Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

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16 July 2013

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Letter to the Secretary of State

Dear Secretary of State for Health,

In February you and the Prime Minister asked me to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates. Your rationale was that high mortality rates at Mid Staffordshire NHS Foundation Trust were associated with failures in all three dimensions of quality - clinical effectiveness, patient experience, and safety - as well as failures in professionalism, leadership and governance. I selected 14 trusts for this review on the basis that 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). This letter and overarching report, as well as the detailed reports for each trust, also published today, mark the conclusion of my review.

The NHS embodies the social conscience of our country. Every week, our NHS positively transforms the lives of millions of people and we should be deeply proud of this fact. Sadly, there are times when the NHS falls well short of what patients and the public rightly deserve. The harrowing accounts set out by Robert Francis in his two reports into the failures at Mid Staffordshire NHS Foundation Trust highlight the lasting physical and emotional damage we can cause to patients and their families when we get things wrong and fail to make quality our primary concern.

Our NHS is the only healthcare system in the world with a definition of quality enshrined in legislation. It is simple. An organisation delivering high quality care will be offering care that is clinically effective, safe and delivering as positive an experience as possible for patients. These are not unreasonable expectations. The NHS should be good in all three. Being good in one or two is simply not good enough.

We found pockets of excellent practice in all 14 of the trusts reviewed. However, we also found significant scope for improvement, with each needing to address an urgent set of actions in order to raise standards of care.

These organisations have been trapped in mediocrity, which I am confident can be replaced by a sense of ambition if we give staff the confidence to achieve excellence. This is consistent with the ambitions that I know the new clinical commissioning groups have for their local populations and the legal duties they have to secure continuous improvements in the quality of services provided to patients.

So, I was never interested in simply confirming whether or not there were problems at these trusts. They knew they had problems, which they have tried but struggled to address. I was keen to provide an accurate diagnosis, write the prescription and, most importantly, identify what help and support they needed to assist their recovery or accelerate improvement.

To achieve this we developed a methodology that was both transparent and comprehensive. It should be adopted and improved by the new Chief Inspector of Hospitals.

Firstly, we gathered and conducted detailed analysis of a vast array of hard data and soft intelligence held by many different parts of the system. This helped identify key lines of enquiry for the review teams, allowing them to ask penetrating questions during their site visits and to focus in on areas of most concern.

Secondly, we used multidisciplinary review teams to conduct planned and unannounced site visits. These teams, around 15-20 strong, were composed of patient and lay representatives, senior clinicians, junior doctors, student nurses and senior managers. The diverse make-up of these teams was key to getting under the skin of the organisations.

Thirdly, these review teams placed huge value on the insight they could gain from listening to staff and patients as well as to those who represented the interests of the local population, including local clinical commissioning groups and Members of Parliament. Unconstrained by a rigid set of tick box criteria, the use of patient and staff focus groups was probably the single most powerful aspect of the review process and ensured that a cultural assessment, not just a technical assessment, could be made.

Finally, once the teams had completed their reviews, we convened a meeting of all involved statutory parties - a Risk Summit - to agree with each trust a coordinated plan of action and support to accelerate improvement.

Transparency has been key to this process. Every aspect of these reviews has been conducted in the most transparent way the NHS have ever seen, with everything published on NHS Choices, from the data used to inform the reviews, videos of presentations by the review panels to the risk summits and the subsequent improvement plans. For these hospitals the public have now become not just informed participants in the process, but active assessors and regulators of the NHS. This represents a turning point for our health service from which there is no return.

Although all 14 trusts face a different set of circumstances, pressures and challenges ahead, this review has also been able to identify some common themes or barriers to delivering high quality care which I believe are highly relevant to wider NHS. These include:

- 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. For example, we know from academic research that there is a strong correlation between the extent to which staff feel engaged and mortality rates;
- the capability of hospital boards and leadership to use data to drive quality improvement. This is compounded by how difficult it is to access data which is held in a fragmented way across the system. Between 2000 and 2008, the

NHS was rightly focused on rebuilding capacity and improving access after decades of neglect. The key issue was not whether people were dying in our hospitals avoidably, but that they were dying whilst waiting for treatment. Having rebuilt capacity and improved access, it was then possible to introduce a much more systematic focus on quality. But more clearly needs to be done to equip boards with the necessary skills to grip the quality agenda;

- the complexity of using and interpreting aggregate measures of mortality, including HSMR and SHMI. The fact that the use of these two different measures of mortality to determine which trusts to review generated two completely different lists of outlier trusts illustrates this point. However tempting it may be, it is clinically meaningless and academically reckless to use such statistical measures to quantify actual numbers of avoidable deaths. Robert Francis himself said, 'it is in my view misleading and a potential misuse of the figures to extrapolate from them a conclusion that any particular number, or range of numbers of deaths were caused or contributed to by inadequate care';
- the fact that some hospital trusts are operating in geographical, professional or academic isolation. As we've seen with the 14 trusts, this can lead to difficulties in recruiting enough high quality staff, and an over-reliance on locums and agency staff;
- the lack of value and support being given to frontline clinicians, particularly junior nurses and doctors. Their constant interaction with patients and their natural innovative tendencies means they are likely to be the best champions for patients and their energy must be tapped not sapped; and
- the imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement. Unless there is a change in mind set then the transparency agenda will fail to fulfil its full potential. Some boards use data simply for reassurance, rather than the forensic, sometimes uncomfortable, pursuit of improvement.

In 2008, Lord Darzi set out a comprehensive strategy for improving quality. NHS England is continuing to pursue this strategy with vigour. However, the findings from this review have demonstrated the need to set out an achievable ambition for improvement and raising standards in our hospitals. I believe we can make significant progress in the next two years.

As the Care Quality Commission puts in place its new inspection model it will be important for them to develop a clear and transparent trigger for conducting future inspections. We used mortality statistics. However, I am clear that they must consider a broader set of triggers spanning the three dimensions of quality, because poor standards of care do not necessarily show up in mortality rates. The sharing of soft intelligence, particularly between local clinical commissioning groups and regulators, will be vital and the new network of Quality Surveillance Groups provides

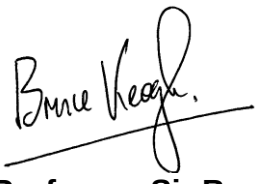
an important mechanism for supporting this and avoiding duplication of effort and must be nurtured.

I would like to thank the staff of the 14 trusts for the way in which they have embraced this review, for their openness and honesty and for the hard work and commitment they demonstrated to improving quality for patients. I would also like to thank the chairs of each of the review teams for the outstanding leadership they have shown and the hundreds of patient and lay representatives, clinicians and managers who participated in these reviews and have shown their dedication to improving our NHS.

Finally, not one of these trusts has been given a clean bill of health by my review teams. These reviews have been highly rigorous and uncovered previously undisclosed problems in care. The rapid responsive review reports and the risk summit summaries make uncomfortable reading.

However, this is not a time for hasty reactions and recriminations. Any immediate safety issues we uncovered have been dealt with. It is a time for considered debate, a concerted improvement effort and a focus on clear accountability. So, I expect the carefully considered and agreed action plans to be enacted with serious consequences for failure to do so.

Yours sincerely



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1 An achievable ambition for improvement

Having conducted these reviews across 14 hospitals, it has been possible to identify some common challenges facing the wider NHS. Below I have set out my ambition for improvement which seeks to tackle some of the underlying causes of poor care. I want to make significant progress towards achieving this ambition within two years.

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.**
Based on	This review has shown the continuing challenge hospitals are facing around the use and interpretation of aggregate mortality statistics. The significant impact that coding practice can have on these statistical measures, where excess death rates can rise or fall without any change in the number of lives saved, is sometimes distracting boards from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals. Mortality outliers are characterised by the sub-optimal way in which emergency patients are dealt with, particularly at the weekend and at night.
Action	• All trusts should rapidly embed the use of an early warning system and have clinically appropriate escalation procedures for deteriorating, high-risk patients - in particular at weekends and out of hours. Commissioners and regulators should seek assurance that such systems are in place. • I have commissioned Professor Nick Black at the London School of Hygiene and Tropical Medicine and Professor Lord Ara Darzi at Imperial College London to conduct a study into the relationship between 'excess mortality rates' and actual 'avoidable deaths'. This will involve conducting retrospective case note reviews on a substantial random sample of in-hospital deaths from trusts with lower than expected, as expected and higher than expected mortality rates. • This study will pave the way for the introduction of a new national indicator on avoidable deaths in hospitals, measured through the introduction of systematic and externally audited case note reviews. This will put our NHS ahead of other health systems in the world in understanding the causes of and reducing avoidable deaths.

Ambition 2	**The boards 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.**
Based on	This review found that providers and commissioners are struggling to understand and take full advantage of the enormous and very rich set of data available on quality, as it is held in a fragmented way across the NHS and difficult to use to benchmark performance. We also found a deficit in the high level skills and sophisticated capabilities necessary at board level to draw insight from the available data and then use it to drive continuous improvement. Too often, boards were honing in on data that reassured them they were doing a good job, rather pursuing data that revealed inconvenient truths, thereby missing opportunities for improvement.
Action	• All those who helped pull together the data packs produced for this review must continue this collaboration to produce a common, streamlined and easily accessible data set on quality which can then be used by providers, commissioners, regulators and members of the public in their respective roles. Healthwatch England will play a vital role in ensuring such information is accessible to local Healthwatch so that they and the consumers they serve can build a picture of how their local service providers are performing. The National Quality Board would be well placed to oversee this work. • Boards of provider organisations - executives and non-executives - must take collective responsibility for quality within their organisation and across each and every service line they provide. They should ensure that they have people with the specific expertise to know what data to look at, and how to scrutinise it and then use it to drive tangible improvements. Over the last decade, many hospitals in the United States have recognised the importance of this by creating board level Chief Quality Officers. Creating a new board role is not essential, but having someone with the breadth of skills required is. • NHS England, the NHS Trust Development Authority and Monitor should work together to streamline efforts to address any skills deficit amongst commissioners, NHS Trusts and NHS Foundation Trusts around the use of quantitative and qualitative data to drive quality improvement. • I will ensure that the requirements for Quality Accounts for the

2014-15 round begin to provide a more comprehensive and balanced assessment of quality.

Ambition 3	**Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment 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.**
Based on	Involving patients and staff was the single most powerful aspect of the review process. Patients were key and equal members of review teams. Well-attended listening events at each trust provided us with a rich understanding about their experiences at the hospitals. Accessing patient insight in this way need not be complex, yet many of the trusts we reviewed did not have systematic processes for doing so, and all have actions in their action plan to improve in this area.
Action	• Realtime patient feedback and comment must become a normal part of provider organisations' customer service and reach well beyond the Friends and Family Test. • Providers should forge strong relationships with local Healthwatch who will be able to help them engage with patients and support their journey to ensuring more comprehensive participation and involvement from patients, carers and the public in their daily business. • The very best consumer-focused organisations, including some NHS trusts, embrace feedback, concerns and complaints from their customers as a powerful source of information for improvement. Patients and the public should have their complaints welcomed. Transparent reporting of issues, lessons and actions arisng from complaints is an important step that the NHS can take immediately to demonstrate that it has made the necessary shift in mindset. • Monitor and the NHS Trust Development Authority should consider the support, development and training needed for Non-Executive Directors and Community, Patient and Lay Governors to help them in their role bringing a powerful patient voice to Boards.

