Learning from investigations
# Contents

About the Healthcare Commission 2

Foreword 3

Executive summary 5

Introduction 15

Our approach to investigation 17

Interventions 25

Investigations 30

Common themes from our investigative work 39
  - General themes 39
  - Specific themes 44

A coordinated approach to protecting the safety of patients 48

Conclusions 51

Appendix: Overview of actions taken following our investigations 53

References 58
About the Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission’s role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare. In this work, we collaborate closely with the Healthcare Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

Investigating serious failings in healthcare

The Healthcare Commission is empowered by section 52(1) of the Health and Social Care (Community Health and Standards) Act 2003 to conduct investigations into the provision of healthcare by or for an English NHS body.

We usually investigate when allegations of serious failings are raised, particularly when there are concerns about the safety of patients.

In investigating allegations of serious failings in healthcare, we aim to help organisations to improve the quality of care they provide, to build or restore public confidence in healthcare services, and to seek to ensure that the care provided to patients is safe throughout the NHS.
I served as a member of the Healthcare Commission for the years covered by this report, and know very well the benefit of the powers given to it by Parliament to carry out investigations on behalf of patients. Early interventions and the identification of root causes are the best way to ensure improvement. But the use of an independent and authoritative voice to highlight problems and suggest improvements also means that lessons are learned quickly and on a wide scale, whether they relate to the safety of maternity services, the support and care provided to people with learning disabilities or the management of infection in our hospitals.

Most of the serious concerns referred to the Commission are resolved without the need for formal investigation. Where there is a need for action, experience has shown that collaboration between the Commission, other stakeholder agencies and the healthcare provider can be the most effective way of bringing about improvement.

Over the course of the Commission’s investigations, consistent themes have emerged. The purpose of this report is to highlight some of the common factors found, to ensure that lessons from these serious episodes can be learnt more widely and that we make sure they do not happen again.

Increasingly, the Healthcare Commission acts to identify potential concerns early. However, there will remain a minority of the most serious cases where formal investigation is necessary to identify the precise causes of failure. The Commission has helped NHS leaders take difficult and sometimes uncomfortable decisions in order to protect patients and improve healthcare. When necessary in the most serious cases, it has recommended that the Secretary of State for Health should take special measures to ensure that change occurs. Without exception, the Secretary of State has acted on such recommendations.

This report makes clear why it is in the interests of patients and the public to have a strong, independent, regulator – one that is empowered to decide when investigation is needed, undertake its work in a robust and professional manner, and publish its findings and recommendations for improvement.

Professor Sir Bruce Keogh
NHS Medical Director
The Healthcare Commission’s overriding purpose is to promote improvement in the safety and quality of healthcare services provided to patients.

In order to fulfil this remit, the Commission has been given an explicit power to conduct investigations into the provision of healthcare by and on behalf of NHS bodies. From its inception, the Commission has made full use of these investigative powers.

Healthcare providers make considerable efforts to ensure that patients receive safe, good quality care. There is a strong focus today on having effective systems for managing risks, reporting failures and errors, and learning from them. Chief executives are now personally accountable for the quality of clinical care provided by their trusts.

Despite this, things sometimes still go wrong. Inspections or assessments against standards will tell us whether something does or does not meet the standard measured, but only investigation can diagnose the precise cause of failure. The Commission’s investigations team plays a vital role in establishing why, despite the many systems designed to keep patients safe, failures still happen and still get repeated.

Our staged approach to investigation

Our approach to investigation is targeted and proportionate. We only investigate where we think there is evidence of a serious failure and the causes of that failure are unclear. In our first three years, we dealt with over 200 cases referred to us. Of these, only 13 resulted in a formal investigation. The remainder we were able to resolve in a number of other ways.

Where appropriate, we try to resolve concerns and encourage improvement without resorting to investigation. When it is clear that the causes of problems are readily identifiable and the organisation has the capacity and the willingness to improve, we intervene by issuing recommendations. It is important that trusts demonstrate that they have taken the matter seriously and show a real intent to address the problems. We always reserve the right to take matters to a formal investigation if we do not see sufficient progress.

We put all referrals through a staged approach, from screening and ‘first look’ through to the possibility of intervention or formal investigation.

Screening

Our national Helpline staff carry out the initial screening of requests for investigations. Information comes from a variety of sources: the public, the police, journalists, solicitors, MPs, patient or carer support groups, or direct from the organisations involved.

Where they could meet the Commission’s criteria for investigation, they are passed without delay to the investigations team.

First look

The investigations team then undertakes a ‘first look’ – a review of the concerns raised and an analysis to determine whether the referral does in fact fall within the Commission’s investigation criteria. The team may refer the matter to another body if appropriate.

Initial consideration

The next stage is to decide whether the Commission should intervene or investigate in some form. It involves a closer analysis of the issues and gathering evidence from a variety of sources, for example statistical data, talking
Executive summary

to staff and patients, and reviewing survey results and the trust’s core standards declaration.

Every initial consideration is different and the time taken to progress it depends on the issues raised, the assessed level of risk and the ease with which we are able to gather information.

**Intervention**

We can undertake an intervention if we are not fully assured that the trust is doing all that it should to protect the safety of patients or provide a sufficiently high-quality, responsive service.

Intervention may be appropriate where:

- We believe there are serious shortcomings and the trust needs to act to assure the safety of patients or improve the service in some other way.

- The trust is co-operating fully and openly and its senior management have demonstrated that they accept the need for urgent improvement.

- The trust has the capability and resources (both human and financial) needed to make any urgent improvements.

- We believe that the likely causes are readily identifiable.

- A formal investigation is not considered the most proportionate or practical way to bring about improvements.

On average, one out of every six cases to reach the initial consideration stage has resulted in some form of intervention being taken by the investigations team. We believe that this represents a very important – and pragmatic – approach to protecting patients and bringing about necessary improvements in a relatively short timescale.

Throughout the course of every intervention, we are conscious not to take any responsibility for managing the performance of the trust concerned, as this is clearly the responsibility of others. The approach relies on the willingness and capacity of trusts to work collaboratively with the Commission in a very focused way, but we have been impressed with the positive responses so far.

Below are some examples of interventions and how they have been effective in bringing about improvements.

**Working in partnership** – where appropriate, the Commission’s investigation team works in partnership with other organisations and tries to avoid duplicating the work of other bodies. In our example of acute trust A, we worked closely with the Royal College of Surgeons to recommend and monitor improvements in cancer services.

**Responding to urgent concerns about the safety of patients** – we prioritise cases that present an urgent threat to the safety of patients. For example, when we received credible information about potentially harmful drug trials at trust B, we quickly made an unannounced visit to the trust. Thankfully, this rapid intervention confirmed that the whole matter was a hoax.

**Recommending and monitoring improvement over a prolonged period** – we sometimes need to extend our intervention until we are satisfied that sustainable improvements have been made. For example, at primary care trust C, a referral from a whistleblower led to a detailed list of recommendations and close monitoring throughout the whole of the following year.
Liaising with the police over serious allegations – where interventions are very serious, we work closely with the police authorities to intervene quickly, as in acute trust D. Here we passed allegations of serious harm to elderly and vulnerable patients straight to the police, but happily we found no evidence to substantiate them.

A joint approach to ensuring sustainable improvements – once concerns about the safety of patients have been addressed, the root causes need to be tackled so that improvements can be sustained in the long term. In our example of trust E, the trust, strategic health authority and PCT all signed up to a plan that led to major improvements within six months.

We have reviewed how we intervene and give recommendations to trusts for action. We now publish, on our website, a summary report after interventions where we think there is an opportunity for sharing the learning more widely across the NHS. This demonstrates our belief in working in partnership with trusts wherever possible to resolve serious problems.

Investigation
A full investigation is our last resort. We can start an investigation where we have credible information that suggests a serious failure in the provision of healthcare that is badly affecting the safety of patients, clinical effectiveness or responsiveness to patients.

Factors that might trigger an investigation include:

- A higher number of unexplained deaths than anticipated.
- Serious injury or permanent harm, whether physical, psychological or emotional.
- Events that put at risk public confidence in the healthcare provided, or in the NHS more generally.
- A pattern of adverse effects or other evidence of high-risk activity.
- A pattern of failures in services or teams, or concerns about these.
- Allegations of abuse, neglect or discrimination against patients (particularly those less able to speak for themselves or assert their rights).
- A specific request for investigation from the Secretary of State for Health.

The purpose of an investigation is to identify the underlying (or root) causes of failures in the provision of healthcare. It identifies failings both in systems and individual behaviours, which may have contributed to the poor overall outcome. An investigation provides an explanation of what has happened and why, and makes recommendations to prevent repetition, both in the organisation being investigated and more widely across the NHS.

