Agenda item 7

Dudley Health Scrutiny Committee – 25th September 2013

The Dudley Group NHS Foundation Trust
Keogh Review Update

1.0 Purpose of Report

This document is the Trust's response to the Keogh Review and update on progress to date.

2.0 Background

The Keogh Review visits took place during May 2013. The initial report was received in early June to inform the Risk Summit with NHS Midlands and East Region and an action plan was requested to cover both the urgent, high and medium priorities. The attached gives the Trust's response and progress to date.

The progress against actions will be monitored via Monitor, the Foundation Trust Regulator and by Dudley CCG as our commissioners. It is envisaged that all the actions will be completed by the late autumn however embedding the outcomes of the actions will be ongoing, such as further embedding a learning culture and improving patient experience.

The full Review Report and supporting information can be found on the NHS Choices website.

3.0 Recommendation

Dudley Health Scrutiny Committee to receive the Action Plan for information and assurance.

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Keogh Investigation Action Plan – July 2013

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Quality Governance Structure	1. The Trust should undertake a comprehensive review of the effectiveness of its governance structure. This should review all committees and group agendas and the information reviewed to ensure that all the Trust's quality priorities have a clear focus at an appropriate level.	**High**	1.1 Engagement of Deloittes to conduct a review of the quality governance structure. (The review will cover (though not exclusively) the following areas: Board of Directors composition, background skill sets, gaps in knowledge/ experience etc. • Portfolios of Directors • Backgrounds of NEDs Scope and working of the Board and its Sub Committees: • Do we have the 'right' public, private agendas? Is NED challenge appropriate and well evidenced? • Do we have good Sub Committee coverage or do we miss things? • Do we do work in Committee that should be done at Board or vice versa? • Should we reorganise our Committees to facilitate better working and make responsibility and accountability clearer? Relationship between Board and Council of Governors • Is the degree of Governor Challenge adequate, appropriate and well evidenced? • Does the Council have an appropriate Sub Committee structure? • Recruitment and retention of appropriately qualified and experienced governors Board relationship with Clinical Directorates and Departments • Can the Board be assured that its decisions are being implemented? • Adequacy of Board Assurance Framework • Relationships with the Clinical directorates • Trust Management Executive and clinical directorates roles and responsibilities Clinical and business governance processes and assurance. We are anxious that the review should promote best practice from Deloittes exposure to the wider NHS and the best of the public and private sectors.	**PA**	**September 2013**

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Quality Governance Structure	2. The Board should consider how it reviews management information provided to it to demonstrate adequate challenge on the progress being made on the Trusts quality priorities.	**High**	2.1 This will be covered by the terms of the Deloitte Review at 1.1 above and the Board's response to it.	**PA**	**September 2013**
	3. Following the HAY group training the Trust should ensure that all senior clinical staff are aware of their responsibility for governance in their directorate and are held accountable for this. If this is still not embedded, further training may be required.	**High**	3.1 **Delivering governance** Developing the outcome of the work undertaken by Deloittes (1.1 above) agree with directorate management teams what good governance looks like (via an engagement piece of work) a) Meeting agendas and minutes b) Reports to Board c) Directorate review balanced scorecard	**RC/JC**	**September 2013**
			3.2 **Accountability** Clearer framework for accountability via peer reviews (balanced scorecard, with consequences) – this needs to be both bottom up and top down.	**RC/RB**	**September 2013**
			3.3 **Training** This will be delivered via the governance team during the engagement piece above and as required thereafter to the current structure.	**RC/JC**	**September 2013**
Understanding of Trust's quality objectives in the organisation	4. The Trust should ensure that its quality priorities, are embedded at ward level through dissemination at regular ward and directorate meetings. The Trust should also consider how it uses lessons learnt from the review of mortality indicators to further inform its quality priorities	**High**	4.1 Review communication and information cascade systems in general and specifically in relation to quality governance. (To be reported to the September Board). 4.2 Review the mortality alerts and outliers at directorate performance meetings. 4.3 Utilise the output from above in the next quality priority setting process. Refer also to Section 9	**PC**	**September 2013** **September 2013** **November 2013**