	• All NHS organisations should seek to harness the leadership potential of patients and members of the public as they fulfil their respective responsibilities whether as providers, commissioners or as part of future inspections by the regulators. Patient and public engagement must be central to those who plan, run and regulate hospitals and each has improvements to make in this respect.
Ambition 4	**Patients 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 inspections.**
Based on	The methodology we used for this review has worked well, uncovering both good practice as well as previously undisclosed problems requiring immediate attention and urgent action. The multidisciplinary nature of the review teams - involving patient and lay representatives, junior doctors, student nurses, senior clinicians and managers - was key to getting under the skin of these organisations. The review teams were not constrained by the limitations of a rigid set of tick box criteria. This allowed both cultural and technical assessments to be made, informed by listening to the views and experiences of staff, and particularly patients and members of the public.
Action	• The new Chief Inspector of Hospitals has agreed to adopt and build on this review methodology as he takes forward the Care Quality Commission's new inspection regime for hospitals. • In the new system, the place that data and soft intelligence comes together is in the recently formed network of Quality Surveillance Groups. These must be nurtured and support the Care Quality Commission in identifying areas of greatest risk. • Provider boards might wish to consider how they themselves could apply aspects of the methodology used for this review to their own organisations to help them in their quest for improved quality.

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.**
Based on	The trusts reviewed tended to be isolated in terms of access to the latest clinical, academic and management thinking. We found many examples of clinical staff not following the latest best practice and being 'behind the curve'. They - and other trusts not included in this process - need to be helped to develop culture of professional and academic ambition.
Action	• NHS England should ensure that the 14 hospitals covered by this review are incorporated early into the emerging Academic Health Science Networks. We know that the best treatment is delivered by those clinicians who are engaged in research and innovation. • Providers should actively release staff to support improvement across the wider NHS, including future hospital inspections, peer review and education and training activities, including those of the Royal Colleges. Leading hospitals recognise the benefits this will bring to improving quality in their own organisations. Monitor and the NHS Trust Development Authority should consider how they can facilitate this.
Ambition 6	**Nurse staffing levels 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.**
Based on	The review teams found inadequate numbers of nursing staff in a number of ward areas, particularly out of hours - at night and at the weekend. This was compounded by an over-reliance on unregistered support staff and temporary staff.
Action	• As set out in the *Compassion in Practice,* Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience. • The National Quality Board will shortly publish a 'How to' guide on getting staffing right for nursing.

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.**
Based on	The contribution of junior doctors and student nurses to the review process was hugely important. They are capable of providing valuable insights, but too many are not being valued or listened to. Junior doctors in particular were receiving inadequate supervision and support, particularly when dealing with complex issues out of hours. They often felt disenfranchised. In some trusts we visited junior doctors are not included in mortality and morbidity meetings because they were considered 'not adult enough to be involved in the conversations'.
Action	• I strongly advise Medical Directors to consider how they might tap into the latent energy of junior doctors, who move between organisations and are potentially our most powerful agents for change. Equally, I would strongly encourage Directors of Nursing to think about how they can harness the loyalty and innovation of student nurses, who move from ward to ward, so they become ambassadors for their hospital and for promoting innovative nursing practice. • Junior doctors must routinely participate in trusts' mortality and morbidity review meetings.
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.**
Based on	From talking to people in the 70 focus groups we conducted as part of the review, it was clear that staff did not feel as engaged as they wanted or needed to be: yet academic research shows that the disposition of the staff has a direct influence on mortality rates.
Action	• All NHS organisations need to be thinking about innovative ways of engaging their staff. • Addressing this issue is part of the action plans for all of the 14 trusts which provides them with an opportunity to lead the way on this.

2 Introduction

On 6th February, the Prime Minister and Secretary of State asked me to review the quality of care and treatment being provided by those hospital trusts in England that have had higher than average mortality rates over the last two years. The review was announced in a statement to the House of Commons responding to the publication of the Mid Staffordshire Hospitals NHS Foundation Trust Public Inquiry Report.

The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on one of two well-established measures of mortality: the Summary Hospital Level Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). This report summarises the findings and actions resulting from the reviews into the 14 hospitals.

The terms of reference for the review are set out below.

Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these trusts.

Identify:

i) whether existing action by these trusts to improve quality is adequate and whether any additional steps should be taken;

ii) any additional external support that should be made available to these trusts to help them improve; and

iii) any areas that may require regulatory action in order to protect patients.

It is important to note that whilst the 14 hospital trusts covered by the review have been selected using national mortality measures as a 'warning sign' or 'smoke-alarm' for potential quality problems, the investigations have looked more broadly at the quality of care and treatment provided within these organisations. The review has considered the performance of the hospitals across six key areas: mortality; patient experience; safety; workforce; clinical & operational effectiveness; and leadership & governance.

2.1 Taking a fresh approach

I have been advised by a National Advisory Group of experts drawn from across the NHS, patient groups, the regulators and leading academics. Whilst they advised on design and process, the final recommendations are mine. The membership of this group is shown at Annex C.

We wanted this review to be different from other investigations into the quality of care in the NHS. In a relatively short space of time, we wanted to understand whether there were any serious failings that needed immediate action, while setting

the trusts on the road to improvement with appropriate support from the wider NHS. It was clear at the outset that we needed to take a fresh look at these organisations, many of which have been inspected many times before and granted a clean bill of health, despite the continuing high mortality rates.

The review process was guided by the following principles:

Patient and public participation

Patients and members of the public have played a central role in the overall review and the individual investigations. The views of patients in each of the 14 hospitals have been sought. We have held open 'listening events' at each Trust and heard directly from some 750 people. We have received over 1200 individual submissions to the review via the website, through a dedicated phone line and by post.

Listening to the views of staff

Staff in the each of the 14 hospital trusts have been offered the chance to provide frank and honest opinions about the quality of care and treatment provided to patients in their hospital. We ran focus groups for all grades of staff (around 70 focus groups in total), and also listened to their views via one-to-one interviews and during observations on wards.

Openness and transparency

All the working papers, reports and data generated by the 14 reviews were published on NHS Choices (www.nhs.uk) as we progressed through the process. We did not seek to hide anything from anyone.

Co-operation between organisations

The review process sought to encourage co-operation between the different organisations that make up the health system. We held a 'risk summit' for each hospital at the end of the process so that all the key players - the regulators, improvement agencies and clinical commissioning groups (CCGs) – together with senior members of the trust board, could come together to agree a plan of action to drive forward improvements in the interests of patients. The full list of risk summit participants is show on the next page.

2.2 The process we followed

The review process was designed by a team of clinicians and other key stakeholders, based on the NHS National Quality Board guidance. There were three stages.

Stage 1 – Information gathering and analysis

All available information about each trust was analysed and compiled into a 'data pack', which covered the six key areas listed above under the terms of reference. This was the first time so much disparate data had been compiled for the purposes of assessing quality of care in the NHS (See Annex E). The indicators for each trust were compared to the average national standards. Areas of concern were

established as ‘key lines of enquiry’ (KLOEs) to be followed up in a visit to the hospital. A critical step in the process was for CCGs to feed in their local intelligence from the GPs who commission services from the trusts.

Stage 2 – Rapid Responsive Review (RRR)

Following training, to ensure consistency, an experienced team of doctors, nurses, patients, managers and regulators - visited each of the 14 hospitals and observed the hospital in action for two or three days (depending on the size and geography of the hospital). The team was chaired by either a Regional Medical Director or Chief Nurse from NHS England. The visit involved walking the wards and engaging with patients, trainees, staff, governors and the senior executive team. This scheduled visit was followed by one or two unannounced visits. The results of the visits were documented in a Rapid Responsive Review (RRR) report which was then shared with the CEO of the Trust for accuracy checking. A full list of everyone who took part in a review team visit is shown at Annex D.

Stage 3 – Risk summit and action plan

Following the Review team’s visit, a risk summit was called by the relevant NHS England Regional Director. The risk summit considered the RRR report, alongside other information, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned.

Risk Summit participants

- Chair – NHS England Regional Director or Regional Director of Operations and Delivery
- Trust representatives (Chief Executive, Medical Director, Director of Nursing)
- CCG representation (Accountable Officer and/or Chair)
- CQC
- Monitor
- NHS Trust Development Authority
- Health Education England
- Health and Wellbeing Board Chair
- Postgraduate Deanery representative
- GMC and NMC representation
- Local Health Watch (patient representation)
- Representation from local authorities
- Regional Medical Director and Chief Nurse
- NHS England Regional Director of Operations and Delivery
- NHS England Area team representation
- Key members of the Review team, including patient representatives
- Recorder
- Independent moderator

The main output from the risk summit was a detailed action plan setting out what each Trust needs to improve, by when, and who is accountable. This sets out any areas where external support is required to accelerate the pace of improvement. Follow up arrangements to check on progress have been agreed for each trust, and documented in the risk summit report.

The next section of this report summarises the key findings and actions agreed for the 14 trusts that have been reviewed.

3 Key findings from the review

In all 14 hospitals, we found examples of good care as well as areas where improvement is needed urgently. Annex A summarises the headline results for each of the 14 trusts.

We also found numerous examples, in every hospital we visited, of staff working extremely hard to deliver great care for their patients. Many patients and former patients told us about staff who had 'gone the extra mile' to be kind and generous or to save their lives or those of their families.

But we found boards and management teams struggling to understand and deal with the complex causes of high mortality, particularly relating to urgent and emergency care. In several cases, we identified issues that had to be tackled immediately in order to avoid causing possible harm to patients.

3.1 Factors leading to high mortality

The starting point for this review was the results from the widely-used indicators of mortality - SHMI and HSMR. But our analysis of these 14 hospitals proves that understanding mortality (and concepts such as excess and avoidable deaths) is much more complex than studying a single hospital-level indicator. There are many different causes of high mortality and no 'magic bullet' for preventing it.

It is important to understand that mortality in all NHS hospitals has been falling over the last decade: overall mortality has fallen by about 30% and the improvement is even greater when the increasing complexity of patients being treated is taken into account. Interestingly, the rate of improvement in the 14 hospitals under review has been similar to other NHS hospitals.

Factors that might have been expected – and are frequently claimed - to impact on high mortality, such as access to funding and the poor health of the local population, were not found to be statistically-correlated with the results of these trusts. The average for the 14 trusts is broadly the same as the England average in terms of funding and the socio-economic make-up of the populations they serve.

Clinical coding accuracy, and depth of coding, can in some cases impact on mortality indicator values for hospitals. Coding patients to make them appear sicker or identifying a higher amount of co-morbidities can improve mortality ratios. No statistical measure is ever perfect, but some organisations were not engaging in the message the data was giving as they felt it was wrong. Investigation into the signals that the data gives needs to be both about how data quality can be improved by clinician engagement and also clinical care and service delivery investigation to identify if improvements can be made. We found some trusts focusing too much time on the former and not the latter.

Over 90% of deaths in hospital happen when patients are admitted in an emergency, rather than for a planned procedure. It is not altogether surprising, therefore, that all of the 14 trusts we reviewed had higher than expected mortality in non-elective (urgent and emergency) care and only one (Tameside General Hospital) had high mortality for elective (planned) care. The performance of majority of the trusts was much worse than expected for their emergency patients, with admissions at the

weekend and at night particularly problematic. General medicine, critical care and geriatric medicine were treatment areas with higher than expected mortality rates.

Understanding the causes of high mortality is not usually about finding a rogue surgeon or problems in a single surgical speciality. It is more likely to be found in the combination of problems that to a differing extent are experienced by all hospitals in the NHS: busy A&E departments and wards, the treatment of the elderly in and out of hospital, and the need to recruit and retain excellent staff. Such issues are complex and require a 'whole system' approach to deal with them. This is why it has been so important that this review has involved all the key players the NHS system to decide what to do to address problems, and agree who is responsible for implementing agreed improvements.