A dedicated team is selected at the start of each investigation to ensure that the necessary expertise and advice is available to the investigation manager at all times. This may include clinical experts, chief executives of NHS trusts and a range of other specialist advisors.

Below are some recent examples of the type of investigations we undertake.

Uncovering widespread institutional abuse – this investigation revealed widespread abuse of people with learning disabilities at an NHS trust in Cornwall, made possible by serious and wide-reaching flaws in the trust’s procedures for protecting vulnerable adults.
Executive summary

Failings in maternity services – concerns about a high number of maternal deaths at a North West London trust led to an investigation which found serious problems with teamwork, staff shortages, consultant cover and the capacity to safely manage the number of births at the trust.

Managing outbreaks of Clostridium difficile – our first investigation into healthcare-associated infection, at a Buckinghamshire trust, concluded that poor infection control had been compounded by insufficient priority being given to the problem by the trust’s leadership.

The poor use of mortality data – this investigation at an Oxfordshire trust looked into concerns over mortality rates following heart operations. While we found that the deaths fell within accepted statistical limits, we made recommendations about the trust using its own data to monitor whether services were safe.

Outmoded care for people with learning disabilities – this investigation uncovered outmoded models of care at a primary care trust. The views of people with learning disabilities were seldom heard and few staff had specialist training. Some of the environments in which these people lived were impoverished or completely unsatisfactory.

Widespread failures in clinical governance – systemic management failings, from the most senior level down, were revealed in an investigation at a Yorkshire trust. Significant and wide scale improvements were implemented as a result of the investigation.

Following each investigation, the trust concerned drafts an action plan based on our recommendations and shares it with us for final sign-off. We agree a timescale for the Commission to conduct a formal assessment of progress, to ensure that improvements have been made.

Common themes from our investigative work

Throughout the process of managing cases – from referral to possible intervention or full investigation – we pay close attention to similarities and themes that may emerge. Although our initial concerns are usually about the quality of care in a particular service, what we find may highlight a more widespread, often national, issue.

General themes

Leadership – this is clearly important in setting the direction of an organisation, developing its culture, ensuring delivery and maintaining effective governance. We have found that the boards of NHS trusts we have investigated are particularly vulnerable to being consumed by the business of healthcare, in the form of mergers, reconfiguration of services, financial deficits, and targets. While these are important matters in their own right, boards must also maintain their focus on clinical quality throughout. Ensuring they have the relevant information and act on it is crucial to this.

Continuity of leadership is important, too. We have found recurring cases of poor leadership in the trusts we have investigated, with frequent changes in senior personnel and a lack of strategic direction, serious financial or capacity concerns and failure to deal with
historical problems. In one case, there had been seven chief executives in 10 years, as well as four different trusts under three different health authorities – all creating a lack of continuity and follow-up of management action.

Teamwork is also essential to the delivery of safe, good quality care but it is not always given the priority we believe it needs. Many of our investigations featured serious failures in teamwork, both between managers and clinicians and between clinical groups. Clinical staff have a responsibility to work together: nurses, doctors, midwives, allied health professionals and those involved in social care.

Management and targets – targets or outcome measures are an integral feature of a modern 21st century healthcare system, and have resulted in measurable improvements for patients in some important areas.

NHS managers have always had to deal with conflicting priorities. The vast majority do it successfully. Our investigations have looked at how managers tackle these potential conflicts and our overriding message has always been that it is not acceptable – nor is it necessary – for the safety of patients to be compromised by any other objectives, no matter how compelling these may seem. In fact, if a trust takes the view that meeting a target may put the safety of patients at risk, it may apply for some form of special treatment in relation to the target. This will allow it to deal with the matter of safety without affecting its annual assessment inappropriately.

We have seen different approaches taken by managers in these challenging environments, and, in some investigations, have noted that there is a fine distinction between what some perceive as a firm management style, and what appears to others as the suppression of uncomfortable messages or bullying.

Our investigations always try to take full account of the pressures faced by managers, but we remain concerned that, too often, management styles are perceived as being autocratic. This can discourage the open reporting of serious incidents, restricting a trust’s ability to learn from failure and make necessary improvements.

Governance and the use of information – we have been surprised at the extent to which some large, complex organisations have not had adequate systems in place to ensure that the board is properly informed about potential issues at ward level or in specialist services. The collection and proper use of data on outcomes is essential for every trust, for board members to assure themselves about the quality of services for which they are responsible. Trusts should have clear structures and experienced staff making sure this happens properly. Boards must satisfy themselves that they have this information.

However, we have seen examples where the information generated was either not sufficiently detailed to identify serious problems, or the information was merely collected on a regular basis and not used to inform decisions. These situations can provide a ‘false assurance’ within the trust, because board members take comfort in the knowledge that data is collected and that no concerns have been raised. This false assurance may also inappropriately reassure the strategic health authority responsible for managing the performance of the trust, and the primary care trust commissioning the service in question.

Every NHS board member has a responsibility to ensure they understand the data they are
given. What is more, they need to challenge or question information whenever it appears unclear, so that they can provide a genuine assurance that patients are receiving safe, appropriate care.

**The impact of mergers and organisational change** – services for patients can often be improved by reorganising the strategic delivery of health services or by merging organisations. Changes are inevitable over time. However, our investigations show that, if not carefully managed, the process of organisational change can divert management away from maintaining service quality. It is important to recognise that, while mergers and other organisational changes will continue to be necessary in some situations, there is clear evidence that they also bring with them a high degree of risk, if not handled appropriately by senior leaders.

**Safeguarding vulnerable adults** – there appears to be poor understanding of adult protection procedures among the NHS healthcare providers that we have looked at. Incidents that, in an ordinary domestic environment, would be viewed as domestic violence are too often accepted as customary in some NHS settings. They are excused on the grounds that the person committing the assault did not intentionally do so, or could not help themselves, because the behaviour is part of their condition.

However, it does not follow that patients or staff should endure this. We question whether our society genuinely thinks it acceptable for those who cannot exercise full control and choice over their lives to be hit or hurt on a regular basis. NHS boards must make themselves aware of, and challenge, the repeated occurrence of such incidents.

Institutional abuse also poses a problem to the safeguarding system. Staff become used to ways of working that they do not readily recognise as institutional abuse. It can be difficult for new staff to challenge or for unqualified staff to recognise it as poor practice.

**Poor care of patients on general wards** – the relatively small number of our investigations of acute hospitals has revealed worryingly similar stories of poor care for patients on general wards. Patients who were older or otherwise vulnerable were most at risk, since they were most dependent on good nursing care and not always able to express their needs.

We found examples of patients not being helped with eating or cutting up their food, tablets not being given on time and medication missed, charts not completed properly, and patients being moved from one location to another because of the pressure on beds.

In some cases there were too few nurses on the wards for the needs of the patients they were looking after, or the ratio of qualified staff was low. We spoke to some nurses who told us they had raised concerns and filled in incident forms but nothing appeared to have happened. These concerns either did not filter through to the level of the trusts’ boards, or were disregarded.

**Specific themes**

**Poorly-performing maternity services** – after finding worrying similarities in major investigations into deaths at three maternity units, we identified a number of issues that suggest a unit may be in difficulties, including weak risk management, poor teamworking, inadequate training and supervision, poor facilities and staff shortages. We have since worked closely with individual trusts and the Royal Colleges to focus on
these issues. We have also carried out a review of maternity services in England. The results are due to be published in 2008.

**Foetal heart monitoring** – a common theme in referrals regarding maternity issues is foetal heart monitoring and cardiotocograph (CTG) interpretation. The failure of staff to recognise and act upon signs of distress on the CTG traces can lead to serious complications and, ultimately, could lead to the death of a baby.

Our maternity services review will create a set of indicators covering clinical quality, women’s experience, capability and efficiency, enabling trusts and commissioners to compare outcomes and benchmark their performance.

**Services for people with learning disabilities** – we have undertaken two major investigations and managed eight other referrals about services provided for people with learning disabilities. We have identified numerous similarities in the findings, including outdated models of care and an ignorance of what constitutes institutional abuse.

To be sure that serious failures are not occurring elsewhere, we conducted a comprehensive audit of specialised inpatient learning disability services, both in the NHS and the independent sector throughout England. We published the results of this audit in December 2007.

**The control of infection in hospital** – two separate investigations into outbreaks of infection have revealed a number of similarities. Both trusts had had difficult mergers, and were preoccupied with finances and a demanding reconfiguration agenda. Additionally, financial pressures led to low numbers of nurses. Both trusts had very high bed occupancy levels and some patients had to be treated in unsuitable environments.

It seems unlikely that these similarities are coincidental. We are concerned that where trusts are struggling with a number of problems that consume senior management time, and are under pressure to deliver against targets or outcomes, they should take steps to ensure that similar problems do not develop.

