AGENDA ITEM 5

HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Cllr Mohammed Khan
DATE:	2nd June 2014

SUBJECT:
Keogh Review Working Group
East Lancashire Hospital Trust and Blackburn with Darwen Health and Wellbeing Board

1. PURPOSE

To update the Health and Wellbeing Board on progress made with East Lancashire Hospital Trust, Blackburn with Darwen Clinical Commissioning Group and the Blackburn with Darwen Health and Wellbeing Board as a result of the Keogh Review.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

To note the report and progress of the Group to date.

3. BACKGROUND

Following discussions at a meeting of Blackburn with Darwen Health and Wellbeing Board on Wednesday 12thMarch 2014, a follow up session with East Lancashire Hospital Trust (ELHT), Blackburn with Darwen Clinical Commissioning Group and key stakeholders from the Health and Wellbeing Board was agreed for Monday 31st March 2014 at Blackburn Town Hall.

This informal session was one of a series; the first one taking place on 3rd September 2013 shortly after the first Risk Summit resulting from the Keogh Review where a small working group of key stakeholders from the Blackburn with Darwen Health and Wellbeing Board, Local Healthwatch and the Councils Health and Adults Overview and Scrutiny Committee was convened.

This second session was Chaired by the Deputy Leader of the Council (Councillor Mohammed Khan) in his capacity as Executive Member for Health on the Blackburn with Darwen Health and Wellbeing Board:

The outline of the session followed a similar format to that of the first and the group received an overview of the key challenges ELHT faces over the next six months and what progress has been made since the first Risk Summit. Using the draft high levels KLOEs used by the original Review, the group received an update of how these linked to the most recent Action Plan(s) ELHT put in place.

There was also an opportunity for ELHT to update stakeholders on how they have considered the recommendations made in September to support the delivery of their Action Plan(s) in both the long and short term.

4. RATIONALE

The Group were led through a presentation on the Keogh Quality and Assurance Framework which explained that:

- The Keogh Review Team reported in July 2013.

12

- East Lancashire CCG in collaboration with ELHT and the Local Area Team of NHS England developed a CCG Quality Assurance Framework (QAF).
- This QAF was designed to provide Commissioners with the level of assurance required to be confident that appropriate action was being taken by ELHT and partner organisations to address the issues and concerns raised by the Keogh Team

The QAF focused on 4 key themes identified in the Keogh review report which are:

- Governance & Leadership
- Alignment of Strategies
- Organisational Development, Values & Behaviours
- Patient Experience

Within each of those areas the specific key lines of enquiry (KLOE) had been identified from the Keogh review report and then best practice outcomes had been described against each area in order to articulate the expected levels of attainment to be achieved.
When advised of progress to date, the group were advised that:

- The current review of draft strategies show an alignment of vision, values and shared outcomes
- There was demonstrable evidence of Ward to Board Communication and staff engagement
- That new people joining the organisation have reinvigorated leadership. Positive influence in the direction of travel and culture

The Group were advised that the areas for improvement were as follows:

- Governance review – needs a comprehensive action plan, with timescales and outcomes.
- Deanery report – issues need to be addresses urgently across ELHT.
- Safeguarding – training figures are not compliant across the divisions.
- Complaints – need to see a new policy, audit of new process, closure of Keogh complaints
- Cost Improvement Plans (CIP's) – Evidence needed on Quality Impact Assessments and Board debate.

5. KEY ISSUES

The Chief Executive (James Birrell) and the Medical Director (Ian Stanley) provided the group with an Executive Summary of responses to the recommendations previously submitted by the Group and the Keogh review carried out in June / July 2013. The report is outline below:

1. The review into the Quality of Care and Treatment (Keogh Review) at East Lancashire Hospitals NHS Trust (ELHT) was carried out in June and July 2013. The report of the Review Team and subsequent Risk Summit process identified key areas that we must focus on to improve the quality of care we provide, the safety of our care and the experience our patients have of the care we provide.