In section 4 of this report, I comment on some reasons why these hospitals may find it particularly difficult to respond to these complex challenges, and what this means for the type of external support they will need to make improvements.

3.2 Where we took immediate action to protect patients

The most important part of my remit was to take action to protect patients from harm where we found instances of poor care or risky environments or practices. We employed the 'precautionary principle' in undertaking this review. Where we found areas of concern, we acted immediately (we didn't wait for a disaster so that we could be absolutely certain).

Actions taken included: immediate closure of operating theatres; rapid improvements to out of hours stroke services; instigating changes to staffing levels and deployment; and dealing with backlogs of complaints from patients. In all cases, management and the regulators have taken immediate action to rectify the problem.

Annex A includes the issues addressed at each trust in this way during the course of the review.

4 Areas for improvement in the 14 trusts

The following key themes were identified in the design of the review as being core foundations of high quality care for patients and each panel investigated a minimum set of key lines of enquiry under each heading.

- **Patient experience** – understanding how the views of patients and related patient experience data is used and acted upon (such as how effectively complaints are dealt with and the 'visibility' of feedback themes reviewed at board level);
- **Safety** – understanding issues around the trust's safety record and ability to manage these (such as compliance with safety procedures or trust policies that enhance trust, training to improve safety performance, the effectiveness of reporting issues of safety compliance or use of equipment that enhances safety);
- **Workforce** – understanding issues around the trust's workforce and its strategy to deal with issues within the workforce (for instance staffing ratios, sickness rates, use of agency staff, appraisal rates and current vacancies) as well as listening to the views of staff;
- **Clinical and operational effectiveness** – understanding issues around the trust's clinical and operational performance (such as the management of capacity and the quality – or presence - of trust wide policies, how the trust addresses clinical and operational performance) and in particular how trusts use mortality data to analyse and improve quality of care;
- **Governance and leadership** – understanding the trust's leadership and governance of quality (such as how the board is assured of the performance of the trust to ensure that it is safe and how it uses information to drive quality improvements).

The review teams made recommendations prioritised as requiring urgent action across all five of these areas. The need for action was signalled by the data analysis, but this only gave the teams a partial understanding of where improvements were needed.

A full picture of severity and urgency could only be established during the review team visits to the hospitals.

4.1 Patient experience

Direct evidence about the experience of patients receiving care is, of course, a key source of information about quality of care and treatment more generally. The data analysis indicated that only United Lincolnshire was an outlier across the majority of patient experience measures. The visits to the hospitals, however, established that this was in fact a key area in which improvement was needed at most of the trusts.

4.1.1 Pre-visit indicators

4.1.2 What we found

The review teams spent a large part of their visits talking to patients. They also received written feedback sent to the review directly. The most important finding was not the level or type of feedback from patients, but the different approaches the trusts took to seeking out such information and acting upon it. There was a tendency in some of the hospitals to view complaints as something to be managed, focusing on the production of a carefully-worded letter responding to the patient's concerns as the main output. The length of time to respond adequately to complaints was also too long in a number of the trusts, as was the simple lack of acknowledgement or apology where care was not provided to the appropriate standard. The review teams would much rather have seen evidence that trusts were actively seeking out and encouraging feedback (low level of complaints should be seen as a cause for

concern not celebration), trying to investigate and understand it, and then using that insight to make improvements to services (in the way that successful customer-focused organisations do).

The majority of trusts reviewed have agreed actions to improve the way in which they engage external stakeholders, patients and the general public. Several will be improving their complaints processes and doing more to publicise the PALs service. 12 trusts are working on improvements to their complaints process and reviewing how they learn from serious incidents and feed this into service improvements.

4.2 Safety

As a key indicator of overall quality of care, it was critical that all review teams considered each trust's arrangements to ensure patient safety. This included looking at a number of national indicators measuring patient safety and harm, including incident reporting, the NHS Safety Thermometer, infection rates and pressure ulcers[1]. Statistical analysis performed showed a positive correlation between safety incident reporting data and a high HSMR score.

4.2.1 Pre-visit indicators

	General			Specific Safety Measures					Litigation and Coroner	
	Number of harm incidents reported as 'moderate, severe or death' from Apr 11-Mar 12	Number of 'Never Events' (2009-2012)	Reporting of Patient Safety Incidents	Medical Error	MRSA	C diff	Pressure Ulcers	'Harm' for all four Safety Thermometer Indicators	Clinical Negligence Scheme Payments	Rule 43 coroner reports
Basildon	563	7	🔴	🟢	🟢	🟢	🔴	🔴	🔴	🟢
Blackpool	449	2	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🟢
Buckinghamshire	932	5	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢
Burton	947	4	🟢	🟢	🟢	🟢	🔴	🔴	🟢	🔴
Colchester	158	2	🔴	🔴	🟢	🟢	🟢	🟢	🔴	🟢
Dudley		0	🟢	🔴	🟢	🔴	🔴	🔴	🔴	🟢
East Lancashire	102	1	🟢	🟢	🔴	🟢	🟢	🟢	🔴	🟢
George Eliot	263	4	🔴	🟢	🟢	🔴	🔴	🔴	🔴	🟢
Medway	207	4	🔴	🟢	🟢	🟢	🟢	🟢	🟢	🟢
Northern Lincolnshire	446	3	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🟢
North Cumbria	500	0	🔴	🟢	🟢	🟢	🔴	🔴	🔴	🟢
Sherwood	259	2	🟢	🔴	🟢	🟢	🔴	🟢	🟢	🟢
Tameside	13	1	🟢	🟢	🔴	🔴	🟢	🔴	🔴	🔴
United Lincolnshire	207	12	🟢	🟢	🔴	🟢	🟢	🟢	🔴	🟢

4.2.2 What we found

The review teams talked to management and staff on wards about their understanding of the safety procedures and adequacy of reporting of incidents.

[1] The harm incident data for Dudley was not available at the time of compiling the data packs.

They reviewed documentation and observed clinical practice and equipment checks. The reviews found areas for improvement across all the trusts including:

- processes were generally in place but not fully understood by staff, resulting in patchy implementation;
- inadequate safety and equipment checks at some organisations which required immediate escalation and action by management;
- more work was needed at some trusts on issues such as infection control and reducing incidents of pressure ulcers; and
- poor quality root cause analysis of incidents and limited dissemination of learning from when things go wrong.

All but two trusts had 'never events' which is extremely concerning (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented), and require significant action in response to this. Of even more concern is that a number had multiple never events relating to similar themes, such as retained foreign objects post-operation, where we were not assured that lessons had previously been learnt in response. On reviews and in risk summits, trusts have demonstrated that they have taken these failings seriously as part of their responses to the reviews and improvements are being made.

One consistent theme throughout almost all of the organisations reviewed was the management of complex deteriorating patients and the monitoring of Early Warning Scores. The basic failure of observation at ward level gives rise to multiple problems following on from this, most notably for some of the organisations an increase in renal failure and nosocomial pneumonia. In addition to this, we noted that the single most common complication of chest infections was under addressed. There was evidence about positive addressing of surgical site infections and wound infection post-operatively, but not in chest infections (which carry a higher risk to patients, but can be easily treated). We were not assured that there were always the appropriate processes in place for junior doctors or nurses to access senior clinical staff quickly or higher dependency beds where necessary, when complications such as these arose.

4.3 Workforce

The initial analysis of the available data indicated that there were various workforce-related problems, including high rates of sickness absence and heavy reliance on agency staff to compensate for large numbers of vacant posts. Statistical analysis performed showed a positive correlation between in-patient to staff ratio and a high HSMR score. But the data analysis alone did not show nursing levels on wards as being a particular problem in eight of the 14 hospitals.

4.3.1 Pre-visit indicators

	WTE nurses per bed day	Spells per WTE staff	Vacancies – medical	Vacancies – non-medical	Consultant appraisal rates	Agency spend	Sickness absence – overall	Sickness absence – Medical	Sickness absence – Nursing Staff	Sickness absence – Other Staff	Staff leaving rates	Staff joining rates
Basildon	🟢	🔴	🟢	🟢	🔴	🟢	🟢	🟢	🟢	🔴	🟢	🟢
Blackpool	🟢	🟢	🟢	🟢	🔴	🔴	🟢	🔴	🔴	🟢	🟢	🟢
Buckinghamshire	🟢	🟢	🟢	🟢	🔴	🟢	🟢	🔴	🔴	🔴	🔴	🔴
Burton	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🔴	🟢	🔴	🔴
Colchester	🟢	🟢	🔴	🟢	🔴	🔴	🟢	🔴	🟢	🟢	🟢	🟢
Dudley	🔴	🔴	🔴	🟢	🟢	🔴	🟢	🟢	🟢	🔴	🟢	🟢
East Lancashire	🟢	🟢	🔴	🟢	🟢	🟢	🔴	🔴	🔴	🔴	🟢	🔴
George Eliot	🔴	🟢	🟢	🟢	🟢	🔴	🔴	🔴	🔴	🔴	🔴	🟢
Medway	🟢	🔴	🟢	🟢	🟢	🟢	🟢	🔴	🟢	🟢	🟢	🔴
Northern Lincolnshire	🟢	🟢	🔴	🟢	🟢	🔴	🔴	🔴	🔴	🔴	🔴	🟢
North Cumbria	🔴	🔴	🔴	🟢	🔴	🔴	🔴	🔴	🔴	🔴	🟢	🔴
Sherwood	🟢	🟢	🔴	🟢	🟢	🔴	🔴	🔴	🔴	🔴	🟢	🔴
Tameside	🔴	🟢	🔴	🟢	🟢	🔴	🟢	🔴	🟢	🟢	🟢	🟢
United Lincolnshire	🟢	🟢	🟢	🟢	🟢	🔴	🔴	🔴	🔴	🔴	🔴	🔴

4.3.2 What we found

Contrary to the pre-visit data, when the review teams visited the hospitals, they found frequent examples of inadequate numbers of nursing staff in some ward areas. The reported data did not provide a true picture of the numbers of staff actually working on the wards. In some instances, there were insufficient nursing establishments, whilst in others there were differences between the funded nursing establishments and the actual numbers of registered nurses and support staff available to provide care on a shift by shift basis. This was compounded by an over-reliance on unregistered staff and temporary staff, with restrictions often in place on the clinical tasks temporary staff could undertake. There were particular issues with poor staffing levels on night shifts and at weekends. There were also problems in some hospitals associated with extensive use of locum cover for doctors.

During several of the reviews, staff came forward to tell the review teams about their concerns in confidence. These staff felt unable to share their anxieties about staffing levels and other issues with their senior managers, which suggested that staff engagement at some of the trusts was not good.