**Mental health services** – a consistently high proportion of cases managed by the investigations team relate to concerns about mental health services. These include assaults and rates of suicide among users of services, as well as allegations of abuse by staff. They are often accompanied by operational concerns, such as a lack of permanent staff, inadequate training and poor risk management. It is a common perception that serious incidents are more likely to occur at mental health trusts, due to the nature of the service provided.

We do not believe that this should be used as an excuse for poor standards of safety. Trusts must learn from serious incidents. When we investigate, we are most concerned to understand the attitude within the trust to serious incidents – what level of importance they are given and whether lessons have been learnt and improvements made as a result.

**Escalation and the use of special measures**

At any time during the consideration or investigation of a referral, the Commission is required to report to the Secretary of State if it finds “significant failings”. Where it does so, it may decide to recommend “special measures”. Special measures are not defined in law, but are intended to ensure improvement. The
Commission will only recommend them where they offer the most appropriate solution, and where other methods have failed to achieve the necessary improvement or are thought unlikely to do so. Special measures are appropriate where we do not believe the trust alone can achieve the improvement needed and it requires outside help to do so.

Over our first three years, we have formally reported significant failings on four occasions and three of these have been accompanied with a recommendation of special measures. The Secretary of State has responded positively to each of our recommendations and accepted them in full.

Our coordinated approach to protecting the safety of patients

It is clear that, in relation to service failure, problems often occur at the borders between one organisation or team and another. We have therefore put considerable effort into working jointly with other bodies: sharing information, referring or receiving concerns, and where appropriate working in partnership on investigations.

Another facet of our integrated approach is our work following up statistical ‘outliers’. We often have to analyse data when we consider referrals for investigation – usually to review the mortality rates or other health outcomes of a particular service or consultant team. This data, when compared with similar services or teams in other parts of the country, is an important guide in deciding whether further action is required. Sometimes these other services or teams, included in the analysis for comparison, are themselves found to have extremely poor outcomes – we refer to these as statistical outliers.

We follow these up by talking to other expert bodies and the healthcare providers themselves, to establish the quality of the data we used. If the investigations team has any doubts about the information received back from the healthcare provider, or considers that there may be a serious risk to the safety of patients, the case can be escalated as a referral for investigation.

We have started to build even further on this experience and deliberately search for statistical outliers, with the aim of identifying potential failure at the earliest possible stage. With the right handling, this will be a potentially powerful means of highlighting problems – and addressing them before they build up into the sort of systemic failings uncovered in previous investigations.

Finally, we feed our findings from consideration, interventions and investigations into the process of assessment against core standards. In this way, we are helping to develop the flow of intelligence within the Commission and ensuring that learnings are continually built upon.

Conclusions

In our first three years, we have operated a professional and independent process for investigating potential failures in healthcare. Through this, we have uncovered evidence of serious, systematic failures. The resulting reports and actions plans have helped healthcare providers to learn about common problems seen elsewhere and how system improvements might be identified and implemented.

The Commission has already made an impact on a national scale, being instrumental in bringing about improvements in the safety of
our maternity services, the care provided to people with learning disabilities and the management of infection in our hospitals. Our processes involve regular follow-up in trusts where we have carried out an investigation. The improvements made are striking.

It is clear that it is in the interests of patients and the public that our healthcare system has an independent regulator with strong investigative powers and functions.

Within the NHS, there is a high degree of commitment and caring at the front line. However, we are concerned that where failure does happen, it is too often associated with recurrent themes.

In most cases, we find that the trust is open and willing to work with us, with a view to identifying any improvement that may be necessary. But there are those trusts where an open attitude is not so evident, where systems for clinical governance are muddled or not given a high priority at the most senior level. In these cases, we have often been left with no alternative but to launch a full and exhaustive investigation.

We urge the NHS to take note of this and, as a basic requirement in every trust:

- Senior managers need to encourage a culture of openness and actively elicit the views of frontline staff on matters relating to safety.

- Every board member should make it their business to understand the nature of the incidents being reported in their organisation, and satisfy themselves that action is taken and improvements made.

- Systems for clinical governance must be ‘built in’ to the running of trusts, rather than being ‘bolted on’.

- Boards and senior management teams should regularly build in protected time, uncluttered by other priorities, to reflect on whether they are meeting the needs of their most vulnerable patients and how they can be assured that these individuals are safe from harm.

In addition, those bodies responsible for commissioning services and managing the performance of provider trusts need to pay particular attention to these points. They should actively check to make sure patients are protected from harm, rather than assuming this is someone else’s job.

At the Healthcare Commission we will continue to evaluate our work and improve our approach wherever possible, ensuring that it is proportionate and effective in improving healthcare and protecting the safety of patients.

Our challenge, leading up to the creation of the new health and social care regulator in 2009 and beyond, remains to ensure that healthcare providers learn from our investigations and continue to remember those lessons in years to come. We will develop our use of data to identify potential problems at an early stage, thus hopefully reducing the need for full investigations, continue to watch how trusts take action at a local level, and focus even more on achieving sustained improvement at a national level.
Introduction

The Healthcare Commission’s overriding purpose is to encourage improvement in the safety and quality of healthcare services provided to patients.

This report looks at how we have approached the task of investigating failures in healthcare, and what we have learnt, over the course of our first three years. It is not intended to be a formal review of the impact of our investigations – this is currently being undertaken separately by an independent research company and it will be published later in 2008.

Since 2000, when the Government published An organisation with a memory, the NHS has worked hard to learn from its mistakes and improve the safety of its services. There is a strong focus today on having effective systems for managing risks, reporting failures and errors, and learning from them.

NHS trusts have developed clinical governance systems and largely understand the need for effective use of committees, clear reporting structures, good use of information and regular auditing. Chief executives are now personally accountable for the quality of clinical care provided by their trusts.

Clinicians regularly review cases where patients have died, so that they can learn from them. They also carry out audits to review the care of patients following ‘near misses’ or other serious incidents.

The independent regulator Monitor oversees the effectiveness of foundation trusts. Twelve strategic health authorities manage the performance of all other provider and commissioner trusts. Primary care trusts are responsible for monitoring the quality of services they commission.

Healthcare providers work to a number of Government standards and guidelines, including Standards for Better Health and national service frameworks. Their premises are inspected regularly and their systems for the management of risk are assessed independently. The Healthcare Commission assesses their performance against national standards and conducts other audits and audits and

Clinical governance

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. All NHS trusts have responsibility for making sure that the principles of clinical governance are embedded at all levels in the organisation. These include:

• Making certain that they have in place systems and processes to ensure the delivery of safe, high quality care.

• Ensuring that all clinicians are involved in regular clinical audits and reviews of clinical services.

• Developing an open culture where incidents are reported and lessons are learned.

• Monitoring trends in key clinical quality data and outcome measures.

• Demonstrating that they are continuously improving the quality of the experiences of patients.
reviews – all aimed at assessing the quality of care and identifying any areas that need improvement.

Considerable efforts are therefore being made to ensure that patients receive safe, good-quality care.

Despite this, things sometimes still go wrong. Inspections or assessments against standards will tell us whether something does or does not meet the standard measured, but only investigation can diagnose the precise cause of failure. The Commission’s investigations team plays a vital role in establishing why, despite the many systems designed to keep patients safe, failures still happen and still get repeated.

A need for constant vigilance

“In April 2000, the National Assembly for Wales invited CHI to undertake an investigation into the Carmarthenshire NHS Trust ... the immediate trigger for this was an incident ... in which a patient had the wrong kidney removed.”

Commission for Healthcare Improvement investigation, 2000

“A surgeon took out a patient’s functioning kidney, instead of her diseased one, at the Middlesex Hospital in March 2004... An enquiry found system and procedure failure.”

BBC News, 2006

“An inquiry is under way at a Scottish hospital where surgeons removed a cancer patient’s healthy kidney by mistake ... we want to be sure that no other family experiences this in future.”

The Times, 2006
Our approach to investigation

The Healthcare Commission’s work is governed primarily by two Acts of Parliament. The Health and Social Care (Community Health and Standards) Act 2003 gives the Commission an explicit power to conduct investigations into the provision of healthcare by and on behalf of NHS bodies. This enables the Commission to investigate NHS provider trusts, including primary care trusts, and any private or independent provider of healthcare commissioned by the NHS to provide services on its behalf.

The Care Standards Act 2000 does not contain a comparable power to investigate independent healthcare providers, although it does permit inspectors to enter and inspect at any time. In general, independent providers do not operate on the scale of an NHS trust. However, we retain the ability to investigate them under section 52 of the Health and Social Care Act where they provide services for NHS patients.

Our approach to investigation is targeted and proportionate. We only investigate where we think there is evidence of a serious failure and the causes of that failure are unclear. In our first three years, we dealt with over 200 cases referred to us. Of these, only 13 resulted in a formal investigation.*

The remainder we were able to resolve in a number of other ways.

