Report to the Health and Adult Social Care

Select Committee (HASC)

Title: HASC Keogh Working Group Final Report

Committee date: 17th October 2013

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Purpose of Agenda Item
To outline the findings of the work conducted by the HASC working group which was established to review the Keogh Report into Buckinghamshire Healthcare NHS Trust (BHT), and agree recommendations, most of which are directed at the BHT Board.

Background/Introduction
At the request of the Prime Minister and Secretary of State for Health the NHS Medical Director, Sir Bruce Keogh conducted a review into 14 hospital trusts in England which had reported higher than average mortality rates over the last two years. The review commenced in February 2013 and included BHT. Keogh reported his findings on BHT and the 13 other trusts on 16th July 2013. The report into all 14 Trusts was critical, and resulted in 11, including BHT, being placed in special measures.

The Keogh review methodology was very comprehensive and included evidence from:

- Detailed analysis of an array of hard data and soft intelligence from numerous sources identifying key lines of inquiry.
- A 15-20 multidisciplinary review team which conducted planned and unannounced inspections of BHT.
- Staff, patients and local stakeholders.

The evidence gathering culminated in a risk summit of all involved statutory parties to agree a coordinated action plan, and support required. The agreed action plan is published here: http://www.buckshealthcare.nhs.uk/For%20patients%20and%20visitors/action-plan.htm
With reference to BHT, whilst the Keogh report noted generally that the wards were clean and tidy, patients were well cared for and there were examples of good practice, it found six broad areas that the Trust should focus on to improve the quality of care. These were:

1. Governance (including risk management and reporting);
2. Urgent Care (pathways);
3. Patient Safety;
4. Organisation-wide monitoring of clinical and operational effectiveness;
5. Patient and public engagement (including communication and complaints); and
6. Workforce (including recruitment, training and leadership).

Across the 14 Trusts, Sir Bruce Keogh identified the following themes or barriers to delivering high quality care which he concluded are highly relevant to the wider NHS:

- Limited understanding of the importance and simplicity of genuinely listening to the views of staff and patients and engaging with them.
- Hospital boards and leadership capability in using data to drive quality improvement.
- The complexity of using and interpreting aggregate measures of mortality.
- That some hospital trusts are operating in geographical, professional or academic isolation.
- The lack of value and support being given to frontline clinicians, particularly junior nurses and doctors.
- The imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement.

At the meeting of Buckinghamshire County Council on 18th July 2013 the Chairman of the Health and Adult Social Care Select Committee (HASC) Lin Hazell announced the committee would establish a working group to go through the Keogh report in detail, understand the planned actions being taken in response by BHT, and any work the committee need to undertake as a result of this work.
HASC Keogh Working Group - Final Report (October 2013)

Objectives

1. The working group agreed that the HASC should pursue the following objectives in relation to the Keogh Report into the Quality of Care and Treatment provided by Buckinghamshire Healthcare Trust (BHT):

   - Agree that all committee concerns with the Healthcare Trust have been identified, with any not clearly identified by Keogh to be passed to the Trust and Clinical Commissioning Groups (CCG’s) to be addressed.
   - Be satisfied with the Trust action plans and responses to the concerns raised in Keogh and any additional topics identified by the committee.
   - Be satisfied with the arrangements made for the general on-going monitoring and scrutiny of the Trust performance, and specifically regarding the six areas which Keogh identified as requiring improvement.

2. From petitions which have been submitted to the Council, feedback received by local members and local press coverage, there is clearly strong feeling in High Wycombe and surrounding areas concerning the urgent care services available. A number of factors are behind this. A significant issue concerns the quality of services available at Stoke Mandeville A&E, and the Keogh report provides the most up to date and detailed assessment of these and how they should be improved. Another significant issue concerns the lack of more local services, and continued dissatisfaction over the removal of some services from Wycombe General Hospital in recent years, resulting in longer journey times.

3. Mindful of this the working group also agreed that as part of their work they would compile a summary of the evidence behind the current configuration of acute hospital services across the Stoke Mandeville and Wycombe Hospital sites. The summary will draw on evidence previously given to the HASC as part of the 2012 configuration changes (such as from the former Primary Care Trust and BHT), and more recent evidence on the subject including relevant sections of the Keogh Report. The working group will meet on the 28th October to discuss what further work is required to address continuing local concerns on the BHT Urgent Care Pathway, including A&E provision, which the evidence summary will assist with.
Working Group Methodology

4. The working group comprised the following members of the HASC: Brian Adams, Margaret Aston, Lin Hazell (Chairman), David Martin, Mark Shaw, Jean Teesdale, Julia Wassell, Wendy Matthews, Tony Green, Shade Adoh (some meetings were attended by Janice Campbell as a substitute Buckinghamshire Healthwatch representative).

5. The working group met on the 12th, 14th and 22nd August to discuss the Keogh Report. At their meeting on the 14th they were able to question Chris Gordon who sat on the BHT Keogh review panel, and Matthew Tait who is the NHS England Thames Valley Area Team Director. The notes of this session are included in the appendices of this report.

6. In their review and discussions of the Keogh report, the working group were assisted by representatives from the County Council Public Health Team and Adults & Family Wellbeing Service.

7. An interim working group report was published at the HASC meeting on the 26th September, when the committee questioned BHT management at length on the Keogh findings and their response. These discussions have informed this final report.

Report Structure

8. This report is divided into three sections. These are:

A. Additional issues and/or areas of concern that the HASC has identified which should be addressed as part of BHT’s response to the Keogh findings. This includes how it publicises its response to Keogh, so as to provide adequate assurance to the HASC and general public on the quality of its services.

B. Improvements to how the Better Healthcare in Bucks (BHiB) service reconfiguration outcomes are reported in future, to support scrutiny of the Trust and provide adequate assurance that these changes have benefitted residents.

C. An outline of HASC planned activity relevant to the Trust and the Keogh report which is intended to provide public assurance that the local health scrutiny committee is taking the issues raised by Keogh seriously and performing effectively.
Recommendations

i. The Trust Board development programme gives serious consideration to how robust clinical, nursing and carer challenge at board level is achieved, and whether the Non-Executive Directors (NEDs) need to be drawn from more varied backgrounds to provide this level of challenge. The views of the development programme, and our own concerns should be acknowledged during any future NED appointment process by the Board and Trust Development Authority.

ii. The Trust Board development programme examine whether the Healthcare Governance Committee is adequately transparent in its operation, the level of detail provided to the Board, and what is published online concerning this committee’s reports, discussions and decisions.

iii. That discharge planning and processes are singled out for focus in the delivery of relevant Keogh actions, resulting in improved Board awareness of patient experience during discharge, and evidence published on how processes and outcomes have been improved to a high standard.

iv. That the Trust Board explains what they have done to understand the accessibility of the services relocated as part of Better Healthcare in Bucks, clarify the gaps in provision for people without access to a car, and to implement and monitor actions to address these gaps in transport service over the next 6 months.

v. That the HASC supports the Trust in its lobbying efforts with the Department of Health and NHS Trust Development Authority to secure additional funding to assist with its preparations for winter and in its response to the Keogh report.

vi. In order to provide assurance to the HASC and general public that the issues raised by Keogh are being addressed, the Trust should produce a more comprehensive response summary which aligns the issues raised by Keogh, to the actions taken, and details how the subsequent improvements in patient care will be evidenced.
A) Working Group Concerns

9. We are keen not to burden the Trust with an additional raft of concerns and actions at the present time. However, we wish to highlight a few areas which we feel need to be considered and addressed alongside the actions the Trust are already working on in response to Keogh.

