Health and Wellbeing Board
Hertfordshire

Agenda Item No.

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HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
18 September 2013 AT 13.30 P.M.

SUBJECT: UPDATE ON RISKS AT WEST HERTFORDSHIRE HOSPITALS NHS TRUST

Author: Nicola Bell, Accountable Officer Herts Valleys Clinical Commissioning Group

1. Purpose of report

1.1 The aim of this paper is to inform colleagues of transitional activities underway at West Herts Hospitals Trust (WHHT) as a result of risk discussions held between WHHT and the wider health system during the latter part of 2012 through to July 2013. The actions being undertaken are being led by the WHHT Executive Team supported by the CCG and a number of system wide organisations. Performance management of the Trust and its action plans remain the responsibility of Herts Valleys Clinical Commissioning Group led by the Accountable Officer, Nicola Bell.

2. Recommendation

2.1 The Board is asked to note the report.

3. Background

3.1 In recent years attention has been drawn to failings in the health and social care system, where quality and patient safety has been criticised on many levels. These issues have highlighted the need for greater clarity about who is responsible for identifying and responding to failures in quality. The four reports below aim to provide such clarity and guidance about early warning signs and improving quality through transition. Being clear about roles and responsibilities is one side of the coin and the other is the need for a consistent approach to how these difficult judgements about quality are made. How should we judge whether a service is failing or not? What tools might be used to better understand the situation, and what action should be taken as a result?

1. Review of early warning systems in the NHS (24 February 2010)[1]
2. Maintaining and improving quality during the transition: safety, effectiveness, experience (March 2011)[2].

3.2 Quality is complex. It is systemic: that is, the delivery of high quality care depends upon many different parts of the system working together. Therefore, the most important part of any operating model for quality in the NHS must be the culture and behaviours that our respective organisations adopt within and between ourselves.

1. The Mid Staffordshire NHS Foundation Trust: Public Inquiry - Chaired by Robert Francis QC[3]
2. The Keogh Mortality Review[4]

3.3 **The NHS has proposed some operating principles:**

1. The patient comes first – not the needs of any organisation or professional group
2. Quality is everybody's business – from the ward to the board; from the supervisory bodies to the Regulators, from the commissioners to primary care clinicians and managers
3. If we have concerns, we speak out and raise questions without hesitation
4. We listen in a systematic way to what our patients and our staff tell us about the quality of care.
5. If concerns are raised we listen and 'go and look'
6. We share our hard and soft intelligence on quality with others and actively look at the hard and soft intelligence on quality of others
7. If we are not sure what to decide or do, then we seek advice from others
8. Our behaviours and values will be consistent with the NHS Constitution

[1] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020
[2] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125234
[3] http://www.midstaffspublicinquiry.com/report
[4] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

3.4 In response to any of the above principles or if early warning signs emerge the process of calling a 'risk summit[5]' has been formalised. A risk summit is called because there are some concerns about the quality of care being provided for patients. Risk summits aim to "provide a responsive mechanism for a detailed discussion and assessment of risk".

3.5 Effective communication between all stakeholders is essential in making sure that everyone stays alert to the potential for failings in patient care. Sharing information willingly and in a timely fashion is crucial to ensuring that material intelligence about trusts is not overlooked. No one player in the system holds all the available intelligence about NHS funded services. This is why collaboration, communication and co-operation between commissioners, providers, local area teams and other stakeholders are important in protecting patients and staff. Medical directors and nurse directors play key roles in making sure risk summits remain focussed on patients and that the actions required to safeguard them are both sensible and appropriate.

3.6 West Herts Hospitals Trust:
At West Herts Hospitals Trust in the time between December 2012 and now, there have been three whole system discussions including two formal risk summits in response to some continued contractual performance failings, a significant number of serious incident reports and a thorough internal review of WHHT systems and processes by the new executive team in response to the Francis report and the Keogh Mortality review.

3.7 Following the operating principles above, the areas of concern are:

1. **The patient comes first – not the needs of any organisation or professional group:**
Various health system stakeholders have been involved with West Herts Hospitals Trust including the CCG as commissioners and we are not yet fully assured that patients are receiving safe and high performing services in all areas. There are areas where the Trust is performing well and others where recent improvements are significant, like A&E, but there is more to do.

2. **Quality is everybody's business – from the ward to the board; from the supervisory bodies to the Regulators, from the commissioners to primary care clinicians and managers:**
The Trust has a new Chief Executive and several new Executives on the board. They are not sufficiently assured themselves that quality is everybody's business at the Trust and want to undertake some more deep dives into services to provide themselves and the public with that assurance. The West Herts Board in recent months has received papers on Infection control; Adult nursing establishment review; Serious Incidents; Mortality; Safeguarding; Staff Survey; Integrated Performance review and the Quality Account. Each point

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212820/How-to-Organise-and-Run-a-Risk-Summit.pdf

to areas of under performance or risk to patient safety that the Trust is working to improve.

