

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th September, 2013

10.00 am

**Darent Room, Sessions House, County Hall,
Maidstone**





AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th September, 2013, at 10.00 am
Darent Room, Sessions House, County
Hall, Maidstone

Ask for: **Tristan Godfrey**
Telephone: **01622 694196**

Tea/Coffee will be available from 9:45 am

Membership

- Conservative (7): Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
- UKIP (3): Mr L Burgess, Mr J Elenor and Mr R A Latchford, OBE
- Labour (2): Dr M R Eddy and Ms A Harrison
- Liberal Democrat (1): Mr D S Daley
- District/Borough
Representatives (4): Councillor C Woodward, Councillor Mr M Lyons, and Councillor S Spence (one vacancy)

Webcasting Notice

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

- | Item | Timings |
|----------------------------|---------|
| 1. Introduction/Webcasting | |

2. Substitutes
3. Declarations of Interests by Members in items on the Agenda for this meeting.
4. Minutes (Pages 1 - 6)
5. Forward Work Programme (Pages 7 - 10) 10:00 – 10:10
6. Medway NHS Foundation Trust: The Keogh Review (Pages 11 - 62) 10:10 – 11:00
7. West Kent CCG: Mapping the Future (Pages 63 - 76) 11:00 – 12:00
8. Date of next programmed meeting – Friday 11 October 2013 @ 10:00 am

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
 Head of Democratic Services
 (01622) 694002

29 August 2013

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 19 July 2013.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr R A Latchford, OBE, Mr G Lymer, Mrs Z Wiltshire (Substitute for Mr L Burgess), Cllr M Lyons and Cllr R Davison (Substitute for Cllr Chris Woodward)

ALSO PRESENT: Cllr Mrs A Blackmore

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting

(Item 1)

2. Declarations of Interest

- (a) Mr Nick Chard declared a personal interest in the Agenda as a Non-Executive Director of Health Watch Kent.
- (b) Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes

(Item 4)

- (a) Following up one the issues discussed at the previous meeting, the question was put to the Chairman as to the possibility of having a look at outpatient services at Deal Hospital. The Chairman responded positively and said it would be found a place on the Forward Work Programme.
- (b) RESOLVED that the Minutes of the meeting of 7 June 2013 are correctly recorded and that they be signed by the Chairman.

4. The Francis Report: Update

(Item 5)

Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England), and Dr Steve Beaumont (Chief Nurse, NHS West Kent CCG) were in attendance for this item.

- (a) The Chairman welcomed the Committee's guests and they introduced themselves and provided an overview of the topic with the aid of a PowerPoint

which was shown in the meeting and also made available in advance of the meeting and contained in the Agenda pack Members had before them.

- (b) Dr Beaumont explained that in his previous career in the military, he had sent staff to Mid-Staffordshire Hospital and feedback mirrored the comments in the Francis Report about the hospital's 'unhealthy, dangerous culture'. However, it was also stressed that underneath there was still good nursing care provided. He went on to explain that along with the other Chief Nurses at Clinical Commissioning Groups (CCGs) across Kent, his priority was to address issues around quality of care. The Francis Report contained 290 recommendations and promoted a 'board to ward' approach to implementation. In the new NHS landscape, this was the equivalent to saying 'CCG to provider'. Dr Beaumont explained that he would be visiting all providers, starting with the main Acute Trust in his CCG area (NHS West Kent CCG), Maidstone and Tunbridge Wells NHS Trust, and moving on to all others, including independent providers.
- (c) His CCG held their board meetings in public and there were PPGs (Patient Participation Groups), lay member involvement and patient satisfaction data on which to draw. There was a new complaints system in the NHS and information was available direct from providers as well as that which went direct to CCGs. In addition, the NHS Constitution underpinned everything which was done in the NHS. This covered actions by staff and patients as it was in effect a concordat. The NHS had to deliver safe care, but patients had a responsibility to turn up to appointments.
- (d) One particular area of data was highlighted, that around serious incidents and 'Never Events.' Members asked for some examples of what came under these terms and it was explained that the context defined what or was not a serious incident. An example was given of an incident where the patient was satisfied with the outcome of the treatment received, but which was still reported and classified as a serious incident. In this particular case a simple change was possible, reducing the chance of it recurring. The key aim was to get people to regard serious incidents as an opportunity for learning rather than to pinpoint somebody to blame. In places where there has been a defensive culture, events might be downgraded to avoid reporting. This was something which needed to change. Staff involved in a serious incident were debriefed. The other side of this was the importance of spreading best practice. These points were relevant to health and social care, with each sector able to learn from the other. The outcomes of the Berwick review were awaited and were expected later in July. Professor Don Berwick was an international safety expert, and had particular experience of the USA, which had a different culture in its health services and which would mean the results of the report would need careful consideration.
- (e) In response to a specific question it was explained that attitudes to whistle-blowing were changing and becoming more positive. It was suggested that the defence ombudsman model could be something the NHS could consider. In addition, each CCG had a Chef Nurse who was outside of the chain of command and they were all a source of support for nursing staff.

- (f) Tackling issues of safety and quality of care involved looking at the education and training of staff. NHS representatives brought the Cavendish Report to the attention of the Committee. This looked at the training received by Health Care Assistants (HCAs). The report found this to be variable, with some training consisting of nothing more than the viewing of a DVD. This had an impact as registered nurses were still responsible for the quality of any care delegated to a HCA. It was unclear how this worked in the community setting. Against this variability, there was a need for a clear career progression for HCAs. The debate on whether there was a need to register HCAs was also raised. Although no definitive answer on one side or the other was given by NHS representatives, the point was made that it was currently perhaps too easy for a HCA who had been sacked in one area to move to another and find a new job.
- (g) There were also wider issues around recruitment and training to consider. The importance of recruiting people with the right values was discussed. This included medics and values based assessment was being introduced across the NHS. Members brought up the suggestion that the idea of nursing being a vocation had been lost when nursing became a graduate career. It was explained that this had been introduced in part to ensure nurses had parity of esteem with other professions within the NHS. However, work was currently ongoing locally with Canterbury Christ Church and Greenwich University to make nurses education more practical. Work was also being done to address the fact that there were minimum standards for midwifery and intensive care nursing, but not for nursing on general wards. The Chief Nursing Officer for England introduced the 6 Cs last year and these were being relaunched with the idea of covering all caring staff, including those in social care. These 6 Cs are Care, Compassion, Competence, Communication, Courage and Commitment.
- (h) At the national level, Health Education England was a new organisation charged with providing leadership for the new education and training system. The improvement of training around end of life care was a priority. More broadly it was recognised that there was a need to avoid a system where a trainee's energy and enthusiasm was reduced.
- (i) Members also raised concerns about the barriers to putting quality at the heart of care due to the apparent tendency for NHS organisations to work in silos, both within an organisation and between organisations. NHS representatives replied that there was a genuine opportunity to make positive changes in this area now. There had been a series of major reports which required a response. Locally, there was the Keogh report into Medway Hospital, and this report raised questions for all hospitals to consider, not just Medway. The point was also raised as to why it needed a major report to be published before action was taken. It was acknowledged that there was a need to tap into knowledge of local issues and react before this stage. CCGs were visiting local providers and leading clinicians in CCGs were working shifts at local providers to see the situation at the ground level and data was being used to identify the key areas to investigate further. NHS representatives also pointed out that the experiences of students needed to be tapped into as they saw a range of places and services and were in a good position to make comparisons between good and bad practice.

- (j) Part of the issue was the difficulty in defining quality and there was a need to get beneath a service being simply labelled as 'green' or 'red'. This was where the Quality Surveillance Groups (QSG), hosted by NHS England local teams, were so valuable. For the first time there was a formal way to bring soft and hard intelligence on the quality of health and care provision together. Commissioners, local authorities, regulators and Health Watch were all represented on the local QSG. There was a QSG for Kent and Medway. In the transition from Primary Care Trusts to CCGs, there had been a quality handover as well of the kinds of information which would be of value to the new commissioners. The question was asked about the role of the public on the QSG. It was explained that there was a need to ensure public access to the relevant records. It was suggested the role of Health Watch might also need to be strengthened.
- (k) There were also changes to the regulatory system reported to the Committee. There was a Burdens review underway with the aim of reducing regulations and paperwork by a third. There were acknowledged issues at the CQC and this was one area where the system was being simplified. This would include ratings for providers and a 'well run' test. The current system was too complex to enable members of the public to properly judge the quality of a service. Separate Chief Inspectors for hospitals, social care and primary care had either been already appointed, or would be appointed. Opinions on these were split between seeing them as a positive way forward or an additional layer of bureaucracy. It was explained that the Chief Inspector of hospitals would be available to go into hospitals which had been placed in special measures. More broadly there was an accountability review looking at three levels – individual, organisational, and system failure.
- (l) The 'friends and family' test was being rolled out across a number of health sectors, including for prisoners. This would provide a useful source of data and information.
- (m) The hope was expressed that the measures being taken would improve public confidence in the NHS. Members of the Committee and NHS representatives discussed the difficulty in getting good practice and success stories a higher profile in the media, who were more interested in negative stories. NHS representatives explained that the media reaction to stories also differed across the sector with the Keogh report into Medway getting a higher profile in the local papers than on the radio. The point was also made in discussion that public confidence was more than just a matter of reporting in the media, with nursing and other staff travelling to and from work in uniforms given an example of the negative impression which could be given.
- (n) The impact of the Francis Report was also discussed. A Member indicated that there were 290 recommendations, which was a large number to consider. Some of the recommendations dealt directly with scrutiny. One of them was for the need for health scrutiny to have the appropriate support and this meant that Members needed to know enough to be able to ask the right questions when presentations were delivered at HOSC. NHS representatives explained that they were more than happy to have more involvement by HOSC Members in the day to day business of the health sector, including taking part in visits or

shadowing. On the number of recommendations, it was indicated that it would not be possible to come up with a response to all 290 locally and there was a need to be aware of and link into work being led nationally by the Department of Health and others. The request was made that a paper be prepared on how HOSC, the Health and Wellbeing Board, and Health Watch all fitted together.

- (o) A series of questions on specific services were asked during the meeting. It was explained that the Deputy Chief Nurse had a special interest in working with the police on mental health issues and work was being done with Kent and Medway NHS and Social Care Partnership Trust around custody suites and that this should show some benefits. On the levels on attendance at accident and emergency departments, it was explained that there were 17,000 care home beds across Kent and Medway and it was necessary to ensure better care was being delivered here to reduce attendance at accident and emergency departments. More broadly, there a need to ensure appropriate community health services were in place. For example, the current model of district nursing needed to be considered to see if it was the best way of delivering services, particularly as many district nurses were nearing the age of retirement.
- (p) The Chairman proposed the following recommendation:
 - That the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting and looks forward to receiving a further update in November, in particular in relation to quality surveillance aspects.
- (q) AGREED that the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting and looks forward to receiving a further update in November, in particular in relation to quality surveillance aspects.

5. Chairman's Update

- (a) The Chairman explained that, through the South East Health Scrutiny Network, he had taken part in a visit to the 111 call centre in Dorking along with the Researcher to the Committee. This had been an interesting and informative day and had also provided the opportunity to hear from South East Coast Ambulance Service NHS Foundation Trust about their future plans more broadly. Members responded positively to the suggestion that a similar site visit be arranged for them to the 111 call centre in Ashford.
- (b) The Chairman proceeded to then explain that a Forward Work Programme for the Committee was being developed and asked for suggestions as to what could be included. The specific request to consider outpatient and post-operative care in Deal was raised again. The request was also made as to whether it might be possible for the Committee to meet in Deal to consider the commissioning plans of the Thanet CCG. In response the Chairman and Researcher to the Committee explained that there had been correspondence between the Chairman and the Chairman of the Overview and Scrutiny Panel at Thanet District Council as to the ability locally to look at these plans. It was also stated that it was already the intention to consider the commissioning

plans of CCGs as part of the regular work of the Committee and this would commence in September.

- (c) The need for Members to be better informed and trained on issues around the Francis Report was also raised as this was one area where the Committee needed to be on top of the subject. The Chairman said this was something which would be looked at.

6. Date of next programmed meeting – Friday 6 September 2013 @ 10:00 am
(Item 6)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 September 2013

Subject: Outline Forward Work Programme

Summary: This report invites the Health Overview and Scrutiny Committee to note a suggested Outline Forward Work Programme pending the development of a longer term Forward Work Programme in the near future.

It provides additional background information which may prove useful to Members.

1. Introduction

- (a) The majority of the changes to the health sector landscape introduced by the Health and Social Care 2012 came into effect on 1 April 2013. Following the County Council elections on 2 May 2013, the new Membership of this Committee was confirmed.
- (b) The intention is for meetings to be arranged between representatives of the new Clinical Commissioning Groups and the Chairman, Vice-Chairman and Group spokespersons with a view to drawing up a longer term Forward Work Programme.
- (c) In the interim, the following Outline Forward Work Programme for the next series of meetings is presented, based on issues already raised by Members of the Committee or arising from requests from the NHS.

2. Outline Forward Work Programme

- (a) 11 October 2013:
 - Patient Transport Services.
- (b) 29 November 2013:
 - NHS 111 in Kent. (NB: An opportunity to visit the 111 call centre in Ashford will have been made available prior to this meeting).
 - Francis Report: Quality Surveillance.
- (c) January 2014:
 - Adult Mental Health Inpatient Services: Action Plan.

Item 5: Outline Forward Work Programme

- (d) In addition, an appropriate time will be found for a discussion on the strategic commissioning plans of all the CCGs in Kent. This process has begun with today's item on NHS West Kent CCG.
- (e) At the meeting of 19 July, the request was made that the Committee look at outpatient services at Deal Hospital. It is proposed that a site visit and briefing take place initially, to which all HOSC Members will be invited.
- (f) Ways of developing the relationship between HOSC and the Health and Wellbeing Board are also being discussed. It is likely that there will be items originating from the Health and Wellbeing Board on the Agenda in future meetings, such as the Joint Health and Wellbeing Strategy.
- (g) The changes to the health sector landscape initiated by the Health and Social Care Act 2013 are also likely to generate changes of interest to the Committee, such as the creation of Academic Health Science Networks. Where appropriate, briefings on these will be arranged for Members and/or time will be found during formal meetings.
- (h) There is a need to retain as much flexibility as possible in the forward work programme in order to deal appropriately with issues which may arise within the health economy. The exact scheduling of some of the items listed above may vary.
- (i) In order to assist with forward planning, the forward work programme will be circulated to all NHS Trusts in Kent. If any Member has any specific question on any of the items on the forward work programme which they would like asked of the relevant Trust(s) in advance of the item being discussed, please pass them to the Research Officer to the Committee for inclusion in the list of questions submitted to the NHS in advance.