These concerns are as follows:

**Governance Board Composition & Patient Challenge**

10. The Keogh Report is critical of BHT’s governance citing it as reactive and not providing satisfactory assurance through adequate examination of data and challenge. To address this it is recommended that the Board undertakes a development programme to enhance its capability and capacity and provide sufficient scrutiny and challenge.

11. We consider that the Board Non-Executive Directors (NEDs) have a key role in challenging other members of the Board. Having reviewed the background of the current NEDs on the Trust Board it is apparent their medical, nursing or caring professional experience is limited. Having looked at other Trusts, and from discussions with Chris Gordon and Matthew Tait, we understand that this low level of medical and nursing experience amongst the Board is not particularly unusual. However, this raises concerns as to who on the Board can provide a robust challenge to Board executives, particularly those with a clinical background such as the Medical Director and Chief Nurse.

12. At the HASC (26.9.13) the Board Chairman emphasised that the Board’s philosophy is centred on patients and explained how at recent meetings they had discussed complaints and the patient voice, and heard videos from patients on the care they had received. He also emphasised that the Board members were also able to draw on their own experiences as patients using the Trust services, and that he is a trustee of an organisation that does research on patient experience (DIPEx).

13. Since the Keogh report was released the Berwick Review into patient safety has been published (www.gov.uk/government/publications/berwick-review-into-patient-safety). This report makes a number of recommendations on the changes required in the NHS in light of recent events such as those uncovered at Mid Staffordshire NHS Trust by Robert Francis. Berwick’s third recommendation is that “Patients and
their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts”.

14. Items in the Trust’s Keogh Action Plan seek to enhance the collation and review of patient experience data and feedback, but we feel it falls short of ensuring at the very highest level there is an effective challenge to the Trust management which safeguards the interests of patients. We do not at this stage wish to prescribe how this is achieved, but request that as part of the Board Development Programme this issue is fully explored. Possible options could include the appointment of new NEDs with more clinical/nursing experience, and/or the co-opting of representatives from patient groups or Healthwatch onto the Board.

15. We understand from the Trust that they have limited control over the NEDs on their Board given appointments are made by the NHS Trust Development Authority. However the Trust are able, through networking, to encourage individuals they consider would be suitable candidates to apply, and so can have some influence on who could be appointed. We have also been informed that as many as three NEDs may be replaced in April 2014, having served their term of office.

Recommendation 1: The Trust Board development programme gives serious consideration to how robust clinical, nursing and carer challenge at board level is achieved, and whether the Non-Executive Directors (NED’s) need to be drawn from more varied backgrounds to provide this level of challenge. The views of the development programme, and our own concerns should be acknowledged during any future NED appointment process by the Board and NHS Trust Development Authority.

Transparency of the Healthcare Governance Committee

16. The Healthcare Governance Committee have a key role in reviewing and investigating the quality and safety of services provided by the Trust, providing assurance to the Board and escalating any areas of concern. The committee is chaired by Keith Gilchrist, a Non-Executive Director, and reports directly to the Trust Board. The Keogh Risk Summit Report identifies a lack of oversight on the quality impact of CIPs (Cost Improvement Programmes) by the committee (p.16), recommends that a new integrated quality report comparing divisions be reported to the committee on a monthly basis (p.27), and identifies a lack of a patient/Healthwatch representative on the committee as contributing to a shortfall in transparency on learning from issues (p.31).

17. The Healthcare Governance Committee had been meeting bimonthly but it was recently agreed they would meet more frequently than this (BHT Board meeting 31st July 2013 minutes). At the time of writing the committee last reported to the public
board meeting at the July 2013 meeting, by way of a ‘summary report’. This report essentially provides a series of discussion headings and the titles of the reports which were received. There are no other details published on the reports viewed and discussions of this committee.

18. We feel that this level of transparency is inadequate, and fails to provide the necessary assurance to the Board or public on the effectiveness of this committee. We recommend that as part of the board development programme that the transparency of the Healthcare Governance Committee is assessed and actions are taken to improve this.

**Recommendation 2:** The Trust Board development programme examine whether the Healthcare Governance Committee is adequately transparent in its operation, the level of detail provided to the Board, and what is published online concerning this committee’s reports, discussions and decisions.

**Discharge Process**

19. The Keogh Report makes little mention of the Trusts management of patient discharge, although ‘Patient Story 2’(Rapid Response Review Report, Appendix 8) which formed part of the evidence base cites unsatisfactory discharge arrangements, and the inpatient survey is referenced which identified the Trust as poor in terms of information given to discharged patients.

20. Two detailed complaints\(^1\) received by the County Council concerning patient experience of the hospital and social care interface during 2013 and shared with the group raise a number of issues. These include:

- Inadequate advance warning to patients or their families as to when the patient will be discharged, and inadequate liaison on this with community health teams.
- Inadequate oversight by hospital staff of discharged patient’s on-going transport and/or care arrangements, mindful of their condition.
- Misinformation given to patients at discharge concerning the social care process and care package arrangements understood to be in place, which is then found not to have been arranged when the patient arrives home.

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\(^1\) These complaints were received by the County Council, and the complainants have been asked if they would like them to be passed onto BHT’s PALs. To date no reply has been received so the complaint detail has not been shared with the NHS, and it would not be appropriate for the working group to expand on the detail provided in this report.
21. We understand from speaking with County Council Adult Social Care Officers that there is no joint discharge planning policy in place between BHT and the Adult Social Care service. We also understand there is scope for improvement in how BHT and Social Care staff work with each other and the relationship between the two. Chris Gordon from the Keogh Review panel made reference to this and highlighted that given their integrated (acute and community hospital) status the Trust is potentially in a brilliant position to improve and deliver good discharge planning.

22. The May 2013 Trust Board papers included the Inpatient Survey results, with discharge delays from medication waits highlighted as an area of worsening performance, but other areas of discharge performance being in line with the national average, albeit with a number scoring poorly. Under comments made in the survey there is a sub section on discharge and this flags up issues with communication with patients and families, inadequate notice given, and lengthy waits by patients to be discharged.

