HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

20 AUGUST 2013

REVIEW INTO QUALITY OF CARE AND TREATMENT - MEDWAY NHS FOUNDATION TRUST

Report from: Barbara Peacock, Director of Children and Adults

Author: Rosie Gunstone, Democratic Services Officer

Summary

This report sets out a briefing on the findings of the Sir Bruce Keogh review into the quality of care at Medway Maritime Hospital in Gillingham. The Chief Executive of Medway NHS Foundation Trust will be present to introduce the report.

1. Budget and Policy Framework

1.1 Under Chapter 4 – Rules, paragraph 22.2 (c) terms of reference for Health and Adult Social Care Overview and Scrutiny Committee has powers to review and scrutinise matters relating to the health service in the area including NHS Scrutiny.

2. Background

2.1. 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 Trust's Quality Improvement Plan

2.2. The Chairman of this Committee has invited the Chief Executive, Medway NHS Foundation Trust to attend this meeting and introduce the report's findings.

2.3. Attached, as two appendices, to this report is the briefing from the Chief Executive, Medway NHS Foundation Trust, as requested along with the Quality Improvement Plan.

3. Risk management

Risk	Description	Action
Potential risk to safeguarding of children and vulnerable adults in Medway	As part of the Director of Children and Adults' statutory position as Director of Children Services and of Adult Services there is a duty to ensure that children and vulnerable adults are protected and their needs are being addressed	The Director of Children and Adults will need to be assured by Medway NHS Foundation Trust that the current arrangements and plans for safeguarding of children and vulnerable adults in Medway are being addressed. It is for Medway NHS Foundation Trust to provide evidence to give this assurance and to share plans. The Director of Children and Adults would welcome an invitation to comment on the Trust's plans in this regard.

4. Legal and Financial Implications

4.1. There are no legal or financial implications for the Council.

5. Recommendations

5.1. Members are asked to consider and comment on the Quality Improvement plan following the Keogh Review at Medway Maritime Hospital.

Background papers:

None.

Lead officer:

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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? *(This KLoE was covered in clinical and operational effectiveness)*
Trust Specific – Quality Care Strategy and Implementation	How have they refreshed their Quality Care Strategy (April 2012)? *(This KLoE was covered in Governance and Leadership)*

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:

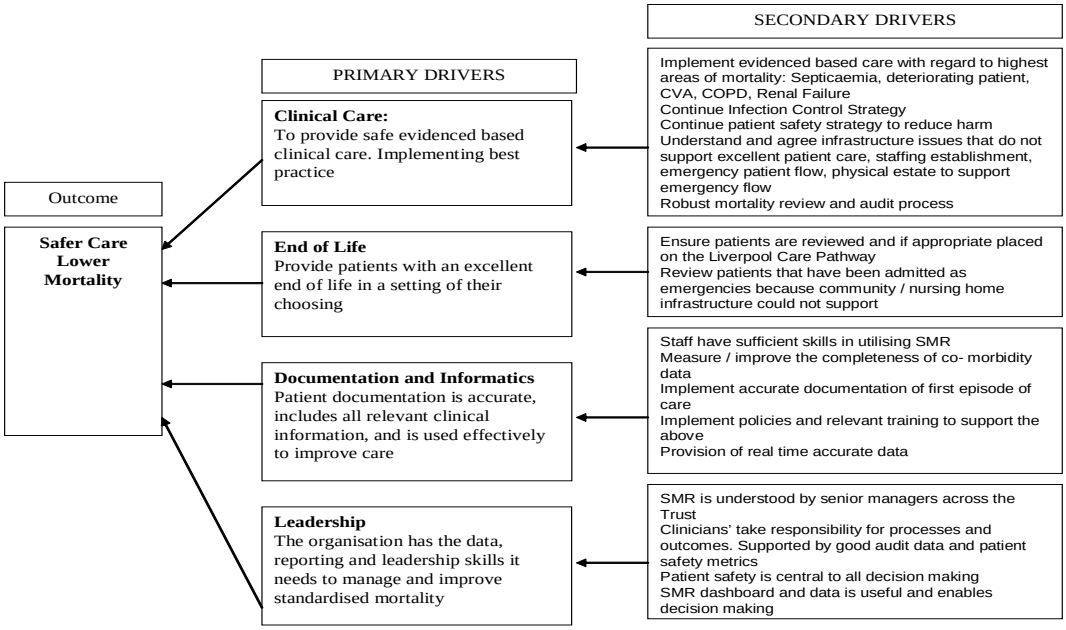
- Need for greater pace and clarity of focus at Board level for improving the overall safety and experience of patients
- Review of staffing and skill mix to ensure safe care and improve patient experience
- Re-design of unscheduled care and critical care pathway
- Improved senior clinical assessment 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.