3. Kent and Medway NHS Joint Overview and Scrutiny Committee: Adult Inpatient Mental Health Services Review.

- (a) The work of the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) into the Adult Inpatient Mental Health Services Review concluded at its meeting of 30 July 2013 with the following recommendation:

The Committee supports the NHS proposals and asks that the report and recommendations of the independent report commissioned by the JHOSC be presented to the CCGs when they are asked to consider the next steps set out in the NHS briefing paper on p.21 of the Agenda. In particular, the Committee asks for, in line with the independent report:

Item 5: Outline Forward Work Programme

- *A significant increase in the retention for reinvestment, to be spent on further increases in crisis resolution/home treatment and a small number of additional acute beds*
 - *A clear plan being developed for the delivery of the elements of genuine centres of excellence in the three remaining sites*
 - *An action plan to be prepared within three months to be overseen by NHS England and Kent County Council and Medway Council Health Overview and Scrutiny Committees.*
 - *Regular monitoring of performance to be undertaken in light of experience as changes progress.*
- (b) The Kent and Medway NHS Joint Overview and Scrutiny Committee will not meet again on this topic having concluded this review. The Health Overview and Scrutiny Committee will receive the action plan for review as set out in the JHOSC recommendation above. As can be seen above, January 2013 has been suggested for this.

4. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to note the report.

Background Documents

Agenda for the Kent and Medway NHS Joint Overview and Scrutiny Committee, 30 July 2013,
<https://democracy.kent.gov.uk/ieListDocuments.aspx?CIId=757&MIId=5337&Ver=4>

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Item 6: Medway NHS Foundation Trust: The Keogh Review.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 September 2013

Subject: Medway NHS Foundation Trust: The Keogh Review

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Medway NHS Foundation Trust on the Report for Medway NHS Foundation Trust produced as part of the Keogh Review into the Quality of care and Treatment provided by 14 Hospital Trusts in England.

It provides additional background information which may prove useful to Members.

1. Introduction

(a) Following the publication of the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report), on 6 February 2013 Sir Bruce Keogh was asked by the Prime Minister and Secretary of State for Health to conduct an immediate investigation into the care at hospitals with the highest mortality rates and to check that urgent remedial action was being taken.¹

(b) 14 Trusts were selected on the basis of being outliers for two consecutive years on one of two measures of mortality. Sir Bruce Keogh initially named five Trusts who had been outliers for a period of two years against the Summary Hospital-level Mortality Indicator (SHMI).² This was followed up by naming 9 Trusts who had been outliers for a period of two years against the Hospital Standardised Mortality Ratio (HSMR).³ These Trusts are:

- Colchester Hospital University NHS Foundation Trust (SHMI)
- Tameside Hospital NHS Foundation Trust (SHMI)
- Blackpool Teaching Hospitals NHS Foundation Trust (SHMI)
- Basildon and Thurrock University Hospitals NHS Foundation Trust (SHMI)
- East Lancashire Hospitals NHS Trust (SHMI)
- North Cumbria University Hospitals NHS Trust (HSMR)
- United Lincolnshire Hospitals NHS Trust (HSMR)

¹ The full set of documents relating to The Keogh Review are available on the NHS Choices website, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/Overview.aspx>

² NHS Commissioning Board, *Professor Sir Bruce Keogh to investigate hospital outliers*, 6 February 2013, <http://www.commissioningboard.nhs.uk/2013/02/06/sir-bruce-keogh/>

³ NHS Commissioning Board, *Sir Bruce Keogh announces final list of outliers*, 11 February 2013, <http://www.commissioningboard.nhs.uk/2013/02/11/final-outliers/>

- George Eliot Hospital NHS Trust (HSMR)
 - Buckinghamshire Healthcare NHS Trust (HSMR)
 - Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (HSMR)
 - The Dudley Group NHS Foundation Trust (HSMR)
 - Sherwood Forest Hospitals NHS Foundation Trust (HSMR)
 - Medway NHS Foundation Trust (HSMR)
 - Burton Hospitals NHS Foundation Trust (HSMR)
- (c) HSMR and SHMI are different statistical indicators and produced a different list of hospitals. HSMR measures whether mortality is higher or lower than would be expected. A high HSMR does not mean for certain there are failings in care but can be a ‘warning sign that things are going wrong.’ SHMI is a high level indicator published quarterly by the Department of Health. It is a measure based upon a nationally expected value and can be used as a ‘smoke alarm for potential deviations away from regular practice.’⁴
- (d) Medway NHS Foundation Trust was selected for the review due to a HSMR above the expected level for the last two years (a score of 115 for financial year 2011 and 112 for financial year 2012).⁵

2. Key National Findings

- (a) The national overview report stresses that understanding mortality requires more than a single indicator. ‘There are many different causes of high mortality and no “magic bullet” for preventing it.’⁶ A whole system approach is needed to understand and tackle high mortality. It is ‘not usually about finding a rogue surgeon or problems in a single surgical specialty.’⁷
- (b) Overall mortality in NHS hospitals has fallen by about 30% in the last decade. The rate of improvement has been similar in the 14 Trusts under review compared to other hospitals.
- (c) The review looked at factors such as access to funding and the poor health of the local population. The average for the 14 Trusts in terms of funding and socio-economic make-up was similar to that of England as a whole.

⁴ The Keogh Review, *Report for Medway NHS Foundation Trust, Rapid Responsive Review Report for Risk Summit*, pp.33-34, ‘SHMI and HSMR definitions’, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf>

⁵ The Keogh Review, *Medway NHS Foundation Trust Data Pack*, Slide 13, ‘Why was Medway Chosen for this Review?’, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-medway-data-packs.pdf>

⁶ The Keogh Review, *Review into the Quality of care and Treatment provided by 14 Hospital Trusts in England: overview report*, 16 July 2013, p.16, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

⁷ *Ibid.*, p.17.

- (d) More than 90% of deaths that occur in hospitals follow admittance for an emergency rather than a planned procedure. All 14 Trusts had a higher than expected mortality in urgent and emergency (non-elective) care. Only one had high mortality for elective/planned care (Tameside General Hospital). In general, problems were seen with admissions at the weekend and at night. Treatment areas with higher than expected mortality rates were general medicine, critical care, and geriatric medicine.
- (e) Although each Trust had a unique set of challenges, some common characteristics were identified which were seen as being of value to the wider NHS. These challenges were:
- Quality governance. The role of Trust Boards on quality issues needed strengthening. In some Trusts, clinical leadership also needed strengthening.
 - Isolation. The reviewed Trusts tended not to be well linked to professional networks and/or were in relatively isolated places or spread across a number of sites a distance apart.
 - Learning. Quality and safety processes were by and large complied with but learning lessons from when things went wrong was slow.
 - Financial pressures. A number of the Trusts were in the process of undergoing mergers, restructures, and/or applications for Foundation Trust status along with the need to make cost savings.
 - Capacity for self-improvement and external support. Sustained external support will be needed by all Trusts along with the need to establish networks. The new Academic Health Science Networks will play a key role.
 - Follow up. Regional Quality Surveillance Groups will co-ordinate follow up activity. The new Chief Inspector of Hospitals will prioritise a full inspection of the 14 Trusts in his first year of the new role.
- (f) Eight ambitions for improvement were also set out with the expectation that significant progress will have been made within two years:

Table 1: The Keogh Review Ambitions⁸

Ambition 1	We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.
Ambition 2	The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

⁸ Ibid., pp.7-12.

Ambition 3	Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.
Ambition 4	Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.
Ambition 5	No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.
Ambition 6	Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.
Ambition 7	Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.
Ambition 8	All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

3. The Keogh Review Process

- (a) Although these mortality indicators were used to select the Trusts, the review looked more broadly across six key areas: mortality; patient experience; safety; workforce; clinical and operational effectiveness; and leadership and governance.
- (b) A three stage process was followed for each Trust:
- Stage 1 – information gathering and analysis. Data packs were compiled under each of the six key areas above and analysed.
 - Stage 2 – Rapid Responsive Review (RRR). Each of the hospitals was visited by an experienced team of doctors, nurses, patients, managers and regulators. These visits lasted two or three days and were followed up by one or two unannounced visits.
 - Stage 3 – Risk summit and action plan. The relevant NHS Regional Director called a risk summit to consider the RRR report and other information. Out of this a detailed action plan was produced. The *Key Findings and Action Plan following Risk Summit* for Medway NHS Foundation Trust is included in full in this Agenda following this report.
- (c) Urgent action was taken during the review where areas of concern were identified. The urgent action taken at each Trust is set out in Annex A to the national overview report. The section for Medway NHS Foundation Trust can be found in the Appendix to this report.

4. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from Medway NHS Foundation Trust.

Appendix

Summary of findings and actions for Medway NHS Foundation Trust.

Background Documents

Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published 6 February 2013, <http://www.midstaffspublicinquiry.com/report>

Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, Professor Sir Bruce Keogh KBE, published 16 July 2013, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

Report for Medway NHS Foundation Trust, Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England, Rapid Responsive Review Report For Risk Summit, June 2013, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf>

Medway NHS Foundation Trust, Data Pack, 9 July 2013, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-medway-data-packs.pdf>

Contact Details

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Appendix – Summary of Findings and Actions for Medway NHS Foundation Trust⁹

Medway NHS Foundation Trust

The capacity of the Board and Clinical Executive Group has been diminished by changing personnel and the work associated with the possible merger with Darent Valley Hospital in Dartford and Gravesham NHS Trust. This has led to a lack of clear focus and pace at Board and Executive level for improving the overall safety and experience of patients.

Issues that were escalated immediately

No specific issues were escalated to the Trust or regulators.

Other urgent actions

The urgent actions identified included:

- Greater pace and clarity of focus at Board level for improving the overall safety and experience of patients.
- Reviewing staffing and skill mix to ensure safe care and improve patient experience.
- Improving consistency of early senior clinical review of patients in some areas, particularly the Emergency Department.
- Implementing a universal escalation protocol to rapidly identify patients at risk of deteriorating.

The Trust urgently needs a single, coherent quality strategy and action plan, supplemented by systematic staff training and roll out.

The panel identified a number of areas of good practice which need to be better disseminated throughout the Trust, as do lessons learnt from complaints and incidents.

Follow up

The Trust accepted the findings and welcomed the support to improve its action plans. A detailed response to the review was reviewed by risk summit attendees in early June and it was agreed a further risk summit will be held in August 2013 to review progress on these actions.

⁹ Sourced from: The Keogh Review, *Review into the Quality of care and Treatment provided by 14 Hospital Trusts in England: overview report*, 16 July 2013, p.43, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>



Medway NHS Foundation Trust

Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England

Page 17

Key Findings and Action Plan following Risk Summit

July 2013

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1. Overview

A Risk Summit was held on 3 June 2013 to discuss the findings and actions of the Rapid Responsive Review (RRR) of Medway NHS Foundation Trust (“the Trust”). This report provides a summary of the discussion held, including the Trust response to the findings, any support required from health organisations, including the regulatory bodies and the agreed actions and next steps.

Overview of review process

On 6 February 2013, the Prime Minister asked Professor Sir Bruce Keogh, NHS England Medical Director, to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR)¹.

These two measures are intended to be used in the context of this review as a ‘smoke alarm’ for identifying potential problems affecting the quality of patient care and treatment at the trusts which warrant further review. It was intended that these measures should not be reviewed in isolation and no judgements were made at the start of the review about the actual quality of care being provided to patients at the trusts.

Key principles of the review

The review process applied to all 14 NHS trusts was designed to embed the following principles:

- 1) **Patient and public participation** – these individuals have a key role and worked in partnership with clinicians on the reviewing panel. The panel sought the views of the patients in each of the hospitals, and this is reflected in the reports. The Panel also considered independent feedback from stakeholders related to the Trust, received through the Keogh review website. These themes have been reflected in the reports.
- 2) **Listening to the views of staff** – staff were supported to provide frank and honest opinions about the quality of care provided to hospital patients.
- 3) **Openness and transparency** – all possible information and intelligence relating to the review and individual investigations will be publicly available.
- 4) **Cooperation between organisations** – each review was built around strong cooperation between different organisations that make up the health system, placing the interest of patients first at all times.

¹ Definitions of SHMI and HSMR are included at Appendix I of the full Rapid Responsive Review report published here <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx>

Terms of reference of the review

The review process was designed by a team of clinicians and other key stakeholders identified by NHS England, based on the NHS National Quality Board guidance on rapid responsive reviews and risk summits. The process was designed to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these Trusts.
- Identify:
 - i. Whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken.
 - ii. Any additional external support that should be made available to these Trusts to help them improve.
 - iii. Any areas that may require regulatory action in order to protect patients.

The review followed a three stage process and this report documents the conclusions of Stage 3:

• **Stage 1 – Information gathering and analysis**

This stage used information and data held across the NHS and other public bodies to prepare analysis in relation to clinical quality and outcomes as well as patient and staff views and feedback. The indicators for each trust were compared to appropriate benchmarks to identify any outliers for further investigation in the rapid responsive review stage as Key Lines of Enquiry (KLOEs). The data pack for each trust reviewed is published at <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/data-pack-medway.pdf>.

• **Stage 2 – Rapid Responsive Review (RRR)**

A team of experienced clinicians, patients, managers and regulators, following training, visited each of the 14 hospitals and observed the hospital in action. This involved walking the wards and interviewing patients, trainees, staff and the senior executive team. This report contains a summary of the findings from this stage of the review in section 2.

The two day announced RRR visit took place at the Trust's main site on Thursday 9th and Friday 10th May 2013 and the unannounced visit was held on Friday 17th May 2013. A variety of methods were used to investigate the Key Lines of Enquiry (KLoEs) to enable the panel to analyse evidence from multiple sources and follow up any trends present in the Trust's data pack. The KLoEs and methods of investigation are documented in the RRR report for Medway NHS Foundation Trust. A full copy of the report was published on 16 July 2013 and is available online: <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx>

• **Stage 3 – Risk summit.**

This stage brought together a separate group of experts from across health organisations, including the regulatory bodies (Please see Appendix I for a list of attendees). The Medway NHS Foundation Trust Risk Summit was held on 3 June 2013. The risk summit considered the report from the RRR, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned.

The meeting was Chaired by Andrea Young (Deputy Chief Executive and Chief Operating Officer, NHS England) and focused on supporting the Trust in addressing the priority actions identified to improve the quality of care and treatment. The opening remarks of the Risk Summit Chair and presentation of the RRR key findings were recorded and are available online: <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx>

Conclusions and priority actions

The review panel did not identify any sustained failings in the quality of care and treatment provided by the Trust that required regulatory action to protect patients. However, the panel did identify the following issues which might increase the risk of excess mortality and impact the Trust's ability to provide consistently high quality and safe care and treatment to patients:

- A need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients
- A need to review staffing and skill mix to ensure safe care and improve patient experience
- A need to improve the consistency of early senior clinical review of patients in some areas, particularly patients admitted through the Emergency Department
- A need to implement a universal and unambiguous escalation protocol to rapidly identify patients at risk of deteriorating.

These are described in more detail in section 2 of this report and the recommended actions agreed with the Trust are in section 3.

Next steps

The Trust supported the findings of the review Panel and welcomed the support of risk summit attendees to increase the pace and focus of improvement. It was acknowledged that the Trust need to rapidly agree the improvement journey for the Medway NHS Foundation Trust over the next 12- 24 months, and as part of that plan the Board should agree a patient safety and quality improvement plan with clearly documented accountabilities and timescales. This was reviewed by risk summit attendees in early June.

