To:	**Trust Board**
From:	**Director of Clinical Quality/Medical Director**
Date:	**25 July 2015**
CQC regulation:	**16**

Trust Board Paper N

Title:	**SUMMARY REPORT OF THE "REVIEW INTO THE QUALITY OF CARE AND TREATMENT PROVIDED BY 14 HOSPITAL TRUSTS IN ENGLAND: OVERVIEW REPORT"**

Author/Responsible Director: Director Of Clinical Quality/Medical Director

Purpose of the Report:
To provide a summary of the findings and recommendations in the Keogh report on areas of quality of care and treatment provided by 14 hospitals Trusts in England.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

- In February the Secretary of State for Health and Prime Minister asked Professor Sir Bruce Keogh to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates.
- There were 14 trusts selected 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).
- A detailed analysis took place on a vast array of hard data and soft intelligence to identify key lines of enquiry.
- Sir Bruce Keogh identified some common themes or barriers to delivering high quality care relevant to the wider NHS.
- Sir Bruce set out a vision (articulated in a series of ambitions) for where the NHS can get to within two years.
- The Trust/Medical Director/Quality Assurance Committee will be carefully considering the Keogh report and will be assessing our compliance against actions and will report back to the QAC in August and the TB in September.

Recommendations:
The Trust Board is asked to note this preliminary analysis of the Keogh report and agree the timeframes for providing a detailed response.

Previously considered at another corporate UHL Committee ?
No

Strategic Risk Register n/a	**Performance KPIs year to date** n/a
Resource Implications (eg Financial, HR) No	
Assurance Implications	
Patient and Public Involvement (PPI) Implications In public domain	
Equality Impact n/a	
Information exempt from Disclosure No	
Requirement for further review? TBC	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Report to: **TRUST BOARD**

Report from: **DIRECTOR OF CLINICAL QUALITY/MEDICAL DIRECTOR**

Date: **25 JULY 2013**

Subject: **SUMMARY REPORT OF THE "REVIEW INTO THE QUALITY OF CARE AND TREATMENT PROVIDED BY 14 HOSPITAL TRUSTS IN ENGLAND: OVERVIEW REPORT"**

1.0 Introduction

1.1 In February the Secretary of State for Health and Prime Minister asked Professor Sir Bruce Keogh to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates.

1.2 The 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. There were 14 trusts selected 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).

1.3 The full report was published on 16th July 2013 and can be found at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf.

2.0 Methodology for review

2.1 A detailed analysis took place on a vast array of hard data and soft intelligence to identify key lines of enquiry. Multidisciplinary teams of 15-20 people then conducted announced and unannounced visits using patient, lay representatives, senior clinicians, junior doctors, student nurses and senior managers.

2.2 The teams placed huge value on the insight gained from listening to staff and patients as well as these who represented the interests of the local population (including CCGs and MPs).

2.3 Risk summits were held to agree with each Trust a co-ordinated plan of action and support to accelerate improvement.

2.4 Transparency was key to the process with information published on NHSChoices (data, videos, presentations and improvement plans).

3.0 Common Themes Identified

3.1 Sir Bruce Keogh identified some common themes or barriers to delivering high quality care relevant to the wider NHS including:-

- The limited understanding of how important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services.

- The capability of hospital boards and leadership to use data to drive quality improvement. This is compounded by how difficult it is to access data which is held in a fragmented way across the system.

- The complexity of using and interpreting aggregate measures of mortality, including HSMR and SHMI.

- The fact that some hospital trusts are operating in geographical, professional or academic isolation.

- The lack of value and support being given to frontline clinicians, particularly junior nurses and doctors.

- The imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement.

3.2 Eleven of the hospital trusts investigated by Prof Sir Bruce Keogh's review have been placed under special measures by Monitor and the Department of Health.

4.0 Key Findings from the Review

4.1 The Keogh report has identified the following key themes as being core foundations of high quality care.

4.2 Patient experience:-

- Key area in which improvement was needed at most of the trusts.

- 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.

4.3 Safety

- Processes for safety were generally in place but not fully understood by staff, resulting in patchy implementation;

- Inadequate safety and equipment checks

- More work was needed 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.

4.4 Workforce

- Various workforce-related problems, including high rates of sickness absence and heavy reliance on agency staff to compensate for large numbers of vacant posts.

- Inadequate numbers of nursing staff in some ward areas.

- Over-reliance on unregistered staff and temporary staff

- Poor staffing levels on night shifts and at weekends

- Extensive use of locum cover for doctors.

4.5 Operational Effectiveness

- High levels of demand on 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.

- Large increase in the numbers of elderly patients with complex sets of health problems.

4.6 Understanding and Use of Data

- Few had a good understanding of the reasons for their high mortality figures. Therefore weak or incomplete strategies for improving performance.

- Unaware of what information was reported nationally on their own organisations.

- 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.

- Information was only rarely used in an enquiring manner - in order to seek out and understand the root cause of a problem area.

- Insufficient evidence to demonstrate that many Board and clinical leaders were effectively driving quality improvement.

- Poor articulation of the strategy for improving quality

- A lack of comprehensive and consistent approach to learning from internal and external reviews

- 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.

- Incomplete performance dashboards.

- Inconsistency in seeking independent assurance.

5.0 Actions Required

5.1 The report identified the need for a series of actions including:

- 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.

- 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.

- Real-time 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 and patients and the public should have their complaints welcomed.

- Need 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.

- Consider how to apply aspects of the methodology used to help improve quality.

- Releasing 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.

- Signing off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.

- Consider how they might tap into the latent energy of junior doctors and harness the loyalty and innovation of student nurses.

- Junior doctors must routinely participate in trusts' mortality and morbidity review meetings.

- Develop innovative ways of engaging their staff.

6.0 Keogh's Ambitions

6.1 The report sets out a vision (articulated in a series of ambitions) for where the NHS can get to within two years. This includes:

- Making demonstrable progress to reducing avoidable deaths in hospitals

- Patients and clinicians will have confidence in the quality of assessments made by the CQC, not least because they will have been active participants in inspections

- Harnessing energy and creativity of Junior Doctors in specialist training

- No hospital will be an island – professional, academic and managerial isolation will be a thing of the past

- 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

- Patients will not just feel like they have been listened to but will be able to see how their feedback is impacting on their own care and the care of others

- Boards and leaders confidently and competently using data/other intelligence for the forensic pursuit of quality improvement including rapid access to the service line data

- Quality improvement strategies should include the positive impact that happy and engaged staff have on patient outcomes, including mortality rates.

7.0 Implications of the Keogh Review for UHL

7.1 This paper provides a summary of the Keogh review however there is much more valuable learning in the body of the report.

7.2 The new Chief Inspector for Hospitals (Professor Sir Mike Richards) has confirmed that the CQC would be using the methodology developed for the Keogh report in future hospital inspections.

7.3 The Trust Medical Director and Director of Clinical Quality are carefully considering the Keogh report. Over the past 12 months considerable progress has been made by the Trust in developing its approach to the delivery of high quality care (for example UHL's Quality Commitment). However the Trust will

ensure that it is either compliant with all recommendations or has developed robust action plans to be so. The report has already been shared with our Clinical Divisions who have been asked to benchmark their current compliance.

7.4 The Trust will assess its compliance against actions and will report back to the ET/QAC by August 2013 with a follow up report to the TB in September 2013.

8.0 Recommendations

The Trust Board is asked to note this preliminary analysis of the Keogh report and agree the timeframes for providing a detailed response.