Where appropriate, we try to resolve concerns and encourage improvement without resorting to investigation. When it is clear that the causes of problems are readily identifiable and the organisation has the capacity and the willingness to improve, we intervene by issuing recommendations. It is important that trusts demonstrate that they have taken the matter seriously and show a real intent to address the problems. We always reserve the right to take matters to a formal investigation if we do not see sufficient progress.

Despite the often intense interest shown by the media, we always seek to be measured in any criticism we make. We are very mindful of the challenges faced by staff, both executives and those on the front line, and of the discomfort that an investigation causes to people who are invariably well intentioned. But our job is to find and report the truth. Patients must be kept safe.

The investigations team

The role of the investigations team is to assess referrals against the Commission’s published criteria, identify whether action is required and respond in a proportionate way, undertaking interventions or investigations where necessary. The team also helps to deliver the Commission’s broader strategic goals and our overall aim of improving healthcare.

Throughout our work, the highest priority is accorded to protecting the safety of patients.

Staff in the core team come from a variety of professional backgrounds with a high degree of expertise. The team also consults a network of expert clinical advisors, both from within the Commission and from external bodies such as the Royal Colleges, as well as dedicated legal advice.

The work of the team is overseen by the Investigations Committee, which comprises commissioners and senior staff. This meets regularly to consider requests for investigation, review draft reports and advise on significant cases.

* We have since completed our 14th investigation, into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust. We published our report in October 2007.
Our approach to investigation

We hold regular ‘development forums’ attended by a cross section of staff to discuss and develop investigation policies and processes. Out of this, we have developed detailed procedures, which help to guide investigations staff and ensure consistency in our approach.

The team also makes regular use of case conferences when making key decisions, involving, as necessary, clinical or other expert advisors, legal advisors, analysts and colleagues from regional teams. The perspectives of different experts mean that evidence and findings are challenged to ensure that they are sufficiently robust.

A staged approach to considering referrals

All referrals go through a robust process to ensure that concerns are handled appropriately and that the Commission responds in a proportionate way. It is a staged approach from screening and ‘first look’ through to the possibility of intervention or formal investigation.

Figure 1 illustrates the way referrals are ‘funnelled’ through the consideration process.

Figure 1: The staged process for considering referrals for investigation

<table>
<thead>
<tr>
<th>Screening of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>First look</td>
</tr>
<tr>
<td>Initial consideration*</td>
</tr>
<tr>
<td>Intervention*</td>
</tr>
<tr>
<td>Investigation*</td>
</tr>
</tbody>
</table>

At any time, the option exists to report “significant failings” and recommend the use of “special measures”

*Note that these stages are not necessarily followed in order. After the first look, a decision can be made to go straight to an intervention or an investigation, and likewise straight from an initial consideration to an investigation.
Screening
The Commission’s national Helpline is the first point of call for people needing help and advice. Part of the role of the Helpline is to carry out the initial screening of requests made for investigations. Between August 2004 and April 2007, the Helpline received a total of 302 such requests.

Information comes from a variety of sources, including the public, the police, journalists, solicitors, MPs, patient or carer support groups, and sometimes direct from the organisations involved. A significant number of requests are made by NHS staff, many of whom have tried unsuccessfully to address their concerns internally.

Trained staff in the Helpline assess the requests and pass them to the investigations team if they match up to our criteria for investigation. Those people whose requests are not passed on are given advice on other avenues that may be more appropriate to progress their concerns.

First look
When the investigations team receives a referral, it takes what is known as a ‘first look’, to review the concerns raised and determine whether it falls within our criteria for investigation.

The first look enables cases to be resolved quickly wherever possible. For example, there may be elements that can be handled through the NHS complaints process, or by the employer’s human resources department, or referred on to the General Medical Council. Where appropriate, the concerns are shared with other Commission staff to feed into the annual health check, which assesses the overall quality of care in each trust.

If there are urgent concerns about the safety of patients at this stage, we will escalate the matter immediately.

Initial consideration
The next stage is to decide whether the Healthcare Commission should intervene or investigate in some form. It involves further analysis of the issues and gathering of other evidence.

<table>
<thead>
<tr>
<th>Public Interest Disclosure Act 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Public Interest Disclosure Act 1998 was introduced to protect employees who are worried about wrongdoing in their place of work and want to ‘blow the whistle’.</td>
</tr>
<tr>
<td>Ideally, all NHS employees should feel able to raise issues with their own employer, whether it is a trust, PCT or health authority. Each NHS body should have its own policy and procedures for responding to staff concerns. In reality, NHS staff sometimes feel unable to talk directly to their employer and therefore approach the Healthcare Commission for help.</td>
</tr>
<tr>
<td>We treat all such communication in strict confidence. In all cases, we ensure that we:</td>
</tr>
<tr>
<td>• Explain the protection that is given by the Public Interest Disclosure Act.</td>
</tr>
<tr>
<td>• Investigate the concern under the powers given to us.</td>
</tr>
<tr>
<td>• Contact the referrer when our investigation is complete to provide feedback.</td>
</tr>
</tbody>
</table>
Our approach to investigation

information to judge whether the standard of care is appropriate, and whether there are any areas for improvement.

This usually includes examining evidence from a variety of sources. For example:

- A document request from the trust
- Statistical analysis of data on clinical outcomes
- Detailed examination of policies
- Reviewing root cause analyses or investigation reports performed by the trust
- Talking to staff and patients
- Reviewing information held by the Commission on the trust, such as the results from surveys of staff and patients and the trust’s core standards declaration.

We also work regularly with other regulatory and official bodies such as the Mental Health Act Commission, the police, the Commission for Social Care Inspection, professional bodies including the Royal Colleges, the Medicines and Healthcare products Regulatory Agency and the General Medical Council.

Using statistical data

The Commission uses data from a variety of sources throughout its investigation work. Clinical data can also help us spot organisations that may be ‘at risk’ and allow us to be more proactive with our interventions.

One of the main sources is the Hospital Episode Statistics (HES), a national database compiled by the NHS Information Centre and originating from the patient administration systems in individual hospitals or trusts. It includes a wide range of information about patterns and outcomes of treatment for inpatients in NHS hospitals throughout England.

However, while the HES database collects very valuable information on outcomes for patients, it was not designed to collect detailed clinical information. Nor does it allow for outcomes to be adjusted for a comprehensive number of risk factors.

For example, in our investigation into the cardiothoracic surgical service at Oxford it was clear that there had been some concern from clinicians and specialists about the use of HES for monitoring outcomes and rates of mortality following surgery. The HES data for the period under investigation clearly showed the trust to be a significant clinical outlier for the national benchmark procedure: the coronary artery bypass graft.

However, when analysing the more detailed clinical data contained in the specialist Central Cardiac Audit Database, the trust’s results were not as concerning. On the other hand, the use of the CCAD presented its own challenges. The very detailed information required by the CCAD from the cardiac units resulted in a lack of consistency of submission and quality of the data provided. This made detailed analysis and comparison between organisations difficult.

Data such as that contained in HES and CCAD are a valuable source of information, but it is important that they are used in context and their limitations acknowledged. Any concerns identified from data analysis should be supported by other information.
Over its first three years, an average of 82 cases each year have been handled at this stage.

Each initial consideration varies greatly and the time taken to progress it depends on the issues raised, our assessment of the level of risk to patients and the ease with which we are able to gather information.

It is often necessary for us visit the trust to test the effectiveness of systems and talk to staff. This fact-finding visit gives us a better understanding of the issues and puts us in a better position to make an informed decision on the next steps.

In our first three years, we have arranged two independent audits of our management of initial considerations, to make sure that we are following our procedures correctly. The initial consideration stage has developed to such an extent that it can now involve in-depth investigative approaches in their own right. For example, we make greater use of unannounced visits to trusts than when we first started out, usually accompanied by clinical advisors, and we will also consider the need to conduct detailed reviews of case notes at this stage.

Each initial consideration is mapped against the Department of Health’s core standards for trusts, enabling the team to build an understanding of where the most common breaches are likely to be.

<table>
<thead>
<tr>
<th>Department of Health core standards domain*</th>
<th>Number of cases 2004/2005</th>
<th>Number of cases 2005/2006</th>
<th>Number of cases 2006/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>35</td>
<td>43</td>
<td>32</td>
</tr>
<tr>
<td>Governance</td>
<td>33</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>Clinical and cost-effectiveness</td>
<td>10</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Patient focus</td>
<td>9</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Accessible and responsive care</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Care environment and amenities</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public health</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>95</strong></td>
<td><strong>82</strong></td>
<td><strong>67</strong></td>
</tr>
</tbody>
</table>

* Each initial consideration can relate to more than one domain.
Our approach to investigation

The majority of referrals relate to safety and governance, which reflects the criteria for investigation. Table 1 shows a comparison across the three years.