It was agreed a further risk summit will be held in August 2013 to review progress against the plan. The risk summit will consider the ongoing review and monitoring arrangements required, which will involve the new Chief Inspector of Hospitals and the regulators.

2. Summary of Review Findings and Trust Response

Introduction

The following section provides a summary of the Review Panel's findings and the Trust's response to the risks identified.

Overview of Trust's response

The Trust's response was presented by the Chief Executive, Mark Devlin. The Trust accepted the findings of the Panel and risk summit participants agreed the RRR report provided an accurate analysis of the Trust's current position.

Summary of Review Findings

1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients

The capacity of the Board and Clinical Executive Group has been diminished by changing personnel and the work associated with the possible merger with Darent Valley Hospital in Dartford and Gravesham NHS Trust. This has led to a lack of clear focus and pace at Board and Executive level for improving the overall safety and experience of patients.

Recommendation

The Trust urgently needs a single visible strategy and action plan based on a recognised patient safety improvement model and underpinned by systematic staff training and roll out.

Accountability needs to be threaded through the organisation, via the clinical directorates, to embed responsibility for patient safety and experience at every level of the Trust. In order to achieve the required pace and focus the Trust should drive it through a strong programme delivery structure, with accountability for delivery at Board level. Responsibility for developing and delivering a coordinated action plan should be the full-time day job of one individual (Programme Director – Patient Safety) with input from the current Head of Audit and Patient Safety Lead accountable via one of the clinical executives to the CEO. The Programme Director should be supported by an appropriately staffed project management office.

Trust response

The Trust accepted the need to improve the pace and focus for improving the safety and experience of patients. The Trust has previously focussed on the merger with Dartford and Gravesham NHS Trust as the solution for providing clinical and financial sustainability and, now the merger has been paused, the Trust needs to focus on what it can do itself to improve patient safety and experience.

The Trust has a new leadership and management commitment framework that includes competencies, values and behaviours to deliver the highest levels of patient safety and experience. This will be launched as part of the appraisal for all staff in June 2013. A new method to make Ward rounds more multidisciplinary is being piloted by the Medical Director and Chief Nurse in 2013 and the Trust has undertaken a full review of how it responds to serious incidents. The Trust will continue its Listening in to Action methodology and welcomed advice on implementation of a patient safety model.

1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients

As a result of the merger being paused, the Trust agreed that it urgently needs to develop a strategic plan to agree and communicate what the improvement journey looks like over the next two years. The Trust also recognised that it needed a 100 day plan to implement improvements to cope with increased pressure during the winter months.

2. Review of staffing and skill mix to ensure safe care and improve the patient experience

The Panel observed that in some areas of the Trust it was clear that staffing levels and skill mix are potentially unsafe. The Trust's proposal for additional nursing staff was considered to be a good start but a holistic medical staffing review and recruitment strategy needs immediate attention. Reducing the level of locum usage for consultants indicates a clear starting point for this work.

Recommendation

The Trust urgently needs a holistic medical staffing review and recruitment strategy.

Trust response

The Trust recognised that its ratio of registered to unregistered nurses was inappropriate. Following a comprehensive review by the Interim Director of Nursing, the Trust has started to increase the ratio of registered to unregistered nurses, however the Board needs to agree the funding available for implementing the recommendations of the review. The Trust is also strengthening the leadership of senior nurses and improving focus on the importance of multidisciplinary working. The Trust has also completed a review of medical staffing and identified 25 vacancies – 14 new posts and 9 replacements. Recruitment into these posts is a challenge but work is underway.

3. Redesign of unscheduled care and critical care pathways and facilities

Poor A&E admission processes and a lack of early senior clinical review means the Trust is failing to take enough opportunity to prevent admission. The impact of this failure to properly manage admissions in A&E is felt right across the Trust with frequent use of escalation wards, overstretched staff and a failure to predictably and systematically manage patients on the correct care pathway, including critical care. The review team recognise the totally unsuitable layout of the A&E department and the constant work arounds staff are using to try and cope with working in an environment unfit for purpose. This is not a new problem and the limited Board and Executive capacity and the diversion of the merger work appears to have delayed an earlier solution being planned. The Trust has a limited timeframe to develop and implement a plan to manage quality and safety through the winter period. This will require proactive engagement with partners.

Recommendation

The Trust urgently needs to review the design and layout of the emergency department, admission and critical care areas to be incorporated in an estate strategy. Partnership working with health and social care providers will be important to the success of this.

Trust response

The Trust commissioned an assets optimisation review from Capita in 2011. There are ongoing discussions with KMPT and MCH about vacating areas of the Medway Maritime Hospital site to free up space and the Trust needs to agree a timescale with the support of the Local Area Team. The short term estates strategy is focussed on internal redesign to maximise space for emergency patient flow and this is currently being costed. The Trust would require temporary extra capacity while the work is

being completed. The Trust is close to reaching its borrowing level and is planning to borrow £3.7M in 2013/14 to support implementation of a new IT system (PAS) and replacement MRI. Further borrowing to redesign the Emergency Department would require additional support from Monitor.

The medium term estate strategy involves a total redesign of the internal layout of the Trust and refurbishment of space currently occupied by Kent and Medway Partnership Trust (KMPT) and Medway Community Healthcare (MCH). It is not yet known what it would cost to convert this area in to Ward space. The Trust recognise that it needs to agree the short, medium and long term estate strategy to form part of the Medway Foundation Trust (MFT) Strategic Plan and that each option should be fully costed and where necessary discussed with stakeholders such as Monitor. Agreement on the estate strategy will provide further clarity on the improvement plan for Medway Hospital.

4. Improved senior clinical assessment and timely investigations

Insufficient senior medical assessment of acute medical and surgical admissions and timely investigations and interventions for them means the Trust is not taking enough early opportunity to prevent deterioration. This is particularly so out of hours and at weekends, but not exclusively. As a result of this and pressure on meeting A&E waiting times there is also evidence that patients are potentially being admitted unnecessarily.

The Medical and Nursing Director must urgently agree a single model to assess the deteriorating patient and a clear protocol for escalating concerns which is rapidly implemented on every ward. Junior Doctors must be trained in the system so when they are called by nursing staff they understand how to respond, including asking for consultant help, and that the single model is part of the induction process for all staff.

Recommendation

The Trust should ensure appropriate consultant cover for acute medicine and medical high dependency unit at night and weekends. A review of care provided in the admissions and discharge lounge should be urgently completed. The Trust should develop a clear, universally understood, mandated, unambiguous, graded, activation protocol for escalating, monitoring or summoning a response to a deteriorating patient. This should be standardised across the whole hospital.

Trust response

The Medical Director and Interim Director of Nursing are re-enforcing the single assessment and early warning system for deteriorating patients to ensure it is universally understood and implemented. As part of this work it was agreed the Trust should jointly train nursing and medical staff on the system. The Trust is also placing greater emphasis on documentation, planning of patient care, review and evaluation, improving the skill mix on wards is a key to making this happen. The Trust is currently modelling 24/7 working and is ensuring sufficient senior medical staff in the Emergency Department.

5. Need to galvanise the good work that is already going on in Wards and to adopt and spread good practice

The panel met a large number of committed and concerned staff who frequently reported that they feel unable to raise patient safety concerns and when they do, little or no action is taken. The Trust needs to create a culture that welcomes improvement, galvanises the good work that is already going on in some Wards and adopts and rapidly spreads good practice.

Staff feedback on patient safety must be taken seriously by the Board and Clinical Executive Group. This will require the Executive to engage all staff in suggesting ideas for improvement, and where good ideas are identified action plans must be developed and implemented to deliver improvements consistently. Staff need to know that they are not only being listened to but that their concerns are being acted upon. The Big Conversation staff engagement and empowerment methodology adopted by the CEO over the last year is a good start to this.

Recommendation

The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some Wards and adopts and rapidly spreads good practice.

Trust response

The Trust launched the Big Conversation to engage staff in the improvement journey and identify good practice, this has started to achieve traction with staff. The high level culture and experience plan provides a starting point for the Trust to develop a culture that welcomes and encourages feedback at all levels. It was recognised that the Trust will need to be proactive in handling performance management issues and increase the pace of the Big Conversation to quickly capture all staff groups.

2025

6. Improve public reputation

The review team held two public meetings in Gillingham, Kent and in Minster, Isle of Sheppey, Kent. The public meetings identified a number of common themes about the way this Trust is viewed by the public that attended and in many cases supported the key themes emerging from interviews, observations and data review. Many of the patient stories we heard had common threads of inconsistent and inaccurate communication with patients, poor identification and management of deteriorating patients, inappropriate referrals and medical interventions, delayed discharges and long A & E waiting times. The Trust needs to improve the methods and frequency with which it engages with the public and as a starting point extend its staff Big Conversation work to the public.

Recommendation

The Trust should improve the methods and frequency with which it engages with the public and as a starting point extend its staff Big Conversation work to the public.

Trust response

The Trust agreed that it needs to change the way it engages with the public and move away from lecture style events towards a more open and engaging listening style of event to inform the improvement plan. This will provide a platform for the Trust to describe what it is doing to improve patient safety and experience.

3. Risk Summit Action Plan

Introduction

The following section provides an overview of the discussion at the Risk Summit and actions agreed for each of the key issues. The following section provides an overview of the issues discussed at the risk summit with the developed action plan containing the agreed actions, owners, timescales and external support. This is followed by details of the agreed next steps following the risk summit.

All attendees agreed the report accurately reflects the current position of the Trust and there was no new information attendees felt the Panel should be aware of.

Action Plan

Key Issue	Agreed Action & support required	Owner	Timescale
1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients <i>The Trust urgently needs a single visible strategy and action plan based on a recognised patient safety improvement model and underpinned by systematic staff training and roll out</i>	<p>The Trust Board will endorse this Improvement Plan at its public board meeting in June 13 (subject to current understanding of publication timeline).</p> <p>Work on the revised strategy will take place over the next two months with an update to the August Board meeting. The new Patient Safety Strategy will be presented in its final form to the Trust Board on 3rd September 13 by the new Medical Director and Chief Nurse. It will articulate a clear and compelling vision for patient safety and continuous improvement, building on the patient safety key driver framework (endorsed by the Mortality Working Party in May 2013 and reflecting national learning from AQuA²).</p> <p>Ongoing support from MWP will be required.</p>	Trust Chief Nurse	<p>Outline Comprehensive Strategic Plan and Detailed Quality and Safety Plan 25 June 2013</p> <p>Comprehensive Strategic Plan – Sept Board</p>
	<p>The delivery of the patient safety strategy will be underpinned by a comprehensive training programme. NHS IQ (NHS Change Model) has been invited to lead a board master class, followed by systematic roll out throughout the organisation, including clinical leads and multi disciplinary teams. The process will commence this summer. External support is required from NHS Improving Quality.</p>	Trust Director of Organisational Development and Communications	Rollout to be completed by June 2014
	<p>The Trust's patient safety strategy will be complemented by the introduction of dedicated multi-disciplinary Schwartz rounds to encourage multi professional assessment and learning. This will commence in October</p>	Trust Medical Director	Commence October 2013

² AQuA. Informatics observatory providing benchmarked intelligence and evidence based best practice

Key Issue	Agreed Action & support required	Owner	Timescale
<p data-bbox="96 730 125 837">Page 21</p> <p data-bbox="107 810 369 1038">1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients</p> <p data-bbox="107 1082 362 1345"><i>Accountability for patient safety and quality needs to be threaded through the organisation, via the clinical directorates, to embed responsibility for</i></p>	13 and rollout over a six month period.		
	A dedicated Programme Management Office, including a Programme Director Patient Safety, project manager, data analyst and co-ordinator is being developed to spearhead this work. The Trust has asked for NHS England support to set this up.	Trust Chief Executive	Complete June 2013
	<p data-bbox="407 549 1671 644">The new Director of Organisational Development & Communications has developed an Organisational Development framework (for consideration by the Workforce sub Committee of the Trust Board on 17 June 2013 prior to formal ratification by the Trust Board on 25 June 2013).</p> <p data-bbox="407 687 1662 778">The capability plan incorporates all learning and development, which is required to deliver the annual plan, including this Improvement plan. It includes essential training, continuous professional development, leadership and management development.</p>	Trust Director of Organisational Development and Communications	25 June 2013 Launch July 2013
	The new Director of Organisational Development & Communications has developed a leadership and management development framework. It illustrates the accountability and underpinning knowledge and expectations of all staff, at every level, in respect of the vision, values and strategic objectives of the organisation – including patient safety, outcomes and experience. It is being launched in July 2013 as part of the 5 priority areas for action and the implementation of a new style appraisal to underpin the implementation of the Agenda for Change Agreement (initially for all leaders operating at band 8 and above, or equivalent, including Consultants).	Trust Director of Organisational Development and Communications	Launch July 2013
	The Trust is undertaking a corporate governance review to ensure that the terms of reference and membership of board sub committees (including their role in providing adequate scrutiny, and performance management arrangements are clear, particularly in relation to patient safety, outcomes and experience. This will include the Boards role in defining strategy and gaining assurance. This will take place in July and August and report to the September 3 rd Board.	Trust Director of Governance and Strategy	Complete 3 Sept 2013
	The Medical Director and the Chief Nurse remain responsible for presenting evidence to comply with the Monitor Quality Governance Framework.	Trust Medical Director and Chief Nurse	Completed Sept 2013

Key Issue	Agreed Action & support required	Owner	Timescale
<i>patient safety and experience at every level of the Trust</i>	<p>The Director of Operations, supported by the new Director of Strategy and Governance will introduce “new style” monthly directorate performance reviews in July 2013. These reviews will enable the executive team to review the performance of clinical directorates using a balanced score card approach including: patient safety, outcomes and experience, workforce, finance and service development; activity and efficiency.</p> <p>This will be developed to include external benchmark information to drive an improvement culture.</p>	Trust Director of Operations	<p>Complete July 2013</p> <p>Complete Sept 2013</p>
<p>The Trust must ensure learning from serious incidents and complaints is disseminated in a timely manner and that actions to prevent a recurrence are implemented</p>	<p>The Medical Director will continue to develop the Serious Incident (SI) process.</p> <p>The Board will receive a monthly report on the analysis of serious incidents. To include key themes and actions arising.</p>	Trust Medical Director	Reports to be received by Board July 2013
	<p>The Chief Nurse will continue to present regular reports on complaints to the Patient Safety Committee and Patient Safety Forum, identifying themes, learning and actions to prevent recurrence. The learning and outcomes of these reviews will be reported to the CCG Quality Committee.</p> <p>The Board will receive a report quarterly illustrating key themes arising from patient complaints and actions that have been taken.</p>	Trust Chief Nurse	<p>Ongoing</p> <p>24 Sept 2013</p>
<p>2. Review of staffing and skill mix to ensure safe care and improve patient experience</p> <p><i>Holistic medical staffing review and recruitment strategy needs immediate attention.</i></p> <p><i>Reducing the level of locum usage for consultants provides</i></p>	<p>The new Organisational Development framework set includes a capacity plan, which will align the acuity of patients with the workforce – both in terms of numbers of staff by staff group and the skill mix. This will build on the existing medical, nursing and midwifery reviews. Healthcare Education England has committed to supporting the Trust with the development of a long term workforce plan – maximising opportunities for introducing new roles and ways of working to address 7 Day Services as well as national skill shortage areas and hard pressed specialities.</p>	Trust Director of Organisational Development and Communications (CN/MD)	September 2013
	<p>A Rapid Recruitment Program is in place to fill existing medical and nursing vacancies with high calibre candidates.</p>		Commenced
	<p>All locum medical staff will receive high quality local induction.</p>	Trust Director of Operations	Commenced
	<p>The Clinical Training Programme has been extended to enable multi disciplinary teams to learn together and adopt the best clinical standards in relation to Care planning, Handover, Safe patient transfers internally and externally and implement National Early Warning System.</p>	Trust Chief Nurse	Commenced April 2013