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Quality impact assessment of CIPs	5. All CIPs should be fully assessed for their quality impact prior to implementation and should be regularly reviewed. Where a concern over quality is identified, this risk should be properly mitigated before the plan is allowed to go ahead/continue.	**High**	5.1 All CIPS are assessed by the Medical and Nursing Directors for their quality impact prior to implementation. The process has been amended to require Clinical Directors and General Manager's attendance. This is now part of the procedure 5.2 Identified concerns will be followed up at the Directorate Performance Review meetings (*Refer to 6. Below)*	**D Mc / PH**	**Implemented**
	6. Executives and senior staff should be able to clearly and consistently articulate the impact assessment and monitoring process within their area of responsibility.	**High**	6.1 Review the format and agenda of the Directorate Performance Review meeting to incorporate the quality impact of CIPs. **6**.2 Governance - See template Directorate meeting agendas at 3.1 above. Ensure that new and extant CIP quality Impact assessments are reviewed at Directorate level – escalated or terminated.	**PA** **RC**	**Implemented** **Implemented**
Role of Governors in challenging the Board	7. Governors should consider how they can be more proactive in their role of holding the Board to account on all aspects of quality.	**High**	7.1 Undertake a review of the CoG effectiveness. Self assessment to be undertaken by the COG Development Group. 7.2 Review and confirm the current arrangements for Governor participation and challenge of the Quality Agenda including the quality accounts.	**JE/RJ** **PA / DMC**	**October 2013** **October 2013**
Developing a learning Culture	8. The Board should review its approach to learning and ensure there is a clear focus in the organisation on learning from incidents and when things go wrong. It should disseminate this approach through the clinical and operational leadership and ensure that regular audits are undertaken to monitor progress.	**High**	8.1 Investigation Manager to review incident reporting process including the opportunities to learn from incidents and ensure that incident reporting is robust, investigations are completed in a timely manner and lessons shared and results monitored. 8.2 Audit process to be confirmed and added to Forward Audit Programme.	**DMc** **DMc**	**In progress** **As part of above**

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Understanding of mortality issues throughout the Trust	9. The trust should review how it can introduce more rigour and challenge into the overall mortality review process. This should include developing a clearer understanding of the root causes of mortality data at both Board level and within Directorates and prioritised action plans to drive improvements in care pathways.	**High**	9.1 The Medical Director and Deputy Medical Director will review the mortality process in light of the comments received from the investigation team. 9.2 The detailed information from the Mortality and Morbidity Review meeting will be formally received at the CQSPE and Board. 9.3 Mortality and Morbidity review data and learning will be discussed at the Directorate Performance Review Meetings and disseminated at Directorate level. 9.4 Mortality data education training sessions will be held for all Clinical Directors and Medical Service Heads. 9.5 The mortality tracker will be linked to the M&M meetings and clinical coders / matrons will be involved in future meetings (with immediate effect). 9.6 Feedback and learning from mortality reviews initiated as a result of the mortality tracker data will be fed into the Mortality and Morbidity meetings. The mortality reviews themselves will now involve nursing and coding staff. 9.7 The Trust will engage with the North West AQuA programme including Board development. 9.8 The Trust will audit against the AQuA mortality checklist, reporting the outcome to the September CQSPE.	**PH** **PH** **RC** **PH** **PH** **PH** **PC/PH** **PH**	**With immediate effect** **With immediate effect** **Implemented** **October 2013** **Implemented** **With immediate effect** **Implemented** **September 2013**
Mortality review process and dissemination of lessons learnt	10. The Trust has an opportunity to build on the work already carried out in this area. The current systems could be better joined up to ensure the benefits are being realised and themes from reviews can be summarised and shared more effectively.	**High**	10.1 *Refer to 9.5 & 9.6 above.*	**PH**	**As above**
	11. There is a need to engage clinical teams more in the mortality review process and emphasising clinical director leadership of this issue	**High**	11.1 *Refer to 9.3 & 9.4 above*	**PH**	**As above**