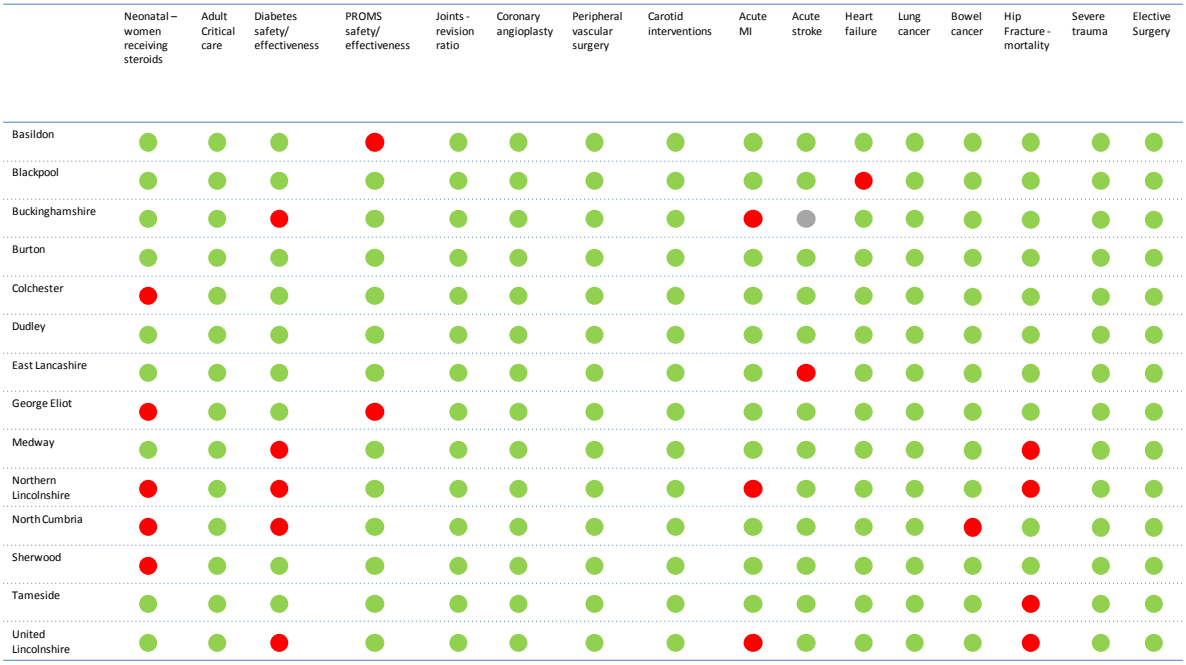
All 14 trusts have recommendations in their action plans relating to workforce issues. They are all undertaking urgent reviews of safe staffing levels. Four trusts are also taking forward actions to improve whistle-blowing policies.

4.4 Clinical and operational effectiveness

The review teams talked to management and staff on wards about their understanding of the clinical and operational effectiveness of the care provided; this was supported by detailed analysis.

4.4.1 Pre-visit indicators

Clinical effectiveness



Operational effectiveness

4.4.2 What we found

All trusts were functioning at high levels of capacity in the urgent care pathway. This frequently led to challenges in A&E and, as a consequence, cancellations of operations due to bed shortages and difficulty meeting waiting time targets. This, in turn, put pressure on staff and also on the management of patient flows in the rest of the hospital.

Much of this pressure is due to the large increase in the numbers of elderly patients with complex sets of health problems. It is imperative to understand in detail the complex care needs of the patients within the first point of contact or episode of care with the relevant health professional. This includes treating not just the medical problem they were admitted for, but any underlying health issues or conditions such as diabetes. Ensuring this is consistently undertaken will improve the outcomes for these complex patients and ensure the outcome of their care can be recorded accurately. Better clinical oversight of this process would also improve the quality and speed of decision-making on admission and discharge.

All trusts need to engage more effectively with local health economy partners to improve the urgent care pathway, including reviewing options to reduce A&E attendances and ensure efficient and effective discharge into community beds or alternative care arrangements.

Understanding and use of data

Few of the hospitals we reviewed had a good understanding of the reasons for their high mortality figures. This contributed to them having weak or incomplete strategies for improving performance. The hospitals reviewed were often unaware of what information was reported nationally on their own organisations, and consistently challenged the validity of this (even if they provided the data themselves). There are three specific problems that require action:

- the complexity of the data and the difficulties this presents for professionals, patients and the public who want to understand and use it;
- the shortage of key skills in data analysis and interpretation available to trust boards and management teams; and
- consistency of metrics and information to be used to monitor quality on an ongoing basis.

Issues relating to data and insight feature in a number of the trusts' action plans. Often this was in response to where the trusts were failing to cross reference data from different sources to identify quality risks and target local improvement.

The review teams often witnessed information being used for justification: to confirm a particular viewpoint the trust had of a specific issue. Information was only rarely used in an enquiring manner - in order to seek out and understand the root cause of a problem area.

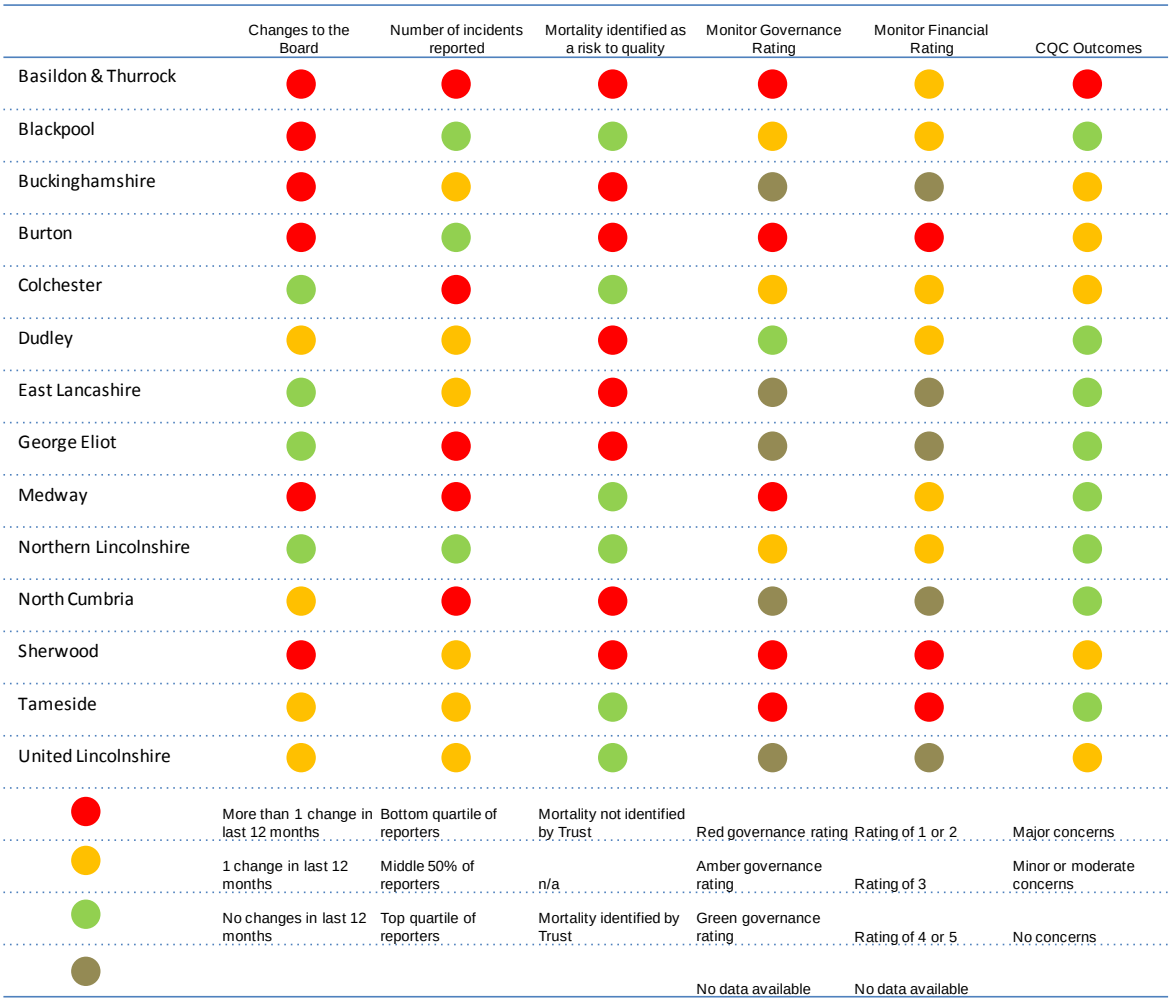
4.5 Leadership and governance

This review used and built on Monitor and TDA's quality governance framework for trusts to investigate:

- whether the trust board and staff could clearly articulate the governance processes and assurance over quality of care and demonstrate these were working; and
- how the board used quality and performance information to support assurance.

Five of the trusts reviewed have not yet achieved Foundation Trust status, but of the nine that are FTs, six were already below green on Monitor's governance risk ratings.

4.5.1 Pre-visit indicators



4.5.2 What we found

We did not see sufficient evidence to demonstrate that many Board and clinical leaders were effectively driving quality improvement. In a number of trusts, the capability of medical directors and/or directors of nursing was questioned by the review teams. Common concerns were:

- poor articulation of the strategy for improving quality;
- many trusts had findings from quality and safety reviews undertaken recently by internal and external parties but could not show a comprehensive and consistent approach to learning from these; and
- a significant disconnect between what the clinical leadership said were the key risks and issues and what was actually happening in wards and departments around the hospitals.

There were also weaknesses in the assurance that Boards were getting over this important area, in part because of the incomplete performance dashboards presented to them and in part because they are not consistently seeking independent assurance. All trusts need to review their quality performance reporting to ensure it is measuring the right things, triangulated effectively to identify risk areas

and is tested through systematic assurance programmes. Some of the significant issues highlighted in the reviews were not on Boards' agendas at all. They are not probing in the right areas and not listening to staff, patients and stakeholders to gather independent sources of assurance. Only eight of the organisations identified mortality as a top risk to the quality of the care that they provided.

5 The capacity for improvement and requirement for external support

Each of the 14 trusts reviewed as part of this process has a unique set of challenges. But there are some common characteristics of these hospitals with persistently high mortality that the review teams identified. These findings should be instructive for other trusts (regardless of current performance on mortality) and the wider NHS.

We have established that one of the primary causes of high mortality in these 14 hospitals are found primarily in urgent and emergency care, and particularly in care for frail and elderly patients. Every hospital leadership team finds these issues difficult to deal with. They require exceptionally strong management and clinical leadership to grapple with this successfully.

These 14 hospitals face some particular challenges that have hampered their ability to do so. This includes:

5.1 Quality governance

Too often our reviews found quality issues of which the Board were unaware. Whilst many Boards could point to improvements in quality governance processes (e.g. undertaking walkabouts in the hospitals), review teams were concerned that Boards could too easily accept the assurances they were receiving and were not really listening to contradictory evidence or seeking more robust assurance. In some cases, the non-executive directors and chairs of the trusts were not providing appropriate critical challenge to the management team.

While certainly not the case in all trusts, the capability of medical and nursing directors was a key issue for several of them. Most trusts reviewed were either struggling without a strong clinical leader in one or both of these key roles, or had experienced a capability gap in the recent past. Addressing this problem is a pressing priority for those organisations.

5.2 Isolation

The trusts we reviewed tend not to be well-linked to professional networks and other centres of knowledge. The review teams found many examples of clinical staff who were not following the latest practice and being ‘behind the curve’ in some key areas. In particular, there were frequent examples of not using a multi disciplinary approach; not rolling out nationally recognised ‘care bundles’ to improve clinical effectiveness and care; and poor record keeping processes leading to inefficiencies, duplication and administrative burdens. Generally, the trusts could not demonstrate that they were consistently sharing and learning from good practice either internally, across their own sites or with other trusts.

A number of the trusts are in relatively isolated places, or are spread across a number of sites which are some distance apart. Some trusts told the teams that this

makes it harder to attract a high quality workforce, and to fill vacancies with the best people. Attracting top managers is a long-standing challenge for these trusts.

This issue may be compounded by a problem identified frequently during discussions the review teams had with junior doctors and nurses – a lack of focus on providing high quality supervision, mentoring and pastoral support. Many of these hospitals appear not to rank highly in the eyes of ambitious junior staff as great places to build a career as a leader of tomorrow.

Five of the organisations are being actively monitored by the General Medical Council (GMC) in response to concerns raised with them about aspects of medical education and training. Five organisations have had medical training staff removed from their organisations by the GMC.