Key Issue	Agreed Action & support required	Owner	Timescale
<p><i>a suggested starting point for this work.</i></p>	<p>The HE KSS action plan is being implemented to strengthen the clinical supervision and teaching of junior medical staff. In addition, two experienced consultants have been identified to provide pastoral support to supplement the formal clinical tutor roles. This will complement listening exercises such as the Big conversation with junior staff on the 20 June 2013.</p>	<p>Trust Medical Director</p>	<p>Commenced</p>
	<p>The Trust is working with the HE KSS to explore options for a new Director of Medical Education. This includes consideration in partnership with the Dean of a joint post, GP / Physician who will lead the development of education and training of junior doctors for the future.</p>		<p>Sept 2013</p>
<p>3. Redesign of unscheduled care and critical care pathways and facilities</p> <p><i>Urgent review of the design and layout of the emergency department, admission and critical care areas to be incorporated in an estate strategy.</i></p> <p><i>Partnership working with health and social care providers will be important to the success of this.</i></p>	<p>The Trust has been working with the Emergency Care Intensive Support Team (ECIST) to establish a Medway Emergency Flow Programme Board which will oversee the review of emergency pathways. It is likely that these pathways lend themselves to the greatest improvement.</p> <p>This programme will build on best practice from other sites facilitated by ECIST and in collaboration with HEE KSS. It will need support from Medway CCG and NHS England 's local area team.</p>	<p>Trust Chief Nurse</p>	<p>Commenced</p>
	<p>The Trust is in the process of appointing an Associate Director of Estates to develop an estates strategy for the Medway site. The short term priority is to lead the internal redesign of the emergency department to maximise space for emergency patient flow and to relocate the MDU and emergency assessment areas. The medium term priority is to redesign services into vacated clinical areas (currently occupied by KMPT and MCH). Longer term it is proposed to establish a new purpose built Emergency Department.</p> <p>It will need support from NHS England and external project management and Capital funding support.</p>	<p>Director of Governance and Strategy</p>	<p>Commenced</p>
	<p>In preparation for winter 2013, the Trust will scope and procure additional modular capacity to create decant space and enable reconfiguration. This will require funding.</p>	<p>Trust Director of Operations</p>	<p>Aug 2013</p>
	<p>Through the CCG Urgent Care Board, the Trust will work in partnership with stakeholders and ECIST to understand the demand on the emergency pathways and review:</p> <ul style="list-style-type: none"> • the provision of out of hospital care • adequate commissioning of emergency pathways • adequate commissioning of out of hours care 	<p>Trust Director of Operations</p>	<p>June 2013</p>

Key Issue	Agreed Action & support required	Owner	Timescale
	The Trust will need support from the CCG / NHS England / ECIST.		
4. Improved senior clinical assessment and timely investigations <i>Ensure appropriate consultant cover for acute medicine and medical HDU at night and weekends</i>	An urgent review of consultant cover on medical High Dependency Unit has been carried out to ensure appropriate cover and timely review. It has been agreed to implement daily consultant ward rounds 7 days a week.	Trust Medical Director	First Board Report July 13
	As part of the capacity planning work to support the ECIST programme and the move to seven days services, senior clinical decision makers are currently timetabled 'at the front door' from 8am to midnight.	Trust Medical Director	Completed
	The timescale on the implementation of Rapid Assessment and Treatment system is planned to allow the full engagement of the consultant team in designing and agreeing the change required in working practices. This will be implemented throughout July. The Trust will require support from Health Education Kent Surrey Sussex.	Trust Medical Director	Complete July 2013
<i>Review care provided in the Admission and Discharge Lounge</i>	As an interim measure, the Chief Nurse has converted the Admission and Discharge Lounge to a ward with a Head of Nursing overseeing clinical quality and undertaking a daily review of all patients. The ward is adequately equipped and established to function as a ward.	Trust Director of Operations	Completed
	The Trust is committed to revert to a fully functioning ADL through the ECIST work programme.	Trust Director of Operations	Aug 2013
<i>Develop a clear universally known activation protocol for escalating a response to deteriorating patients. This should be standardised across the whole</i>	The Medical Director and Interim Director of Nursing will re-launch a standardised activation protocol for the deteriorating patient. This will form part of the personalised and team objectives of all clinical staff and monitored and reviewed daily through the normal line management process. The Trust will require support from the Health Foundation / HE KSS.	Trust Medical Director/Chief Nurse	30 June 2013
	The Trust has established a weekly multi-disciplinary mortality review. The outcomes from this review go back immediately to the originating consultant and team. The process is led by the Deputy Medical Director. The key themes and actions arising from this process will be reported to Board monthly.	Trust Medical Director	Commenced 30 July 2013

Key Issue	Agreed Action & support required	Owner	Timescale
<p><i>hospital.</i></p> <p>5. Need to galvanise the good work that is already going on in Wards and to adopt and spread good practice</p> <p><i>The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice</i></p>	<p>An electronic database is being developed so learning can be collated and acted upon through the Trusts audit programme and patient safety committee structure.</p>	Trust Medical Director	Complete July 2013
	<p>The Trust has implemented the CHKS Q Lab programme via the audit programme. Q lab is a continuous improvement process that provides the Board with the assurance that the performance across the directorates is within expected ranges.</p>	Trust Medical Director	Commenced
	<p>The organisational development framework includes a Culture and People Experience Plan. It is due for consideration by the Workforce sub Committee of the Trust Board on 17 June 2013 prior to formal ratification by the Trust Board on 25 June 2013. The plan will embed a culture which is consistent with the Trust values and behaviours including the learning from patient feedback and the Francis Enquiry. It will improve the working experience of staff through actively listening and responding to staff feedback and improve staff engagement across the organisation and within multi disciplinary teams. It will develop a consistent approach to change management which maximises opportunities to involve and support staff throughout the change process.</p> <p>Support is required from HE KSS / Leadership Academy / IHI.</p> <p>Key actions include:</p>	Trust Director of Organisational Development and Communications	Commenced
	<ul style="list-style-type: none"> • Adoption of the 'NHS Change Model' providing a framework for developing the capabilities of individuals and teams (within the organisation and across the system) in service improvement techniques 		March 2014
	<ul style="list-style-type: none"> • Develop staff and leaders in assertiveness techniques, handling challenging people and situations 		Sept 2013
	<ul style="list-style-type: none"> • Encourage the identification and treatment of "cause(s) not effect(s)" of culture 		Commenced
	<ul style="list-style-type: none"> • Promote the "speaking up campaign" - voicing and reporting concerns and closing the feedback loop 		June 2013
	<ul style="list-style-type: none"> • Launch the board visibility and assurance programme ("Director of the week" - Pairings with wards/ clinical areas, "Back to the Floor" programmes) 		Commenced
	<ul style="list-style-type: none"> • Introduce monthly Pulse surveys to provide regular feedback on staff experience by June 2013 		Commenced
	<ul style="list-style-type: none"> • Maintain existing staff recognition schemes 		Commenced

Key Issue	Agreed Action & support required	Owner	Timescale
6. Improve public reputation <i>The Trust should improve the methods and frequency with which it engages with the public and as a starting point extend its staff Big Conversation work to the public.</i>	<ul style="list-style-type: none"> The Trust will continue to use the Listening into Action methodology. The Trust has signed up to move into the second phase of implementation and become a 'Beacon' site. This phase commences in September 2013. 		Sept 2013
	<p>The Trust is planning to pilot a Clinician Led Quality improvement Team to drive clinical improvement and rapidly spread good practice. As part of the pilot, a software platform 'Crowdicity' has been procured to provide an electronic means for staff to share good practice, innovate and problem solve.</p>	Trust Chief Executive	July 2013
	<p>An annual communications and engagement plan has been developed which identifies Executive relationship leads for all stakeholders, including the public, members and governors. The plan is due for consideration and ratification by the Trust Board on 25 June 2013 and where possible will be aligned to national publication timelines and the Trust annual plan. It is likely that a new communications officer role will be created to focus on good news stories for publication and to improve public relations in a sustained manner.</p>	Trust Director of Organisational Development and Communications	June 2013
	<p>Continued promotion and improvement of Friends and Family feedback.</p>	Trust Chief Nurse	Commenced
	<p>Plans are in place to build on the Friends and Family test with a patient electronic feedback APP. This will provide instant feedback to wards and clinical areas.</p>		Sept 2013
	<p>Promote the PALs service as an effective advocate for patients.</p>		July 2013

Appendix I: Risk Summit Attendees

Role and Name	
NHS England	Andrea Young (Chair)
NHS England	Liz Redfern CBE (Chair of RRR Panel), Chief Nurse (South)
NHS England	Nigel Acheson, Regional Medical Director (South)
Medway NHS Foundation Trust	Mark Devlin, Chief Executive
Medway NHS Foundation Trust	Susan Osborne, Interim Director of Nursing
Medway NHS Foundation Trust	Dr Gray Smith-Laing
Kent & Medway Area Team	James Thallon, Medical Director
Kent & Medway Area Team	Felicity Cox, Director
Kent & Medway Area Team	Sally Allum, Director of Nursing
Medway CCG	Peter Green, Accountable Officer
Kent CCGs	Geoffrey Wheat, Chief Nurse
Swale & Dartford, Gravesham & Swanley CCGs	Patricia Davies, Accountable Officer
Panel member	Priscilla Chandro, Patient/Public Representative
Panel member	Georgina McMasters, Patient/Public Representative
Panel member	Chris Gordon, Leadership Academy
PwC	Kate Bennett, Senior Moderator
PwC	Daniel Burke, PwC Programme Director
CQC	Ian Biggs, Deputy Director of Operations (South)
CQC	Sue Sheath, Head of Regional Compliance South (East)
Monitor	Paul Streat, Regional Director (South)
Monitor	John Sparrowhawk, Regional Director
KSS Deanery	Professor David Black (by phone)
GMC	Michael Cotton, Employer Liaison Adviser (South East & Channel Islands)
Healthwatch	Dan McDonald, Lead for Kent Healthwatch
KSS Deanery	Alison Crombie

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Medway NHS Foundation Trust Keogh Review Briefing to HOSC

1. Introduction

In February 2012 the Prime Minister asked Sir Bruce Keogh to undertake a review into the Quality of Care at 14 Acute Hospitals. These Hospitals were identified as being consistently higher than average on either Hospital Standardised Mortality (HSMR) Ratios or Standardised Hospital Mortality Index (SCMI) for two consecutive years. Medway NHS Foundation Trust was identified for having higher than average HSMR.

This report outlines:

- The purpose of the review
- The review process
- The findings
- The Trusts Quality Improvement Plan
- The next steps

2. The Purpose of the Review

“The purpose of my investigation is to assure patients and myself that these hospitals understand their problems and have all the support they need to improve. These hospitals are already working closely with a range of regulators. If there were concerns that services were unsafe, the regulators should have intervened. The purpose of this investigation is to provide solutions that speed up improvement.”

Bruce Keogh

The review was established to determine whether there are any sustained failings in the quality of care and treatment being provided to patients at the trusts.

It was to identify:

- whether existing action by these trusts to improve quality was adequate and whether any additional steps should be taken
- any additional external support that will be made available to these trusts to help them improve
- any areas that may require regulatory action in order to protect patients.

The review was guided by the NHS values set out in the NHS Constitution and underpinned by the following key principles:

- Patient and public participation
Patients and members of the public played a central role in the overall review and the individual investigations, working in partnership with clinicians. The views of patients in each of the 14 hospitals, either directly or through representatives, were sought by the teams and reflected in their reports.
- Listening to the views of staff
Staff in the each of the 14 hospital trusts were supported to provide frank and honest opinions about the quality of care and treatment provided to patients in their hospital.
- Openness and transparency
All possible information and intelligence relating to the review and the individual investigations has been made publicly available.
- Co-operation between organisations
The overall review and the individual investigations were built around strong co-operation

between the different organisations that make up the health system, placing the interests of patients first at all times.

3. The Review Process

The Trust were informed in February 2013 that they would be part of the review. In April a data pack was developed and published (this is available on the www.nhs.uk website). This formed the basis of the Key Lines Of Enquiry:

Theme	Key Line of Enquiry
Governance and leadership	Can the trust articulate its governance processes for assuring the quality of treatment and patient care? Can staff at all levels of the organisation describe the key elements of the quality governance processes?
	Are the leadership roles and responsibilities clearly defined for the quality processes?
Clinical and operational effectiveness	What processes does the Trust have in place to support monitoring mortality data and clinical effectiveness? What actions is the Trust taking to improve mortality performance, particularly in general medicine and elderly care?
	How does the Trust manage deteriorating patients?
	What processes does the Trust have to manage bed occupancy? How does the Trust manage patient moves during their time in hospital?
Patient Experience	How does the Trust seek views from patients about their experience? What are the key themes from patients on their experiences? What action is the Trust taking to address the key themes emerging?
Workforce and Safety	What do staff groups interviewed (including trainee/student groups) say are the main barriers in the Trust to delivering high quality treatment and care for patients?
	How does the Trust approach workforce planning including skill mix to ensure that patient safety is managed effectively?
Trust specific – Diabetes	What specific contribution is the Trust making to improve the health outcomes of the local population with diabetes? <i>(This KLoE was covered in clinical and operational effectiveness)</i>
Trust Specific – Quality Care Strategy and Implementation	How have they refreshed their Quality Care Strategy (April 2012)? <i>(This KLoE was covered in Governance and Leadership)</i>

The Trust Rapid Review Team visited in May. As well as the planned visit there were two unannounced out of hours visits. The review team also met with the public twice, once at a Medway Forum and once at a Swale Forum. The Review Team met separately with staff groups on an individual and group basis over the two days.

A risk summit was convened in June and subsequently the Trust has developed an Action Plan in response to the recommendations.

The Trust is expecting a follow up visit and risk summit in August and September.