23. Later on in the Board Reports, the Integrated Performance Report presents a positive picture on the discharge process with ‘discharges before 11am’ and ‘delayed transfers of care’ shown to be on target. The County Council produces a Delayed Transfers of Care monitoring report, which provides data on how rates of delay compare in the county compared to other authorities, and the breakdown of which organisations (health providers or the county council) the delays are attributable. In Buckinghamshire the rates attributable to the council’s social care service are very low compared to other areas for the period April to June 2013 (where the rate was 2.2 compare to an average of 8.4 across a comparator group of other county councils). Over this period delays attributable to local health organisations accounted for 82% of delays, with BHT accounting for 24 cases (it should be noted that 46 cases were attributable to Heatherwood and Wexham Park Foundation Trust, with 22 attributable to Oxford University Foundation Trust). This data would suggest that although BHT are performing better than some other healthcare providers in avoiding delays, there is still significant scope for improvement, which is not evident in current board performance reports.

24. The HASC have not seen the recommendations made by the ECIST (Emergency Care Intensive Support Team) who were invited by the Trust to identify improvements to the urgent care pathway in early 2013. The July Board papers do identify “transforming discharge and community alternatives to hospital focussing on a) delivering step-up beds in community hospitals to support admission avoidance; b) Further embed effective Daily Facilitated Meetings (DFMs) to ensure timely discharge across the 7 day week; c) delivering nurse-led discharge” as an ECIST
work stream. This would suggest that the Trust acknowledge this as an area for improvement and is appearing to take action on this.

25. At the September HASC (26.9.13) BHT did explain discharge was an area for improvement and they emphasised it is important patients are comfortable and confident with the discharge, know what’s happening to them and understand what services they will receive outside hospital, and get the correct information on any further medication or treatment they require. The Trust is focussing on these areas, and explained that it is important to work with patients when in hospital so they go home confident, and this includes some current pilot work with the Trust’s pharmacy department to support the self-administration of medicine by patients post discharge, which the Trust intend to include in their discharge process.

26. It is not obvious in the Keogh Action Plan how the discharge process will be improved in future, although actions under the Patient Experience, Workforce and Governance could feasibly contribute. We would like discharge to be an area of focus so that in future the Board can demonstrate how they are monitoring patient experience of this and are delivering actions to address any poor performance, working with social care and other health partners.

Recommendation 3: That discharge planning and processes are singled out for focus in the delivery of relevant Keogh actions, resulting in improved Board awareness of patient experience during discharge, and evidence published on how processes and outcomes have been improved to a high standard.

Transport and Accessibility

27. At the time of the Better Healthcare in Bucks service reconfiguration proposals (April 2012), the Trust published a Transport Impact Assessment by Cottee Transport Planning. Unfortunately this did not attempt to assess the accessibility of the Stoke Mandeville site, and the problems that could be faced by those without the use of a car attempting to access or return home from the reconfigured services. Indeed for the purpose of the transport assessment, which was more concerned with the carbon emission impacts, it was assumed that all those affected would travel by car.

28. Steps have been taken to address some of the concerns regarding transport with additional parking capacity about to be built at Stoke Mandeville, BHT have helped support the establishment of the Community Transport Hub to ease public access to alternative transport options, and there is free travel between hospital sites on Arriva buses. Unfortunately we feel these improvements fail to address the gap in transport
provision available to people being discharged or leaving A&E at Stoke Mandeville outside the hours of local public transport operation. We consider these to be two obvious gaps in provision, but there may be others.

29. At the July HASC meeting, questions were put to BHT representatives on the monitoring of the initiatives introduced to try and address some of the accessibility issues, namely the Community Transport Hub (usage and satisfaction) and Arriva bus travel (usage and split by patients, staff and visitors). Anne Eden (BHT Chief Executive) accepted there was more to do on transport and accessibility and we are glad that this was acknowledged. We would like to know the role of the patient transport service in this, and the role this does or could play in assisting with patients returning home from Stoke Mandeville when public or community transport options are not available.

30. Having centralised urgent and acute services in recent years, the HASC considers that the Trust has a responsibility to ensure the patients affected do not experience a significant reduction in the accessibility of these services. For patients requiring urgent care the ambulance service meets their accessibility needs, and for the majority of others private cars and public transport should meet their needs. The Trust cannot ignore the remainder, who due to circumstance or the time they leave Stoke Mandeville, have very limited transport options.

31. We would like the BHT Board to acknowledge this issue, and explain what they have done to understand the scale (i.e. the patients affected) and nature of accessibility constraints faced by people getting to and from their sites, particularly Stoke Mandeville. We would then like to see evidence that options to address any gaps have been explored, with actions taken and the impact/performance of these monitored.

Recommendation 4: That the Trust Board explains what they have done to understand the accessibility of the services relocated as part of Better Healthcare in Bucks, clarify the gaps in provision for people without access to a car, and to implement and monitor actions to address these gaps in transport service over the next 6 months.

Trust Finances

32. An area of concern that was highlighted at both the Trust Annual General Meeting and Board Meeting on the 25th September 2013, as well as at the HASC meeting the following day is the lack of financial support being provided to the Trust to address both the quality issues uncovered by the Keogh Review, and to avoid a repeat of the poor A&E performance during the last winter. During 2012/13 A&E waiting times for
six consecutive months during winter were below the national standard of 95% of patients being seen within 4 hours (see table below).

<table>
<thead>
<tr>
<th>% of patients seen within 4 hours at A&amp;E (target = 95% or more)</th>
<th>Nov 12</th>
<th>Dec 12</th>
<th>Jan 13</th>
<th>Feb 13</th>
<th>Mar 13</th>
<th>Apr 13</th>
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<tr>
<td></td>
<td>94.7</td>
<td>90.3</td>
<td>88.1</td>
<td>90.6</td>
<td>86.9</td>
<td>92.3</td>
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Figures taken from BHT Board Papers (29 May 2013:150)

33. In view of this performance it is surprising BHT were not granted any money from the Government’s £500m A&E bailout plan when the allocations were announced on the 10th September. The Trusts which were selected were deemed the ones thought most likely to fail this winter and included most of the surrounding acute trusts; Oxford University NHS Trust (£10.2m), Heatherwood & Wexham Park Foundation Trust (£6.6m), Bedford NHS Trust (£3.7m) and Milton Keynes NHS Trust (£2.7m). We understand the allocations were based, somewhat arbitrarily, on quarter one performance in 2013/14, and so do not take account of performance during the winter.

34. Coupled with the lack of winter pressure funding, the Trust is currently not being given any financial support to address the issues highlighted by Keogh, despite the agreed Action Plan requiring significant investment by the Trust. The HASC are sympathetic to the Trusts situation in this regard and will support it in its lobbying efforts to both the Department of Health and NHS Trust Development Authority, as it seeks additional funding from government.