5.3 Learning

We found that, while trusts in the main complied with quality and safety processes, they were slow in learning lessons when things go wrong and embedding that learning in improved ways of doing things. A common finding was that the feedback loop back to staff who reported quality issues was ineffective – they reported an issue, but did not know what action had been taken as a result. Sometimes staff did not feel empowered to take action when they had identified an issue and in a few cases, staff felt uncomfortable raising issues with senior management (which may explain the fact that review teams were frequently approached by staff who wanted to explain their concerns in private).

5.4 Financial pressures

A number of the trusts have been undergoing mergers, restructures or applications for Foundation Trust status and many have needed to make significant cost savings. These issues may have diverted management time and attention from focusing on quality. This was a key factor raised in the inquiry into problems at Mid Staffordshire Hospitals NHS Foundation Trust. While we did not consistently find this level of distraction in the 14 trusts, it has been important that this review has forced quality of care to its rightful place at the top of the board's agenda.

At each of the trusts, we found there were processes in place to ensure cost improvement programmes were not adversely affecting quality, but there was more for all the trusts to do to ensure these are applied consistently and monitored continuously.

5.5 Capacity for self-improvement and external support

Detailed action plans have been agreed for each of the trusts. They set out what trusts need to do to raise standards to a satisfactory level. They have pressing deadlines and state clearly who is accountable for delivery.

The regulators will also have to consider how they seek assurance from Boards to address the risks identified in these reviews more consistently. The comprehensive and detailed action plans that have been produced through the risk summit process

are key first step, but a concerted and collaborative effort on the part of all the key players will be required to support the trusts.

These trusts will need considerable and sustained external support from a range of external sources to improve. In particular, they need help to establish networks with leading organisations within and outside the NHS to help them to counter the effects of the isolation described above. The new Academic Heath Science Networks will have a key role to play here. Leaders of these organisations will need support, including by taking up opportunities to learn from others through tailored mentoring and pairing arrangements.

5.6 Follow up

This review is not the end of the process for the 14 trusts. Each of the risk summit action plans include tailored arrangements for following up and checking on progress. In some cases, a follow-up risk summit will be scheduled. Regional Quality Surveillance Groups will co-ordinate this activity.

The new chief inspector of hospitals will prioritise a full inspection of the 14 trusts during the first year of taking up his new role. This will lead to a formal rating for each hospital under CQC's new inspection model.

Throughout this process, all the NHS organisations responsible for helping the trusts improve will regularly reassess what further support can be provided to help them succeed in delivering the highest possible services for patients.

6 Learning from the review process

We have conducted a short evaluation of the mortality review process in order to identify lessons from the experience that should inform CQC's current consultation on the way in which it monitors, inspects and regulates care services, A New Start, and other similar reviews of quality instigated by CCGs, NHS England or trusts themselves.

An evaluator from a separate team interviewed:

- the panel chairs who led the visits to the trusts;
- clinical and nursing panel members;
- patient and public panel members; and
- chief executives from six of the trusts with reviews that were completed earliest in the review schedule.

In this section of the report, we set out strengths and areas for improvement for each of the three stages of the review, make recommendations based on this learning, and provide some commentary on the overall management of the review process.

6.1 Engagement with the trusts

The majority of trust Chief Executives who participated in interviews said that overall the review was a positive process, and whilst it was intensive, it was also fair and provided them with an appropriate level of challenge. Regular and honest communication with trusts was important and key to securing engagement with the process.

The trusts that have benefited the most – in terms of progress made during the course of the review and level of support gained to support improvement – were those that engaged positively in the process. A small number of trusts spent disproportionate time challenging the findings of the review team, which was disappointing because others used this time to move ahead with their improvement plans.

Trusts worked hard to set up listening events and focus groups at short notice and the majority did not attempt to influence this part of the process. Some trusts briefed their staff on what to say. This was inappropriate and ill conceived because it reflects a less than open culture and was easily exposed by the visiting teams.

6.2 Openness and transparency

The principle of openness and transparency has been important in helping access views and insights that reviews conducted behind closed doors fail to capture. I have been committed from the outset to sharing our work with the public. I believe that this has been critical both in terms of public engagement and in shifting trusts from defensive to open positions. This needs to become the default position for future NHS reviews.

Stage 1 – Information gathering and analysis

Strengths

- The production of comprehensive data packs, drawing together all key facts about the trust in advance of the review was viewed by panel members as being essential to a successful review. The detailed analysis contained in the packs helped steer the panels effectively to areas for further investigation, which both maximised the value of their time at the hospitals, and has a broader focus than previous reviews which have tended to focus on a single specialty, pathway or issue.
- All of this work was conducted centrally by the Department of Health, which certainly provided some economies of scale and reduced the administrative burden on the trusts. While there were some disputes with trusts about data interpretation issues, this affected only a small number of areas in the data packs because the team used data that is already provided by the trusts as part of their normal reporting arrangements.

Areas for improvement

- Some changes to the structure of packs have been suggested (e.g. looking separately at workforce and safety). This will help with alignment with the CQC's proposed inspection framework.
- The packs could be made more user-friendly by introducing a summary version and a user guide. We have also learnt that it takes some time to absorb all this information and this should be built into future review processes.

Stage 2 – Rapid Responsive Review (RRR)

Strengths

- The review teams were of high quality. Although large (around 20 members), they were well-led by senior and highly credible people, and included a blend of experienced, skilled members who worked well together. Mandatory training for review teams was a critical factor in this. Mixing the teams who conducted interviews, focus groups and observations was a key strength, particularly where there was representation from lay members, clinical and nursing representatives and across a range of levels of seniority.
- Our objective of encouraging patients and members of the public to play a central role in the review was met. Listening events in particular were extremely important. The inclusion of lay panel members in the review process was described by one Panel Chair as 'a revelation', and many other panellists and indeed NHS Chief Executives appreciated the fresh insights which the lay panel members brought on the visits.
- The reviews have succeeded in finding ways to listen to the views of staff. Most panellists have indicated that they thought trust staff had provided frank and honest opinions on the quality of care in their trusts. This had been facilitated primarily through focus groups, but also through one-to-one interviews and discussions during the observations. The inclusion of student nurses and junior doctors in the panels was positive, given their credibility with their peers in trusts being reviewed, which in turn promoted open and honest discussion.

- Unannounced visits were viewed as a necessary part of any visit schedule, and trusts were familiar with the concept from other inspections. Panellists mainly commented that the unannounced visits were helpful for re-testing or confirming their findings from the announced visits. During the announced and unannounced visits, the range of techniques used to gather data (i.e. focus groups, interviews and observations) was useful, and provided the opportunity to identify consistent themes emerging. Unannounced visits also uncovered any special preparation for the planned visits, such as staff briefings or attempts to plug staffing gaps.

Areas for improvement

- The general feedback from review team members is that two days is the absolute minimum amount of time needed for a review to be completed, and that three days would be preferable. Visits were very intensive and time-pressured and an extra day would be useful to allow time for reflection and drawing together of conclusions. A small number of interviewees felt that further training may have been necessary for panellists, such as on dealing with difficult situations (e.g. listening to stories about poor care from patients).
- In a number of instances, panellists felt that trusts could have made more effort to advertise the listening events to the public. It was suggested that the advertising of such events should be managed centrally rather than by trusts to ensure that these are advertised as widely as possible. Future advertising might also include promotion of these events to existing groups such as Patient Participation Groups within CCGs, local Healthwatch and other organisations working with hard-to-reach groups.
- Focus groups with staff should avoid mixing staff across different grades. In the small number of cases where this happened, the presence of more senior staff in these groups, or mixed-grade groups made staff in lower grades less willing to speak out, or to be truly honest. Similarly, focus groups should not mix professions, as often views from medical staff 'drowned out' views from others.

Stage 3 – Risk summit and action plan

Strengths

- The risk summit stage of the process was critical in bringing the various local and regional NHS bodies together to agree the priority actions and the plan for improvement. This was particularly important because the issues raised by the reviews were complex and requires a 'whole system' solution.
- The chair of each Risk Summit was crucial to the overall success of this stage and many indicated that their chair was excellent and had played a key role in moving the process forward. This role was fulfilled for this review by the relevant Regional Director of NHS England and the seniority of their position was an important factor in achieving consensus on the way forward for each trust.
- Filming of the early section of the Risk Summit so that it could be placed in the public domain was viewed as positive, and many felt that this aided openness and transparency in a way that has never been the case in previous reviews. A number indicated that this might have gone even further, by the filming of the whole Risk Summit.
- Review panellists were pleased to be invited to the Risk Summits and most indicated that they had played a larger role in these than expected – for example,

by presenting findings or suggesting and commenting upon trust actions based on their observations.

Areas for improvement

- Some interviewees highlighted that whilst the Risk Summits had a large number of attendees present, some did not have a clear contribution to make to the follow-up actions. This may mean that risk summit attendance could be streamlined in future.

6.3 Conclusion

My overall conclusion is that these reviews have found problems and areas for improvement that other reviews have missed. This model of review – based around a clear trigger for action; skilled data analysis leading to Key Lines of Enquiry, rather than inspection against a pre-determined framework; intensive visits to hospitals by experienced, multi-disciplinary teams; talking in-depth to patients and staff – works well. It should inform the way in which all hospital reviews and inspections are carried out in future.

Annex A Summary of findings and actions for the 14 trusts

Below are summaries for the 14 hospitals covered by the review. They are drawn from the full Rapid Responsive Review reports and Risk Summit reports and summarise about pages of findings. They are available on the NHS Choices website.

Basildon and Thurrock University Hospitals NHS Foundation Trust

The Trust's historical culture has been focused on financial targets and the tone from the top now needs to focus on improving quality and long term sustainability. The Trust has undergone significant leadership changes and a transformation programme is underway. The review identified the need for an explicit delivery plan with timelines to prioritise quality improvement actions to ensure all staff are engaged and harness clinical leadership to accelerate the pace of change.

The review identified a number of areas of good practice at the trust, although these generally related to specific areas, wards or specialities. There was more for the Trust to do in ensuring good practices were in evidence across the organisation, all of the time.

Issues that were escalated immediately

At the time of our visit, the Trust had recently implemented 'NHS Professionals' and discussions with a number of staff identified issues with the implementation including operational deployment, management and payment of temporary staff. This was observed to be a significant risk to quality of care for patients during the visit and was escalated to the chief executive of Trust for immediate action.

Other urgent actions

- The Trust needs to review and improve its current systems for bed management and patient flows, particularly the management of medical outliers (those patients on wards that are not primarily in the speciality in which the patient is being treated).
- The Trust needs to ensure that its new governance structure is embedded and well communicated to its staff.
- The Trust needs to ensure infection control procedures are applied consistently.
- The Board needs to urgently review and understand what their patients' views are and address key complaints themes.
- The Trust needs to review current staffing levels for nursing and medical staff and make any changes required for improving quality and safety of care.
- The Trust should undertake focused work with the local health economy commissioners to improve the urgent care strategy and reduce pressure in A&E.

Follow up

The Trust responded positively to the review process and implemented a number of immediate actions in response to the RRR feedback provided prior to the risk summit. This included improvements in the implementation of the 'NHS Professionals' system.

Some of the findings were being addressed by improvements already planned in the Trust but there were a number of findings, consistent with previous reviews of the Trust, which management was yet to address fully. The risk summit set some clear urgent priorities to support the Trust in addressing the multitude of issues raised by previous reviews which had swamped the management team.

Support will be provided to the Trust from NHS England to improve the consistency of infection control practice and implement Hospital at Night to improve clinical cover out of hours. A review is planned for later in October 2013, likely to include a targeted one day site visit to the Trust reviewing key areas.

