RCN Policy and International Department
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The Keogh Review and special measures

A short briefing for RCN members, activists and staff

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Introduction

This aim of this briefing is provide a brief overview of the Keogh Review report and to provide factual information on the special measures being applied to the 11 NHS trusts named by the Secretary of State for Health on 16 July 2013 (Hunt, 2013).

Background

Following the inquiry into the tragedy at Mid Staffordshire NHS Foundation Trust (Francis, 2013) the Prime Minister asked Professor Sir Bruce Keogh, the Medical Director of NHS England, to conduct a review of the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of 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).

The Keogh Review

The review of these trusts led by Sir Bruce Keogh was expert-led and consisted of both planned and unannounced and out-of-hours visits, placing particular weight on the views of staff and patients. The review was guided by the NHS values set out in the NHS Constitution (DH, 2013) and underpinned by the following key principles:

- patient and public participation
- listening to the views of staff
- openness and transparency
- co-operation between organisations.

Although the 14 hospital trusts covered by the review were selected using national mortality measures as a "warning sign" or "smoke-alarm" for potential quality problems, the investigation looked more broadly at the quality of care and treatment provided within these organisations. The review considered the performance of the hospitals across six key areas:

- mortality
- patient experience
- safety
- workforce
- clinical and operational effectiveness
- leadership and governance.

Following the publication of the Keogh Review report (Keogh, 2013) on 16 July 2013 the Secretary of State announced that 11 of the 14 trusts reviewed would be placed in to “special measures for fundamental breaches of care”. Those trusts are:

- Tameside Hospital NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust

- Sherwood Forest Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Basildon and Thurrock University Hospitals NHS Foundation Trust
- George Eliot Hospital NHS Trust
- Medway NHS Foundation Trust
- Burton Hospitals NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust.

The three trusts which are not subject to special measures are:

- Colchester Hospital University Foundation Trust
- The Dudley Group Foundation Trust
- Blackpool Teaching Hospitals Foundation Trust.

However all 14 trusts have been ordered to act on the recommendations made by Sir Bruce Keogh. His review team found that, while there were some examples of good care, none of the 14 hospitals was providing consistently high quality care to patients. For all the Trusts visited the review team uncovered previously undisclosed problems in care. They identified patterns across many of the hospitals including:

- professional and geographic isolation
- failure to act on data or information that showed cause for concern
- the absence of a culture of openness
- a lack of willingness to learn from mistakes
- ineffectual governance and assurance processes. In many cases trust boards were unaware of problems discovered by the review teams.

Specific examples mentioned in the Keogh Review report include:

- patients being left on trolleys, unmonitored for excessive periods and then being talked down to by consultants
- poor maintenance in operating theatres, potentially putting patients in danger
- patients often being moved repeatedly between wards without being told why
- staff working for 12 days in a row without a break
- blood being taken from patients in full view of the rest of the ward
- low levels of clinical cover – especially out of hours.

It has been acknowledged in the review report that since 2010, each of the trusts examined as part of the Keogh Review has seen substantial changes to its management, including a new chief executive or chair at nine of the 14.

What are special measures?

In terms of taking forward the recommendations of the Keogh Review the special measures applied to the 11 Trusts are that:

- Each hospital will be required to implement the recommendations of the Keogh Review, with external teams sent in to help them do this. Their progress will be tracked and made public.
- The Trust Development Authority or Monitor will assess the quality of leadership at each hospital, requiring the removal of any senior managers unable to lead the improvements required.
- Each hospital will be partnered with high-performing NHS organisations to provide mentorship and guidance in improving the quality and safety of care.

Sir Brice Keogh makes it clear that that "these trusts which need considerable and sustained external support" to improve. He also said that there may be changes to the management at the top of the trust, but it was hoped in many cases their leaders are given enough breathing space to make use of the support provided.

In addition all 14 trusts have been placed on notice (by either Monitor or the NHS Trust Development Agency depending on their status) to fulfill all the recommendations made within the Keogh Review report.

All the trusts will be inspected again within the next 12 months by the Chief Inspector of Hospitals, Professor Sir Mike Richards. There are further press reports that the Keogh Review team will also re-inspect all the trusts named but this has not been confirmed to date.

Nine of the 14 Trusts reviewed under the Keogh Review are foundation trusts. All of the remaining five trusts were in the process of applying for foundation trust status.

Monitor has highlighted that five of these trusts are already in special measures for breaches of their licence and are therefore subject to a variety of existing sanctions by Monitor. Monitor has now served notice to the trusts concerned that suspected breaches of the licence will trigger enforcement action. David Bennett, Chief Executive of Monitor, said: "The Keogh review has identified a number of serious issues at these foundation trusts, and we are taking appropriate action to ensure they are fixed as quickly as possible" (Monitor, 2013).

The NHS Trust Development Authority (TDA) has written to five NHS trusts (with non-foundation trust status) suspending their foundation trust applications and asking them to set out their plans for implementing the findings of the Keogh Review. Each trust will have their action plans rigorously scrutinised and the board leadership at each organisation will be further assessed by the NHS TDA Medical Director, Dr Kathy Mclean (NHS Trust Development Authority, 2013).