Recommendation 5: That the HASC supports BHT in its lobbying efforts with the Department of Health and NHS Trust Development Authority to secure additional funding to assist with its preparations for winter and in its response to the Keogh report.

Trust Response to Keogh: Buddy Trust

35. The committee heard (HASC 26.9.13) that BHT has been ‘buddied’ with Salford Royal NHS Foundation Trust which itself has been on a 12 year quality improvement journey to get them to their current high performing level. BHT will not reach the level Salford is now at by implementing overnight measures, and not within the five month timescale set by Keogh to address its most urgent issues detailed in its Action Plan. The Board Chairman, Fred Hucker, spoke of a three year journey in the Trust’s own quality improvement activity.
36. We were reassured to hear that beyond the delivery of the Keogh Action Plan the Trust would continue on its own improvement programme, to be detailed in a forthcoming Quality Strategy, which would pick up all the Keogh issues.

37. We heard from Anne Eden that a lesson she took from speaking with Salford was to focus on two or three key areas to get right, rather than try and address multiple issues over too large an area. She felt BHT would focus on the key areas of urgent care pathway (particularly at weekends), care of the deteriorating patient, and getting staffing right and this would make a real difference.

Trust Response to Keogh: Mortality Rates

38. The Trust is very keen to rebuild the public’s faith in BHT, and provide assurance that the lessons from Keogh have been learnt and real improvements will be made. The Keogh review was instigated by the Trust’s higher than expected HSMR (mortality) rates over recent years. The Trust’s interim Medical Director Dr Cann provided a very useful response to the HASC (26.9.13) on this where she explained that the HSMR has its limitations as an indicator of quality given:
- It is only rebased annually so the impact of any changes is not very timely.
- Over two thirds of deaths in hospital are expected, and of the remaining third of unexpected deaths the majority will be unavoidable. Hence very few will ever be the result of poor care.

39. She advised that what the Trust should focus on is the quality of care and whether there are avoidable deaths, which can only be identified by reviewing patient case notes. The HSMR on its own does not indicate how many deaths were avoidable, contrary to some of the press coverage at the time of the Keogh report publication. The Trust is, post Keogh, reviewing every hospital death (rather than the monthly sample of 50 it had been doing) which will give an accurate figure on the level of avoidable deaths and inform measures to address any failings. Through this and a renewed focus on quality post Keogh, the Trust expects avoidable deaths and sub-optimal care to be reduced. The interim medical director however did warn that because of the Trust’s composition of community and respite hospitals alongside its acute hospitals, it would always expect to have a higher than average mortality rate.

Trust Response to Keogh: Reporting Improvements

40. One area we feel needs addressing urgently, and which would go a long way to reassuring the public over the quality of care at the Trust and provide better
assurance to the HASC that the issues raised by Keogh have been addressed would be to improve how the Trust reports on its Keogh response. The HASC chairman wrote to the Trust Chief Executive on 22nd August to relay comments made by the working group on BHT’s published Keogh Action Plan (entitled Every Patient Counts Action Plan) suggesting the following improvements were required:

- The RAG status (the progress status of an action using red, amber or green indicators) needs explaining as to whether this indicates an action has been delivered or is on track to be delivered, and whether this is the assessment of the Trust or of the NHS Trust Development Authority (TDA).

- Read in isolation, the Action Plan has lost the detail of the nature of the issues identified by the Keogh Team which the actions are expected to address. Numerous issues were identified in the Rapid Response Review Report, which were then rationalised into a smaller number of broad actions in the Action Plan following the risk summit. We think there is a risk some of the original issues in the risk report may be overlooked now the focus has shifted to this action plan. We would like to see reference to how each of the recommended actions in the Rapid Response Report (pages 17-46) will be addressed by each relevant action in this finalised action plan.

- We would like to see more detail against each action, with the action broken down into specific tasks and outcomes which clearly demonstrate that the original issues in the Rapid Response Report have been addressed. Evidence should be included that demonstrate the outcome has been delivered.

- The Action Plan should make it clear which of the ‘Urgent’ and ‘high priority’ recommended actions in the Rapid Response Report have been delivered.

- Before each action is given a ‘green / completed’ assessment, we would like to see comments from the NHS TDA which provides the assurance they are fully satisfied with what has been delivered, and whether any further work is required to fully address the issue.

41. In her response Anne Eden referred to the progress reports going to the public Board meeting each month. Having reviewed the 25th September version of this, it still falls short of what the working group would like to see published. Anne does state that once the immediate (Keogh) actions have been completed the Trust will update and strengthen its Quality Improvement Strategy with the goal of achieving measurable improvements in the quality and safety of care for patients. It appears
that what the working group has requested lies somewhere between the action plan currently published and the Quality Improvement Strategy yet to be published.

**Recommendation 6:** In order to provide assurance to the HASC and general public that the issues raised by Keogh are being addressed, the Trust should produce a more comprehensive response summary which aligns the issues raised by Keogh, to the actions taken, and details how the subsequent improvements in patient care will be evidenced.

42. We recognise that a number of the issues we have identified cannot be effectively addressed by BHT on their own, and particularly with regards to improving the discharge process and with transport and accessibility the County Council has a role to play in supporting the Trust. Pressures on the A&E service which impact on the whole hospital system needs to be tackled in partnership with wider local health and social care service, with NHS 111, GP’s, care homes, social services, and pharmacies all a having a part to play. In future scrutiny of the Trust and service commissioners by the HASC we will want to see evidence of effective multiagency working, particularly with the County Council, in addressing the issues identified.
B) Scrutiny of the Better Healthcare in Bucks (BHiB) Outcomes

43. At the July 2013 HASC meeting, the committee reviewed the BHiB Benefits Realisation Plan. This report was produced after the Keogh Panel had completed their review of the Trust, but there is reference made to its forthcoming release in the Rapid Response Review Report (page 23). The Benefits Realisation Plan, alongside the monitoring of risks and issues arising from the reconfiguration, are clearly important areas for the Board to maintain oversight and provide assurance on. As such, as part of the board development programme and/or the next iteration of the Benefits Realisation Plan published, we would like to recommend that the following reporting improvements are made to the monitoring of BHiB:

I. Inter Hospital Ambulance Transfers from Wycombe to Stoke Mandeville and Wexham Park A&E’s. It was indicated at the July HASC that for this figure to remain stable was adequate, yet when we discussed this with Chris Gordon from the Keogh Panel he felt there should be aims to reduce this. We would like to see BHT work towards a reduction target in line with the original stated intention. Given the Keogh report concerns over multiple transfers between the sites by the same patients, there also needs to be some data provided on whether these transfers involve the same patients and how many times. The inter-hospital transfer data should also be given as a rate per 1000 patients/percentage, as well as an absolute number.