Blackpool Teaching Hospitals NHS Foundation Trust

The Trust has been proactive in seeking external reviews to find solutions to its quality challenges, including high mortality. However, the pace of change is not at the level required to deliver the needed improvements in patient care.

The panel considered that the Board displayed a positive attitude to the review process and were supportive of the new Executive team in making the required changes. The Trust staff were enthusiastic and committed to change. They were candid about the issues they faced in delivering high quality care and patient experience.

Issues that were escalated immediately

There were a number of equipment safety checks that were not being consistently undertaken, which was escalated to the chief executive to address during the visit.

Other urgent actions

- Nursing staff levels were found to be not always sufficient across the Trust and need urgent review, particularly on elderly care wards.
- The incident review system is unreliable in terms of reporting and classification of serious incidents, multi-disciplinary investigation and dissemination of findings.
- In some areas the panel had a concern about there being sufficient medical staff. Consultant job planning and appraisal are not done often enough. The impact of this was that teaching, continuing professional development (CPD) and other management or governance roles required within specialities, are not given sufficient time.
- Infection control policy is not being implemented consistently.

Follow up

As the risk summit had focused on urgent priority actions, the Trust also agreed to submit a more detailed action plan to all outstanding concerns. Follow up of the action plan will be undertaken by the regulators and local commissioners with a formal review later in 2013.

Buckinghamshire Healthcare NHS Trust

The Trust has recently undergone significant change, most notably the consolidation of the A&E department from Wycombe to the Stoke Mandeville site and the creation of three large organisational divisions from the original six.

The Trust and ward areas were found to be clean and tidy, with patients generally seen to be well cared for during the visit.

Issues that were escalated immediately

- The panel identified the lack of clear and formally agreed pathways for the recognition and management of acutely ill and deteriorating patients, particularly in areas where there is higher mortality such as pneumonia and acute renal failure.
- The review panel observed patients who required transfer between the two sites. To improve patient experience and safety this needs to be more consistently managed through an agreed clinical process.
- Community nurses reported experiencing delays accessing medical advice out of hours (the NHS 111 service is provided by Bucks Urgent Care).

Other urgent actions

- The Trust needs a more robust method to provide assurance on the impact of major service change on quality of care, especially in regard to the consolidation of A&E at the Stoke Mandeville site.
- Leadership at Board level appears “reactive” to issues and there seems to have been limited challenge and examination of the data presented to the Board.
- The panel had a concern over staffing levels of senior grades, in particular out of hours. The Nursing staffing levels and skills mix was also found to be suboptimal in places.
- While there are a number of recent developments which focus on safety (e.g. National Early Warning Scores), the Trust needs to adopt national initiatives in developing a mature “safety culture.” They need to use incident reporting positively and constructively alongside more proactive tools.

Follow up

The Trust accepted the highlighted areas for development and responded positively to the process. An action plan was agreed at the risk summit addressing all the urgent priority actions discussed. The Trust is to provide a detailed action plan to all outstanding concerns and recommended actions included in the RRR report.

Follow up of the action plan will be undertaken by key organisations within the system, including the Trust Development Agency ("TDA"). A formal follow up will take place later in 2013.

Burton Hospitals NHS Foundation Trust

The review found that the Trust did not have a systematic approach in place for the collection, reporting and acting upon information on the quality of services. The Trust has also not identified all the causes behind its excess mortality.

The review found a number of urgent issues that increased the risk in the Trust and impacted on the organisation's ability to provide consistently high quality and safe care and treatment to patients.

Issues that were escalated immediately

- The panel escalated immediate concerns raised by staff in certain wards about rotas requiring them to work shifts 12 days in a row without a rest day. The Trust confirmed this practice had been immediately ceased.
- There was an allegation that death certificates were not being completed in line with the Trust's procedures. The panel formally escalated this to the CQC during the announced visit. CQC visited the Trust on 31 May 2013 to perform an inspection into medical record keeping at the Trust. Following the inspection, the Trust was found to be compliant with the standards and was reported as having an effective system in place to ensure patient's records were appropriately complete
- Inconsistent safety checks of medical equipment identified were immediately escalated to management to address.

Other urgent actions

- Issues with clinical practice including escalation, delegation and supervision.
- Examples of poor communication with patients and staff, particularly junior doctors, many of whom felt unsupported.
- A lack of trust-wide understanding of its quality objectives.

Follow up

The Trust has responded positively to the review process, accepting the findings of the panel and actions from the risk summit. It was acknowledged that the Trust was on an improvement journey and some of these actions would take longer to address in their entirety. The Trust will work with its local CCG and Healthwatch on a number of the actions.

As the risk summit focuses on urgent priority actions, the Trust will provide a detailed action plan to all outstanding concerns and recommended actions, and progress against this will be monitored by the local Quality Surveillance Group. A follow up review will be undertaken later in 2013.

Colchester Hospital University NHS Foundation Trust

The review identified that the Trust had made a number of quality improvements since the change of leadership in 2010. The review panel noted that the Trust's staff were committed and enthusiastic but there were examples where they needed better clinical leadership. The Trust needs to rapidly develop a clearer focus on quality improvement, which is based on transparent performance information and the right tone from the top.

Issues that were escalated immediately

- The Trust's policy for ensuring appropriately qualified escorts for patients to radiology was not being consistently followed – CQC has sought assurance on this issue following the risk summit.

Other urgent actions

- Development and effective communication of a comprehensive and clear quality strategy that pulls together the numerous actions underway at the Trust related to quality improvement and mortality. This should focus on priority areas identified in this review such as sepsis, managing deteriorating patients and surgical site infections.
- Staffing in some high risk wards needs urgent review.
- Ownership amongst medical staff for deteriorating patients overnight was unclear and patient at risk (PAR) escalation was not effective.
- Clinical leadership (both medical and nursing) needs to be strengthened and embedded throughout the organisation structure.

Follow up

The Trust recognised the issues and the need to increase the pace of change. The review also found more work is required with local partners to find solutions for patients who could appropriately be at home or in their normal place of residence to receive end of life care. There is a complex system in place at present, with limited joined up working, so the Trust needs to continue discussions with the CCG to develop this pathway further.

As the risk summit focused on urgent priority actions, the Trust agreed to provide a detailed action plan to all outstanding concerns and recommended actions included in the RRR report. Follow up of the action plan will be undertaken later in 2013.

The Dudley Group NHS Foundation Trust

The RRR identified that the Trust is improving and there were a number of areas of good practice, although these could not be evidenced as being in place systematically throughout the organisation.

Staff were committed to the Trust and to providing great care but improved clinical leadership at all levels of the organisation, and better communication of quality priorities, is needed to harness this and drive real improvement.

The Trust has not taken opportunities to use its mortality review process to systematically improve quality of care across pathways and at speciality level.

Issues that were escalated immediately

- Some patient safety and quality processes, such as equipment checks, were not being consistently applied at ward level – a number of these were escalated immediately to management to address.

Other urgent actions

- Inadequate qualified nurse staffing levels on some wards, including two large wards which needed to be reviewed in light of concerns raised by the panel.
- Shortfalls in learning from serious incidents and complaints.
- A complaints process which is not fit for purpose and does not adequately respond to patients needs.
- Further work is needed at Board level to simplify the quality governance processes and communicate this to staff, as well as reviewing the performance information required to obtain more complete assurance on quality improvement.

Follow up

The Trust has responded positively to the review process with some urgent issues already addressed. The Trust accepted the findings and welcomed the support of risk summit members to increase the pace and focus of improvement. Further support was offered to develop clinical leadership, with input from NHS England and the NHS Leadership Academy to embed accountability and ownership for quality improvement in the organisation.

A detailed plan addressing each of the recommended actions in the RRR report will be completed by the Trust and progress against this will be monitored by the local Quality Surveillance Group. A follow up review will be undertaken later in 2013.

East Lancashire NHS Trust

The review identified a number of concerns at the Trust particularly related to the quality governance assurance systems. The review panel also identified a number of areas of good practice and dedicated staff, but there was more for the Trust to do to communicate effectively to staff and share learning to ensure consistent approaches to quality improvement across the organisation, all of the time.

Issues that were escalated immediately

- The panel identified that there had been a high level of still born babies in March 2013 but this had not been escalated to the Board or investigated. The Trust has is now investigating this and is setting clearer procedures for triggering escalation.
- The review team also expressed concern over the appropriateness of the location of two close observation beds (referred to as high dependency beds by some staff) in the Delivery Care Centre in the maternity unit, which were used for pre- and post-delivery pre-eclampsia. This is being reviewed urgently by management.

Other urgent actions

- The Board's quality governance processes were not cohesive and failed to use information effectively to improve the quality of care.
- The governance systems are not providing the expected level of assurance to the Board, and the escalation to the Board of risks and clinical issues is inconsistent.
- Managing high patient levels, particularly in A&E, and understanding and addressing the issues causing high readmission rates of patients treated in the Trust's hospitals.
- The Trust's complaints process was poor and lacking a compassionate approach.

The review team considered that staffing levels were low for medical and nursing staff when compared to national standards. Particular issues should be addressed regarding registrar cover and medical staffing in the emergency department, and levels of midwifery staff.

Certain clinical concerns raised by staff have not been addressed, including known high mortality at the weekends.

Whilst some of these actions will take longer to address entirely, assurance in respect of patient flows in A&E and concerns over staffing in the midwifery unit had already been sought by the CQC.

Follow up

The Trust has responded positively to the review process with some urgent issues already addressed, for example, the establishment of a multi-professional Mortality Steering Group. The Trust is working very closely with the TDA and others to address the other key priorities.

The Trust will develop a detailed action plan, working with the TDA, to all outstanding concerns and recommended actions included in the RRR report. A follow up risk

summit will be held in September 2013 to monitor progress and provide an updated action plan for ongoing review and monitoring arrangements.

George Eliot Hospital NHS Trust

The panel observed that the Trust has engaged, passionate and loyal staff and is clearly supported by the local public. Staff consistently spoke of the positive impact of the Chief Executive and some of the senior team, but this needs to be built on to systematically improve the quality of care at the Trust.

Issues that were escalated immediately

No issues were identified during the course of the review that required immediate escalation to protect the safety of patients.

Other urgent actions

Some issues were identified which need urgent action as they may be detrimentally impacting on patient experience and continuity of care. These were:

- The panel had concerns in relation to low levels of clinical cover, particularly out of hours.
- The panel identified that a number of wards appeared to contain patients with a range of illnesses, and multiple bed moves were common during a patient stay.
- Governance processes require further development, with reporting on quality and mortality found to be of unsatisfactory quality.
- It was not clear that there is sufficient focus on quality and patient safety in the Trust, and targets for improvement were not always stretching.
- The Trust serves an elderly population and needs to work with its health economy partners to improve plans for End of Life care outside hospital.

A key concern for the Board to address is that, while the leadership had taken difficult decisions on the long term future of the Trust, it was difficult to identify evidence of proactive clinical leadership that is focussed on pursuit of excellent quality of care and treatment.

The Trust found the RRR process challenging, thorough but fair. It accepted the recommendations to build on work already in place, as well as immediately acting on new recommendations.

An action plan was agreed at the risk summit addressing the first seven of the urgent priority actions discussed. Due to time constraints, the action plan could not be agreed for the remaining three areas identified for discussion at the risk summit. The Trust and the risk summit chair committed to agreeing an action plan for the remaining three areas within two weeks of the risk summit, along with agreeing the required external support for the action plan. There will be a follow up review of all actions in the RRR report later in 2013.

Medway NHS Foundation Trust

The capacity of the Board and Clinical Executive Group has been diminished by changing personnel and the work associated with the possible merger with Darent Valley Hospital in Dartford and Gravesham NHS Trust. This has led to a lack of clear focus and pace at Board and Executive level for improving the overall safety and experience of patients.

