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.

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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)

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[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.

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[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 Ambitions[8]

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

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Appendix – Summary of Findings and Actions for Medway NHS Foundation Trust[9]

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.

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[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