II. A number of the BHiB outcomes would benefit from the inclusion of patient feedback/experience and complaints data. This is particularly pertinent to new/enhanced services that have been implemented (A&E, Minor Injury & Illness Unit/MIIU, One Stop Breast Service etc). Unlike the plan submitted to the HASC in July, complaints and incident data would be better presented specific to the A&E department rather than by division/specialty.

III. There is an issue with people being initially seen at the MIIU, redirected to A&E and then facing a lengthy wait with no account taken of the previous wait and subsequent travel to Stoke Mandeville. At the July HASC Neil Dardis (BHT Chief Operating Officer) explained that the surgical assessment unit could allow relevant patients to bypass A&E from MIIU, and a medical assessment unit was also being proposed. It would be useful if alongside A&E and MIIU waiting times, improvements in the waits experienced by patients straddling both departments could be published.
IV. Communications and public understanding on where to go in various situations remains a concern. We would therefore like to see evidence of how forthcoming communication and social marketing campaigns were informed, implemented and their impact monitored to demonstrate this issue is being addressed.

V. It is important that BHT provide more data as assurance that the benefits of centralisation of acute and urgent care services to residents outweighs the longer journey times some are now having to make, with data on medical outcomes (mortality etc) for varying population areas likely to be the best way to demonstrate this.

VI. Evidence should be included on the effectiveness of transport initiatives (free Arriva bus travel take up, with this broken down by staff/patient/visitors; and whether the Community Transport Hub is meeting needs with data on month on month usage, and feedback on it) implemented to address reductions in service accessibility arising from the relocation of services.

VII. All ‘enablers’ (those initiatives which were expected to be implemented and which would contribute to the improved outcomes) should include an indication as to whether they have been achieved or are still to be delivered.

VIII. Under ‘Reduction in emergency admissions for acute conditions that should not usually require hospital admission’ we would like to see this reduced in future and for a revised benchmark target to be agreed, if as we understand zero is not realistic.

IX. Patient Report Forms (PRF) data should be improved to cover greater and more consistent numbers sourced from the weekly PRF audit.

44. A number of forecast outcomes from BHiB still need to be demonstrated (safer A&E services, more appropriate use of urgent and unplanned care services, patients being treated closer to home, patients more aware of transport options, improved car parking at Stoke Mandeville, one stop breast service, prevent ill health/help people better manage long term conditions, growth of community services, numbers of Wycombe residents effected by reconfiguration actual vs forecast, use of telemedicine) and we will be looking for evidence of these in future iterations of the Benefits Realisation Plan.
C) Future HASC scrutiny activity

45. In reviewing the Keogh Report, we have sought to clarify the role of the HASC in the future scrutiny of BHT and delivery of the Keogh action plan. This is intended to assure the public that the HASC is taking the scrutiny of BHT seriously, and learning from both the Keogh report findings and those of Robert Francis (following his review into Mid Staffordshire NHS Trust) to enhance its effectiveness. Some of the areas of future HASC activity and improvements are detailed below.

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<th>HASC Activity</th>
<th>Details</th>
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<tr>
<td>Oversight of Keogh Action Plan Delivery and Monitoring</td>
<td>The NHS Trust Development Authority (TDA) will lead the monitoring of the delivery of the Keogh actions by the Trust, and we understand once implemented, and re-inspected in 2014 the Trust will come out of special measures. The HASC has a role to oversee this process and receive assurance and evidence that the actions have been implemented to the satisfaction of the TDA. Beyond this the HASC will draw on the Keogh report evidence and findings in its on-going scrutiny of the Trust, will monitor the operation of the Trust Board, and will engage with other agencies such as the Care Quality Commission and Clinical Commissioning Groups to ensure that improvements continue to be made.</td>
<td>Jan 2014</td>
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<td>BHT Scrutiny</td>
<td>HASC to ensure it monitors future BHT Board reports and meetings to ensure adequate information is being provided and that there is sufficient challenge at meetings. A particular focus should be on monitoring complaint response times and evidence of trend analysis, timely learning and actions implemented and monitored to address these. At the September HASC, the Trust Chief Nurse explained a range of methods the Trust is now using to gather timely patient experience data and opinions (such as suggestion boxes, BHT website, complaints, patient experience trackers, volunteers to support patients with trackers, member focus groups) with patients able to submit these anonymously. BHT intends to publicise this data (in addition to board reports) and the HASC will seek to use this data in future scrutiny, alongside other emerging sources of patient experience on the NHS Choices (<a href="http://www.nhs.uk">www.nhs.uk</a>) and Patient Opinion (<a href="http://www.patientopinion.org.uk">www.patientopinion.org.uk</a>) websites.</td>
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We also learnt the Trust were interested in measures of patient...
satisfaction with complaint responses, and the HASC will monitor how successful they are in developing this, given effective complaint handling will encourage further patient engagement with the trust in future.

Future scrutiny will include reviews of patient experience data and staff surveys, and ensure trends are identified and acted upon. HASC will also review evidence that Patient Safety Strategy Actions are being implemented.

**Staffing levels** needs to be an area of focus (see Keogh Action Plan 3.1-3.3 to complete by 31/12/13). HASC will want to see evidence of improved Board level monitoring of this and demonstrable increases in staffing where required. The issue raised in the Keogh Report of more devolved control/flexibility on ward staffing levels and mix also needs to be resolved.

At HASC (26.9.13) the Trust Chief Nurse explained an external review on staffing levels is being done as part of the Keogh Action Plan, and the issue had been identified as a financial risk in previous board reports in case such a review identified shortfalls in some areas. The Trust reassured the committee that they use recognised staff multipliers for various types of ward, and that whilst most national organisations work to a ratio of 1 registered nurse to 8 patients, BHT have been working to a ratio of 6:1. There are recruitment issues, hence the need to recruit staff overseas, and the use of agency and bank staff. The Trust acknowledged that excess use of temporary staff could affect quality and so it is developing a new minimum standard for wards across the Trust on the ratio of permanent to temporary staff. Ward display boards will be used in future to inform patients and their relatives on the levels of staff on duty to enhance transparency.

In terms of A&E consultant cover and the move to seven day working we heard that the Trust had recruited additional consultant staff and two extra consultants were working on the busiest weekend periods, which is an improvement on last year. The Trust does have a desire and expectation to recruit more alongside acute and emergency physicians, but there is a recruitment pressure nationally, and there will be cost implications.

