Item 7: Medway NHS Foundation Trust (Written Update)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 28 November 2014

Subject: Medway NHS Foundation Trust (Written Update)

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

It is a written update only and no guests will be present to speak on this item.

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

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1. Introduction

(a) Medway NHS Foundation Trust has attended the Health Overview and Scrutiny Committee on three occasions (6 September 2013, 7 March 2014 and 5 September 2014) following the publication of Professor Sir Bruce Keogh KBE's review into the quality of care and treatment provided by 14 hospital trusts in July 2013.

(b) At the end of the discussion on 5 September 2014, the Committee agreed the following recommendation:

- *RESOLVED that guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in six months and submit a two monthly report to the Committee.*

2. Keogh Review

(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 (NHS England 2013a).

(b) 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). 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' (NHS England 2013a; NHS England 2013b; NHS England 2013c).

(c) 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 (NHS England 2013d).

(d) In July 2013, 11 of the 14 Trusts including Medway NHS Foundation Trust were put into 'special measures'. Special measures was a new regime introduced following the Keogh Review in 2013. It involves action and scrutiny by three organisations: the Care Quality Commission (CQC), Monitor (for NHS Foundation Trusts) and the NHS Trust Development Authority (TDA) (for NHS Trusts) (CQC 2014).

3. Monitor

(a) The NHS TDA and Monitor put in place support packages for the 11 trusts in special measures.

(b) The support package provided by Monitor for Medway NHS Foundation Trust included:

- the appointment of an improvement director to the trust to provide challenge and support to board members on the delivery of the Keogh action plan;
- the appointment of an interim Chair and Chief Executive in February 2014 to strengthen the Trust's leadership;
- A buddying arrangement with East Kent Hospitals University NHS Foundation Trust to support Medway in improving its quality reporting systems (CQC 2014).

4. CQC

(a) Professor Sir Mike Richards, the Chief Inspector of Hospitals, prioritised full inspections of the 14 trusts that were in the Keogh Review (including the 11 trusts in special measures) under CQC's new inspection model for acute hospitals (CQC 2014).

(b) The inspections took place between mid-March and early May 2014. A wide range of quantitative and qualitative information was gathered before the inspections. The inspections were undertaken by a team comprising of clinicians, Experts by Experience and CQC inspectors. Eight core services were inspected, with each being assessed against the five key questions. A rating was given to each service for each of the five questions on a four-point scale (outstanding, good, requires improvement or inadequate). An overall rating for the 11 trusts was given (CQC 2014).

(c) The CQC inspected Medway NHS Foundation Trust in April/May 2014. The Trust was rated inadequate overall. The ratings awarded for the five key questions were:

Safe?	Inadequate
Effective?	Requires improvement
Caring?	Good
Responsive?	Inadequate
Well-led?	Inadequate

(d) Following the CQC's inspections, the Chief Inspector of Hospitals made recommendations about special measures for the 11 trusts to Monitor and the NHS TDA. The Chief Inspector of Hospitals concluded that significant progress had been made at 10 of the 11 trusts. Two had made exceptional progress and were rated 'good' overall. A further three had made good progress but required further improvements; it was recommended that they should exit special measures with ongoing support. Five trusts were recommended a further period in special measures, with an inspection in six months to ensure that they are continuing to make progress (CQC 2014).

(e) Medway NHS Foundation Trust was the only Trust found to have failed in making significant overall progress. It was recommended that the Trust remains in special measures. The reasons for this recommendation were given:

- Significant improvements had been made in the maternity services, but overall there has been little or no progression the quality and safety of care;
- Multiple inadequate CQC ratings;
- Unstable leadership throughout the past year;
- Poorly defined vision/strategy;
- Very poor alignment or engagement of clinicians (CQC 2014).

5. Recommendation

RECOMMENDED that the Trust be invited to submit a written report for the January meeting and attend the March meeting of the Committee.

Background Documents

CQC (2014) *'Special Measures: One Year On (05/08/2014)*', http://www.cqc.org.uk/content/special-measures-one-year

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29237

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Medway NHS Foundation Trust (2014) *'News Release 26 June 2014 (27/06/2014)*', http://www.medway.nhs.uk/news-and-events/latest-news/news-release-26-june-2014/

NHS England (2013a) *'Professor Sir Bruce Keogh to investigate hospital outliers (06/02/2013)*', http://www.england.nhs.uk/2013/02/06/sir-bruce-keogh/

NHS England (2013b) '*Sir Bruce Keogh announces final list of outliers (11/02/2013),*' http://www.england.nhs.uk/2013/02/11/final-outliers/

NHS England (2013c) *'Rapid Responsive Review Report for Risk Summit - Medway NHS Foundation Trust (01/06/2013)*', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf

NHS England (2013d) *'Medway NHS Foundation Trust: Keogh Review Data Pack (09/08/2013)*', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-medway-data-packs.pdf

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