Issues that were escalated immediately

No specific issues were escalated to the Trust or regulators.

Other urgent actions

The urgent actions identified included:

- Greater pace and clarity of focus at Board level for improving the overall safety and experience of patients.
- Reviewing staffing and skill mix to ensure safe care and improve patient experience.
- Improving consistency of early senior clinical review of patients in some areas, particularly the Emergency Department.
- Implementing a universal escalation protocol to rapidly identify patients at risk of deteriorating.

The Trust urgently needs a single, coherent quality strategy and action plan, supplemented by systematic staff training and roll out.

The panel identified a number of areas of good practice which need to be better disseminated throughout the Trust, as do lessons learnt from complaints and incidents.

Follow up

The Trust accepted the findings and welcomed the support to improve its action plans. A detailed response to the review was reviewed by risk summit attendees in early June and it was agreed a further risk summit will be held in August 2013 to review progress on these actions.

North Lincolnshire and Goole NHS Foundation Trust

The review found a lack of sufficient implementation of clinical strategies to improve the quality of care. Data reporting and governance processes are in place, but there was little evidence of widespread clinical change. Some areas of the Trust are not providing high quality care or patient experience, particularly the emergency and acute pathway.

Issues that were escalated immediately

Out of hours stroke services are currently inadequate on one of the Trust's sites (Grimsby) and improvements have not been implemented consistently across the organisation. This is currently being reviewed urgently by the Trust with its commissioners to address this risk.

Other urgent actions

- Clear issues were identified around clinical systems, for example, the new early warning system was not taken up or universally understood.
- An emphasis on finance and targets was felt by some staff to detract from quality. It was not obvious to some staff that quality was the priority.
- The patient pathway at Grimsby requires particular consideration - issues were identified with regard to triage in A&E and handover, as well as the management of bed moves and outliers.
- There were concerns over the staffing of key elements of acute care, including recruitment of staff and maintenance of adequate staffing levels and skill mix on the wards.

The panel found a number of examples of good practice across the Trust, including diagnostics, the midwifery service in Grimsby and the diabetes ward in Scunthorpe.

Follow up

The Trust responded positively to the findings and presented detailed actions to the risk summit addressing each of these areas. The Trust was challenged at the risk summit to provide assurance that the action plans would be implemented successfully.

The Trust will provide a detailed action plan to cover all outstanding concerns and recommended actions included in the RRR report. Follow up of the action plan will be undertaken by Monitor, who will work with the Trust to review progress on a monthly basis. A formal follow up will take place later in 2013.

North Cumbria University Hospitals NHS Trust

The Trust is currently in the process of being acquired, with the preferred bidder being Northumbria Healthcare NHS Foundation Trust. Positive changes have been made at the Trust over the past six months as a result of its relationship with Northumbria Healthcare NHS Foundation Trust. However, the extent and pace of change has been insufficient to rectify all weaknesses in governance.

Issues that were escalated immediately

Sustained failings in the governance arrangements to ensure the adequate maintenance of the estate and equipment. This resulted in the closure of two theatres at the Whitehaven site pending validation by the Trust that its ultra-clean ventilation (UCV) was meeting relevant standards.

Other urgent actions

- Improvements in clinical leadership and the organisation's focus on quality, including developing quality performance reporting.
- Inadequate staffing levels and over-reliance on locum cover in some areas of the Trust.
- Shortfalls in learning from serious incidents and never events.
- Significant weaknesses in infection control and prevention practices.

Follow up

The Trust has responded positively to the review process with some urgent issues already addressed, including rectification at the Whitehaven theatres. The Trust is working very closely with the TDA and CQC to address the other key priorities.

The Trust supported the findings and acknowledged that to rapidly agree the improvement journey it will need to engage with other stakeholders within the health economy. The Trust Board should agree a single plan for patient safety and quality improvement, with clearly documented accountabilities and timescales.

A detailed plan focussing on outcomes and addressing each of the recommended actions in the RRR report was completed by the Trust by the end of June 2013. A further risk summit will be held in September 2013 to review progress.

Sherwood Forest Hospitals NHS Foundation Trust

The Trust has had very recent appointments of a new Chair, Chief Executive and new Non Executive Directors. When the Trust was placed in breach by Monitor for finance and governance in October 2012, an interim Chair and CEO were put in place to oversee the actions for improvements of the Trust. During this time until June 2013, the Trust had a rapid improvement regime, and priorities were made to meet the breach notices.

The Trust was welcoming and all staff that the panel met were engaged, committed and loyal to the Trust.

Issues that were escalated immediately

The panel identified the following issues:

- A significant backlog of complaints at the time of the review visit, including complaints dating back to 2010.
- Significant backlog in discharge letters and clinic appointments, and backlogs in reading scans and x-rays.

Other urgent actions

- Significant concerns around staffing levels at both King's Mill Hospital and Newark Hospital and around the nursing skill mix, with trained to untrained nurse ratios considered low, at 50:50 on the general wards.
- Concerns about the effectiveness of the governance at Newark Hospital, with no clear way for this group to feed into the overall Trust governance structure.
- Better training, and frequent audits of fluid management processes, is needed to improved fluid management.
- Concerns over the number of patient moves and outliers within the Trust, and the quality of handovers for patient care.
- The Trust did not appear to have a patient engagement strategy or systems to engage with and obtain feedback from patients and act upon it.

During the review process, the panel observed that a Board-level focus on quality and the patient was still developing. There was an absence of a strong strategic direction and trust-level working, as well as a lack of performance information to support quality improvement. This was also seen through the absence of a clear strategy for Newark Hospital, with no clearly articulated future for the hospital or strategy for the best use of the facilities there.

Follow up

The Trust welcomed the review and found the process thorough and fair. It recognised the review found a number of things it needed to get right, along with the recognition of what it was doing well. It accepted all the recommendations in the report and stated that it had the capacity to improve and would seek support to enable this.

An action plan was agreed at the risk summit addressing all of the urgent priority actions discussed and the Trust is developing a comprehensive response to all issues. Follow up of the action plan will be undertaken later in 2013.

Tameside Hospital NHS Foundation Trust

The panel found that the Board was not leading the Trust as effectively as necessary in delivering quality care. The Trust's governance and leadership has not delivered the improvements in quality of care required. Monitor has taken action to put in an interim Chief Executive and interim Medical Director following the previous post-holders stepping down after the risk summit.

The panel found committed staff at the Trust and examples of good practice in relation to quality of care but there were a number of areas of concern identified, including a culture of accepting sub-optimal care, which needed urgent action to address.

The experience of patients in the emergency and acute medical pathway was often poor and issues were identified which required urgent review and action to be taken.

Issues that were escalated immediately

- The panel identified concerns with infection control practice in an area of the hospital and escalated this to management.

Other urgent actions

Trust management had not sufficiently advanced recommendations that had been received from external reviews regarding the acute medical pathway. This has led to a number of systematic issues impacting on quality and patient safety in some areas, including:

- Insufficient senior clinical cover, particularly out of hours.
- Lack of timely investigations, and poor management of deteriorating patients.
- Inappropriate use of escalation areas and poor bed management.
- The panel did not see clear evidence that the Trust is listening to patients and families or staff to improve the quality of patients' experience.
- The Quality Strategy and performance management information needs significant improvement, to enable the Board to scrutinise and gain assurance on quality improvements.

Follow up

The action plan presented by the Trust at the risk summit focused on urgent and high priority actions, and did not set out all necessary details, including measures and milestones. The Trust agreed to provide a specific and detailed action plan to respond to all outstanding concerns and recommended actions included in the RRR report. However, given the changes in management which took place shortly after the risk summit, it is acknowledged that the action plan will be reviewed by the incoming management team. Monitor and CQC will monitor progress closely on this action plan and a further risk summit will be held in September 2013.

United Lincolnshire Hospitals NHS Trust

The review identified that the Trust has been developing its quality strategy over the last few years but, with constant change in leadership, it had been challenging to make systematic improvements in quality. The review panel noted that the Trust's staff were dedicated, loyal and committed, but there were examples suggesting they needed better, more joined up leadership to really address the challenges it faces. The panel identified a number of areas of good practice, although these were not applied consistently.

Issues that were escalated immediately

- Inadequate staffing levels and poor workforce planning particularly out of hours – concern over the low level of registered nursing staff on shifts in some wards during the unnannounced visit out of hours was escalated to CQC. Further investigation is underway.
- Issues with the completion of 'do not attempt resuscitation' (DNAR) forms, which the Trust has immediately reviewed and rectified.

Other urgent actions

- A disconnect between leadership at Board level and leadership at clinical levels within the organisation, which may be contributing to the lack of knowledge amongst staff of the quality strategy.
- Lack of clarity around escalation procedures, leading to inconsistent application and use across the Trust sites.
- Patient experience is not at the heart of the organisation and the complaints process is not fit for purpose.
- Lack of staff awareness of the Mental Capacity and Deprivation of Liberty Act 2005 which may affect the care that patients with mental health needs receive.

Follow up

The Trust accepted the findings, although it considered that it had many actions already underway to address the concerns. The risk summit challenged the Trust management to consider why these actions had not had the necessary impact so far.

The risk summit agreed prioritised actions with the Trust to address these issues. Many of the recommendations contained in the RRR report are issues internal to the Trust, with some joint working required within the health community on capacity and staffing issues.

Annex B **Resources required for the reviews**

The 14 reviews were conducted in a relatively short timescale. Each review took around six weeks from start to finish. Reviews were run in three ‘batches’ so that the resources of the central team and panel members could be deployed most effectively.

The Department of Health conducted a tender exercise to procure support for the programme. This included all training, logistics, project management and moderation. The contract was awarded to PricewaterhouseCoopers (PwC). The details can be found at www.gov.uk/contracts-finder

In addition, the following programme costs were incurred.

Expense	Approximate cost, total for 14 reviews
Travel and subsistence for 190 panellists, plus £100 payment to lay representatives	£169,000
Filming Risk Summit presentations	£28,000
Legal advice	£30,000

Annex C **National advisory group members**

Dr. Na'eem Ahmed
Junior Doctor and National Clinical Fellow, Faculty of Medical Leadership; National Medical Director's Fellowship Programme

David Behan
Chief Executive, Care Quality Commission

Professor Nick Black
Professor of Health Services Research, London School of Hygiene and Tropical Medicine and Chair, National Clinical Audit Advisory Group

Jane Cummings
Chief Nursing Officer for England (NHS England)

Ian Dalton
Deputy Chief Executive and Chief Operating Officer, NHS England

Professor Lord Darzi
Paul Hamlyn Chair of Surgery, Imperial College London

Mike Farrar
Chief Executive, NHS Confederation

Dr Paul Husselbee
Accountable Officer, Southend Clinical Commissioning Group

Professor Sir Brian Jarman
Director, Dr Foster Intelligence Unit

Tim Kelsey
National Director, Patients and Information, NHS England

Sir Ian Kennedy QC
Chair, Independent Parliamentary Standards Authority; formerly Chair of Healthcare Commission, and Bristol Royal Infirmary Enquiry

Professor Sir Bruce Keogh – Chair
National Medical Director NHS England

Dame Julie Mellor
Parliamentary and Health Service Ombudsman

Dr Kathy McLean
Medical Director, NHS Trust Development Authority

Sir Jonathan Michael
Chief Executive, Oxford Radcliffe Hospitals NHS Trust

Katherine Murphy
Chief Executive, The Patients Association

Dr Katherine Rake
Chief Executive, Healthwatch England

Professor Elizabeth Robb
Chief Executive, Florence Nightingale Foundation

Jeremy Taylor
Chief Executive, National Voices

Stephen Thornton
Non Executive Director, Monitor and Chief Executive, Health Foundation