The Trust advised that seven day working in other consultant areas will be a longer journey, requiring similar working patterns in other areas too such as radiology and pharmacy.
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<th><strong>Clarity of HASC Scrutiny Role and Over-sight of Quality Surveillance Group</strong></th>
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<td>To illustrate the cost implications Anne Eden referred to Bristol where the move to seven day working was put at around £4m. Safe weekend care is the priority for the trust, and seven day working is the aim. The Interim Medical Director advised that the Trust’s consultant body and division of medicine are very keen to address the urgent care pathway and weekend working. HASC work programme already includes further BHT scrutiny as part of: Care of Older People Report implementation of recommendations (Oct), Dementia Services (Oct), Winter Plans (Nov), Better Healthcare in Bucks (April 2014).</td>
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<td><strong>Through-out 2013/14</strong></td>
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<th><strong>HASC training and capacity</strong></th>
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<td>HASC must be clear on its role in the scrutiny and oversight of the Trust. The NHS TDA will lead on Keogh Actions, and the CQC will lead on the in-depth inspection of the quality of services. Matthew Tait informed us (working group meeting 14.8.13) that the Thames Valley Quality Surveillance Group (QSG) will be performing heightened scrutiny of Trust for the foreseeable future and will be triangulating data across partners (such as with the CQC, and CCG’s). We feel the HASC needs to be engaged in QSG matters. HASC has a role in being assured the overall scrutiny web is effective (minimal duplication, clear roles, good communication across organisations) in monitoring and driving improvement at BHT through its engagement with all parties. Given the role of QSG in overseeing quality at BHT and across the healthcare system, the HASC should have greater oversight of what is discussed here. <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216996/Establishing-Quality-Surveillance-Groups.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216996/Establishing-Quality-Surveillance-Groups.pdf</a> indicates (page 13) meeting notes are required at QSG meetings and these are subject to Freedom of Information Act requests, as such HASC should request to be copied in on paperwork as a routine.</td>
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<td><strong>On-going</strong></td>
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| **OCT 2013** |

| **2013/14** |

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<th><strong>To strengthen the committees scrutiny ability, the committee would benefit from some tailored training to equip them with the skills and knowledge to ask the right questions of local healthcare providers. There may be benefit in identifying committee members who are happy to remain on the committee for the four year term to maximise the benefits of this. The NHS and Centre for Public Scrutiny may be able to assist with this.</strong></th>
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<td><strong>2013/14</strong></td>
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To expand the HASC’s reach and expertise it is suggested that HASC members develop specialisms/rapporteurs to become more expert in specific areas and feedback information to the committee (e.g. attendance of neighbouring scrutiny meetings of non-BHT hospitals, attend BHT Board meetings etc).

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<tr>
<th>Support Healthwatch Bucks</th>
<th>Support / inform Healthwatch in their enter and view activity at BHT, by feeding in any areas of concern. Explore areas of joint working in areas of shared concern.</th>
<th>2013/14</th>
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<tr>
<td>HASC scrutiny of Adult Social Care</td>
<td>Some of the evidence collected and issues identified as part of the Keogh process will be a useful resource in the future HASC scrutiny of Adult Social Care Services such as those around governance and patient experience/engagement. It will also be a further opportunity to look at discharge process.</td>
<td>During 2013/14</td>
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**Next steps**

46. This final report will be approved at 17th October HASC meeting, and then submitted to Cabinet on 11th November and to the BHT Board for response.

47. The working group will meet again in October to discuss further work required on the urgent care pathway at Buckinghamshire Healthcare NHS Trust, and the scope of any investigation they feel is required given the evidence already published, improvements already being implemented, and level of public concern. Buckinghamshire Healthwatch are about to undertake some work on transport issues, and the working group will also discuss how they will contribute to this.
Appendix: Notes from the working group meeting of 14\textsuperscript{th} August attended by Chris Gordon and Matthew Tait

Information on attendees
Chris Gordon is Programme Director of QIPP (Quality, Innovation, Productivity and Prevention), supporting hospital trust development at the NHS Leadership Academy. He is also a consultant physician in Winchester specialising in Parkinson’s Disease. He was recently a Trust Chief Executive in Hampshire and was a panelist on three Keogh reviews, one of which he was Deputy Chair and also led one of the Teams.

Matthew Tait is the Thames Valley Area Team Director of NHS England. One of his roles is to engage stakeholders to ensure consistent quality across the area and he chairs the Quality Surveillance Group. He was involved in pre-Keogh discussions with Buckinghamshire Hospital Trust (BHT) and attended the Keogh Review for one day. He will be involved in the on-going monitoring of the Keogh Review.

The Chairman welcomed Chris Gordon and Matthew Tait to the Working Group meeting and Members asked the following questions:-

1. Board composition – It appears to us that there is limited nursing or caring experience among the non-executive directors. Is this unusual and does it not mean there is inadequate challenge at Board level on issues of poor care and patient experience? Would you agree with what the Berwick report suggests that there should be patient/carer/Healthwatch presence at all levels of Trust management including Board level?

Matthew Tait reported that in any Trust Board the role of non-executive director was critical and that they have a good range of experiences and knowledge outside of the NHS. A generic expertise is required but it was debatable whether they should have nursing or caring experience. The appointment of non-executive directors was a matter for the Trust Board or organisation. However, it was important to have a good mix of Members who added value and presented reasonable challenge. They needed to have a systematic approach to patient quality and Board development was one of the recommendations of the Keogh Review.

Chris Gordon reported that the Trust Board need to have a clear understanding of their strategic needs in terms of Board Development and non-executive directors need to recognise their responsibilities. Non-executive directors need to have the ability to generate a high level of challenge and scrutiny. The makeup of the Buckinghamshire Hospital Trust was not unusual. The Board may not need a specific health background but needed to be more clinically focusses and govern quality. Non-executive Directors needs to understand the business but also bring outside experience e.g. knowledge of locality or industry.
A Member commented that the Board needed to have an understanding of what was happening on the wards. Chris Gordon commented on the need for a ‘Board to Ward relationship’ in that Members had a clear knowledge of what was happening at the coalface.

A Member asked whether the inspections during the review were announced or unannounced and whether they had detailed discussions with the nurses, other staff and patients. Chris Gordon responded that Board Members should familiarise themselves as much as possible with their business. They should not be experiencing a ‘presidential visit’ as such but making sure that it was a working exercise to understand the true nature of how wards were run.

2. Healthcare Governance Committee – We understand service quality concerns are discussed at the Healthcare Governance Committee, and Trust Board Papers include the headings of what items were discussed. Should there be more transparency on the activity of this committee, either with more detail at Board level or minutes and papers from the committee meetings be available online?

Chris Gordon reported that the Healthcare Governance Committee should be providing regular assurance to the Board that the business was operating well. Audit information reports and complaints should be considered and there should be a drive for a continuous improvement culture. The Board needed to be very challenging in terms of requesting information and providing scrutiny.

A Member expressed concern that complaints information was not being picked up. Chris Gordon reported that complaints were reported to the Board but that the challenge was to learn from complaints and take action if required. This area of focus could be improved by looking at complaints in a positive light in terms of improvement.

Matthew Tait reported that the direction of travel for the governance model for NHS Trusts was an important consideration. With the changes to Foundation Trust a different governance model was required which included patient engagement. A suggestion could be made that NHS Trust governance should be reviewed in light of the Keogh Review but it had not been considered as part of the general Keogh debate.

