Pre-Action Protocol for the Resolution of Clinical Disputes*, which can be found on the Ministry of Justice website.

The first step is for the Claimant's solicitor to apply to the Trust for a copy of the patient's medical records, which must be provided within 40 days. The solicitor will then send these to an independent doctor to consider if the clinical practice may have been negligent. If so, the solicitor will submit a formal *Letter of Claim* to the Trust. This sets out the allegations of negligence and the suffering or loss which is alleged to have resulted. The Trust then has 4 months to respond in a formal *Letter of Response*. The information for the Letter of Response will come from appropriate Trust clinicians and independent doctors asked to consider the evidence on the Trust's behalf. If a claim is admitted, settlement will be negotiated at this stage. If a claim is denied but the Claimant still thinks they have a case, a claim will now be issued in court. Further evidence will then be obtained by both parties and the claim will be defended or settled on the basis of this. It is rare for a claim to reach court, due to the exchange of evidence and the costs involved.

Clinical Negligence Scheme for Trusts

NHS Litigation Authority

Payments in respect of successful clinical negligence claims are made from the Clinical Negligence Scheme for Trusts (CNST), administered by the NHS Litigation Authority (NHSLA). The CNST is a pooling scheme, which provides indemnity for clinical negligence claims against members and UHMB is a member. Each year, money is collected from the members to cover the estimated total cost of claims to be paid during that year.

In the calendar year 2017, the Trust received 112 requests for records and 29 new claims were reported to the NHSLA. The NHSLA publishes claims data on its website (look for Factsheet 5) and this shows that in 2015/16, the scheme paid out £7M in damages in respect of clinical negligence claims against UHMB and a further £3M in Claimant legal costs.

Ranu and the Legal Team

UHMB LIBRARY SERVICES

Professor Ian Cumming OBE, Chief Executive, HEE said: "Every day across the healthcare sector more than a million decisions are made which have a profound impact on people's lives and which influence the quality and cost of healthcare services. The Government and health organisations have obligations under the Health and Social Care Act to ensure the use of evidence from research and to make use of the best available evidence in their decision-making."

A MILLION DECISIONS

#Amilliondecisions was launched by Health Education England on the 30th January (UHMB Case study used in campaign) thought this was a good opportunity to share some of the questions we've helped with over the past six months:

- In undergoing primary myringoplasty, are artificial grafts better than autologous grafts for revision rates? Type 1 tympanoplasty, biodesign, temporalis fascia
- How does this Trust compare to other trusts in terms of same day patient cancellations in ophthalmology theatres?
- Do we need to use filter needles to draw up drugs for IV administration in adults? The research that says glass particles cause problems appears to be >20 years old.
- A piece of equipment exists to help GPs identify bacterial/viral infections is available and if installed in GP practices could potentially reduce the antibiotic prescription budget - details, costs etc. and evidence please?

Contact us if you think we can help - email library@mbht.nhs.uk; twitter @UHMBTLibrary or website https://www.uhmb.nhs.uk/our-services/library-and-knowledge-services/contact

Tracey and the Library Services Team