**Intervention**
At any time during an initial consideration, a decision may be taken that an intervention is required.

We can intervene if we are not fully assured that a trust is doing all that it should to protect the safety of patients or provide a sufficiently high-quality, responsive service, and that the trust itself needs to take specific action to rectify known and serious problems.

Intervention may be necessary if:

- We believe there are serious shortcomings and the trust needs to take action to assure the safety of patients, or to improve the service in some other way.
- The trust is cooperating fully and openly and its senior management have demonstrated that they accept the need for urgent improvement.
- The trust has the capability and resources (human and financial) necessary to make any urgent improvements.
- We believe that the likely causes are readily identifiable.
- A formal investigation is not considered the most proportionate or practical means of bringing about sustainable improvements in the services concerned, in a timely manner.

In these circumstances, we make formal recommendations for improvement and commit to monitoring progress until the necessary action has been taken by the trust. We also commit to escalating our concerns (for example, by launching a formal investigation) if at any stage we are not satisfied with the response of a particular trust.

On average, one out of every six cases to reach the initial consideration stage has resulted in some form of intervention being taken by the investigations team. Examples of interventions are described in the next chapter.

**Investigation**
We can begin an investigation where we have credible information that suggests a serious failure in the provision of healthcare that is badly affecting the safety of patients, clinical effectiveness or responsiveness to patients’ needs.

Factors which might trigger an investigation, include:

- A higher than anticipated number of unexplained deaths.
- Serious injury or permanent harm to patients, whether physical, psychological or emotional.
- Events which put public confidence in the healthcare provided, or in the NHS more generally, at risk.
- A pattern of adverse effects or other evidence of high-risk activity.
- A pattern of failures in services or teams, or concerns about these.
- Allegations of abuse, neglect or discrimination against patients (particularly those less able to speak for themselves or assert their rights).
- A specific request for investigation from the Secretary of State for Health.
A dedicated team is selected at the start of each investigation to ensure that the necessary expertise and advice is available to the investigation manager at all times. This may include clinical experts, chief executives of NHS trusts and a range of other specialist advisors. The terms of reference and the project plan ensure that the investigation is focused and that a consistent approach is adopted throughout, leading to a report which sets out the evidence, findings, conclusions and recommendations.

The team completed 13 formal investigations during its first three years up to April 2007. Recent examples and the findings from them are described in the chapter beginning on page 30, and a full list in set out in the appendix.

We have recently completed our 14th investigation, into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust. We published our report in October 2007 and many of the findings were similar in principle to our findings in other reports.

**Escalation and the use of special measures**

At any time during the whole consideration and investigative process, we will report any "significant failings" that we find to the Secretary of State (and, where relevant to the Welsh Assembly Government and the independent regulator of NHS foundation trusts). Where we do so, we may decide to recommend "special measures".

Significant failings are not defined within legislation but we consider that failings may become "significant" either:

- Because of their potential to cause harm (which includes both the scale of impact and the likelihood of occurrence), or impair the quality of care.
- Because of their potential to damage public confidence.
- Because they are of particular importance – perhaps having implications for services across the country or a particular area.

Similarly, special measures are not defined in law. They might include recommendations for practical assistance or organisational support from outside the trust or, in extreme circumstances, suspension of a service. Special measures as appropriate where we do not believe the trust alone can achieve the improvement needed and it requires outside help to do so. We will only recommend them where they offer the most appropriate solution, and where other methods have failed to achieve the necessary improvement or are unlikely to do so.

During our first three years, we have formally reported significant failings on four occasions and three of these (at Mid Yorkshire Hospitals NHS Trust, North West London Hospitals NHS Trust and Cornwall Partnership Trust) have been accompanied with a recommendation of special measures. The Secretary of State has responded positively to each of our recommendations and accepted them in full. There is little doubt that, on each occasion, our recommendations have brought about the sort of fundamental impact that we had hoped for and shown that with the right support, it is possible to ‘turn around’ a failing organisation. As with all aspects of our work, our judgement on whether to escalate matters is in proportion to the potential for harm to patients.
## The impact of special measures

Mid Yorkshire Hospitals NHS Trust was the first trust to be subject to special measures.

David Dawson, appointed Medical Director of the trust after our investigation, commented: "Relentless adverse publicity had left staff ‘disillusioned’ ... But ‘tangible improvements’ are now evident. There was a feeling of mistrust in the previous senior management and that has changed. Many clinical staff – doctors in particular – didn’t know what effective management was. They had never been managed. Now there is much more openness, inclusivity and consistency of approach. Promises are delivered. If clinicians have unrealistic expectations then we are open about it – we are not going to promise things that cannot be delivered.”

Chief Executive of the trust, John Parkes "says special measures were ... ‘challenging’ but admits the speed of change at the trust surprised even him. Now he believes there is a ‘real buzz’ around the trust.”

Gill Morgan, Chief Executive of the NHS Confederation agrees that the system of special measures works, and that: “If used sparingly and where there is a genuine problem, it appears to be a powerful and effective intervention. It allows the organisation, with the aid of outside help and often clinical help, to really think differently about how to deliver services.”

Similarly positive comments were made by leaders of the second trust to undergo special measures, North West London Hospitals NHS Trust:

Mary Wells, Chief Executive “calls special measures ‘an opportunity realised’ ... the important thing in the changes we have made was to create a unit in which that scale of tragedy cannot happen again” ... “having a more structured programme in which senior staff from other organisations come in here and bring good practice and ways of doing things from other places is one of the most important things that came out of this.”

The ultimate impact of special measures is reflected in comments from Professor Sabaratnam Arulkumaran, President of the Royal College of Obstetricians and Gynaecologists, and Lead for the external maternity support team at Northwick Park Hospital: "The first Healthcare Commission report on Northwick Park Hospital highlighted fundamental issues that needed to be rectified – the lack of efficient and forward looking managerial and clinical leadership, poor working culture, team work and environment aggravated by inadequate staff and poor morale. There were several other issues that were picked up and these issues are unlikely to be identified by individual case investigations or the confidential enquiries into maternal deaths (CEMACH).

“The fact that there was only one unavoidable maternal death in the two subsequent years compared with 10 in the previous three years and the lifting of special measures in 18 months is a testimony to how women’s health and lives could be improved by the work and recommendations of the Healthcare Commission along with its implementation by the local team with some external support.”
Interventions

On average, one out of every six cases to reach the initial consideration stage has resulted in some form of intervention being taken by the investigations team. We believe that this represents a very important – and pragmatic – approach to protecting patients and bringing about necessary improvements in a relatively short timescale.

Throughout the course of every intervention, we are conscious not to take any responsibility for managing the performance of the trust concerned, as this is clearly the responsibility of others. The approach relies on the willingness and capacity of trusts to work collaboratively with the Commission in a very focused way, but we have been impressed with the positive responses so far.

Below are some examples of interventions and how they have been effective in bringing about improvements.

Working in partnership: NHS Acute Trust A

Where appropriate, the Commission’s investigations team works in partnership with other organisations and tries to avoid duplicating the work of other bodies.

For example, the team received a referral about an allegedly substandard urological service at NHS Acute Trust A. The referral concerned higher than average mortality and morbidity rates for certain procedures, poor team working, lack of medical leadership, delays in treatment and the absence of reviews of several incidents.

The trust and neighbouring acute trusts and primary care trusts agreed to restrict referrals while some diagnostic work was undertaken. We performed a statistical analysis and confirmed that mortality rates in relation to urological services were not significantly high compared to other trusts. The Royal College of Surgeons undertook a rapid review of urological services and concluded that on the whole core urology services were satisfactory, but remained concerned about the safety of cancer services. These included poor management of the two-week wait referrals, patients suspected of having cancer not being treated in line with best practice, and poor systems for tracking results and acting on abnormal results. The trust produced an internal action plan to address the issues.
To ensure the effective monitoring of progress, the investigation team and the Royal College of Surgeons agreed the specific areas of concern that needed to be addressed and raised these with the trust in the form of a questionnaire. Analysis of the trust’s response to this questionnaire and associated documentary and interview evidence showed that satisfactory progress had been made in most areas, and a follow up visit was not required. However, the investigation team continues to monitor the service and is kept informed of any serious incidents.

This sort of cooperation was designed to ensure the safety of patients, reduce the burden of inspection and create a clear picture of the service. It was the first time that the Commission had worked with a Royal College in this way.

**Responding to urgent concerns about the safety of patients: NHS Partnership Trust B**

We prioritise cases which appear to present an urgent threat to the safety of patients. While these must be progressed quickly, we have to strike a balance between immediate action and the need to collaborate with other agencies that may have a role to play.