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	12. Consider having coding representation in mortality review meetings.	**Medium**	12.1 *Refer to 9.5 above*	**PH**	**Implemented**
	13. Given the emphasis on Palliative care coding the Clinical Coding team may wish to focus one of their internal audits solely on this	**Medium**	13.1 Department to attend a workshop that provides training to ensure consistency of coding for treatment and full understanding	**PA**	**October 2013**
Infection Control Concerns	14. The Trust should review how it can further embed the infection control audit programme at ward level, including the lessons learnt from the overall board monitoring.	**High**	14.1 The Trust will develop a ward dashboard of quality indictors to be monitored at the Directorate Performance Meetings with Executives. 14.2 The Saving Lives audit and MRSA screening audit will be added to the Trust Audit Plan and reviewed at Audit Committee (Committee of Board).	**DMc**	**August 2013** **Implemented**
Managing capacity including bed management and patient flows.	15. The Trust should discuss more sustainable solutions to the high capacity levels and bed management challenges with its key stakeholders such as the CCG and social care colleagues.	**Urgent**	15.1 Play a constructive part in the Dudley Urgent Care Board, Black Country Urgent Care Board Area Team Urgent Care Board to: a) Identify an innovative solution to ambulance diversion to appropriate solutions b) Review Ambulance handover measurement and fining processes c) Ensure that capacity chases demand using WMAS predictions to influence availability of staffing in ED d) Construct working relationship with Sandwell MBC to support their patients repatriation	**RC**	**November 2013** **Implemented** **September 2013** **August 2013**
Care bundles	16. The trust should audit use of the new care bundles and ensure that all wards are using them effectively.	**High**	16.1 The Falls Care bundle and Pressure Ulcer Care bundles will be added to the Clinical Audit Programme and audited.	**DMc**	**September 2013**

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Patient Experience Strategy	17. The board should review its approach to developing a patient experience strategy and ensure it is clear how its priorities in this area will be measured and monitored.	**High**	17.1 The Patient Experience Strategy will be reviewed in conjunction with the CCG and other partners. A stakeholder event will be held on 10th July to review the Strategy, priorities and systems for measuring and monitoring these. 17.2 Through the review of the governance arrangements (*1.1 above*) the Trust will evaluate the effectiveness of establishing a Patient Experience Group reporting to a Board Committee.	**PC**	**Implemented** **October 2013**
	18. Ensure the friends and family test is embedded across all ward and all staff members are aware of their responsibilities	**High**	18.1 The results of the Friends and Family Test will be displayed in all wards and public areas and will be discussed at directorate meetings. This will added to the Nursing Care Monthly Audits and reported to Directorate Performance Meetings with executives.	DMc & PC	**Implemented**
Complaints process	19. Review of the Trusts compliance against the DH and Ombudsman requirements for complaints management and also to improve the patients experience from this process including: • Ensuring responses to complaints are timely and patients' expectations are managed. • Reviewing style of response to complaints to address patients in an empathetic manner and use language that is easy for non-clinicians to understand.	**Urgent**	19.1 The Complaints and PALS teams will be amalgamated from October 2013 as part of organisational restructure. 19.2 An Interim Quality Manager has been engaged to undertaken a review of the Complaints processes against the Ombudsman's requirements	DMc	**October 2013**
	20. Implement a more effective process to capture learning for the Trust from complaints and ensure these are shared at ward level.	**Urgent**	20.1 Development of a complaints liaison role to support patients and capture learning from complaints. 20.2 Review the arrangements for capturing the learning from both complaints and incidents and develop and share ward level information. Report quarterly to the CQSPE Committee on complaint outcomes, learning and implementation.	DMc DMc	**August 2013** **October 2013**
Patient experience themes.	21. The Trust should consider the themes noted in the broad patient experience feedback obtained in this review. This should be used to further review its strategic approach to responding to patient feedback	**High**	21.1 *Refer to 16.1*	PC	**Implemented**