4. The Findings

The panel presented their findings at the Risk Summit in June (also available on the www.nhs.uk website). The panel's overall impressions were that:

- There was a positive and helpful welcome to the panel
- The Trust had already begun a number of improvements
- A period of stability in the Executive Team will now enable greater focus on patient safety and quality
- There were many examples of good practice, albeit inconsistently implemented in some areas
- Staff are committed and were open to the panel visit
- There are clear areas for further improvement
- Some improvements are within the gift of the Trust and others will require cooperation and support from the wider health community, commissioners and Monitor

The findings concluded that

‘The review panel did not identify any sustained failings in the quality of care and treatment provided by the Trust that required regulatory action to protect patients ‘

However the Team did identify the following issues that would enable consistent high quality and care:

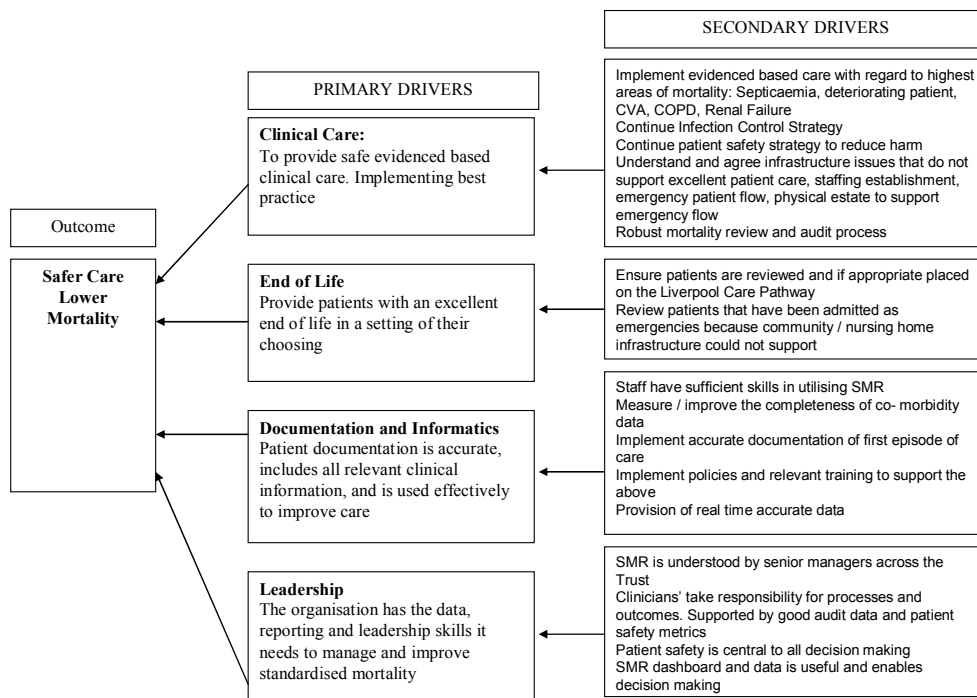
- Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients
- Review of staffing and skill mix to ensure safe care and improve patient experience
- Re-design of unscheduled care and critical care pathway
- Improved senior clinical assessment and timely investigations
- Need to galvanise the good work that is already going on in Wards and adopt and spread good practice
- Improve public reputation

5. The Trusts Quality Improvement Plans

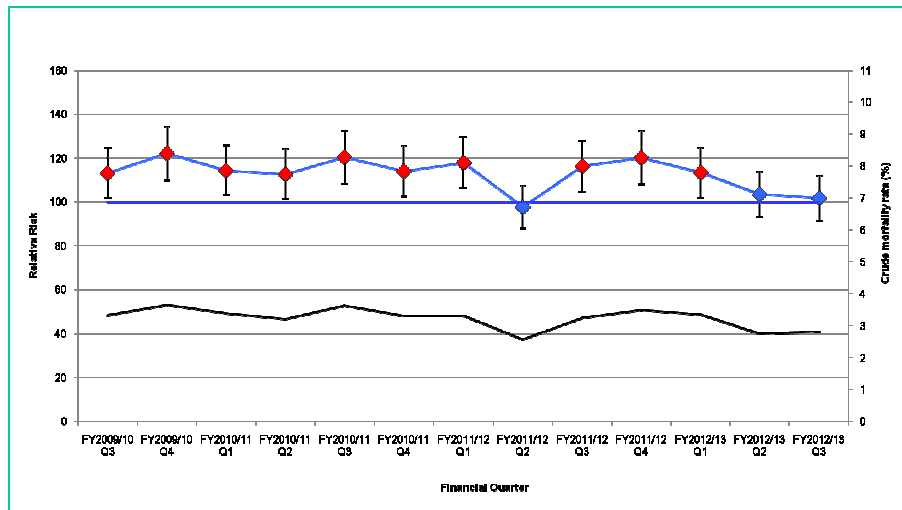
In November 2012, at the request of the Chief Executive and Chair of MFT a Hospital Mortality Working Party (MWP) has been established to oversee a reduction in the HSMR and SHMI at Medway NHS Foundation Trust and provide the Board of MFT assurance that all aspects of quality of care and factors that may affect or contribute to the current mortality rates are addressed.

The membership includes Board and Governing Body representation from MFT, the three North Kent CCGs and the Medical Director from The National Commissioning Board Area Team. It is chaired by the Director of Public Health. The MWP has developed an action plan focused on improving mortality rates.

The key driver:



SHMI Trends: 2011/12 and 2012/13



In response to the six review findings and incorporating all the work already underway, the Trust Developed a Quality Improvement Plan (appendix 1).

5.1 The Six Review Findings

Number One: ‘Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients’

The overarching Quality Improvement Plan was endorsed by the Board in June 13. It will be monitored at Board monthly.

Building on the existing strategy, a new Patient Safety Strategy is being developed. This will be presented to Board in September 13. The launch of new strategy is timed to coincide with appointment of the New Medical Director in August 13.

The Trust is working with NHS Improving Quality Team to develop a Trust wide training programme utilising the NHS Change Model. This will initial focus on our clinical leaders and rollout out across the organisation.

The Trust are refocusing the directorate monthly performance reviews: These reviews will be developed around a balanced scorecard approach and balance financial performance with patient experience and safety.

The Trust has improved its infrastructure and process with regard to learning from Serious incidence. The new process is supported by a senior experienced nurse who ensures that teams respond quickly to identify root causes, develop action plans that address these and spreads the learning across the

organisation. The patient safety committee aims to peer review each incident to ensure appropriate challenge and Improved learning.

The Trust are undertaking a Corporate Governance Review and Monitor Quality Governance Framework. The outcome of this review will report to Board in September 13.

Number Two: Review of staffing and skill mix to ensure safe care and improve patient experience'

The Trust are developing short and long term workforce plans. These plans build on existing medical and nursing reviews. The workforce plans will be developed to reflect evidence based numbers and skill mix. This will be supported by six monthly benchmarking of clinical staff. Within these plans the Trust are reviewing the requirements of a 7 day service.

The Trust is currently recruiting clinical staff and this is being supported by rapid recruitment and focused campaigns.

The Trust is reviewing the way it trains its clinical staff with a focus on multidisciplinary / team training and induction. Plans are also developing around feedback from the Junior Doctors which will result in improvements in supervision and training.

Number Three 'Re-design of unscheduled care and critical care pathway'

There is a requirement to review the design and layout of the emergency department, admission and critical care areas. This work has commenced and short term, medium term and long term strategies are being developed including short term improvements to the emergency department and assessment areas. Trust wide site development, working with the stakeholders that share the site and the long term plan of a new emergency department.

The Trust have established a Medway Emergency Flow Programme with the aims of meeting the 95% emergency department standard and achieving a 90% bed occupancy. This will ensure improved patient safety and experience on our emergency pathways through our assessment and escalation areas.

Working with Medway and Swale Executive Programme Board, and Urgent Care Board the Trust will review pathways and implement best practice.

Number Four 'Improved senior clinical assessment and timely investigations'

Plans are in place to improve ensure appropriate consultant cover for acute medicine and medical HDU at night and weekends This includes improved handover to weekend and out of hours consultants and improved care planning. The medical HDU are also formalising the senior support cover from the intensivists.

The escalation areas that the review team visited as bedded escalation areas are now closed. The emergency flow programme work is aimed at achieving a 90% bed occupancy to ensure that they are not required in future.

The Trust has responded quickly to the need to develop a clear universally known activation protocol for escalating a response to deteriorating patients and standardising across the Trust. A working group has been established that is chaired by the Patient safety Lead Clinician. A new observation chart and escalation protocol has been agreed and will rollout at the end of July. Trust wide training and communication has been arranged with a focus on the new junior intake across the Trust.

The Trust are working with the DOH Emergency Intensive Support Team to implement Senior Treatment and Review in the emergency department. This will result in patients that require a clinical decision at the front door receive one.

The Trust has established a multidisciplinary review of all patients that die at the Trust. The Trust is also working with CHKS to review their outcome data as part of an external assurance / quality programme that is being led by our Clinical Audit Leads.

Number Five 'Need to galvanise the good work that is already going on in Wards and adopt and spread good practice'

The new Director of Organisational Design and Communications has produced an Organisational Development Plan building capacity (people), capability, culture and patient experience, contribution linked to recognition, communications, engagement and brand. This was endorsed at Board in June 13.

As mentioned previously the Trust intend to Implement the NHS Change Model to implement, spread and sustain change.

A number of other schemes are underway including developing staff in assertiveness techniques and promoting a 'speaking up campaign'. The Trust Board have actively increased their visibility, they have implemented a director of the week and each director has been partnered with a clinical area.

The Trust is further developing Listening into Action as an active way of engaging staff. On the initiative of a team of consultants the Trust has also recently launched a Quality Improvement Team. A large group of self selected staff who have committed to implementing improvements across the Trust.

Number Six 'Improve public reputation'

The Trust will improve the methods and frequency with which it engages with the public and improve upon its relationships with Stakeholder, 'Big Conversations' are already in planned with our members and with our Governors.

The Trust will continue to build on its family and friends feedback and further promote its PALs service as an advocate service for patients and carers.

To assist with improving public reputation the Trust will improve its media communications and actively promote good news stories.

6. Conclusion

The Trust is on an improvement journey, there is good evidence that governance, patient safety, patient experience and staff engagement are responding positively, Despite this mortality indicators have continued to be an issue and the Board wish to increase the pace of improvement

The Quality Improvement Plan has been developed and is now being implemented. This is a binding agreement with Monitor as an undertaking on the Trust's licence

Discussions are ongoing with regard to sources of external support to improve facilities at the hospital and accelerate improvement.

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The Medway NHS Foundation Trust

Review into the Quality of Care and Treatment June 2013

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Quality Improvement Plan in Response to the Review Recommendations

Tracy Rouse, Project Director – Patient Safety

1. The NHS England Review

1.1 Introduction

NHS England has undertaken a review of 14 Trusts that have been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). MFT was identified as one of these Trusts.

The Rapid Review Team visited the Trust on the 9th and 10th of May with an unannounced visit on the 17th May. Terms of reference for this review can be found on www.nhs.choices.

On the 3rd June 2013, a risk summit took place with the Rapid Review Team, NHS England, the Trust and our stakeholders. The high priority actions from the review were discussed and it was agreed that these would form the core of the Trusts improvement plan. The themes arising from the review and subsequent actions incorporated in this improvement plan can easily be cross referenced to the Trust's annual strategic plan. Furthermore, plans are in place to re-engage stakeholders in the development of the longer term strategic direction of the organisation in the autumn. At the heart of the Trust's long term vision is pursuit of the highest quality of care and standards for patients, within a clinically and financially sustainable organisation.

This report demonstrates what is currently underway and planned in relation to the high priority actions identifying leads and timescales. Supporting strategic and operational plans will be developed locally to ensure achievement. The work streams will be embedded in our workforce and business plans and will be core to our clinical strategy.

1.2 High Priority Actions

The rapid review identified 6 high priority areas:

1	Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients
2	Review of staffing and skill mix to ensure safe care and improve the patient experience
3	Redesign of unscheduled care and critical care pathways and facilities
4	Improved senior clinical assessment and timely investigations
5	Need to galvanise the good work that is already going on in Wards and adopt and spread good practice
6	Improve public reputation

2. Improvement Plans

1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
1.1 Page 45	The Trust urgently needs a single visible strategy and action plan based on a recognised patient safety improvement model and underpinned by systematic staff training and roll out	<p>The Trust Board will endorse this Improvement Plan at its Board meeting on 25th June 2013.</p> <p>Work on the revised strategy will take place over the next two months with an update at the Trust Board meeting on 3rd September 2013. The new Patient Safety Strategy will be presented in its final form to the Trust Board on 24th September 2013 by the new Medical Director and Chief Nurse. It will articulate a clear and compelling vision for patient safety and continuous improvement, building on the patient safety key driver framework (endorsed by the Mortality Working Party on 24th May 2013 and reflecting national learning from AQuA¹). The framework also incorporates the key priorities identified at the Listening Into Action², patient safety event (6th March 2013). Work on the implementation of the key drivers and improving outcomes has commenced and is progressing well.</p>	MD (CN)	25 th June 2013 3 rd Sept 2013 24 th Sept 2013	Ongoing support from MWP

¹ AQuA. The Advancing Quality Alliance. It is an informatics observatory providing benchmarked intelligence and evidence based best practice

² Listening Into Action is an accredited national programme to actively engage staff

1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
		The delivery of the patient safety strategy will be underpinned by a comprehensive training programme. The 'NHS Change Model' provides a framework for developing the capabilities of individuals and teams (within the organisation and across the system) in service improvement techniques. NHS IQ has been invited to lead a board master class, followed by systematic roll out throughout the organisation, including clinical leads and multi disciplinary teams. The process will commence this summer and rollout will be completed to essential staff by 30 th June 2014.	DODC	Rollout to be completed by 30 th June 2014	NHS IQ
Page 46		It will be complemented by the introduction of dedicated MDT Schwartz rounds to encourage multi professional reflection and learning. This will commence by 31 st October 2013 and rollout over a six month period.	MD	Commence by 31 st Oct 2013	
		A dedicated Programme Management Office, including a Programme Director Patient Safety, project manager, data analyst and co-ordinator is being developed to spearhead this work.	CEO	Complete by 30 th June 2013	NHS England
		The new Director of Organisational Development & Communications has developed an OD framework (for consideration by the Workforce sub Committee of the Trust Board on 17 th June 2013 prior to formal ratification by the Trust Board on 25 th June 2013). The framework aligns the vision, values and strategic objectives of the organisation to 5 priority areas for delivery as follows: <ul style="list-style-type: none"> • Capacity (people) • Capability • Culture and people experience • Contribution linked to recognition • Communications, engagement and brand 	DODC	25 th June 2013	

1. Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients : URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
		The capability plan incorporates all learning and development, which is required to deliver the annual plan, including this Improvement plan. It includes essential training, continuous professional development, leadership and management development.	DODC	Launch by 31 st July 2013	
1.2	Accountability needs to be threaded through the organisation, via the clinical directorates, to embed responsibility for patient safety and experience at every level of the Trust	The new Director of Organisational Development & Communications has developed a leadership and management development framework, which forms Appendix 1. It illustrates the accountability and underpinning knowledge and expectations of all staff, at every level, in respect of the vision, values and strategic objectives of the organisation – including patient safety, outcomes and experience. It will be launched by 31 st July 2013 as part of the 5 priority areas for action (see section 1.1 above) and the implementation of a new style appraisal to underpin the implementation of the Agenda for Change Agreement (initially for all leaders operating at band 8 and above, or equivalent, including Consultants).	DODC	Launch by 31 st July 2013	
		The Trust is undertaking a corporate governance review to ensure that the terms of reference and membership of board sub committees (including their role in providing adequate scrutiny, and performance management arrangements are clear, particularly in relation to patient safety, outcomes and experience. This will include the Boards role in defining strategy and gaining assurance. This will take place in July and August 2013 and report to the Board on 3 rd September 2013.	DGS	Complete by 3 rd Sept 2013	
		The Medical Director and the Chief Nurse remain responsible for presenting evidence to comply with the Monitor Quality Governance Framework.	MD / CN	Complete by 30 th Sept 2013	

2. Review of staffing and skill mix to ensure safe care and improve the patient experience. : URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
2.1	Holistic medical staffing review and recruitment strategy needs immediate attention. Reducing the level of locum usage for consultants provides a suggested starting point for this work.	The new OD framework set out in 1.1 above includes a capacity plan, which will align the acuity of patients with the workforce – both in terms of numbers of staff by staff group and the skill mix. This will build on the existing medical, nursing and midwifery reviews. HEE has committed to supporting the Trust with the development of a long term workforce plan – maximising opportunities for introducing new roles and ways of working to address 7 Day Services as well as national skill shortage areas and hard pressed specialities.	DODC (CN/MD)	25 th June 2013	HE KSS
Page 50		A Rapid Recruitment Program is in place to fill existing medical and nursing vacancies with high calibre candidates. The vacancy factor is currently at 8.7%, with a target of 7% during 2013/14, which will be monitored by the Workforce Committee on a monthly basis.	DODC	Commenced Monthly reporting from 17 th June 2013	
		All locum medical staff will receive high quality local induction	DOP	Commenced	
		The Clinical Training Programme has been extended to enable multi disciplinary teams to learn together and adopt the best clinical standards in relation to : <ul style="list-style-type: none"> • Care planning • Handover • Safe patient transfers internally and externally • Implement SBAR³ and NEWS⁴ 	CN	Commenced April 2013	HE KSS Leadership Academy

³ SBAR (Situation, Background, Assessment and Recommendations) It is an structured pneumonic escalation model that staff use when escalating a deteriorating patient

⁴ NEWS National Early warning System. Vital signs scoring system that triggers a deteriorating patient. Linked to an escalation protocol

2.	Review of staffing and skill mix to ensure safe care and improve the patient experience. : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
		The HE KSS action plan is being implemented to strengthen the clinical supervision and teaching of junior medical staff. In addition, two experienced consultants have been identified to provide pastoral support to supplement the formal clinical tutor roles. This will complement listening exercises such as the Big conversation with junior staff on the 20 June 2013.	MD	Commenced	HE KSS
Page 51		The Trust are working with HE KSS to explore options for a new Director of Medical Education. This includes consideration in partnership with the Dean of a joint post, GP / Physician who will lead the development of education and training of junior doctors for the future.	MD	By 30 th Sept 2013	HE KSS

3. Redesign of unscheduled care and critical care pathways and facilities : URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
3.1	Urgent review of the design and layout of the emergency department, admission and critical care areas to be incorporated in an estate strategy. Partnership working with health and social care providers will be important to the success of this	<p>The Trust has been working with the Emergency Care Intensive Support Team (ECIST) to establish a Medway Emergency Flow Programme Board, which will oversee the review of emergency pathways, ensuring year-round stability (preparing for challenging winter periods in 2013/14 and beyond). It is likely that these pathways lend themselves to the greatest improvement. The terms of reference for the board are as follows :</p> <ul style="list-style-type: none"> - Oversee the Trusts goal to achieve the 95% wait for A&E and <ul style="list-style-type: none"> • Improve patient safety by reducing delays in assessment areas • Increase patient experience and satisfaction • oversee the Trust goal to reduce bed occupancy to below 90% and - Ensure safe care is delivered in the right environment <ul style="list-style-type: none"> • Achieve better patient flow • Reduce transfers in the patient journey - Implement the Enhanced Quality Programmes of Care - Develop a set of metrics to support and monitor the implementation and outcomes of the programme <p>This programme will build on best practice from other sites facilitated by ECIST and in collaboration with HEE KSS.</p>	CN	Commenced	CCG / NHS England HE KSS
		<p>The Trust is in the process of appointing an Associate Director of Estates to develop an estates strategy for the Medway site. The short term priority is to lead the internal redesign of the emergency department to maximise space for emergency patient flow and to relocate the MDU and emergency assessment areas. The medium term priority is to redesign services into vacated clinical areas (currently occupied by KMPT and MCH). Longer term it is proposed to establish a new purpose built Emergency Department.</p>	DGS	Commenced	NHS England External project management

3.	Redesign of unscheduled care and critical care pathways and facilities : URGENT				
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
		In preparation for winter 2013, the Trust will scope and procure additional modular capacity to create decant space and enable reconfiguration (linked to the ECIST and estates work underway).	DOp	By 30 th Sept 2013	CCG / NHS England
		<p>Through the CCG Urgent Care Board the Trust will work in partnership with stakeholders and ECIST to understand the demand on the emergency pathways and review</p> <ul style="list-style-type: none"> • the provision of out of hospital care • adequate commissioning of emergency pathways • adequate commissioning of out of hours care 	DOp	From 27 th June 2013	CCG / NHS England / ECIST

4. Improved senior clinical assessment and timely investigations: URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
4.1	Ensure appropriate consultant cover for acute medicine and medical HDU at night and weekends	An urgent review of consultant cover on medical HDU has been carried out to ensure appropriate cover and timely review. It has been agreed to implement daily consultant ward rounds 7 days a week.	MD	30 th June 2013	
Page 54		As part of the capacity planning work to support the ECIST programme and the move to seven days services, senior clinical decision makers are currently timetabled 'at the front door' from 8am to midnight.	MD	Completed	
		The timescale on the implementation of RAT ⁵ is planned to allow the full engagement of the consultant team in designing and agreeing the change required in working practices. This will be implemented throughout July.	MD	Complete by 31 st July 2013	HE KSS
4.2	Review care provided in the Admission and Discharge Lounge	As an interim measure, the Chief Nurse has converted the Admission and Discharge Lounge to a ward with a Head of Nursing overseeing clinical quality and undertaking a daily review of all patients. The ward is adequately equipped and established to function as a ward.	DOp	Completed	
		However, the Trust is committed to revert to a fully functioning ADL through the ECIST work programme.	DOp	Achieve by 1 st Aug 2013	

⁵ RAT : Rapid Assessment and Treatment AT typically involves the early assessment of 'majors' patients in ED, by a team led by a senior doctor, with the initiation of investigations and/or treatment. The approach consciously removes 'triage' and initial junior medical assessment from the pathway. Instead, the first doctor a patient sees is one who is able to make a competent initial assessment, define a care plan and make a decision whether the patient requires admission or referral to an in-taking specialist team. Nurses and junior doctors in the RAT team then implement the first stages of the care plan.

4. Improved senior clinical assessment and timely investigations: URGENT					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
4.3	Develop a clear universally known activation protocol for escalating a response to deteriorating patients. This should be standardised across the whole hospital.	The Medical Director and Interim Director of Nursing will re-launch a standardised activation protocol for the deteriorating patient. This will form part of the personalised and team objectives of all clinical staff and monitored and reviewed daily through the normal line management process.	MD / CN	By 30 th June 2013	Health Foundation / HE KSS
Page 55		The Trust has established a weekly multi-disciplinary mortality review. The outcomes from this review go back immediately to the originating consultant and team. The process is led by the Deputy Medical Director.	MD	Commenced	
		The key themes and actions arising from this process will be reported to Board monthly	MD	30 th July 2013	
		An electronic database is being developed so learning can be collated and acted upon through the Trusts audit programme and patient safety committee structure.	MD	Complete by 31 st July 2013	
		The Trust has implemented the CHKS Q Lab programme via the audit programme. Q lab is a continuous improvement process that provides the Board with the assurance that the performance across the directorates is within expected ranges. CHKS meets with directorate on a quarterly basis to review aspects of care and treatment that may be driving variation. The issues are debated and actions agreed. This is an iterative process and the outcomes will be included in the audit committee board report	MD	Commenced	CHKS

5.	The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice : HIGH PRIORITY				
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
5.1	The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice	The OD framework referenced in 1.1 includes a Culture and People Experience Plan. It is due for consideration by the Workforce sub Committee of the Trust Board on 17 June 2013 prior to formal ratification by the Trust Board on 25 June 2013. The plan will embed a culture which is consistent with the Trust values and behaviours including the learning from patient feedback and the Francis Enquiry. It will improve the working experience of staff through actively listening and responding to staff feedback and improve staff engagement across the organisation and within multi disciplinary teams. It will develop a consistent approach to change management which maximises opportunities to involve and support staff throughout the change process. Key actions include:	DODC	Commenced	HE KSS / Leadership Academy / IHI
Page 56		<ul style="list-style-type: none"> Adoption of the 'NHS Change Model' providing a framework for developing the capabilities of individuals and teams (within the organisation and across the system) in service improvement techniques 		By 31 st March 2014	
		<ul style="list-style-type: none"> Develop staff and leaders in assertiveness techniques, handling challenging people and situations 		By 30 th Sept 2013	
		<ul style="list-style-type: none"> Encourage the identification and treatment of "cause(s) not effect(s)" of culture 		Commenced	
		<ul style="list-style-type: none"> Promote the "speaking up campaign" - voicing and reporting concerns and closing the feedback loop 		By 30 th June 2013	
		<ul style="list-style-type: none"> Launch the board visibility and assurance programme ("Director of the week" - Pairings with wards/ clinical areas, "Back to the Floor" programmes) 		Commenced	

5.	The Trust should develop a strategy and action plan to create a culture that welcomes improvement, galvanises the good work that is already going on in some wards and adopts and rapidly spreads good practice : HIGH PRIORITY				
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
		<ul style="list-style-type: none"> Introduce monthly Pulse surveys to provide regular feedback on staff experience by June 2013 		Commenced	
		<ul style="list-style-type: none"> Maintain existing IWL and WOW recognition schemes 		Commenced	
		<ul style="list-style-type: none"> The Trust will continue to use the Listening into Action methodology. The Trust has signed up to move into the second phase of implementation and become a 'Beacon' site. This phase commences in September 2013 		Sept 2013	NHS England
Page 57		The Trust is planning to pilot a Clinician Led Quality improvement Team to drive clinical improvement and rapidly spread good practice. As part of the pilot, a software platform 'Crowdicity' has been procured to provide an electronic means for staff to share good practice, innovate and problem solve.	CEO	By 31 st July 2013	

6. Improve public reputation: HIGH PRIORITY					
	Recommended Action	Trust Response	Lead Director	Timescale	External support required
6.1	The Trust should improve the methods and frequency with which it engages with the public and as a starting point extend its staff Big Conversation work to the public.	An annual communications and engagement plan has been developed which identifies Executive relationship leads for all stakeholders, including the public, members and governors. The plan is due for consideration and ratification by the Trust Board on 25 th June 2013 and where possible will be aligned to national publication timelines and the Trust annual plan. It is likely that a new communications officer role will be created to focus on good news stories for publication and to improve public relations in a sustained manner.	DODC	25 th June 2013	
Page 58		Continued promotion and improvement of Friends and Family feedback.	CN	Commenced	NHS England / CCG
		Plans are in place to build on the Friends and Family test with a patient electronic feedback APP. This will provide instant feedback to wards and clinical areas.	CN	By 30 th Sept 2013	
		Promote the PALs service as an effective advocate for patients.	CN	By 31 st July 2013	

Key:

CEO: Chief Executive Officer

MD: Medical Director

CN: Chief Nurse

DOP: Director of Operations

DODC: Director of Organisational and Communications

DGS: Director of Governance and Strategy

MWP: Mortality Working Party

CCG: Clinical Commissioning Group

HE KSS: Health Education Kent Surrey Sussex

CQC: Care Quality Commission

NHS IQ: NHS Improving Quality

3. Monitoring and Delivery

Progress against the action plan will be monitored by Board on a monthly basis. The Improvement Plan will be delivered through the dedicated PMO with regular reports to the Clinical Executive Group, the Quality Committee and Trust Board.

The performance indicators will be presented in a timely and concise manner to facilitate sound clinical decision making, targeted service improvement and robust governance.

The role of the Mortality Working Party will be considered with the independent Chair and stakeholder membership to review the work it is currently undertaking and agree how this fits within this Improvement Plan. The Board recognises the important role that this working party has played and continues to play in improving the Trust's HSMR and its overall aim to achieve a HSMR of 90 (prior to rebasing) in 2014/15.

The review summit will provide an opportunity to evidence progress made over the forthcoming two months. For example:

- (1) All Executive Director posts will be substantively filled (Chief Nurse and Medical Director will be in post), ensuring a new but stable team
- (2) A clear understanding of the improvement plan priorities at the top three levels of the organisation (Board to ward) will have been established, with a clear understanding of roles and timescales. This will commence with an away day with Clinical Directors, Heads of Nursing and General Managers on the 21st June.
- (3) Progress will have been made against actions as timetabled within this improvement plan and programmes of work will be in place to take the remaining actions forward

4. Risks to Achieving

Risk: Stakeholder engagement in the provision of adequate emergency services or alternative care provision and out of hospital care

Mitigation: To work collaboratively with partners to:

- understand the demands on emergency care and size hospital capacity accordingly
- to increase alternative care provision and ensure measures are in place to support patients staying in their place of residence
- to look at hours of hours provision and ensure that it meets demand

Risk: Poor external reputation

Mitigation:

- Agree joint communications with key stakeholders (NHS England, CCG, CQC, Monitor, HEE KSS)
- Positive post review media communications and engagement plan
- Develop a positive brand and employee proposition
- Use of friends and family test results

Risk: Lack of funding to support increased clinical establishment

Mitigation:

- Work with local CCG and NHS England to explore revenue funding issues
- Deanery support in the allocation of junior staff

Risk: Lack of capital funding to achieve emergency pathway development and hospital estate redesign including new emergency department

Mitigation: Work with local CCG, NHS England and Monitor to explore capital funding / borrowing

Risk: Inadequate physical capacity on the Medway site

Mitigation:

- Work with NHS England, KMPT and MCH to expedite vacation of the Medway site
- Begin procurement process on decant facilities as soon as possible having assessed the need and availability

Risk: Poor data quality and lack of analysis support to measure improvement

Mitigation:

- Appoint a data analyst to the PMO office working collaboratively with Public Health Medway
- Implement CHKS Q Lab methodology

Risk: Insufficient workforce capacity and capability to deliver the improvement plan

Mitigation:

- Establish a dedicated PMO
- Conduct an independent capacity and capability review
- Introduce robust appraisal and performance management systems using the Leadership and Management Development Framework

5. Support Required

Stakeholders have already written to the Trust outlining areas of potential support. The Individual Board members will be liaising with their counterparts to access this as appropriate.