For example, the Commission received detailed information from an anonymous source, suggesting that current and ex-employees of a trust had arranged with a pharmaceutical company to carry out clinical trials for personal financial gain.

The allegations involved a potentially harmful drug being tested on individuals with learning disabilities. Clearly, this raised serious concerns such as the consent of individuals with learning disabilities, conflict of interest, misuse of powers by trust employees and failure to protect users of services. Because of the seriousness of the concerns, this was rated as a high priority.

As the case related to clinical trials and the provision of social care, the Commission worked in partnership with the Medicines and Healthcare products Regulatory Agency (MHRA) and the Commission for Social Care Inspection (CSCI). The concerns were also shared in confidence with the local authority officers with lead responsibility for the protection of vulnerable adults – in line with the *No Secrets* guidance – and with the police.

Although there was a suspicion that the matter was an elaborate hoax, detailed information including the names and addresses of staff and users of services was accurate. It was agreed that it was not necessary for the police to accompany these visits, but they were on standby to retrieve any evidence that might have been required for criminal charges.

The trust’s chief executive was informed in confidence only on the day of the visits – so that there was no possibility of staff being forewarned, but at the same time ensuring that the chief executive was in a position to inform and reassure staff once the visits had been completed.

No evidence was uncovered to support the allegations, confirming our suspicions that the tip-off was indeed a hoax. However, it was agreed that the trust would arrange for its own independent investigation, given the elaborate nature of the hoax and the fact that the perpetrators appeared to have access to personal and confidential information.
This follow-up investigation recommended a number of actions for improving the security of personal data.

Managing concerns and monitoring improvement over a prolonged period: NHS Primary Care Trust C

We will sometimes need to extend our intervention over a prolonged period until we are satisfied that sustainable improvements have been made.

In the case of Trust C, we received a referral from a whistleblower that raised concerns about the trust’s mental health services. This included allegations of poor risk management systems, high rates of serious untoward incidents with little or no evidence of improvement, fear of retribution among staff when raising concerns about safety, unacceptably low staffing levels, and poor attendance at mandatory training courses.

We requested documentation from the trust and reviewed the concerns in the light of this information. We formally recommended that the trust needed to:

- Review its arrangements for reporting to the board on serious untoward incidents and progress on action plans.
- Provide evidence that action had been taken following its review of serious untoward incidents and that there had been trust-wide learning as a result.
- Ensure that staff received mandatory training in line with the training strategy.
- Implement recommendations made previously by the Mental Health Act Commission, relating to the levels of qualified staff, environment, dignity and respect.
- Ensure that there is a zero tolerance attitude to bullying and harassment throughout the trust.
- Review its whistleblowing policy and promote an open and supportive environment in which all staff feel comfortable raising concerns about safety.

The case was held open until sufficient evidence was provided to assure us that appropriate action had been taken and that the safety of patients was not being compromised. The judgment was taken that a full investigation was not required, but this was kept under regular review and we would not hesitate to escalate our actions if we felt that the trust was not progressing as agreed.

After a spot check visit and a follow-up meeting, we were sufficiently assured about the trust’s progress and satisfied that the trust’s senior managers were personally involved in driving forward necessary improvements. We passed the responsibility for continued monitoring to regionally based colleagues, working with the strategic health authority, and wrote to each of the individuals who had contacted us about the trust, providing feedback on their concerns and action subsequently taken by the trust.

When a new chief executive was appointed, we arranged a further visit to the trust, to ensure that the concerns and recommendations were fully understood.
Liaison with the police over serious allegations: NHS Acute Trust D

The Commission initially received concerns regarding care provided by NHS Acute Trust D in June 2006.

The allegations came from a source within the trust and were extremely serious in nature:

- That staff working in accident and emergency and intensive care were selectively killing elderly and other vulnerable patients.
- There were a number of risk management failures, clinical incidents and near misses.
- That financial cuts were leading to insufficient numbers of qualified and experienced midwives being on duty, resulting in the death of healthy babies.
- Problems with the control of infection and concerns regarding the sterilisation of theatre instruments.
- That the organs of patients who had died had gone missing.

As with any referral alleging potentially criminal acts, we passed information on to the police and discussed the matter with them at an early stage.

The consideration of the allegations was undertaken in several ways. The investigations team requested and reviewed documentation from the trust, and visited the trust to interview staff in maternity, accident and emergency and intensive care. We also undertook an audit of case notes relating to situations where treatment had been withdrawn from patients in intensive care, and we reviewed the trust’s investigations into the perinatal deaths in maternity services that occurred in 2005.

We sought the opinion of independent clinical advisers (including those in the fields of midwifery, intensive care, obstetrics and gynaecology) throughout our consideration.

We found no evidence to substantiate the allegations and made the decision that further investigation was not necessary.

During the course of our consideration, we were pleased to note the robust arrangements in place in many parts of the trust. A small number of specific and focused recommendations were made, such as the need for a clearly documented audit trail of any decision to withdraw treatment. However, we were broadly impressed by the open and comprehensive response we received, in the light of such serious allegations.

The trust provided an update in February 2007, which assured us that appropriate progress had been made against the recommendations given. In particular, the trust had introduced an intensive care checklist for the end-of-life decisions, which addressed the issues raised in the recommendations.

Rapid response to ensure the safety of patients, followed by a joint approach to organisational change: NHS Health and Social Care Trust E

When urgent concerns about safety are raised, it is clearly important for us to act without delay to ensure that patients are safe. Once this has been achieved, the root causes need to be addressed so that improvements are sustainable in the long term.

A number of concerns were raised about Trust E, including allegations of rape and physical assault of a female patient by a male member of agency staff, and an increasing number of
patient-to-patient assaults. Again, as with all referrals that potentially involve a criminal offence, confidential discussions were held with the police, and in this case the lead agency for the protection of vulnerable adults, to ensure that roles were clear from the outset.

We visited the trust within a matter of days of receiving the referral. We requested that a number of immediate actions be implemented to ensure the safety of patients. We visited shortly afterwards to monitor their implementation and meet with the recently appointed chief executive of the trust. A further meeting was held some months later with the chief executive and deputy chief executive of the strategic health authority, to discuss longer-term recommendations and build on the positive and speedy response to the urgent actions.

The trust, strategic health authority and PCT signed up to the recommendations and it was agreed that monitoring would be undertaken by a group involving all relevant health organisations, and would include Healthcare Commission regional staff. It was also agreed that the investigations team would receive quarterly update reports and undertake further visits if necessary.

Evidence from our six-month ‘spot check’ showed that the trust had moved from being an organisation with a history of poor leadership and poor risk management to one that was proactive in managing risk and ensuring that there is clear leadership at all levels. There has been significant improvement at two distinct levels. Firstly, a range of practical and specific changes was introduced immediately at ward level, to protect the safety of patients and staff. Secondly, a series of organisational changes was introduced, led by the chief executive, over a longer period.

This was achieved without the need for a formal investigation, in a shorter timescale and without any unnecessary burden being placed on the organisations concerned.

Looking ahead

The investigations team has reviewed how we intervene and give recommendations to trusts for action. We now publish, on our website, a summary report after interventions where we think there is an opportunity for sharing the learning more widely across the NHS. This demonstrates our belief in working in partnership with trusts wherever possible to resolve serious problems.
Investigations

The purpose of an investigation is to identify the underlying (or root) causes of failures in the provision of healthcare. It identifies failings both in systems and individual behaviours, which may have contributed to the poor overall outcome. An investigation explains what has happened and why, and makes recommendations to prevent their repetition, both in the organisation being investigated and more widely across the NHS.

The team completed 13 investigations during its first three years up to April 2007, each of which led to a published report setting out in detail our findings, conclusions and recommendations for action.

In every case, the trusts concerned accepted our recommendations in full and agreed a plan for improvement. Here, we summarise a selection of recent investigations.

Analysis of evidence

The conclusions and judgments we reach in investigations are properly supported by evidence. A team of analysts work with the investigations team to help collect and analyse the evidence.

Our methodology includes a number of visits to interview staff and others, while requesting and reviewing relevant documents in parallel. This allows each investigation team to assimilate their findings in a proportionate and efficient manner.

Once they have been checked for accuracy, we consider the notes of each interview alongside a range of other sources (visits, policies, minutes, case notes, correspondence etc). Any gaps identified in the information will prompt the team to request additional written or documentary information, or note more specific questions for further interviews.

Our observations of the environments in which services are delivered form another important source of evidence. Increasingly we use digital photography to record the equipment and facilities being used. We tailor our observations to meet the particular needs of the investigation. For example, we recently shadowed a domestic worker for the duration of a shift.

In some instances, bespoke surveys and questionnaires have been specifically designed for the investigation, but we also make full use of any existing data we already hold. Information from our surveys of patients and staff in the NHS and the ‘acute hospitals portfolio’ work are examples of this.