Professor Terence Stephenson
Chair, Academy of Medical Royal Colleges

Dr Paul Watson
Regional Director, Midlands and East, NHS England

Professor Chris Welsh
Director of Education and Quality, Health Education England

Annex D **Rapid responsive review team members**

Short biographies for all review teams can be found on NHS Choices

Basildon and Thurrock University Hospitals NHS Foundation Trust	
Chair	David Levy
Patient/public rep	Jenny Robinson
Patient/public rep	Asa'ah Nkohkwo
Patient/public rep	Fional Loud
Junior Doctor	Lola Loewenthal
Doctor	Gillian Derrick
Doctor	Jane McCue
Student Nurse	Elizabeth McKerrow
Nurse	Fay Baillie
Nurse	Clare Beattie
CQC inspector	Margaret McGlynn
Senior Trust Manager	Rebecca Brown
Senior Regional Support	Graeme Jones
Senior Regional Support	Finola Munir

Blackpool Teaching Hospitals NHS Foundation Trust	
Chair	Mike Bewick
Patient/public rep	Sue Crutchley
Patient/public rep	Gillian Stone
Patient/public rep	David Tredrea
Patient/public rep	Amit Bhagwat
Junior Doctor	Krishna Chinthapalli
Doctor	Leslie Hamilton
Doctor	Steve Graystone
Student Nurse	Sarah Weight
Nurse	Simon Featherstone
Nurse	Peter Murphy
Nurse	Gill Heaton
CQC inspector	Julia Harratt
Senior Trust Manager	Nikki Pownall
Senior Regional Support	Preeti Sud

Buckinghamshire Healthcare NHS Trust	
Chair	Nigel Acheson
Patient/public rep	David Turner
Patient/public rep	Neeta Mehta
Patient/public rep	Tim Thorp
Patient/public rep	Priscilla Chandro
Patient/public rep	Derek Prentice
Junior Doctor	Nina Wilson
Doctor	Vaughan Pearce
Doctor	Carol Peden
Doctor	Simon Donell
Doctor	Aidan Fowler
Student Nurse	Lowri Aldworth
Nurse	Judy Gillow
Nurse	Nicola Lucey
CQC inspector	Jessica Zeff
Senior Trust Manager	Chris Gordon
Senior Trust Manager	Linda Abolins
Senior Regional Support	Christina Button
Senior Regional Support	Harriet Luximon

Burton Hospitals NHS Foundation Trust	
Chair	Ruth May
Patient/public rep	Norma Armston
Patient/public rep	Alan Keys
Patient/public rep	Leon Pollock
Junior Doctor	Esther Kwong
Junior Doctor	Bethan Graf
Doctor	Balraj Appadu
Doctor	Mike Lambert
Doctor	Daren Forward
Student Nurse	Nicola Hendrick
Nurse	Suzie Loader
Nurse	Michelle Rowley
Nurse	Heidi Guy
CQC inspector	Debbie Widdowson
Coding specialist	Trudy Taylor
Senior Trust Manager	Erica Loftus

Senior Regional Support	Gareth Harry
Senior Regional Support	Shelley Bewsher

Colchester Hospital University NHS Foundation Trust	
Chair	Liz Redfern
Patient/public rep	Neeta Meeta
Patient/public rep	Trevor Begg
Patient/public rep	Margaret Ogden
Junior Doctor	Shelley Griffiths
Doctor	James Bristol
Doctor	Andrew Phillips
Doctor	Colette Marshall
Student Nurse	Sian Ball
Student Nurse	Amy Burgin
Nurse	Brigid Stacey
Nurse	Paul Webb
Nurse	Julie Orr
CQC inspector	Sue Fraser-Betts
Senior Trust Manager	Chris Gordon
Senior Regional Support	Gareth Harry
Senior Regional Support	Lyn Mcintyre

East Lancashire Hospitals NHS Trust	
Chair	Gill Harris
Patient/public rep	Geraint Day
Patient/public rep	Trevor Fernandes
Patient/public rep	Jenny Cairns
Patient/public rep	Howard Naylor
Junior Doctor	Andrew Collier
Junior Doctor	Bethan Graf
Doctor	Alan Paul
Doctor	Graham Cooper
Student Nurse	Lucy Giles
Nurse	Joanne Todd
Nurse	Mandy Bailey
CQC inspector	Robert Taylor
Senior Trust Manager	Fleur Blakeman
Senior Regional Support	Jon Develing

Senior Regional Support	Teresa Fenech

George Eliot Hospital NHS Trust	
Chair	David Levy
Patient/public rep	Tim Thorp
Patient/public rep	Asa'ah Nkohkwo
Patient/public rep	Anthony Glover
Junior Doctor	Krishna Chinthapalli
Doctor	Jane McCue
Doctor	Peter Davis
Student Nurse	Madalina Fabian
Nurse	Em Wilkinson-Brice
Nurse	Bridget O'Hagan
CQC inspector	Andy Brand
Senior Trust Manager	Deborah Needham
Senior Regional Support	Graeme Jones
Senior Regional Support	Finola Munir
Senior Regional Support	Gareth Jones

Medway NHS Foundation Trust	
Chair	Liz Redfern
Patient/public rep	Trevor Begg
Patient/public rep	Jacqueline Joyce
Patient/public rep	Georgina McMasters
Patient/public rep	Priscilla Chandro
Patient/public rep	Christine Pollard
Junior Doctor	Na'eem Ahmed
Doctor	Aidan Fowler
Doctor	Vaughan Pearce
Doctor	Jas Soar
Student Nurse	Rebecca Dodd
Nurse	Julia Hogg
Nurse	Liz Childs
CQC inspector	Kate Dew
Senior Trust Manager	Chris Gordon
Senior Regional Support	Christina Button

North Cumbria University Hospitals NHS Trust	
Chair	Gill Harris
Patient/public rep	Sue Crutchley
Patient/public rep	Maggie Whitlock
Patient/public rep	JackieWilkinson
Junior Doctor	Jenny Nelson
Doctor	Chris Holcombe
Doctor	Paul Curley
Student Nurse	Sarah Weight
Nurse	Samantha Adamson
Nurse	Diane Wake
CQC inspector	Lynne Lord
Senior Trust Manager	Alastair Turnbull
Senior Regional Support	John Develing

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	
Chair	Mike Bewick
Patient/public rep	Anne Crick
Patient/public rep	Maggie Whitlock
Patient/public rep	Olga Jannsen
Patient/public rep	Jenny Shepherd
Junior Doctor	Bethan Graf
Doctor	Sion Barnard
Doctor	Andrew Burtenshaw
Doctor	Bill Cunnliffe
Doctor	Rowena Hitchcock
Student Nurse	Charlotte Johnson
Nurse	Christine Pearson
Nurse	Julie Smith
Nurse	Jill Bryne
CQC inspector	Nick Allen
Senior Regional Support	Tim Savage
Senior Regional Support	Jane Dunning

Sherwood Forest Hospitals NHS Foundation Trust	
Chair	David Levy
Patient/public rep	Gary Robinson
Patient/public rep	Norma Armston
Patient/public rep	Jenny Cairns
Junior Doctor	Mahesh Kudari
Doctor	Esther Fine
Doctor	Paul Molyneux
Doctor	Anna Lipp
Student Nurse	Carl Shooter
Nurse	Liz Rix
Nurse	Liz Hogbin
Nurse	Matt Sandham
CQC inspector	Carolyn Jenkinson
Senior Trust Manager	Francesca Thompson
Senior Regional Support	Finola Munir
Senior Regional Support	Graeme Jones

Tameside Hospital NHS Foundation Trust	
Chair	Gill Harris
Patient/public rep	Steve McNeice
Patient/public rep	David Tompkins
Patient/public rep	Margaret Hughes
Patient/public rep	Jackie Wilkinson
Junior Doctor	Tom Foley
Doctor	Gavin Nichol
Doctor	Roger Hall
Doctor	Gulzar Mufti
Student Nurse	Sarah Weight
Nurse	Helen Carter
Nurse	Mike Wright
CQC inspector	Jeanette Berry
Senior Trust Manager	Chris Harrop
Senior Regional Support	Damian Riley

The Dudley Group NHS Foundation Trust	
Chair	Ruth May
Patient/public rep	Anthony Glover
Patient/public rep	Alan Keys
Patient/public rep	Leon Pollock
Junior Doctor	Veline L'Esperance
Doctor	Marcelle Michail
Doctor	Ronan Fenton
Doctor	Colin Johnston
Student Nurse	Charlotte Johnston
Nurse	Sue Doheny
Nurse	Heather Moulder
Nurse	Paul Webb
CQC inspector	Di Chadwick
Senior Trust Manager	Batsirai Katsande
Senior Regional Support	Alistair McIntyre

United Lincolnshire Hospitals NHS Trust	
Chair	Ruth May
Patient/public rep	Jackie Wilkinson
Patient/public rep	Howard Naylor
Patient/public rep	Jean Gallagher
Junior Doctor	Nassim Parvizi
Junior Doctor	Saheel Mukhtar
Doctor	Geoff Hunnam
Doctor	Mike Lambert
Doctor	Charles Mann
Doctor	Sonia Swart
Student Nurse	Madalina Fabian
Student Nurse	Jane Philpott
Nurse	Nancy Fontaine
Nurse	Marion Collict
Nurse	Lynne Wigens
Nurse	Pol Toner
Nurse	Birte Lam Harlev
Nurse	Vicky Leah
CQC inspector	Alan Swain
Senior Trust Manager	Cara Charles Barks

Senior Regional Support	Mark Driver
Senior Regional Support	Shelley Bewsher
Senior Regional Support	Trish Thompson

Annex E Sources used for compilation of data packs

Patient Experience Survey 2012/13 (http://www.cqc.org.uk/surveys/inpatient)

National Cancer Experience Survey 2011/12

CQC Patient Voice Summary

NHS Friends and Family Test

Ombudsman Reports

HSCIC Complaints Handling Data

Acute Trust Quality Dashboard, Winter 2012/13

BBC News (http://www.bbc.co.uk/news/health-22466496)

Organisation Patient Safety Workbook National Patient Safety Agency (NPSA), Apr 11 – Mar 12

Organisation Patient Safety Reports, NPSA

National Safety Thermometer Tool

NHS Litigation Authority Factsheet on Clinical Negligence Scheme for Trusts

Summary of Reports and Responses under Rule 43 of the Coroners Rules, Ministry of Justice, various dates used.

Acute Trust Quality Dashboard, Winter 2012/13

General Medical Council (GMC) National Training Scheme Survey 2012

The NHS Information Centre for Health and Social care Vacancies Survey March 2010

NHS Hospital & Community Health Service (HCHS) monthly workforce statistics, various dates

NHS National Staff Survey 2011 & 2012

2011/12 Organisational Readiness Self-Assessment (ORSA) Report, April 2011 – March 2012

General and Personal Medical Services, Medical and Dental Workforce Census, Non-medical Workforce Census, Health and Social Care Information Centre.

GMC Deanery Reports, various dates

NHS National Training Survey 2012

National Clinical Audit Data, HQIP

Cancelled Elective Operations Data, NHS England (online)

Health Evaluation Data (HED) system

National Neonatal Audit Programme Annual Report 2011, Royal College of Paediatrics and Child Health

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Index of Multiple Deprivation 2010

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Department of Health Instant Atlas tables 2010.

Dr. Foster UK Medical

Various documents submitted by the 14 organisations and follow up specific information requests as detailed in specific RRR reporting.