Summary of the review into the quality of care and hospital treatment provided by 14 hospital trusts in England: overview report
By Professor Sir Bruce Keogh KBE, published 16 July 2013

1. Introduction

The review was requested in February by the Prime Minister and the Secretary of State for Health following the publication of the Francis Report and the association between high mortality rates and failing quality and governance overall. 14 trusts were selected for review on the basis they had been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR).

The methodology for the review was not conventional in terms of inspection and involved gathering vast quantities of hard data and soft intelligence to establish key lines of enquiry for the review teams, rather than take the structured approach most commonly used by the CQC which tends to concentrate on specific areas. The teams were multidisciplinary and included patient/public representatives, junior doctors, doctors, student nurses, nurses, a CQC inspector, a senior trust manager and regional support, and conducted planned and unannounced visits. The review considered the performance of the hospitals across six key areas: mortality; patient experience; safety; workforce; clinical & operational effectiveness; and leadership & governance. Each trust received a full report, and where areas of concern were found action was taken immediately.

2. Key findings

Within the key areas of the review the following was found:

Patient experience
Whilst only one hospital appeared to be an outlier on patient experience measures, the visits established this was an area where improvement was needed at most trusts. There was a focus in some trusts to 'manage' complaints rather than seeking out and encouraging feedback, and also a significant delay in response to complaints.

Safety
Reviews of documentation and observation of clinical practice and equipment checks revealed processes were generally in place but not fully understood so implementation was patchy. Equipment checks at some organisations necessitated immediate escalation and action as they were inadequate. Some trusts needed to carry out more work on key issues such as infection control and reducing incidents of pressure ulcers, and when things did go wrong the root cause analysis was poorly done and disseminated to only a limited audience.

Workforce
High rates of sickness absence and over reliance on agency staff were contributors to a number of workforce problems, and there was a positive correlation between in-patient to staff ratio and a high HSMR score. Data did not show nurse staffing levels to be a problem in the majority of the trusts, but the data was found to not be an accurate portrayal of the numbers and functionality of staff on

the wards at any given time, as temporary staff were often restricted in the clinical duties they were allowed to undertake.

Clinical and operational effectiveness
All trusts functioned at high levels of capacity in the urgent care pathway, leading to challenges in A&E, cancellations of operations due to bed shortages and difficulty meeting waiting times. This put pressure on patient flows and on staff. This was directly related to the increase in elderly patients with complex needs. The majority of hospitals also had no real understanding of the reasons for their high mortality figures, and therefore had weak or incomplete strategies for improvement.

Leadership and governance
Boards and clinical leaders were failing to effectively drive quality improvement, and the capability of medical director and/or directors of nursing was questioned by the review teams. Common concerns were poor articulation of strategy for quality improvement, lack on a comprehensive and consistent approach to learning from the findings of quality and safety reviews undertaken internally and externally, and a significant disconnect between what clinical leadership perceived to be key risks and issues and the reality of what was happening in the wards. In general, they were failing to seek independent assurance, weren't looking in the right areas, and weren't listening to staff, patients, and stakeholders.

3. Common themes

Although the review acknowledges each of the 14 trusts face different challenges, it also highlights common themes that are applicable to the wider NHS:

- the limited understanding of how important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services
- the capability of hospital boards and leadership to use data to drive quality improvement
- the complexity of using and interpreting aggregate measures of mortality, including HSMR and SHMI
- the fact 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

4. Ambitions for the future

The review sets out 8 ambitions that seek to address some of the underlying causes of poor care, and it is expected that significant progress should be made towards achieving them within two years. The ambitions each have detailed and supportive actions.

Ambition 1: We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

Ambition 2: The board and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful, and easy to use data about quality at service line level.

Ambition 3: Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

Ambition 4: Patient and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in the inspections.

Ambition 5: No hospital, however big, small, or remote, will be an island unto itself. Professional, academic, and managerial isolation will be a thing of the past.

Ambition 6: Nurse staffing level and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

Ambition 7: Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

Ambition 8: All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

5. The review process

The conclusion of the review process was that it worked extremely well and uncovered problems and areas for improvement that had previously been missed. The model was based on triggers for action; skilled data analysis leading to Key Lines of Enquiry as opposed to inspection against a pre-determined framework; intensive visits to hospitals by experienced, multi-disciplinary teams; and talking to patients and staff in-depth. It was recommended that it should inform the way in which all future hospital reviews and inspections are carried out.

6. Next steps for CCGs

There were a number of ways in which CCGs contributed to the review and several areas where their involvement will be required in the future:

- the review emphasised the value of listening to staff and patients as well as representatives of the local population, including CCGs
- it recommends the model be adopted for future inspections, meaning the sharing of information between CCGs and regulators will be vital in the effort to create wider triggers of quality concerns other than mortality

- in creating key lines of enquiry, GPs fed in local intelligence about quality and performance through the CCG; this was acknowledged to be a critical step in the process
- representatives of CCGs were also included in the 'risk summit' that followed each inspection, and were involved in creating the action plans to drive improvements
- the report recommends that 'listening events' to encourage instant feedback should be advertised widely, including the promotion of these events to existing panels such as Patient Participation Groups within CCGs and primary care
- CCGs have a legal duty to secure continuous improvements in the quality of service provided to patients, and Ambition 2 makes clear the obligation on CCGs to confidently and competently use data and other intelligence in the pursuit of quality improvement