Uncovering widespread institutional abuse: Cornwall Partnerships NHS Trust

Widespread institutional abuse of people with learning disabilities at an NHS trust in Cornwall was revealed in this, our first joint report with the Commission for Social Care Inspection.

The investigation was sparked by concerns raised by East Cornwall Mencap Society. Early evidence indicated that users of services were not receiving a safe service based on best practice and, on 26 October 2005, the Commission reported significant failings at the trust and ensured that an external change team was brought in by the strategic health authority to oversee and plan improvement.

The report described many years of abusive practices at the trust and the failure of senior
trust executives to tackle it. The investigation team found an over-reliance on medication to control behaviour, as well as illegal and prolonged use of restraint. Although a number of staff working in the homes were found to be caring and well intentioned, they were not working in accordance with best practice.

The investigation also revealed serious and wide-reaching flaws in the trust’s procedures for protecting adults. Senior managers failed to identify and correct situations involving physical, emotional and environmental abuse. As a result of the investigation, 40 people were referred to Cornwall County Council under the procedure for the protection of vulnerable adults.

The report was issued together with a recommendation to the Secretary of State for Health that she place the trust under special measures. This brought about an external review of the trust’s board by the strategic health authority and ensured that external on-site scrutiny remained in place while other improvements were being made. Budock Hospital, the site of some of the worst conditions, has now been closed.

Performance of the trust is closely monitored and a formal review of progress since the investigation will be undertaken shortly.

Failings in maternity services: North West London Hospitals NHS Trust

This investigation began after a number of adverse events in maternity services at Northwick Park Hospital, including a high number of maternal deaths.

Concerns about the service were brought to the attention of the Commission jointly by the trust and Brent and Harrow primary care trusts. The strategic health authority also supported the request. We escalated our level of concern following a spot check by the investigations team and a further maternal death at the trust, which we were alerted to in April 2005.

Special measures were put in place as a matter of urgency. These were designed to increase capacity in maternity services and to bring in an external team to be present on the wards, improve teamwork and provide guidance to senior professionals at the trust. The report was published in July 2005.

We assessed progress a year later. The trust had successfully increased capacity in maternity services, helped by the transfer of some elective caesarean deliveries and the opening of a newly refurbished delivery suite. Teamwork among consultants and midwives had improved, consultant cover on the labour ward met national guidelines and new midwives had successfully been recruited. All faulty equipment had been repaired or replaced and an improved clinical governance structure had been introduced in the maternity service.

Most importantly, these changes appeared to be having a dramatically positive impact on the previously high maternal mortality rate. Overall, it was agreed that sufficient progress had been made at the trust to enable the special measures to be lifted in September 2006.

We published a second investigation report in August 2006. This focused on the care provided to 10 women who died during or after delivery at the unit at Northwick Park Hospital between April 2002 and April 2005.

The report found a number of deficiencies in the treatment provided to nine of the 10 women and in the action taken by the trust.
The key findings included a lack of cover from consultant obstetricians on the labour ward, along with the failure to manage and oversee the care of women with known complex medical problems or women who developed problems following delivery.

We also highlighted the need for using interventional radiology in cases of catastrophic postnatal bleeding. The Royal College of Obstetricians and Gynaecologists has since issued national guidelines on interventional radiology, making specific reference to this recommendation.

“...The second Healthcare Commission report on Northwick Park Hospital identified the common thread in the cases of maternal mortality. Lack of perception of the seriousness of the case, poor record keeping, results not available in time and consultant not being involved (in six of 10 cases) are shocking revelations. Every death and serious untoward incident should be analysed using the matrix given in the appendix of this report. Every effort should be made to rectify these shortcomings. Increased midwifery provision, consultant presence for more hours, multi-professional learning and a proper clinical governance framework are the key to avoid such poor outcomes.”

Professor Sabaratnam Arulkumaran
President of the Royal College of Obstetricians and Gynaecologists and Lead for the external maternity support team at Northwick Park Hospital

Managing outbreaks of Clostridium difficile: Buckinghamshire Hospitals NHS Trust

In June 2005, the Secretary of State for Health formally asked the Commission to investigate the circumstances behind two outbreaks of Clostridium difficile (C.difficile) at Stoke Mandeville Hospital. The Commission published its investigation report in July 2006.

This was the first investigation undertaken by the Commission into a healthcare-associated infection. We concluded that the first outbreak was a consequence of a poor environment for patients, poor practice in the control of infection, lack of facilities to isolate patients and insufficient priority being given to the control of infection by senior managers.

Following this outbreak, the trust’s leaders chose to implement some changes, but none that might compromise their strategic objectives. They failed to bring the second outbreak quickly under control.

The trust had a dysfunctional system for governance and was insufficiently focused on the management of risk. It failed to follow the advice of its own infection control team and that of the Health Protection Agency. Only the involvement of the Department of Health and national publicity changed its perspective.

The report also noted that there were still shortcomings nationally in the systems to support trusts in their approach to infection control and management of significant outbreaks.

A formal review of progress published in November 2007 showed that there had been a good improvement in the rates of C. difficile infection at the trust.
The poor use of mortality data: Oxford Radcliffe Hospitals NHS Trust

The Commission launched an investigation of the cardiothoracic surgical service at the Oxford Radcliffe Hospitals NHS Trust in December 2005. This followed concerns about the rates of mortality for patients undergoing coronary artery bypass graft (CABG) operations at the trust’s cardiac unit.

Our investigation was triggered by several breaches of the ‘early warning’ limit set by the Society for Cardiothoracic Surgery, a rating of “poor” for the Commission’s clinical indicator for deaths within 30 days after a CABG, and results published in the Hospital Guide by Dr Foster Intelligence which showed the trust to have significantly high rates of mortality for CABG surgery compared with the rest of the country.

We looked at the cardiothoracic service provided by the trust and carried out extensive analyses of the data. We concluded that, while the trust had a higher than average mortality for CABG surgery, it was within the 99.8% statistical control limit.

The Commission was critical of the trust for not using its own data to monitor or improve the treatment that it provided to its patients. This was particularly crucial because our analysis confirmed that the trust was operating on a greater proportion of patients who were at high-risk than many other trusts.

Elements of the service had not developed to meet the needs of these patients. The trust had previously assumed, and provided assurance to others, that the higher than average ‘crude’ rates of mortality were due to the greater proportion of patients who were at high-risk. However, our analysis showed that the trust had a higher than average rate of mortality in all risk groups.

The Commission made recommendations to improve the process for obtaining consent, the planning for patients assessed as high risk for CABG surgery, elements of the clinical governance processes and leadership, and the collection and use of data for cardiac surgery.

A formal review of progress will be undertaken in 2008.

Control limits

| Control limits allow for the expected variability in the observed mortality rate, if the underlying risk is that of an ‘average’ hospital. |
| The observed mortality rate is the proportion of deaths in a series of operations. The underlying mortality risk is the chance of death faced by an ‘average’ patient having an operation. |
| Even if the underlying risk for each patient is average, the observed rate over a period of time will vary by chance. We can calculate the variability expected, and traditionally 95% and 99.8% limits are set. |
| If the observed rate lies outside the control limits, either a series of unlikely events has occurred or the underlying risk for patients in that hospital is above average. An observed rate outside the 95% limit is generally taken as some evidence of excess risk, while lying outside the 99.8% limit is considered strong evidence. |
Outmoded care for people with learning disabilities: Sutton and Merton Primary Care Trust

In February 2006, the Commission launched an investigation into the learning disability services provided by Sutton and Merton Primary Care Trust. The impetus for this investigation came from the trust itself, which had concerns about a number of serious incidents.

The Commission published the investigation report in January 2007, detailing how outmoded, institutionalised care had led to the neglect of people with learning disabilities. Although we found that, in most cases, the trust had followed correct procedures for protecting vulnerable adults, some of the environments in which people lived were impoverished and completely unsatisfactory. Staff were not properly trained or supported to provide an acceptable level of care, and inadequate levels of staff meant that patients were often left for long periods with little to occupy their time.

The overall model of care promoted dependency. People were cared for rather than supported to be as independent as possible. The views of people with learning disabilities were seldom heard and few staff had any specialist training in communicating with people with learning disabilities.

Some of the findings were examples of staff being unaware that certain practices are no longer acceptable and could in some cases constitute abuse. In one case, a woman had routinely been restrained for many years with an arm splint, which was applied to prevent her putting her hand in her mouth. Such practices have long been deemed harmful and inappropriate.

The report was not a condemnation of individual members of staff, some of whom even worked on their days off to ensure adequate cover. The report did highlight that staff were not sufficiently trained or supported to provide adequate care.

There were failures in leadership at all levels, from managers to the trust’s board. There was no robust system for monitoring the service either at the managerial or board levels. Constant change, including seven chief executives within 10 years, four different trusts and three different health authorities created a lack of continuity and follow-up action of managers.

