Item 6: Medway NHS Foundation Trust: Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 7 March 2014

Subject: Medway NHS Foundation Trust: Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the Medway NHS Foundation Trust.

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

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1. Introduction

(a) Medway NHS Foundation Trust attended the Health Overview and Scrutiny Committee on 6 September 2013. The Committee considered the Trust's Improvement Plan produced in response to the Keogh Review into the Quality of Care and Treatment provided by 14 Hospital Trusts. The minutes of this agenda item are appended to the report.

(b) 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]

(c) 14 Trusts were selected on the basis of being outliers for two consecutive years on one of two measures of mortality: Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR).[2] [3] 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]

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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/

[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

(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). A score greater than 100 indicates that a hospital's mortality rate exceeds the expected value. [5]

2. CQC Inspection – Maternity and Midwifery Services

(a) The Care Quality Commission (CQC) carried out an unannounced inspection of Maternity and Midwifery Services provided by the Trust on 19 August 2013. The CQC decided to look at this service after noticing a 'slight increase in the numbers of notifications of incidents which included ante and post natal women and neonates'.[6]

(b) The inspection was carried out by a team of five CQC inspectors, one compliance manager, two pharmacist inspectors and four clinical advisors who visited the maternity wards, delivery suite, antenatal clinic, and three locations in the community, over the space of four days and one evening. The team also held focus groups with expectant and new mothers.

(c) Following the inspection, the CQC served three warning notices to the Trust with action to be met by 31 December 2013. The warning notices set out the hospital's failure to meet national regulations in three specific areas:

- Staffing;
- Supporting workers;
- Assessing and monitoring the quality of service.

3. Recent Developments

(a) Medway NHS Foundation Trust announced the departure of Mark Devlin as the Trust's Chief Executive and Denise Harker as the Trust's Chairman on 30 January 2014.[7] Monitor, the sector regulator of NHS-funded health care services, announced the appointments of Christopher Langley as interim Chairman and Nigel Beverley as interim Chief Executive on 6 February 2014.[8]

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[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] CQC Inspection Report, *Medway Maritime Hospital (19 August 2013)*, http://www.cqc.org.uk/sites/default/files/media/reports/ins1-791174936_rpa02_medway_maritime_hospital_20130819_f2.pdf

[7] Medway NHS Foundation Trust, *Medway Chairman and Chief Executive announce their departure*, published on 30 January 2014, http://www.medway.nhs.uk/news-and-events/latest-news/medway-chairman-and-chief-executive-announce-their-departure/

[8] Monitor, 'Monitor takes urgent steps to improve troubled foundation trust', published on 6 February 2014, http://www.monitor.gov.uk/home/news-events-publications/latest-press-releases-13

(b) Sir Stuart Rose, former Chairman of Marks and Spencer, has been appointed to advise the NHS on how to attract and retain the best leaders to help transform the culture in under-performing hospitals. Sir Stuart will particularly look at the problems faced by the 14 trusts currently in 'special measures' including Medway NHS Foundation Trust.[9]

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

Minutes, Health Overview and Scrutiny Committee, Kent County Council, 6 September 2013, https://democracy.kent.gov.uk/mgAi.aspx?ID=25799

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

CQC Inspection Report, Medway Maritime Hospital (19 August 2013), published 2 November 2013. http://www.cqc.org.uk/sites/default/files/media/reports/ins1-791174936_rpa02_medway_maritime_hospital_20130819_f2.pdf

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[9] Department of Health, 'Super-heads' review on how best NHS CEOs could take-on failing hospitals', published on 14 February 2014, https://www.gov.uk/government/news/sir-stuart-rose-to-advise-on-nhs-leadership

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Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
Internal: 4196
External: 01622 694196

Appendix – Agenda Item 5, Health Overview and Scrutiny Committee, Kent County Council, 6 September 2013

Mark Devlin (Chief Executive, Medway NHS Foundation Trust) and Felicity Cox (Kent and Medway Area Director, NHS England) were in attendance for this item.

(a) The Chairman of the Committee welcomed the Chief Executive of Medway NHS Foundation Trust (MFT) who then proceeded to introduce the item. Mr Devlin explained that following the publication of the Francis Report, 14 Hospital Trusts across England were selected on the basis of having been outliers for 2 years in one of 2 mortality statistical measures – Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). Sir Bruce Keogh was asked to investigate why the statistics were as they were and to ensure that the hospitals were improving. The Trust was visited by a 25 strong group involving active clinicians, regulators and local Clinical Commissioning Group (CCG) representatives. There was an announced visit followed by a second unannounced visit. Public meetings were held in Chatham and Sheppey. MFT was one of only 2 Trusts out of the 14 which had no issues escalated to regulatory bodies. The review concluded that there was good practice at the Trust, but that it was inconsistent; Mr Devlin agreed this was fair comment. Some of the improvements to be made could be undertaken solely by the Trust but some would involve the assistance of other bodies.