2. The review findings were grouped into six areas:

- Governance and Leadership
- Local Capacity
- Clinical and operational effectiveness
- Patient experience
- Workforce and safety
- Nursing

3. This report provides a synopsis of what has been done against each of these areas, the measurable outcomes achieved and the ongoing work programme.

Governance and Leadership

4. Governance

4.1 Much work has been undertaken to improve our underpinning governance structures and processes, which the Review described as "not cohesive", specifically:

- An independent review of our governance processes was commissioned, its findings were approved by the Board and implementation commenced in February 2014.
- All Serious Untoward Incidents have been reviewed and a Board level Oversight Panel (Chaired by a Non Executive Director) has been established.
- A revised Board Assurance Framework, which identifies all the major organisational risks and mitigating actions, is in place.
- All Divisional risks have been reviewed and linked to the Board Assurance Framework.
- Committee structures have been revised to improve Board assurance and a new floor to Board accountability/assurance process is being introduced this month.
- Processes have been implemented which have improved our approach to reducing mortality e.g primary reviews of all deaths, secondary reviews of patient deaths which give potential concern and the development of 8 'care bundles', which aim to give consistent and reliable care for patients suffering from certain potentially life threatening conditions. One of the indicators for measuring mortality, the Summary Hospital Level Mortality Indicator (SHMI), which was an outlier and triggered the Keogh Review, has been in the expected range for the last two months. The other mortality indicator, the Hospital Standardised Mortality Ratio (HSMR), had been in the expected range at the time of the Keogh Review but subsequently increased. The latest data for our HSMR shows this again to be within the expected range.
- The approach to measuring and agreeing the potential impact on the quality of care of schemes designed to make efficiency savings has been strengthened. The Medical Director and Chief Nurse now review and sign off all schemes.
- Board members undertake regular patient safety walkrounds and speak to staff, patients and relatives over concerns as well as discussing areas where good care has been provided.

5. Leadership

We have:

- Refined our vision 'to be widely recognised for providing Safe, Personal and Effective Care'
- Refreshed our corporate objectives, values and operating principles
- Improved our performance management framework
- Implemented a practical 'speak out safely' scheme
- Developed a shared learning policy to demonstrate Board to floor learning

A leadership programme is in place, which is designed to help leaders to understand what is expected of them and how to demonstrate and embed those behaviours. Over 25% of consultant staff have now participated in our leadership programme.

Our senior management capacity has been increased and we have introduced senior roles in our governance and communications teams to help us address the findings of the Keogh Review.

Local Capacity

The Keogh Review identified two main areas of concern under this theme; that we needed to better understand patient flow and therefore improve the emergency pathway of care and also that we appeared to have high readmission rates of patients following their initial discharge from hospital.

6. Better Understanding Patient Flow

Following an independent review of the processes that support emergency patients we have adopted a new approach called 'Right Care, Right Time' which systematically aims to improve all aspects of the emergency care pathway. Improvements have included:

- Our 4 hour target performance in the Emergency Department has significantly improved (95.4% in February, currently 95.2% in March)
- We have a new process to deal with times when we have significant pressure on our beds, such that we now do not use some unsuitable clinical areas for inpatient stays and we have significantly reduced the use of other 'escalation' areas.

- We no longer 'surge' patients to wards and patients are experiencing fewer ward moves.
- Developed a set of interprofessional standards, the aim of which is to challenge clinical staff in the provision of timely and high quality emergency care.
- Created an Ambulatory Care Centre in which patients are assessed and, where clinically appropriate, they access community based services thereby preventing a hospital admission.
- Introducing an Outpatient Antibiotic Therapy service, where patients who need intravenous antibiotics are treated in a community setting.

7. Readmission Rates

Again we commissioned two external reviews of our practices in respect of adult and children who have been readmitted following an initial hospital stay. These reviews noted areas of good practice and care but also identified opportunities to improve, leading to service changes e.g greater use of our virtual ward service in the community, the introduction of 'hot clinics' for children. Our readmission rates are now within what is expected for adult patients and have improved by 2% for children. However, further work is still required.