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Management of Outpatient Appointments	22. The Trust should review its outpatient appointments process to consider how it can address the frequent complaints.	**Medium**	22.1 The Trust is conducting a phased demand and capacity review across all outpatient specialties, starting with areas that have issues with meeting the current demand levels for appointments and have frequent complaints about the service. Ophthalmology, Dermatology and Respiratory are due to be complete by November 2013 with all other specialties completed by December 2014. The output from these reviews are being managed through the Outpatient Steering Group.	**RB**	**Initial November 2013** **All December 2014**
Process to capture informal feedback from patients	23. Continue to promote informal feedback routes and ensure staff and patients are aware of the methods that can be used.	**Medium**	23.1 *Refer to 17 above* 23.3 Continue to distribute 'How did we do today' information cards to patients. 23.3 Continue to promote feedback mechanisms on the Trust website 23.4 Further develop patient experience information on the intranet to raise staff awareness	 PC PC PC	 **Implemented** **Implemented** **October 2013**
Workforce and Safety					
Staff engagement and Survey rates	24. The trust should continue to undertake its own work on staff engagement to understand what improvements staff would like to see.	**High**	24.1 A Draft Staff Engagement Strategy will be presented to the CQSPE Committee in August 2013 24.2 The Trust will explore further opportunities to capture staff views e.g. Graffiti boards. 24.3 Staff Engagement Officer appointed.	PC PC PC	**August 2013** **September 2013** **Implemented**
Theatres staff engagement	25. The Trust should review the staff engagement in theatres and obtain assurance that learning from the whistle blowing case and external review findings have been fully addressed.	**Urgent**	25.1 Review to be undertaken in theatres utilising team meetings and opportunities for individuals to raise concerns. Reviewer engaged to deliver project.	PC	**End of August**

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Mandatory Training	26. The Trust should monitor and take action where mandatory training is below expected levels, particularly on significant areas where there have been recent incidents such as information governance and resuscitation.	**High**	26.1 The HR team will continue to track Mandatory Training levels and report performance to the Finance and Performance Committee, and directorate management teams. We aim to show a steady increase in performance each month to achieve our target of green in all subjects.	AR	**Continuing**
			26.2 Information governance is a 12 month renewable target The Trust will invest in a dedicated trainer for this subject to achieve green by October 2013. This will also enable us to show staff how to access the on line training for future years and therefore make it a sustainable figure.	AR	**October 2013**
			26.3 Resuscitation training is being reviewed to make the training easier to access and to look at the level at which staff are completing the training.	AR/ DMc	**September 2013**
			26.4 Mandatory training is the completion of basic resuscitation only, and a review of the training needs analysis will ensure that the right people receive the right training.	AR/ DMc	**October 2013**
Nurse staffing levels and skill mix	27. The Trust should take urgent action to ensure there are sufficient registered nurses to unregistered staff on all shifts.	**Urgent**	27.1 Nursing staffing escalation procedures to be reviewed to ensure all shifts working below identified staffing levels are supplemented with extra nurse / bank/agency staff. All Shifts working below this level after escalation will be reported on Datix and to the Senior Nurse / Manager out of hours	DMc	**Implemented**
			27.2 Nurse to patient ratios have been added to the Nursing Care Indicators. Manual data collection to be completed in June whilst electronic process is being developed.	D Mc	**Implemented**
			27.3 NCIs reported to Director of Nursing monthly then to CQSPE and the Board of Directors. Exceptions that fall below acceptable standards will be monitored and action plans and a recovery meeting held.	DMc	**August 2013**
			27.4 Recruitment of 18 more qualified nurses. Adverts placed (circa 3 months to complete). Short listing completed	DMc	**September 2013**
			27.5 An application for further staff to support the ongoing process to take between 40 – 50 newly qualified graduates (at risk) will be made. Interview process to commence week beginning 24 June 2013 for graduates qualifying in Sept 2013).	DMc	**September 2013**