(b) It was further explained that most of the recommendations made by the review were in progress anyway. An example was given of the mortality working party set up by the end of 2012. This was chaired by the Medway Director of Public Health and involved Trusts with a good record around mortality. There were 50 points in the action plan and there were 6 areas where improvements were to be focused and these were set out in the Agenda on pages 38-40. HSMR and SHMI were useful as a 'smoke alarm' but did not tell the whole story of what as happening in a hospital. The SHMI at MFT was now at the lowest it had ever been and while the HSMR was still at 12, this was an improvement on the previous year.

(c) MFT was the busiest hospital in Kent and getting the right skill mix was central to being able to deliver 24/7 care. A review of the nursing and midwifery establishment was underway. More acute physicians were being recruited and there was a clear correlation between their numbers and safety. 25 consultants were being sought and 16 had already been recruited, all high calibre candidates. In response to a question, it was acknowledged that staffing levels were lower at weekends and at holidays and that this was being looked at. On the other hand, in response to being asked whether MFT would have responded as well as it had to the previous day's major traffic accident on the Sheppey Crossing if the accident had occurred on a Sunday, Mr

Devlin explained that it would. He was proud of the way the hospital had dealt with the Sheppey Crossing accident and the MFT accident and emergency department was resilient. Consultants were always available on call and the hospital was set up as a trauma unit.

(d) There was however a need to redesign the accident and emergency department, which saw 90,000 patients a year and had limited floor space. There was also a need to ensure staff were properly supported and to improve patient flows to the community. The local Urgent Care Board would be essential in steering this. Further information was given by Felicity Cox, representing NHS England. There were good reasons for thinking that MFT would be able to access significant funds from the money announced by the Department of Health to assist emergency care. In addition, there had been discussions about Swale CCG's 2% transition funding being available for the accident and emergency department at MFT. More generally, the Trust faced the challenge of an old estate.

(e) In response to a specific question about the action plan, it was explained that there was a mechanism to regularly review the governance mechanisms at the hospital and so this would have been done anyway. The action plan was a live document, one which had originally been endorsed by the Board in June. The HOSC Agenda pack contained version 9 and the Trust were now on version 11. 90% of the actions would be completed within 6 months, with the date of the latest set for June 2014. MFT had a legal undertaking with Monitor to achieve the action plan and there was a recovery plan with the Kent and Medway Quality Surveillance Group as well. There was 3,700 staff at MFT and the improvement methodology would first be spread to the top 50-60 clinical leaders before being spread to the rest of the workforce. This shared improvement methodology would ensure consistency.

(f) In response to another question about the action plan, it was explained that a refresh of the executive team was underway and had been for the last 6-9 months. There were the same number of directors, but the job titles had changed in some instances. This was done to emphasise the need to change some deeper rooted cultural challenges at the Trust. In response to a specific request, the offer was made to supply the Committee with an organogram of the hospital.

(g) On the need to improve the public reputation of the Trust, it was acknowledged that this was a challenge and that this had got harder because of the Keogh Review. The Committee were asked for any thoughts and comments. It was explained that the most recent Annual General Meeting had been held in the form of a listening exercise. The Chief Executive explained that he did often spend time talking to patients, sitting with them in outpatients or helping on a meal round and he wanted more senior staff to do the same.

(h) In response to a specific question, it was explained that in the action plan short term meant up to 3 months, medium term meant 3-6 months and longer terms meant longer than that. It was also confirmed that the action plan had also been to the equivalent Committee at Medway Council.

(i) Further questions were asked about the mortality statistics. The impact of the relatively higher level of deprivation in Medway was asked about and it was explained that both mortality indicators should take this into account. The Trust was able to drill down into the data, which was very useful. One area highlighted was the number of patients at the end of their lives who were admitted to MFT. This was partly because there was not a hospice for adults in the area. It was not always appropriate to send an elderly patient by emergency ambulance to hospital when they required end of life care. More needed to be done to ensure people's wishes about end of life were taken into account and acted on. Several Members agreed this should be a priority area to develop.

(j) The Committee proceeded to discuss possible recommendations. In addition to the recommendation, it was suggested that the Chairman write a letter to Mr Devlin expressing the Committee's gratitude to him and the staff of MFT for the way they responded to the previous day's accident on the Sheppey Crossing. The Chairman thought this was a good idea and undertook to do this.

(k) 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 particularly with regards end of life care and looks forward to receiving further updates in the future at the appropriate time within the next twelve months.

(i) 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 particularly with regards end of life care and looks forward to receiving further updates in the future at the appropriate time within the next twelve months.