Item 4: Medway NHS Foundation Trust and NHS Swale CCG – Medway's Emergency Department

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 30 January 2015

Subject: Medway NHS Foundation Trust and NHS Swale CCG – Medway's Emergency Department

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

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.

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 2014a).

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 2014a).

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 2014a).

(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 2014a).

(c) The CQC inspected Medway NHS Foundation Trust between 23 and 25 April 2014 with an unannounced inspection visit on 1 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 2014a).

(e) Medway NHS Foundation Trust was the only Trust found to have failed in making significant overall progress. It was recommended that the Trust remained 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 2014a).

(f) The CQC carried out an unannounced inspection of the Emergency Department on 27 and 28 July 2014 to follow up on its findings from April and in response to receiving information of concern from two separate sources. The key findings from the inspection were:

- The Emergency Department was in a state of crisis with poor clinical leadership;
- The Emergency Department had failed to review and optimally utilise its escalation policy within the ED to avoid the need to 'stack' patients;
- The Emergency Department continued to fail to ensure that children attending the department underwent initial assessment which was in line with national standards (CQC 2014b).

(g) On 30 July 2014 the CQC formally wrote to the Chief Executive of Medway NHS Foundation Trust setting out its concerns and to request the necessary assurances that appropriate action would be taken to ensure the safety and welfare of patients who used the service (CQC 2014b). A Section 31 Notice was issued. Under Section 31, the CQC can suspend the registration or extend a period of suspension of a registered person for a specified period of time; it can also vary, remove or impose conditions to registration. The CQC must have reasonable cause to believe that unless it acts using this section, a person will or may be exposed to the risk of harm (CQC 2013).

(h) The CQC carried out a further inspection of the Emergency Department on 26 August 2014; they found that the Emergency Department

continued to lack any form of effective clinical leadership and there remained a lack of cohesive working amongst nursing, medical and allied healthcare professionals. The process of initially assessing patients in a timely manner remained flawed; in some instances patients were experiencing delays of more than two hours before any effective clinical intervention or treatment was commenced. The inspection report was published on 26 November 2014 (CQC 2014b).

(a) In response to the Section 31 Notice, NHS commissioners and providers in Kent and Medway met with Monitor and NHS England to develop a partnership plan to support Medway Maritime Hospital.

(b) On 10 October 2014 the Committee considered proposals by NHS Swale CCG to reduce elective activity at Medway Maritime Hospital in order to increase internal capacity. Maidstone and Tunbridge Wells NHS Trust agreed to offer Swale patients the option to be seen at Maidstone Hospital for their elective outpatient appointments in three specialties – care of the elderly, respiratory and cardiology. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the Committee are supportive of the decision to take urgent action at Medway NHS Foundation Trust, that the CCG be thanked for their attendance at the meeting and that they be invited to attend the Committee in January with a progress report.*

(c) On 28 November the Committee considered a written update on Medway NHS Foundation Trust which was produced in advance of the latest CQC inspection report published on 26 November 2014. The Committee agreed the following recommendation:

- *RESOLVED that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend the January meeting of the Committee to provide an update on actions taken to support Medway's Emergency Department.*

5. Recommendation

RECOMMENDED that the reports be noted and that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend a meeting of the Committee in six months.

Background Documents

CQC (2013) '*Enforcement Policy (28/06/2013)*', http://www.cqc.org.uk/sites/default/files/documents/enforcement_policy_june_2013.pdf

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

CQC (2014b) *'Medway Maritime Hospital Reports (26/11/2014)*',
http://www.cqc.org.uk/location/RPA02/reports

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (06/09/2014)*',
https://democracy.kent.gov.uk/mgAi.aspx?ID=25799

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (07/03/2014)*',
https://democracy.kent.gov.uk/mgAi.aspx?ID=27666

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

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

Contact Details

Lizzy Adam
Scrutiny Research Officer
lizzy.adam@kent.gov.uk
Internal: 7200 412775
External: 03000 412775