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	28. An updated review of nurse staffing; levels and staff mix should be undertaken by the Trust which reflects patient dependencies, ideally using a nationally accredited tool e.g. AUKUH Safer Nursing Care Tool. This should focus on reviewing staffing on the high risk wards. The risk assessment should take into account dependency of patients and also other factors such as high temporary staff usage and high incident and infection rates. It should also ensure Francis recommendations are fully reflected in the new staffing model.	**High**	28.1 The Trust has committed to use the AUKUH / Safer Nursing Care tool . A Commissioning control plan is being developed. The initial start up briefing meeting was held on 25th June, following which the timeline for staff training and data collection was confirmed. The 20 day data collection process finishes on 31/07/13 28.2 A Staffing audit of all wards will be undertaken. The outcome of this review will be reported to the Board of Directors.	DMc	Implemented **August 2013** **October 2013**
Nurse staffing levels and skill mix	29. The Trust should review its nursing staff rotas and embed the consistent use of the Allocate e-rostering that it is implementing.	**High**	29.1 Implementation of new e rostering system with Allocate in accordance with the approved project plan and timeline. The Trust currently operates an electronic roster system "SMART" the functionality of which is inferior to ALLOCATE with regard to the management information available. The implementation of Allocate will be rolled out as per the project plan. The immediate action until full roll out is to ensure that the SMART system is being operated effectively which will be delivered through the Matrons and the General Managers in Directorates.	PA/ DMc	**September 2013**
	30. The trust should review its use of bank and agency staff to minimise this as a solution for capacity challenges and vacancy cover.	**High**	30.1 An extra capacity nurse pool team has been developed to roster extra nurses daily that are used to supplement staffing. These nurses report to the site co-ordinator who will deploy to appropriate areas. The extra graduates (those who are not identified for substantive vacancies) are being placed in posts where nurses are on long terms sick leave and maternity leave. This will reduce the use of bank and agency staff and improve continuity. These nurses will be moved into a vacancy as they arise which will minimise both the trained nurse and sickness vacancy levels.	DMc / RC	**Implemented**

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	31. The Trust should consider conducting an internal audit to check that the hours worked by its bank nurse are complaint with the European Working Time Directive.	**High**	31.1 An audit of compliance with the European Working Time Directive will be undertaken by Internal Audit. This has been added to the internal audit plan	PA	**Quarter 2** **Implemented**
Equipment and safety checks	32. The trust should reiterate its processes to staff to ensure important equipment and safety checks are completed. Compliance should be regularly audited and non compliance should be followed up urgently.	**Urgent**	32.1 The audit of equipment and safety checks now forms part of the NCI monthly audit and daily checks are undertaken. Additional checks are also undertaken by the Practice Development Team. The Audit has been added to the annual plan and is reported via Audit Committee and CQPSE. It also forms part of the Matrons presentation (monthly) to Board.	DMc	**Implemented**
Quality of Root cause analysis (RCA)	33. The trust should review its process for RCAs to ensure there is sufficient time and review built in to improve the quality of analysis and learning to be shared from the incident. The Trust may wish to use the NPSA toolkit to support the analysis.	**High**	33.1 A full review of the incident reporting and investigation process (including RCAs) has commenced. (Refer also to 8.1 – 8.2) 33.2 The use of the NPSA toolkit will be explored as part of the above review.	DMc	**WIP**
Inconsistent pressure ulcer preventative care	34 Systems should be reviewed to ensure staff can readily identify those patients with high need for pressure ulcer preventative care. White boards already in use on wards could be used to identify patients more effectively – using a magnet or silicone identifier.	**Urgent**	34.1 Magnets (depicting pressure ulcers) will be added to whiteboards on all wards.	DMc	**September 2013**
	35. Systems are needed to ensure that staff are made aware of how well their ward is doing in terms of number of PU free days and of the themes coming out of the RCAs. Ward managers to find effective methods of feedback to staff how well their area is doing and how many PU free days they have achieved. Consider display poster in the clinical area.	**High**	35.1 Laminated wall signs depicting pressure ulcer free days will be displayed on all wards. 35.2 A "How we are doing" board will be displayed on every ward covering the Quality Indicators.	DMc DMc	**Implemented** **Implemented**
	36. TVN to ensure all ward managers are looking at the 50 day dash charts available via the Tissue Viability (TV) intranet site to encourage competitiveness.	**Medium**	36.1 Tissue Viability team to publish a plan of the initiatives to raise awareness of harm free days	DMc	**September 2013**