- The most essential areas where financial support is required is :
 - The establishment of a fully operational Programme Management Office
 - The funding of Trust wide Service Improvement Training
 - Continued financial support for Listening Into Action
 - Contribution to the increased establishment in nursing and medical staff
 - Access to capital finance support for the reconfiguration of clinical areas, the new emergency department and the decant facilities to allow this to happen

There are two remaining funding sources to be explored either separately or in combination:

(1) CCGs identify resources to support revenue requirements for the PMO, establishment increase and Listening into Action Stage 2.

(2) Monitor extends the Trust's external borrowing limits to access capital to support the states redesign.

It should be noted that the latter source would under the proposed changes to metrics, have a potentially adverse effect on the Trust's Financial Risk Rating with Monitor.

It is critical that conversations are held with Monitor, NHS England and the CCG by the end of June 2013, to confirm the funding arrangements for this plan.

The Trust has secured the support of two highly successful Foundation Trusts, which have strong reputations for patient safety, experience and outcomes. These Trusts will be invited, as critical friends, to provide external challenge and support on an ongoing basis, for example external assurance of the Monitor Quality Governance Framework.

The Trust welcomes the opportunity to work with the NHS Institute for Improvement in implementing the NHS Change Model.

The Trust has been encouraged by the positive support offered by Health Education Kent Surrey Sussex (HE KSS), to develop and implement a sustainable workforce and development plan to address the immediate workforce challenges associated with the emergency care pathway as well as the longer term.

6. Conclusion

The Trust is committed to implementing the recommendations from the Rapid Response Review and the associated improvement plan. The risks to delivery have been highlighted and further discussions need to take place with stakeholders to agree mitigation. Whilst the locus of much of the improvement plan is within the Trust's remit, it is clear that stakeholder support and system collaboration is key in the plan's success.

The Trust is confident that it has already made significant progress in improving the quality of care that is delivered. The Trust Board is now entering a period of stability and the time is right to embed and accelerate the spread of good practice within a more externally aware organisational culture. The Trust will harness the demonstrable commitment from staff to improve and ensure a truly patient centred and high quality service to our public, members and all stakeholders.

For any additional information, please do not hesitate to contact:

- Tracy Rouse, Programme Director, Patient Safety , tracy.rouse@medway.nhs.uk

Item 7: West Kent CCG: Mapping the Future.

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 6 September 2013

Subject: West Kent CCG: Mapping the Future

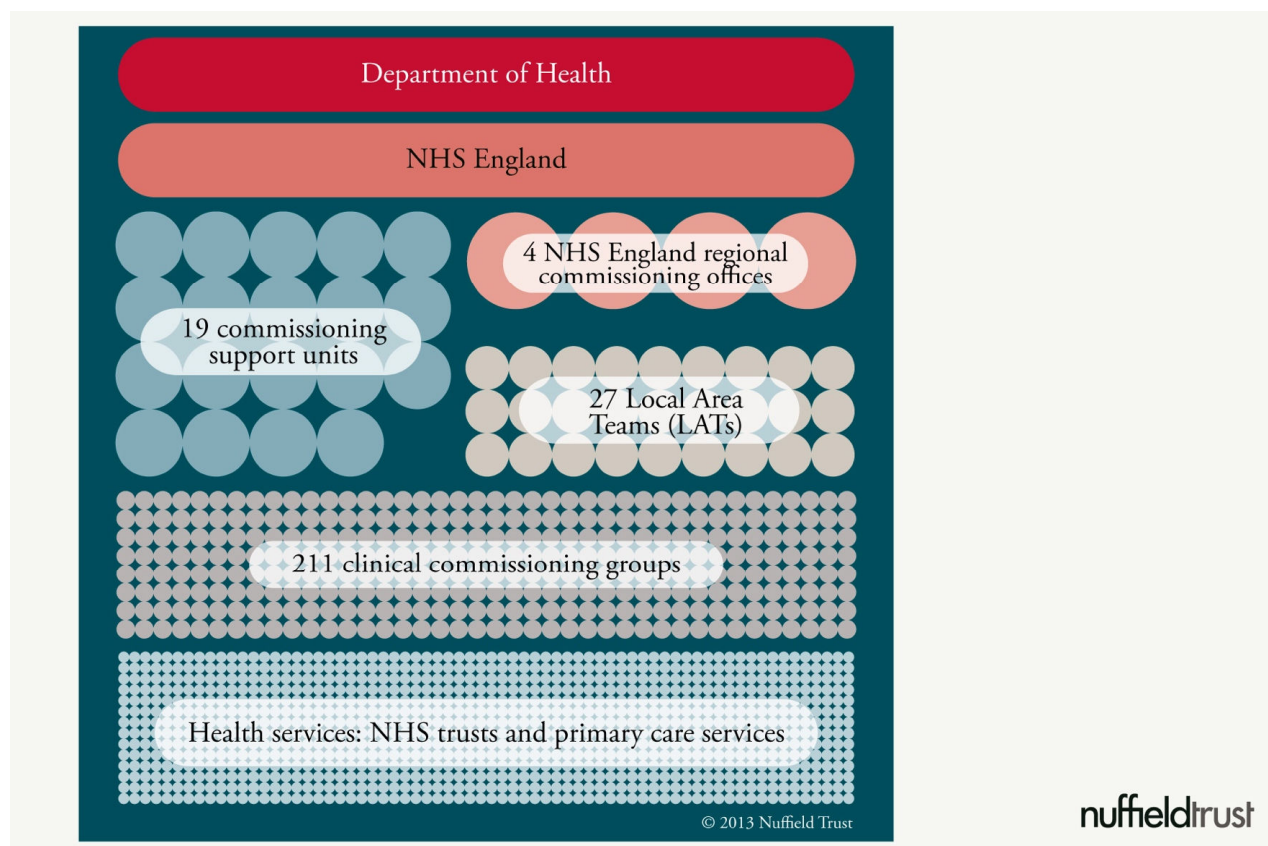
Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS West Kent CCG.

It provides additional background information which may prove useful to Members.

1. Introduction

- (a) On 1 April 2013, the majority of the changes introduced by the Health and Social Care Act 2013 came into effect. The following table from the Nuffield Trust provides an overview of the NHS structure this Act brought about.¹

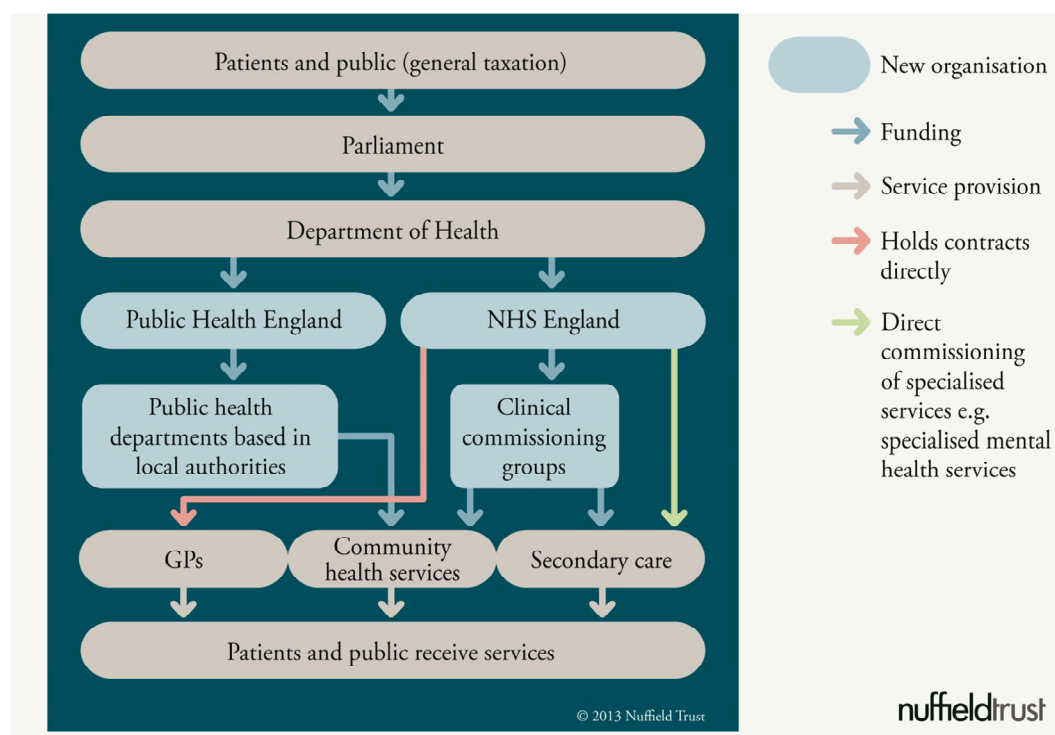
Diagram 1: The Structure of the NHS



¹ Diagrams 1 and 2 sourced from: The Nuffield Trust, *The New Structure of the NHS in England*, <http://www.nuffieldtrust.org.uk/talks/slideshows/new-structure-nhs-england>

- (b) Within the NHS, there is a difference between organisations which commission care and those which provide care. A wide range of organisations provide care with different ones specialising in different types of services. Taken together, across England providers of NHS funded services deal with over 1 million patients every 36 hours.²
- (c) Commissioning organisations are those which undertake the planning and purchasing of NHS services. The NHS is funded by taxation and there is an overall NHS commissioning budget of over £95 billion annually.

Diagram 2: Funding Arrangements



2. Clinical Commissioning Groups (CCGs)

- (a) CCGs are statutory NHS organisations. They are commissioning organisations formed from general practices. All GP practices are part of a CCG and the CCG is responsible for commissioning health services for the population within the CCG boundaries. There are 211 CCGs across England and they are collectively responsible for a commissioning budget of over £63 billion for 2013/14. In addition, £1.3 billion has been allocated for the running costs of CCGs.
- (b) The majority of hospital, mental health and community health services will therefore be commissioned by CCGs. This includes:

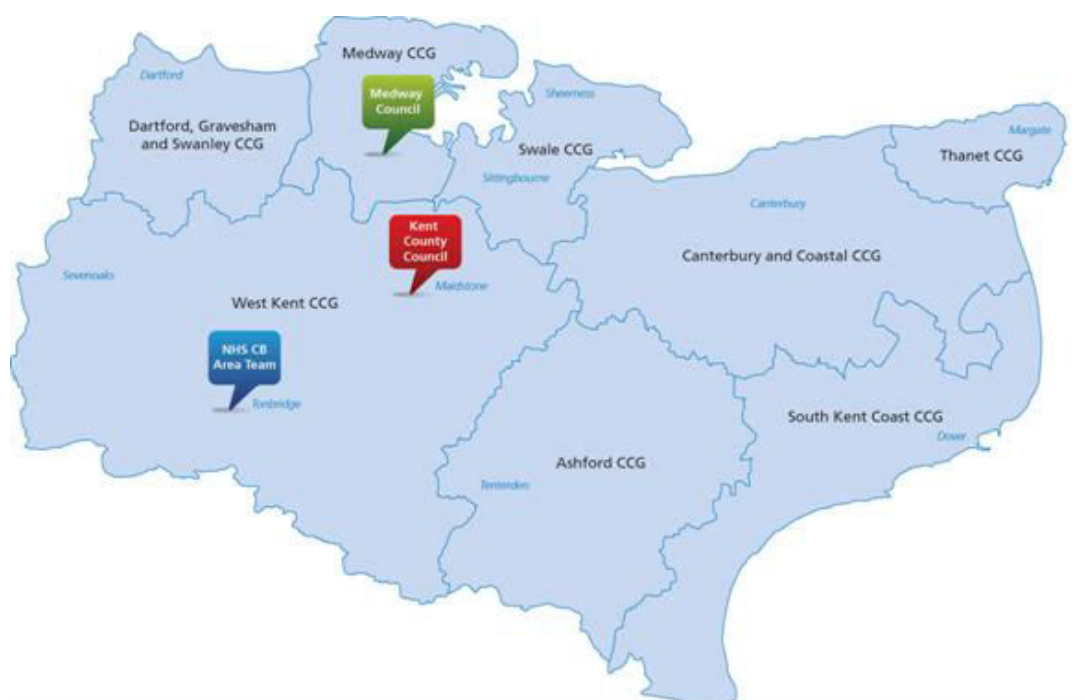
² Department of Health, *Guide to the Healthcare System in England*, May 2013, p.4, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF

Item 7: West Kent CCG: Mapping the Future.

- Urgent and emergency care (including ambulance services, accident and emergency, and NHS 111);
- Out of hours GP services;
- Planned hospital care;
- Community health services;
- Maternity services;
- Children's health services;
- Services for people with learning disabilities; and
- Mental health services.

(c) There are 8 CCGs covering Kent and Medway, as shown below.

Map 1: CCGs in Kent and Medway³



3. Profiles of Kent and Medway CCGs.⁴

- (a) NHS Ashford Clinical Commissioning Group. NHS Ashford Clinical Commissioning Group is responsible for a population of 121,000 people. It comprises 16 GP practices. It has a commissioning budget of £131 million.
- (b) NHS Canterbury and Coastal Clinical Commissioning Group. NHS Canterbury and Coastal Clinical Commissioning Group is responsible for a population of 210,000 people, in Canterbury, Faversham, Whitstable, Herne Bay, Sandwich, Ash and surrounding areas. It

³ Map produced by the Kent and Medway Area Team.

⁴ Information from Kent and Medway Area Team. CCG financial allocations sourced from: NHS England, *CCG financial allocations 2013-14*, <http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-allocations-13-141.pdf>

comprises 23 GP practices. It has a commissioning budget of £235 million.

- (c) NHS Dartford, Gravesham and Swanley Clinical Commissioning Group. NHS Dartford, Gravesham and Swanley Clinical Commissioning Group is responsible for a population of 249,000 people in Dartford, Gravesham and the northern part of Sevenoaks district. It comprises 36 GP practices. It has a commissioning budget of £274 million.
- (d) NHS Medway Clinical Commissioning Group. NHS Medway Clinical Commissioning Group is responsible for a population of 283,000 people. It comprises 58 GP practices. It has a commissioning budget of £327 million.
- (e) NHS South Kent Coast Clinical Commissioning Group. NHS South Kent Coast Clinical Commissioning Group is responsible for a population of 199,000 people in Dover, Deal and Shepway. It comprises 31 GP practices. It has a commissioning budget of £253 million.
- (f) NHS Swale Clinical Commissioning Group. NHS Swale Clinical Commissioning Group is responsible for a population of 106,000 people. It comprises 21 GP practices. It has a commissioning budget of £122 million.
- (g) NHS Thanet Clinical Commissioning Group. NHS Thanet Clinical Commissioning Group is responsible for a population of 140,000 people. It comprises 21 GP practices. It has a commissioning budget of £190 million.
- (h) NHS West Kent Clinical Commissioning Group. NHS West Kent Clinical Commissioning Group is responsible for a population of 464,000 people. It comprises 62 GP practices. It has a commissioning budget of £471 million.