Please note that the enforcement action has not triggered the wider failure regime under legislation and a trust special administrator has not been appointed. The current board and management team will remain in place within each of the 14 trusts unless the Trust Development Authority or Monitor consider that the removal of any senior managers is necessary.

Sir Bruce Keogh said: “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” (Keogh, 2013).

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Matt Tee, Chief Operating Officer of the NHS Confederation said: “We know each of the NHS trusts has undergone a rigorous examination of its processes and practices as part of this review and has identified an action plan for improvement. It is clear that clinicians and managers at these trusts will now need to be fully focused on delivering the agreed action plans” (NHS Confederation, 2013).

The **Care Quality Commission (CQC)** announced that they would learn from the review and improve their inspection process for the future. The CQC played an active part in the reviews of the 14 trusts, sharing information with the review teams and taking part in all of the visits and risk summits. CQC has launched changes to its national inspection regime, introducing Ofsted-style ratings which it claims will better protect patients. Professor Sir Mike Richards has announced plans to recruit hundreds of new inspectors, including hospital patients and their carers, so that future inspections include a wider range of perspectives. It has been reported that inspection teams will also include more junior doctors and nurses.

Commenting on the three (of the 14) hospitals not going into special measures Bruce Keogh announced that whilst there were still concerns about the quality of care provided, the foundation trust regulator, Monitor, had confidence that the leadership teams in place can deliver the recommendations of the Keogh Review.

Responding to the publication of the Keogh Review report, the **RCN** welcomed the emphasis on the need to get NHS care right for everyone and stressed the importance of implementing the review’s recommendations as a matter of urgency.

What comments were made with regard to nursing care?

The review teams that visited the 14 trusts 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.

The Keogh Report highlights the following action in response to these concerns. The report states: “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 report also notes that frontline clinicians including junior nurses have 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”.

The individual action plans for the 14 trusts contain numerous references to actions on staffing levels and the wider provision of nursing care. These will need to be implemented as part of the implementation of the Keogh Review recommendations under the supervision of the external teams sent in to help them complete this process.

The Keogh Report set out eight "ambitions" for the wider NHS in light of its findings:

1. Reduce avoidable deaths with early warning systems for deteriorating patients and introduce more accurate statistical measurement of mortality rates.
2. Expertise and data on how to deliver high quality care to be more effectively shared between NHS trusts.
3. Patients, carers and the public should be more involved, and should be able to give real-time feedback.
4. Patients should have more confidence in the regulator the Care Quality Commission, with wider participation of patients, nurses, and junior doctors on review teams.
5. Hospitals in remote areas should not be left isolated, with staff from better-performing hospitals used to train and inspect others.
6. Nurse staffing levels and mix of skills should be appropriate to the patients being cared for on any given ward.
7. Medical directors should "tap into the latent energy of junior doctors" and include them in review panels.
8. NHS employers should make efforts to ensure staff are "happy and engaged".

Tell us what you think

The Policy and International Department would like to receive comments/feedback from as many members as possible on the Keogh Review report and in particular the special measures being applied to the 11 NHS Trusts. Please email: policycontacts@rcn.org.uk

Further reading

Download the Keogh Review's report *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*:

www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

Read the performance data, inspection reports and the action plan for each of the 14 trusts have on the *NHS Choices* website to find further details about the Keogh Review process:

www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Visit the Monitor web site to find details of the action being taken by Monitor following the Keogh Review:

www.monitor.gov.uk/home/news-events-publications/latest-press-releases/health-sector-regulator-puts-six-foundation-trus

Visit the NHS Trust Development Authority (TDA) web site to find details of the action they are taking following the Keogh Review:

www.ntda.nhs.uk/2013/07/16/nhs-tda-places-five-trusts-in-special-measures

Visit the Care Quality Commission web site to find details of actions they are taking on inspection: www.cqc.org.uk/public/news/prof-sir-mike-richards-chief-inspector-hospitals-announces-our-inspection-plans

References

Department of Health (2013) The *NHS Constitution for England, 26 March 2013*. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf (accessed 19/07/13).

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary*. Available at: www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf (accessed 19/07/13).

Hunt J (2013) *Oral statement – Sir Bruce Keogh Review*. Available at: www.gov.uk/government/speeches/oral-statement-sir-bruce-keogh-review (accessed 19/07/13).

Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf (accessed 19/07/13).

Monitor (2013) *Health sector regulator puts six foundation trusts in special measures.* Available at: www.monitor.gov.uk/home/news-events-publications/latest-press-releases/health-sector-regulator-puts-six-foundation-trus

NHS Confederation (2013*) Keogh Review: 'Ostrich approach' not an option*. Available at: www.nhsconfed.org/priorities/latestnews/Pages/Keogh-Review-Ostrich-approach-not-an-option.aspx (accessed 19/07/13).

NHS Trust Development Authority (2013) *NHS TDA places five trusts in special measures*. Available at: www.ntda.nhs.uk/2013/07/16/nhs-tda-places-five-trusts-in-special-measures (accessed 19/07/13).