A Member commented that there had been pressure on Trusts to focus on obtaining Foundation status which could mean that they could lose direction in other areas. Matthew Tait reported that 10 years ago the focus was on business and finance now the priority was patient safety.

Members noted that the Board meetings were transparent in that they were held in public but this area could be improved. The information relating to NHS Choices could be expanded to include relevant information on all levels of service and information on patient experiences should be put in one place. More information should be put on websites including information on complaints. There were changes in the pipeline in the next year to improve transparency online. A Member commented that it was important to put this into
'plain english'. A Member asked whether there was a general reluctance to do this or whether they had not had time to address transparency. Chris Gordon responded by saying it was both; it was a busy environment dealing with day to day issues and strategic work and concern that being more transparent would create more work through press and public interest as health services were often under the spotlight. However the Service would soon get used to this change in culture. Reference was made to publishing consultant data information on surgery outcomes so this area was improving.

3. HASC Training – Do you think there would be benefit in some of our committee attending joint training sessions with members of the trust board as part of their development programme, if it would equip us to better scrutinise how they perform their function?

Matthew Tait reported that it was important to have well informed debates and to have a good understanding of the subject matter being addressed. However, it was important to be clear about the different roles and responsibilities of each body. There are the roles of the CQC, inspectors and regulators and local commissioners. There needs to be a clear understanding of the regulatory framework and where scrutiny and monitoring takes place.

Chris Gordon reported that debates are enlivened by knowledge and regular meetings with the Chairman of the Committee. They need to have a good understanding of healthcare governance. There is plenty of training around the NHS framework and all Members could attend the Trust Board who have public meetings. The Director of Public Health reported that in terms of monitoring going forward there were now a lot of people around the table interested in this review and it was important to be clear about the different roles of groups, particularly the HASC.

Matthew Tait reported that the NHS Trust did have active Board development and the Trust Development Authority (TDA) required evidence of Board development. There were concerns about leadership and clarity around roles and responsibilities and at what point services are scrutinised. It was important that there was enough capacity and expertise in order to have a rapid response to processes that were not operating effectively. The ability to challenge was an important part of the governance function.

Matthew Tait reported that the action plan should be led by the regulator, the TDA. A range of stakeholders should be involved with a close level of scrutiny as special measures would not be removed without wider engagement with relevant partners. The HASC would need to hold the local health system to account, including the commissioners and regulators to ensure that the action plan was implemented.

4. Mortality data – The Keogh analysis appears very thorough and logical in drilling down into the mortality figures to identify the problem conditions. Did the Trust and its mortality working group not perform such an analysis themselves, or had they but were too slow in implementing audits/actions to address the problem conditions?
Are you confident there is sufficient capability at the Trust / Commissioning Support Unit to perform such rigorous analysis in future?

Chris Gordon reported that the Trust was aware of the mortality rates and had analysed it. They had looked at the evidence in depth and made efforts to improve the situation. There needed to be an understanding of whether this was a statistical deviation or a real deviation. One of the difficult areas for the Trust was monitoring the quality of care particularly with 5-6,000 staff and different information such as audits, adverse events, complaints and incidents and being able to understand the root causes and make beneficial improvements.

The press headlines were not helpful. Any changes in mortality rates should act as a red flag and there was an expectation that the NHS delivers good quality services. Mortality rates have been declining across the NHS. There have been small improvements such as how quickly medicines could be delivered once a patient has arrived in hospital and how quickly the ward recognises patient deterioration. The public need to feel confident that all staff are meticulous and have a culture of attention to detail and improvement.

A Member asked about community care and where patients died? Chris Gordon reported that obviously many patients did die in hospital and that it was important for people to die in their place of choice which was usually their home through good joined up care. This was a difficult discussion in terms of there being a high mortality in hospitals because some patients are only admitted when they are close to dying. However, any change in statistics needed to be investigated. The Chairman referred to the Dr Foster Reports and asked whether there was a problem with coding in terms of mortality rates. Chris Gordon reported that the NHS were good at making assumptions and gave an example at Mid Staffordshire where mortality could be explained in different ways. Any change in numbers needed to be highlighted and investigated to provide reassurance and a detailed explanation of death was required. The Chairman asked about the future steps for the HASC and was informed that Members need to listen to the explanation from the Trust and test the action plan robustly.

5. Working across split sites (page 38 Rapid Response Report/RRR) – Keogh identifies a problem with the split of acute services, necessitating patients being transferred back and forth between Stoke Mandeville and Wycombe. Is the current configuration fundamentally flawed, or what could be done to minimise the impacts on patients from this?

Chris Gordon reported that the configuration was not fundamentally flawed. The Risk Summit had not found a problem with the reconfiguration of services and had seen positive changes in terms of the quality of care. They had however, been critical of the transfer process and general monitoring. He had made an unannounced visit to High Wycombe in the early evening and had been unclear about signage and where he needed to go, with some people also asking him for directions. It was important to centralise high quality services and to understand how patients experienced services. If patients were sent to the wrong hospital this needed to be investigated and improvements made.
Matthew Tait reported that this model was very innovative and enabled some local services to remain local such as cardiac and stroke services. There was a degree of risk with this model but it was considered to be the best clinical option. Transferring patients was a risk and needed to be monitored. The benefits realisation plan needed to measure patient experiences.

A Member asked whether these services were reconfigured because of a funding issue? Matthew Tait reported that funding was always an issue in the NHS but it was important to operate sustainable services. Any service with unlimited money could be better. Whilst many Trusts were under pressure financially, funding did not lay at the heart of the problem. This was clinically driven not financially driven.

A Member asked whether any changes were planned to the heart and stroke units. Matthew Tait reported that there were no changes planned in these services. Chris Gordon reassured Members that as long as the service was sustainable with the right medical cover and the risk of transfers was managed appropriately there would be no need for changes to services.

6. Junior Doctor support - Junior doctors reported a lack of senior support which has been made poorer by the recent reconfiguration. Why is this as you would think centralisation of services would have increased junior doctor support?

Chris Gordon reported that there were always gluts in the NHS in terms of having the right amount of skilled people as it was difficult to plan. It takes many years to train doctors and there was a national shortage with emergency care consultants particularly with the nature of their work; the hours, the intensity and the stamina not to ‘burn out’. There was a crisis in emergency care. Junior doctors have struggled with the level of consultant supervision, particularly at weekends. The change from High Wycombe to Stoke Mandeville was made when the building at Stoke Mandeville was not ready and also the winter period was the worst experienced on record. This was unpredictable and there was a struggle to get the reconfiguration process right. Junior doctors took the brunt of this and had to face an ambulance queue at 3am. The out of hours service was also a national issue. Matthew Tait reported that a key concern was addressing weekend cover and there were changes ahead in relation to contractual issues.