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Availability of equipment and delays from external provider.	37. Repose mattresses were available in the department – link nurses to promote and encourage their use.	**Urgent**	37.1 Buffer stock of 20 mattresses now on site which has eliminated the delay of equipment.	DMc	**Implemented**
	38. Performance indicators need to be reviewed for the contract with Karomed and penalties implemented where failings are occurring.	**Urgent**	38.1 Contract amended.	RB	**Implemented**
	39. TVN team to work with A&E link nurses to develop education in the department and carry out weekly audits of equipment use.	**Urgent**	39.1To develop a team of link nurses within the A&E department to provide in department education and training. 39.2 Weekly audits to be completed as per point 37	DMc	**Commencing July 2013** **Implemented**
Availability of equipment and delays from external provider	40. Staff should report equipment delays via datix so that management and the TV nursing team are made aware of how often this is occurring in real time.	**High**	40.1 To work with the communications department and link nurses to raise awareness of the reporting requirements for equipment delays via datix. 40.2 Datix Manager to ensure TV team receive an alert for each incident reported.	DMc DMc	**July 2013** **July 2013**
	41. Documentation audit by TVN team and/or link nurses to identify extent of delays.	**Medium**	41.1 Tissue Viability will review with the link nurses the possibility that their audit can identify delays 41.2 Tissue viability will discuss the audit of records with equipment coordinators.	DMc	**September 2013**
	42. Consider use of Anderson score in A/E rather than Waterlow to encourage assessment of all patients.	**Medium**	42.1 Tissue viability has looked at Anderson tool. This is a tool that is a useful prompt prior to Waterlow. As our emergency department are already using waterlow there is no need to add the Anderson tool	DMc	**Complete**

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Divergence from guidelines and inaccurate documentation	43. Ward teams to carry out weekly SSKIN bundle audits of a minimum of 5 sets of notes per area with an aim to achieve 100% compliance.	**High**	43.1 Weekly auditing of PU prevention and Management documents is ongoing – Link Nurses to audit 6 sets of notes per ward area where possible. 43.2 Link Nurses are provided with protected time to complete this (7.5 hours per week)	DMc DMc	**Implemented** **Implemented**
	44. Action plans need implementing where compliance is not reaching 100% with particular focus on those elements of the bundle most commonly not being followed.	**High**	44.1To develop an escalation process for those wards not achieving 100% 44.2To relook at audit questions to ensure questions are achievable 44.3Link nurses are guaranteed protected time (7.5 hours per week) to provide training/education and facilitate audits.	DMc DMc DMc	**July 2013** **July 2013** **Implemented**
	45. TVNs to support link nurses to educate re waterlow assessments. Consider use of flash cards or other quick grab educational tools which can be displayed (posters etc)	**High**	45.1Waterlow guidance has been added to the pressure ulcer prevention document to offer guidance to nurses in real time 45.2 E- Learning package to be created to test knowledge and to offer guidance on the assessment and completion of the waterlow. 45.3Visual campaign to be created regarding waterlow accuracy	DMc	**Implemented** **September 2013** **September 2013**
	46. Link nurse and TV team to educate in this area.	**High**	46.1 Lead Nurse and Link Nurse from vascular ward to re-educate staff around the use of dynamic systems – spreadsheet of training to be held by TV Team.	DMc	**WIP**
	47. Link nurses to audit Waterlow assessments and implementation of preventative actions.	**High**	*This forms part of the PU prevention and management audits. See actions in points 37 & 38*	DMc	**Implemented**

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Communication	48. TV Team and matrons to feedback the themes to all involved and set actions for staff locally to improve practice.	**High**	48.1 RCAs completed for all pressure ulcers above a stage 2 48.2 Weekly meetings to discuss pressure ulcer RCAs and share learning	DMc	**Implemented**
	49. A patient information leaflet should be designed if there isn't one already in use. Documentation should demonstrate that the patient has received the leaflet and their risk has been discussed.	**High**	49.1 There is a patient information leaflet in the back of the pressure ulcer prevention document which is perforated so can be removed to issue to the patient. There is space on the document for the nurse to sign to demonstrate the leaflet has been given and discussed 49.2 To monitor compliance by adding to the monthly Nursing Care Indicator Audits	DMc DMc	**Implemented** **September 2013**