Clinical and Operational Effectiveness

8. We are finalising our Quality, Clinical and Organisational Development Strategies. Each will have measurable improvement targets. The Quality Strategy is supported by an underpinning quality improvement methodology in which staff are being trained. We are also working to establish a 'framework for learning', the aim of which is to develop a generic improvement skill set for all staff.

9. A 'lessons learned and sharing' policy has been developed and the Trust has introduced a monthly Board quality report which includes learning from incidents, complaints etc. There are also regular meetings in all clinical areas, called Share to Care, where staff discuss learning from recent episodes of patient care. Staff receive a Share to Care newsletter which again includes learning from incidents and complaints. The aim is to be a transparent learning organisation that learns, and improves, from incidents.

10. There has been a much improved health economy wide approach to planning for the 2013/14 winter, with active discussion between all partner agencies, most manifestly through the Clinical Transformation Board. We have also looked at the balance of work between the Blackburn and Burnley sites and increased the amount of step down beds and undertaken more elective surgery at Burnley, therefore helping the Blackburn site cope with the emergency workload.

11. As previously mentioned we have revised our performance framework to more closely reflect the 'compliance frameworks' of the Care Quality Commission and the NHS Trust Development Authority. Linked to this we have developed improvement trajectories in the four specialties that are currently failing the 18 week waiting times target and there have been specific improvements in general surgery and orthopaedics. We have had supportive external reviews on our processes for helping patients suffering from cancer and the use of our close observation beds in our Maternity Unit.

12. All of the most severe pressure ulcers that are developed when a patient is in hospital are now reviewed by senior nursing staff and a collaborative approach has been introduced to learn from best practice.

13. We have introduced an electronic 'Early Warning Score' (EWS) system which help ensure the best care for our most poorly patients.

Patient Experience

14. The Keogh Report identified the need to improve the complaints process so that it shows more compassion and empathy. Face to face meetings are now offered as a first step in the process. We have audited the compliance with this initiative and have found 80% of patients have been offered such a meeting, previously this was 20%. The Director Team review all complaints.

15. There has been a continued improvement in the combined response rate of the Friends and Family test, and also in the maternity test. The response rate for Accident and Emergency has been poor. To try and address this a 4 month pilot has begun to use SMS text messaging to encourage people to respond. This has resulted in immediate significant improvements in response rates (latest 32% from approx. 5%) with very positive patient feedback.

16. A 'back to the floor' campaign has been introduced. The aim of the campaign is to increase senior nurse visibility and to ensure they have the opportunity to talk to patients and their relatives about their experience

17. Patient stories are now a feature of Board meetings.

18. The Customer Care training programme has been revised, being aligned to delivering Safe, Personal and Effective care, and includes expected behaviours. The programme is being rolled out with priority service areas/job roles specifically targeted. An easy access on-line training package has been developed.

19. We have appointed a senior communications lead and have revised our communications and engagement strategy. Of late there has been more positive coverage of ELHT in the local media. We also have a new community engagement strategy (tell 'ELLIE) and have gained some very useful feedback from the initial round of engagement events. The use of 'soft' intelligence from CCG colleagues is also increasingly being used to improve patient care.

Workforce and Safety

The Keogh review considered that staffing levels were low for medical and nursing staff when compared to national standards.

20. The Trust therefore commissioned an external review of nursing and midwifery staffing levels. From this report a comprehensive action plan, approved by the Board, was developed to support delivery against the findings. A Steering Group has been established to oversee implementation. Actions include:

- Roll out of the use of a daily staffing template
- Daily staffing conference to include all clinical divisions and sites
- Publication of daily staffing numbers – actual against planned for each shift. A pilot is in place for one ward in each Division from 24th March, with roll out to all wards by 23rd April.
- Development of a ward scorecard which will be reported to the Board and used to target areas requiring improvement.