3. Commissioning Support Units (CSUs)

- (a) While CCGs remain legally accountable for their statutory obligations, CCGs may choose to obtain support in carrying out their functions by employing in-house staff, and/or choosing to use new NHS CSUs or other sources of commissioning support.
- (b) There are currently 19 NHS CSUs, hosted by NHS England. The intention is for CSUs to develop and become standalone organisations by April 2016.
- (c) CCGs in Kent and Medway are being supported by in-house officers and the CSU, Kent and Medway Commissioning Support (KMCS).

KMCS also provide services to other health organisations such as the Kent and Medway area team and Department of Health.

4. NHS England

- (a) Prior to 1 April 2013, NHS England was known as the NHS Commissioning Board. It is an executive non-departmental public body of the Department of Health. NHS England has an overarching function to support the NHS nationally and ensure the money spent provides the best possible care for patients and that national standards are drawn up and delivered consistently across the country.
- (b) It is responsible for the overall NHS commissioning budget of over £95 billion annually. From this, the budgets for Clinical Commissioning Groups (CCGs) are provided to enable them to commission services locally. It also supports, develops and assures the CCGs.
- (c) NHS England is responsible for directly commissioning over £25 billion of health services (in 2013/14), specifically:
- Primary care services;
 - Specialised services;
 - Offender healthcare;
 - Some services for members of the armed forces.
- (d) 27 Local Area Teams of NHS England will carry out the commissioning of these services, operating to a common model, and work closely with CCGs. Kent is covered by the Kent and Medway Area Team.
- (e) NHS England will also host a number of clinical networks and senates relating to different clinical areas and operating across a range of geographical areas. Other networks will operate more locally:
- There will be a total of 12 **clinical senates**, 1 will cover the South East Coast area – Kent, Medway, East Sussex, West Sussex, Brighton and Hove and Surrey. These will connect with the development of academic health science networks (AHSNs) and local education training boards.
 - Strategic **clinical networks** hosted and funded by NHS England will support commissioners in areas where an integrated whole systems approach will lead to improvements. They will last 5 years and be supported by 12 locally based support teams. The first four conditions/patient groups selected are:
 - Cancer;
 - Cardiovascular disease (including cardiac, stroke, diabetes and renal disease);
 - Maternity and children's services;
 - Mental health, dementia and neurological conditions.

5. Recommendation

Members of the Health Overview and Scrutiny Committee are asked to consider and comment on the report from West Kent CCG.

Background Documents

None.

Contact Details

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MAPPING
THE FUTURE 

Overview

August 2013

What is Mapping the Future?

Mapping the Future is a project that will modernise health and care services for the 463,730 people who live across the boroughs of Tonbridge and Malling, Tunbridge Wells, Maidstone and most of the Sevenoaks district in west Kent.

Mapping the Future will produce a future picture of the modern, efficient health and care services that we will need to provide in order to meet the changing needs of people in west Kent.

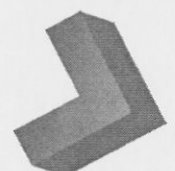
Who is involved in Mapping the Future?

Mapping the Future is being coordinated by NHS West Kent Clinical Commissioning Group (CCG), the main organisation that plans and buys healthcare services for the area.

The other organisations that either pay for or provide services to people in west Kent are also involved in the project, including:

- Kent County Council's Social Services
- Maidstone and Tunbridge Wells NHS Trust
- Kent Community Health NHS Trust
- South East Coast Ambulance Service NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Integrated Care 24 (IC24)
- Voluntary organisations
- GPs.

We want EVERYONE who has an interest in west Kent's health and care services, whether they are representing an organisation, or are a local resident, to let us have their views on this future picture.



Why is Mapping the Future needed?

Put simply, west Kent's health and care services need to change as there is a widening gap between what people in west Kent need and the funding available. Based on current trends, the demand for healthcare will increase by 20 per cent over the next five years but there will be no increase in funding. We have to find a way to give people the quality of care that they want and need, which is affordable.

NHS West Kent CCG has a budget of £471 million per year to spend on healthcare in the area. If we continue to deliver the services in the way we do now and meet new demands for care, we will have a funding gap of £62 million by 2018/19.

By being proactive and working together the NHS can start putting changes in place now, so that we can continue to provide you and your family with the health and care you need in the future.

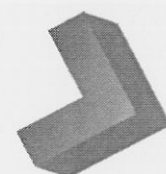
What will Mapping the Future achieve?

At present different organisations and individual services make their own plans. This creates a disjointed and inconsistent service for people who need health and care services.

The Mapping the Future blueprint will help local health care providers develop more coherent plans, provide more joined-up services and reduce unnecessary spend.

Mapping the Future will:

- Lead to the creation of a five-year healthcare plan
- Provide the opportunity for local people to become involved in decisions about what should happen
- Enable commissioners and service providers – hospital trusts, community services, the mental health trust, ambulance services and social care providers – to plan more effectively
- Put patients at the heart of the process so that services are planned, commissioned and delivered in their very best interests
- Make it easier to coordinate care, especially for people with multiple health and/or social care needs
- Ensure resources are used wisely.



What has happened so far?

Between May and June 2013, four meetings took place for clinicians, health and care professionals, managers and patient representatives, to review the way health and care services are currently provided, from prevention through to recovery.

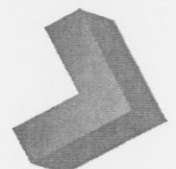
The sessions focused on the following areas:

- Falls and mobility
- Dementia and mental health
- Urgent and emergency care
- Respiratory diseases.

These topics were selected because they are areas where demands for care are increasing, but the topics themselves were not the main focus of the exercise. It was more about pulling out the common themes of how things are currently done and how they could be done in the future, to improve services.

People attending the sessions identified some of the current challenges to be overcome through the Mapping the Future project:

- Missed opportunities to tackle the causes of health problems
- Missed opportunities to tackle health problems early on
- Patient information doesn't 'flow' round the different systems
- Missed opportunities for involving voluntary and community organisations
- Services in the community are not geared to dealing with urgent care needs
- Opening times of services don't work together well and night and weekend access to services could be improved
- Providers of services don't know what other services are available, making it difficult to inform or steer people to the right place for help
- Professionals and the organisations they work in are concerned to protect their own interests but this can result in costly care that is not always best for the people that need care
- Lack of diagnostic services or consultant advice anywhere other than in hospital
- Not enough is done to learn from each other or share in identifying solutions
- The quality and performance of services delivered in the community is inconsistent
- Patients and carers aren't given enough information for them to be more actively involved in their care.

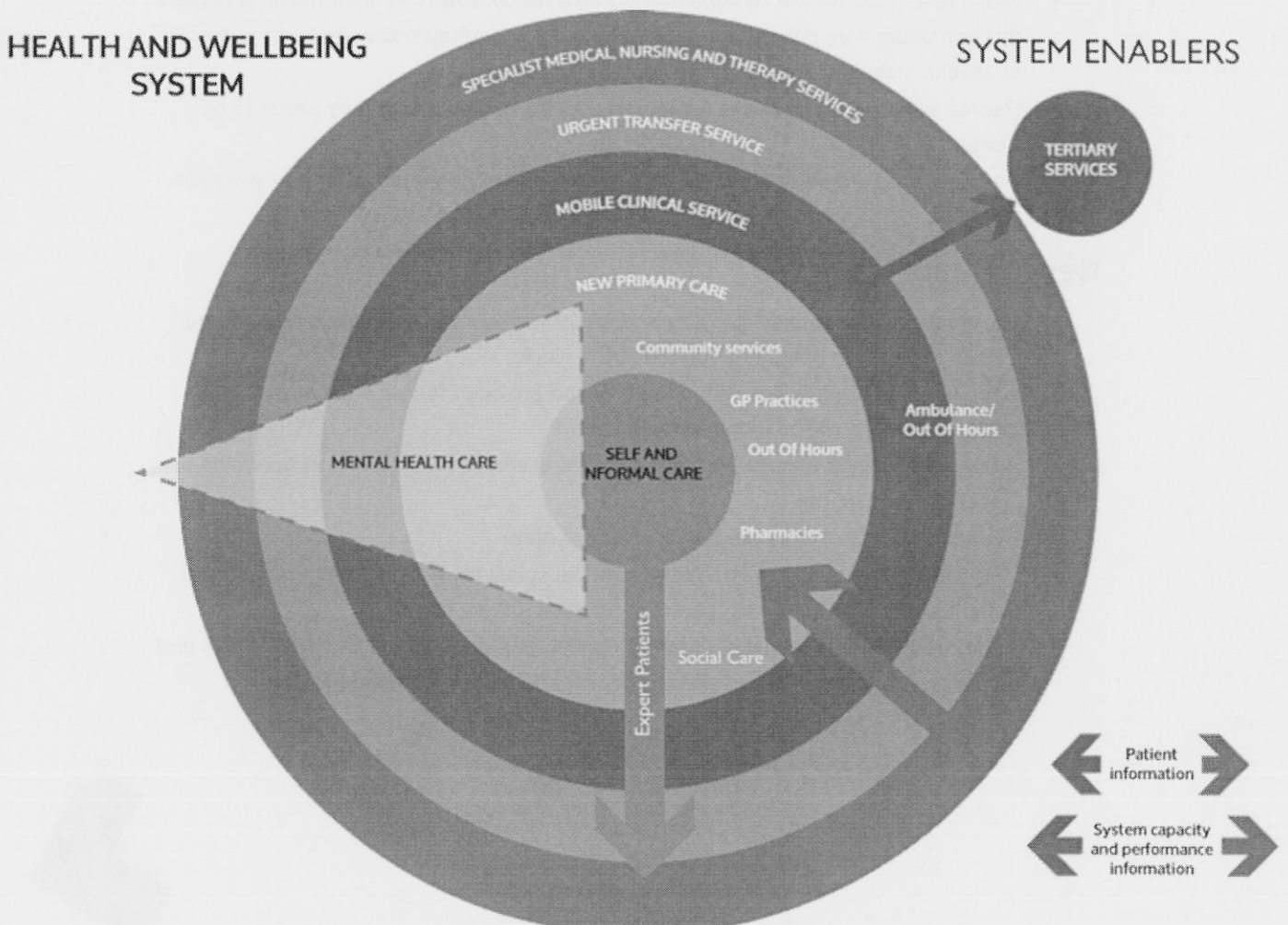


Participants heard the evidence about how other areas have tried different ways of organising health and care services. And they've used this information and their experience and judgement to describe what the future health and care system in west Kent might look like.

The information gathered from these sessions highlighted some common themes around the way health and care services should be delivered going forward in west Kent. A draft plan, known as a 'blueprint' was developed and then shared with everyone who had input to the four meetings.

This blueprint is now being refined in readiness for other health and care staff, voluntary and community organisations, patients and the public to comment on.

What does the 'blueprint' or plan look like?



At the heart of the blueprint are the people who need health and care. A health and wellbeing system ensures that all opportunities are taken to tackle important health risks such as tobacco, drugs and alcohol and enable people to choose healthy lifestyles. The majority of care is delivered by a new primary care system. This comprises pharmacists, GPs, community nurses, mental health and social care working together as a team, operating round the clock and working closely with specialist medical, nursing and therapy services in hospitals. More use is made of paramedics treating people at the point where they are ill. And mental health care is threaded through all of these aspects.

Health and wellbeing system

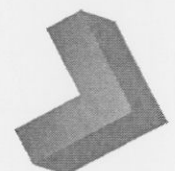
- All organisations involved in health and wellbeing will work together to tackle risks to health and to improve the health and wellbeing of local people.

Self and informal care

- Patients and carers will be supported to take responsibility for their health and care through education, peer support, and signposting so they know what services are available, including voluntary and community options
- People will be encouraged to make early decisions about how they prefer to be treated
- People will be supported to stay independent and at home for as long as possible.

New primary care

- GP practices, community services and social workers will be more joined-up and able to respond to patient needs round the clock
- Appointments or meetings with people will be provided face-to-face or over the phone and there will be longer opening times
- A consistent range of services will be available across west Kent and operating at weekends and nights
- Everyone will use the same patient record system
- GPs will have access to advice from hospital specialists so they can manage their patient's care without sending them to hospital unnecessarily
- Primary care teams will take a more proactive approach to tackling health risks and conditions early on, so they can help prevent people's health deteriorating



- Primary care teams will 'own' their patients' care. They will make sure patients receive specialist care if needed and help plan their return home as quickly as possible
- Professional teams will have advanced skills in diagnosis and treatment of patients with long-term conditions.

Mobile clinical service

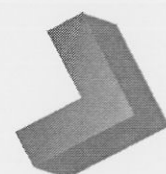
- NHS 111 will provide valuable advice and help to patients and carers by phone and online as part of the health and care system
- Call handlers will be fully briefed on local services and have access to live information
- Mobile clinical services that comprise paramedics and other health professionals, will provide care to the patient at the place where they become ill rather than bringing the patient to the services as a matter of course
- Mobile clinical services will have access to the same information as other health and care professionals (such as patient records) and there will be a clear system in place to transfer people back to the care of their primary care team.

Urgent transfer service

- The traditional ambulance service will continue to transfer patients with urgent care needs where necessary. They may provide a range of treatments and diagnostic tests to patients on the way, providing effective handover to specialist hospital services
- The same health and care protocols will be used across the system
- There will be access to the same information as other health and care professionals (e.g. patient records and awareness of what medicines people may need to take to hospital with them)
- The transfer service may take people to other care locations such as community hospitals or care homes as well as acute hospitals.

Consultant-led services / specialist doctors, nurses and therapists

- Hospital-based urgent and planned care will complement each other but will be managed separately to ensure they work as efficiently as possible
- Some consultant-led services will be concentrated in larger centres where there is evidence that this can improve quality and offer more cost-effective care



- There will be closer links with primary, community and mobile clinical services, with greater sharing of responsibilities, a culture in which there is clear accountability for care which stretches across organizational boundaries, supported by one single patient record system. People should experience more joined-up care as a result
- Information about patient needs and service activity will be constantly analysed to make sure resources are in the right place
- Hospital-based services will help people to make positive changes in their health behavior, e.g. around smoking or alcohol consumption
- There will be better linkages between the treatment of physical and mental health conditions
- Primary and specialist clinicians will work together to agree when it is appropriate to refer patients to specialist centres outside of west Kent and work to establish the same culture of shared care with clinicians in specialist centres.

What are the next steps?

The draft blueprint will be ready to share with the public in September 2013, and local people and organisations will be invited to submit their views through a dedicated Mapping the Future website and a range of engagement events.

Questions

We would welcome your response to the following questions. Responses can be submitted via our online questionnaire: <http://www.surveymonkey.com/s/mappingthefuture>

1. What are your comments on how we tackle west Kent's challenges of rising demand and limited resources for health and care?
2. If we all took responsibility for our own health what would we need to help us do that?
3. How can we make health and social care services more efficient (less wasteful)?
4. How can we ensure the person's experience of receiving services is more coordinated and joined-up?