7. Would the NHS provide 24/7 senior consultant cover in the foreseeable future? Matthew Tait reported that there is a focus on this but not at senior consultant level. Chris Gordon reported that 7 day working was a real issue with consultants on an on call basis. The consultant should be delivering care not supervising it. Junior doctors should not be service deliverers. This would be the same for elective and emergency care. This would also be the case for discharge arrangements (where there was a dependency on social care teams being available, with this being limited during weekends and holiday periods) as some discharges did not take place until Tuesday because arrangements were not being made over the weekend and there was also concern during the Christmas period.
A Member referred to the concerns made by junior doctors that their complaints were not being heard. Chris Gordon reported that the views of junior doctors and nurses were obtained during the Keogh Review, which had not been done previously before. It was important to understand services at the point of delivery. There needed to be a good engagement process to obtain their views but staff needed to submit these formally rather than just complain to colleagues.

A Member referred to a previous dementia report where it mentioned that staff were not trained in patient care. Chris Gordon reported that he found most staff to be well trained and very compassionate. Any incidents needed to be reported formally.

A Member asked why staff were not recruited consistently over a long period to challenge the reactive recruitment process. Matthew Tait reported that this was an issue that should be addressed by non-executive directors.

8. Under Patient experience (RRR pp 29) you cite examples of elderly toilet needs being ignored, as well as poor call bell response times. We hear of this very often. Do you feel this is essentially due to inadequate staffing of wards?

Chris Gordon reported that he had not seen any evidence of poor care and that generally nurses were committed. There were concerns over the flexibility of ward numbers and the need to address short and medium term fluctuations. There was also concern about the level of delegation regarding specific tasks e.g. highly experienced nurses should be dealing with intravenous fluids.

9. Training - on page 42 (RRR) the actions identified in response to concerns over staff training are only deemed high or medium priority. Should these not be address more urgently?

Chris Gordon reported that there was already an excessive load on the Trust and whilst training was important there were other priorities that needed more immediate attention. Good education and training also takes time to develop and a culture of learning needed to be developed.

10. Patient fear to complain – we feel there is an issues with patients being fearful to complain about the care received. Did the Panel identify this and what do you think could be done to address this at the Trust?

Chris Gordon reported that generally patients whilst in hospital will be very dependent and vulnerable and not like to complain for fear of bad treatment. The Trust will need to work hard to look at patient experiences and take complaints seriously so that there is a continuously improving culture. The Chairman referred to a single route of accountability. Chris Gordon reported that whatever form of reporting whether through formal complaint, staff, PALS or a suggestion box the Trust needed to be more proactive about dealing with complaints. PALS staff need to be trained into how to be a patient advocate rather than a
‘defender’ of the Trust to ensure that complaints were dealt with properly. A tough person would be required to stand up to Trust staff when necessary.

A Member asked whether PALs was the right name as it did not sound independent. Matthew Tait reported that it depended on the culture of the organisation rather than the name. The Chairman reported that it was up to the leadership of the Trust to cascade down the right culture. Matthew Tait reported that when he had met the Chief Executive pre Keogh she had been committed to the improvement agenda and was sending out the right messages to the Trust. It was important that all Board Members replicated this and did not have a reactive culture.

11. A Member asked whether all complaints go to the Board?
Chris Gordon reported that all complaints were reported but this needed to be taken a step further. Each Board Member had a responsibility to scrutinise. Some of the minutes reported up to the Board did not have the right level of information and this was not challenged. There was also no sense of urgency to change this.

Matthew Tait reported that the Quality Surveillance Group had been closely monitoring the situation and obtained regular reports from commissioners and regulators. If Keogh had not happened he could have called a Risk Summit given there were a number of concerns raised by the Group such as mortality rates. Following the Review the Group will monitor the action plan and work with the TDA and stakeholders to have a co-ordinated approach to improvement and analysing data.

12. Has the CCG the right skills to monitor the action plan?
Matthew Tait reported that the CCGs have got the right knowledge and that the Keogh Review was not a surprise and they were aware of the key concerns. They would struggle with some of the broader aspects such as Board Governance. They possessed good skills and had the required capacity and their role was different to regulators. It was important also to support the culture of improvement for the Trust and that all stakeholders did not ‘overscrutinise’ the Trust. Role definition was key.

13. Were there any funding issues?
Matthew Tait reported that he had no control over the funding of CCG’s and that this was allocated nationally. If the Trust did not provide the right quality of service this would be addressed immediately by the Surveillance Group and they needed to prioritise what areas to improve first.

A Member expressed concern about the low level of health funding per head in the South East and rural deprivation. Matthew Tait reported that rural deprivation was difficult, particularly if it was in isolated pockets.

14. Discharge Planning/process - To what extent did the Keogh team look at how the Trust manages the discharge of patients, particularly elderly and the interface with adult social care? We have evidence suggesting this is not working very effectively.
Chris Gordon reported that services needed to be more integrated involving all stakeholders and working on a 24/7 basis to make them more effective. Trish Robertson (BCC Adult Social Care) reported that every stakeholder organisation needed to have the will and change in culture to do this. Whilst multi-disciplinary working was exciting the local situation was difficult to change. There was no joint discharge planning process in place and procedures were very fragmented. A change in culture needed to start from the top of all organisations and to move away from a blame culture. Chris Gordon reported that he had seen good examples of best practice which could be applied. A Member expressed concern about some patients being discharged without their carers being informed. Chris Gordon replied that there had not been an audit on this area and there was no evidence to support this. Services needed to be integrated and staff needed to look at different ways of working to achieve outcomes.

15. Transport – We appreciate this is not an issue that necessarily impacts on the Trusts mortality rates, but is a significant factor if poor patient experience and dissatisfaction with the local configuration of services. Following to centralisation of services on the Stoke Mandeville site do you feel the Trust Board should be doing more to understand and address the accessibility of their services for people without access to a car? Particularly during out of hours. (eg. A&E departure during the night).

Matthew Tait reported that the issue of patient transport was a difficult one and work needed to be undertaken following the Better Healthcare in Bucks report to address this. This would require joint funding from the health service and the Council. Chris Gordon reported that the Keogh Review had looked at transport from one site to another and logged conversations with the ambulance service, who had called ahead. They always directed the patient to the correct location. There was a process in place for appropriate transfers and to minimise the number of patients who had to be redirected. The Chairman asked about accessibility of services for those patients without a car. Chris Gordon reported that there were always risks around transferring patients but this was not visible on the hospital risk register and they needed a greater degree of focus on this issue.

Following questioning Members noted that there would be an unannounced visit in the Autumn to see how the action plan was being implemented. If there were any further questions Members wished to ask they could email Chris Gordon and Matthew Tait. Janice Campbell reported that Healthwatch were reviewing all complaints coming to the independent complaints advice service (SEAP) and through the Healthwatch helpline and would pass this information onto Members.

Chris Gordon and Matthew Tait were thanked for their time.