21. A robust recruitment plan has resulted in 118 more nurses and 152 nurse support posts since April 2013. We have launched a major recruitment campaign hosted on our newly developed and innovative recruitment microsite www.caretomakeadifference.nhs.uk. We are using social media platforms such as Twitter and Facebook to increase the number of applications for our vacancies. We are now planning phase 3 of our international recruitment campaign having offered 38 posts to nurses from Portugal and Italy. We have worked hard to forge links with local universities and have made offers to 37 students. In addition 126 qualified nurses are in our recruitment pipeline. We expect to reach the budgeted nursing establishment by May 2014.

22. The Trust has also commissioned an external review of medical staffing models and levels in two Divisions (Medicine and Family Care). We are employing 12 more Consultants than on 1st

April 2013, with particular success in the Emergency Department and the Medical Assessment Unit.

23. Levels of staff completing mandatory and safeguarding training have significantly improved. Over 80% of staff have now completed safeguarding training and mandatory training, at the time of Keogh only 31% of staff within the Medicine Division had completed their safeguarding training (our lowest performing Division), this now stands at 82%. All non-compliant staff have been identified and targeted action implemented. All staff have been reminded that uptake of safeguarding training is a contractual obligation, specifically letters have been sent to all medical staff who are not up to date. Spot audits are being conducted.

24. The NHS Trust Development Authority's infection control team visited the Trust in February 2014 to look at practices, documentation etc. A series of follow up visits are planned in March and April to ensure we are adhering to best practice. Comparatively the hospital acquired infection rates at the Trust are low, although there is room for further improvement.

Nursing

The Review Team considered that the nursing workforce needed more leadership, direction and support to achieve acceptable standards of care.

25. We appointed a new Chief Nurse in January 2014, with a Deputy Chief Nurse commencing in April. A nursing strategy has been developed and launched in December 2013, which incorporates the national strategy, Compassion in Practice (the 6 Cs).

What is Different

26. A huge amount of work has been undertaken and there have been some tangible improvements, some examples being:

- Improvements in the emergency pathway and particularly the 4 hour performance
- Reduced mortality
- Reduced waiting times
- Higher staffing levels
- More effective governance processes
- New ways of engaging with patients, staff and the public
- Better use of feedback from staff
- Compliance with core training requirements
- Revised complaints process

Ongoing work programme

27. There is still much to do, and every effort is being made to implement as much as possible before the Chief Inspector of Hospitals visit on the 29th April 2014. The ongoing work programme includes:

- Further improvements to our governance processes
- Establishing a clear accountability framework and floor to board links
- Providing clear evidence of learning from incidents/risks/complaints
- Improving the public/media perception of the organisation
- Improving the provision of Medical Education for specific groups of junior doctors
- Further developing our complaints process and handling
- Establishing the Trust brand of 'Safe, Personal , Effective', backed by our supporting values

28. We have provided much supporting evidence to our local Clinical Commissioning Groups for their Keogh Assurance Plan. They recognise the progress we have made and agree the areas identified for further work.

Conclusion

29. A considerable amount of work has gone into addressing the findings of the Keogh Review and there is tangible evidence of improvement. However, it is acknowledged we are on a journey and further improvement is required.

6. POLICY IMPLICATIONS
N/A

7. FINANCIAL IMPLICATIONS
N/A

8. LEGAL IMPLICATIONS
N/A

9. RESOURCE IMPLICATIONS
N/A

10. EQUALITY AND HEALTH IMPLICATIONS
N/A

11. CONSULTATIONS
N/A

VERSION:	**1.0**

CONTACT OFFICER:	Ben Aspinall
DATE:	2nd June 2014
BACKGROUND PAPER:	Keogh Review – Informal discussion outcomes Health and Wellbeing Board Agenda Item 2 report of the Chair 23rd September 2013.