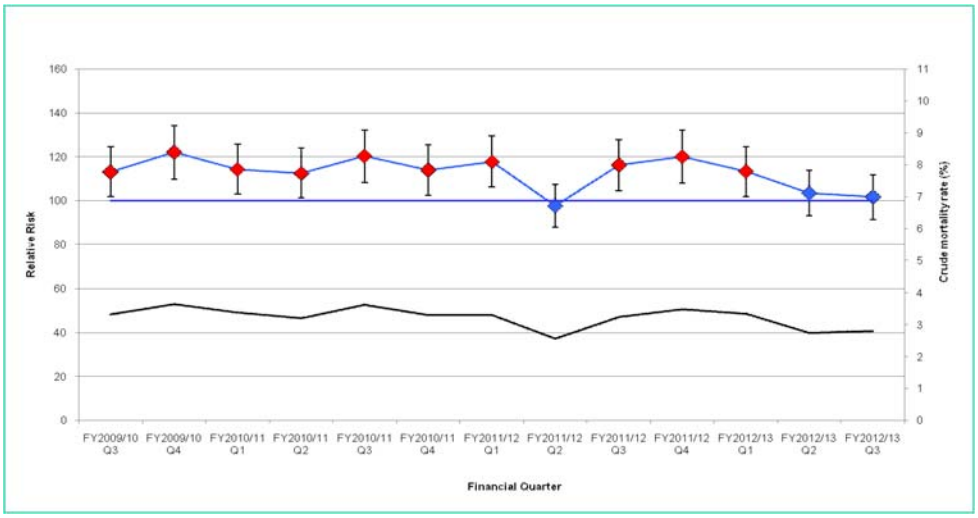
The membership includes Board and Governing Body representation from MFT, the three North Kent CCGs and the Medical Director from The National Commissioning Board Area Team. It is chaired by the Director of Public Health. The MWP has developed an action plan focused on improving mortality rates.

The key driver:



SHMI Trends:
2011/12 and 2012/13

Medway NHS
NHS Foundation Trust



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 overaching 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 thee 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 imitative 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.

Medway NHS
NHS Foundation Trust

The Medway NHS Foundation Trust

Review into the Quality of Care and Treatment
June 2013

Quality Improvement Plan in Response to the Review Recommendations

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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	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	The Trust Board will endorse this Improvement Plan at its Board meeting on 25th June 2013. 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 AQuA[1]). The framework also incorporates the key priorities identified at the Listening Into Action[2], patient safety event (6th March 2013). Work on the implementation of the key drivers and improving outcomes has commenced and is progressing well.	MD (CN)	25th June 2013 3rd Sept 2013 24th 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 30th June 2014.	DODC	Rollout to be completed by 30th June 2014	NHS IQ
		It will be complemented by the introduction of dedicated MDT Schwartz rounds to encourage multi professional reflection and learning. This will commence by 31st October 2013 and rollout over a six month period.	MD	Commence by 31st 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 30th 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 17th June 2013 prior to formal ratification by the Trust Board on 25th June 2013). The framework aligns the vision, values and strategic objectives of the organisation to 5 priority areas for delivery as follows: • Capacity (people) • Capability • Culture and people experience • Contribution linked to recognition • Communications, engagement and brand	DODC	25th 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 31st 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 31st 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 31st 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 3rd September 2013.	DGS	Complete by 3rd 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 30th Sept 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 Director of Operations, supported by the new Director of Strategy and Governance will introduce "new style" monthly directorate performance reviews by 31st 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. This will be developed to include external benchmark information to drive an improvement culture.	DOp DOp	Complete by 31st July 2013 Complete by 30th Sept 2013	
1.3	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	The Medical Director will continue to develop the SI process which will include : • A critical multi –disciplinary review meeting with 48 hours of all involved • Confirmation of immediate action taken at Directorate level • A multi-disciplinary peer review through the Patient Safety Committee to share learning and improve clinical outcomes • A Presentation at the grand round • An audit to close the loop and confirm the learning and action has been embedded • Improved Root Cause Analysis Training to apply an evidenced based approach to RCA and ensure that the right improvements are in place This process has been implemented and is being reported on monthly via the Patient Safety Committee to the Quality Committee and externally to the CCG Clinical Quality Review Group. The Board will receive a monthly report on the analysis of serious incidents. To include key themes and actions arising.	MD MD	Commenced From 30th July 2013	NHS England (external Root Cause Analysis Training)

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 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. The Board will receive a report quarterly illustrating key themes arising from patient complaints and actions that have been taken.	CN CN	Ongoing From 24th 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)	25th June 2013	HE KSS
		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 17th 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 : • Care planning • Handover • Safe patient transfers internally and externally • Implement SBAR[3] and NEWS[4]	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
		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 30th 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	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 : - Oversee the Trusts goal to achieve the 95% wait for A&E and • 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 • 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 This programme will build on best practice from other sites facilitated by ECIST and in collaboration with HEE KSS.	CN	Commenced	CCG / NHS England HE KSS
		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.	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 30th Sept 2013	CCG / NHS England
		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 • the provision of out of hospital care • adequate commissioning of emergency pathways • adequate commissioning of out of hours care	DOp	From 27th 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	30th June 2013	
		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 31st 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 1st 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 30th June 2013	Health Foundation / HE KSS
		The Trust has established a weekly muliti-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 arsing from this process will be reported to Board monthly	MD MD	Commenced 30th 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 31st 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 are actions agreed. . This is an iterative process and the outcomes are will 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
		• 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 31st March 2014	
		• Develop staff and leaders in assertiveness techniques, handling challenging people and situations		By 30th Sept 2013	
		• Encourage the identification and treatment of "cause(s) not effect(s)" of culture		Commenced	
		• Promote the "speaking up campaign" - voicing and reporting concerns and closing the feedback loop		By 30th June 2013	
		• 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
		• Introduce monthly Pulse surveys to provide regular feedback on staff experience by June 2013		Commenced	
		• Maintain existing IWL and WOW recognition schemes		Commenced	
		• 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
		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 31st 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 25th 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	25th June 2013	
		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 30th Sept 2013	
		Promote the PALs service as an effective advocate for patients.	CN	By 31st 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 with 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 process 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:

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