These issues have all been raised and discussed at the risk summits.

3. If we have concerns, we speak out and raise questions without hesitation

All risk summits have incorporated contributions from each relevant organisation, as prescribed in the guidance. The most recent risk summit was chaired by Ruth May, Regional Chief Nurse. It concluded that there was a need to consolidate all of West Herts Hospital Trust's plans into one focussed action plan on the identified risks, and what was being done to address the required improvement of services for West Herts patients.
Priority areas for detailed review have been agreed which include:

a. Nursing establishment review
b. Fundamental nursing care review
c. Data quality and clinical outcome performance
d. Delivery of referral time to treatment (RTT)
e. A review of governance systems
f. A review of the Trusts financial health
g. Estates and health & safety
h. Infection prevention and control
i. Private practice review
j. Development of a refreshed Clinical strategy
k. Organisational development and leadership
l. Complaints review
m. Referrals, systems and processes review
n. Clinical Effectiveness Reviews
    i. Anaesthetics
    ii. Orthopaedics
    iii. Gynaecological cancer
    iv. Obstetrics and gynaecology
    v. Upper GI
    vi. Vascular Surgery
    vii. Pneumonia
    viii. Gastrointestinal haemorrhage
    ix. UTI
    x. Stroke
    xi. Emergency Care

A Risk Summit Response Committee has been established at WHHT, chaired by a WHHT non-Exec and involving the CCG, HealthWatch and other patient and staff groups to monitor progress.

4. We listen in a systematic way to what our patients and our staff tell us about the quality of care.

There are a number of ways in which the CCG hears about patient and staff views of the Trust i.e. through PALs, complaints, various patient surveys, the families and friends test and staff surveys. Generally feedback about the Trust

is positive when compared with others. However some patients do raise serious concerns which have been incorporated into the risk action plans.

5. **If concerns are raised we listen and 'go and look'**
   West Herts Hospitals Trust has engaged HealthWatch and the Patients Association and are in discussion with People Opinion to help them review patient centred activities.

   The CCG is also in discussion with the Trust about supporting a number of 'quality walks' at the Trust facilitating conversations with patients and staff to assist in the triangulation of hard data and more anecdotal stories. The Trust and CCG want to hear 'real patient stories' to assist their reflection and learning about services.

6. **We share our hard and soft intelligence on quality with others and actively look at the hard and soft intelligence on quality of others**
   A lot of work has been undertaken by the Trust and CCG in this respect. The CCG has looked carefully at the Keogh Mortality reviews and the data sets used during these reviews. In doing this the CCG has carried out its own review of West Herts Hospitals Trust and has experienced difficulty in replicating the complete Keogh data set in some instances, firstly, because the CCG does not routinely request the full range of data and secondly, because West Herts Hospitals Trust itself has not readily organised all the data at the granular level the CCG and others require. West Herts Hospital Trust is in the process of organising this data now. The CCG presented this data review to a clinical panel in a table top risk assessment of services at West Herts. The data presented was looked at in a number of different ways. In conclusion the CCG did not find any reason to disagree with the service areas chosen above for review but it was not able to assure itself that all other areas of the Trust were providing safe quality services for patients due to the lack of available detailed data. The CCG has agreed with West Herts Hospitals Trust to do additional further deep dive reviews across all service areas.

7. **If we are not sure what to decide or do, then we seek advice from others**
   Because of principle 6 above and the sheer volume of assurance that the trust needs to provide the CCG and wider system are taking the following steps:

   a. Nicola Bell, HVCCG Accountable Officer, is part of the Risk Summit response board at West Herts Hospital.
   b. Jan Norman, Director of Nursing, is the CCG's executive lead for West Herts response (supported by a dedicated project manager).
   c. Regular discussions are underway between HVCCG and Sam Jones CE at WHHT, Mike Van der Watt, the Trust's Medical Director, Jackie Ardley, the Director of Nursing and Paul Jenkins, the Director of Performance and Partnerships.
   d. HVCCG have input into the Trust's monthly Mortality review Meetings.
   e. UCL Partnership are providing objective clinical support to the design and implementation of each of the clinical effectiveness reviews.

f. Health Education England are working with the Trust in relation to medical training and the quality of learning for junior doctors.
g. HVCCG are supporting the quality walks and collecting our own analysis of these.
h. HVCCG are collecting and tracking evidence of change as it is provided and continuing with our monthly contact and quality review meetings.
i. NHS England will be leading a Responsive Review at West Herts Hospitals Trust later in the year.
j. The Trust Development Authority is working closely with the Trust in relation to their development as an organisation.

8. Our behaviours and values will be consistent with the NHS Constitution

The CCG believe our work is consistent with the NHS Constitution and further we believe we are working with the hindsight of Mid Staffordshire and have actively implemented many of the lessons from the Francis enquiry by acting early and in support of the trust to implement significant work streams to bring about the full assurance that the CCG requires.