The trust has developed a plan to relocate people living at the main site, Orchard Hill Hospital, by the end of 2008 and to close the site by 2009. A formal review of progress since the investigation will be undertaken in 2008.

Widespread failures in clinical governance: Mid Yorkshire Hospitals NHS Trust

In February 2004, the Commission for Health Improvement (CHI) began an investigation into gastroenterology and related surgical services at the Mid Yorkshire Hospitals NHS Trust. This investigation was taken over by the Healthcare Commission in April 2004, when it replaced CHI.

Issues had been raised about these services at Pinderfields Hospital and subsequent public concerns about the quality of care. These included allegations of substandard clinical practice, poor team working and communication among consultants, and management failure to respond to external reviews and to resolve these issues, with a consequent impact on the care for patients.
Our report, published in December 2004, uncovered systemic management failings over a number of years, from the most senior level down. It resulted in special measures being imposed on a trust for the first time by the Secretary of State for Health, on the recommendation of the Commission.

We found that poor management and a lack of medical leadership had resulted in the trust’s inability to deal with disputes between doctors, properly investigate claims of poor performance and address huge financial debt. The trust had also failed to focus sufficiently on the quality of care for patients. It did not collect enough information about the care being provided by its hospitals and so was unable to take action to combat poor performance.

The assessment of progress in March 2006 found that the executive team had been strengthened, financial management and accounting systems were in place and the board was receiving regular, meaningful information about clinical and financial performance. A number of specific improvements had been made in line with the action plan. For example, HR systems had improved, with 98% of staff across the trust having received an appraisal. Interviews with staff also indicated greatly improved cooperation between consultants.

**Delivering improvements for patients**

**Recommendations**

Our published investigation reports have so far contained 205 specific recommendations for action, including a number of national recommendations – that is those made to the government or to other national bodies.

This is the main way we ensure that necessary improvements are made. All of the recommendations included in our published reports have been accepted in full and acted upon by the healthcare organisations concerned. (This is also the case with all of our recommendations arising from interventions, and the recommendations that we have made to the Secretary of State for Health regarding special measures.)

The recommendations cover a wide range of issues, as shown in table 2.

<table>
<thead>
<tr>
<th>Recommendation relates to:</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>43</td>
</tr>
<tr>
<td>Care and treatment of patients</td>
<td>42</td>
</tr>
<tr>
<td>HR and training</td>
<td>30</td>
</tr>
<tr>
<td>Adherence to guidelines</td>
<td>24</td>
</tr>
<tr>
<td>Learning from audits, complaints and incidents</td>
<td>21</td>
</tr>
<tr>
<td>Accountability, roles and responsibilities</td>
<td>18</td>
</tr>
<tr>
<td>Use of information</td>
<td>8</td>
</tr>
<tr>
<td>Teamwork</td>
<td>7</td>
</tr>
<tr>
<td>Leadership improvement</td>
<td>6</td>
</tr>
<tr>
<td>Board responsibility</td>
<td>3</td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>205</strong></td>
</tr>
</tbody>
</table>
Following each investigation, the trust concerned drafts an action plan based on our recommendations and shares it with us for final sign-off. We agree with the relevant strategic health authority and our regional staff the best arrangements for monitoring progress against the plan. We then agree a timescale for the Commission to conduct a formal assessment of progress, to ensure that improvements have been made.

The appendix sets out the arrangements put in place after each investigation and the timescales for assessing progress against these.

---

### Examples of improvement following investigation

#### Reducing cases of *Clostridium difficile*

Earlier this year, the Buckinghamshire Hospitals NHS Trust announced that it had improved by 40% from its last figures on the number of *C. difficile* cases.

The trust’s rate of reported cases was 1.42 per 1,000 bed days in 2006 compared to a figure of 2.34 in 2005.

The trust said that it had “focused on good hand hygiene using soap and water as well as alcohol gels, developed practices on antibiotic usage, minimised patient movements, ensured earlier testing, and standardised assessment of patients with diarrhoea”.

#### Multi-disciplinary working in maternity services

We received correspondence from an NHS midwife, following an investigation into maternity services:

“Our labour ward forum has been running for years and was set up virtually as soon as the guidance came out ... The group didn’t work that well before the Healthcare Commission came in but now I would think it would be difficult to find a better working one. A consultant co-chairs with the delivery suite manager and it is truly multi-disciplinary.

“It is very effective, very efficient and feeds into all the other groups covering areas like antenatal, risk management, audit, and education and training. It is the group that reviews the delivery suite/labour ward guidelines.”

#### Helping senior managers to focus on key problems

We received the following letter from an NHS trust chief executive, shortly after the completion of our investigation:

“As I am sure you know, it has not been an easy time for the trust. When we invited the Healthcare Commission to investigate, we knew that we had problems in the service and were keen to address them. The investigation, the report and the development of the action plan have all helped us to do so and it has been a very productive process. Its constructive nature has owed much to the way in which you led the investigation and we are very appreciative of that.”
National impact

Evidence uncovered during our investigations sometimes suggests wider lessons for the whole NHS. In these cases, we promote improvement through national recommendations. For example:

- Following the investigation, published in 2006, into the care and treatment of Christopher Alder, undertaken jointly with the Independent Police Complaints Commission, we recommended the development of a national protocol between the NHS and the police. A national seminar, hosted by the Commission, helped to ensure that the initiative gained the support of the Home Office, the Department of Health and other relevant national bodies.

- After our investigation into gastroenterology services at Mid Yorkshire Hospitals NHS Trust, the Department of Health was asked to issue guidance to trusts to improve the consistency of reporting waiting times for endoscopy. Since January 2006, the Department of Health has collected monthly data on the number of patients waiting for a gastroscopy, flexisigmoidoscopy or colonoscopy as part of its national monitoring of progress towards the Government’s 18-week referral-to-treatment target. This information is used to help identify where patients are waiting too long.

- As a result of our first investigation into maternity services at Northwick Park Hospital, we recommended that the Department of Health should drive forward the development and implementation of a national dataset for maternity services.

- Following the second investigation at Northwick Park, a national recommendation was made about the need for interventional radiology in obstetric units across the country. In June 2007, the Royal College of Obstetricians and Gynaecologists issued guidance to all obstetric units on this matter, citing the Commission’s report.

- The Cornwall and Sutton and Merton investigations have significantly raised the profile of services for people with learning disabilities. In November 2006, as a direct result of our Cornwall investigation, the Secretary of State for Health, Chief Executive of the NHS and Director General of Social Care wrote to the NHS and local authorities to remind them of their responsibilities in delivering quality services for people with learning disabilities.
Throughout the process of managing cases – from referral to possible intervention or full investigation – we pay close attention to similarities and themes that may emerge.

Although our initial concerns are usually about the quality of care in a particular service, what we find may highlight a more widespread, often national, issue.

We set out below some of the common themes that have arisen during the course of our work: firstly those issues that have broad relevance to healthcare organisations and then those affecting specific aspects of healthcare.

**General themes**

1. **Leadership**

Our work over the past three years has highlighted leadership as one of the most critical factors in providing good, safe and dignified care.

Good leadership is clearly important in terms of setting the direction of an organisation, developing its culture, ensuring delivery and maintaining effective governance. We have acknowledged that healthcare is complicated and executive teams must balance competing priorities and needs and, in particular, be able to maintain their focus on the clinical quality of care alongside some major distractions.

We have found that the boards of NHS trusts we have investigated are particularly vulnerable to being consumed by the business of healthcare, in the form of mergers, reconfiguration of services, financial deficits, and targets. That is not to say that these things are not fundamentally important; they are clearly a necessary part of providing effective healthcare services and delivering value for money. However, boards must also maintain their focus on clinical quality throughout. Ensuring they have the relevant information and act on it is crucial to this.

Continuity of leadership is important, too. We have found recurring cases of poor leadership in the trusts we have investigated, with frequent changes in senior personnel and a lack of strategic direction, serious financial or capacity concerns and failure to deal with historical problems. This was particularly the case at Sutton and Merton PCT, where frequent changes in management played a part in the poor quality of care in the learning disability service. There had been seven chief executives in 10 years, as well as four different trusts under three different health authorities – all creating a lack of continuity and follow-up of management action.

Leadership is vital in two other areas: ensuring effective teamwork and creating an open culture in which staff feel able to express their concerns. Leaders are not solely responsible for this. All professional staff must work together as part of an effective team and exercise their professional accountability. We have been surprised by the degree to which staff tolerate poor conditions and fail to speak out on behalf of their patients. Speaking out is part of the responsibility of a professional practitioner – and a vital means of ensuring that the NHS is able to protect the safety of patients.

Clearly, that is balanced by the responsibility of trust boards to make sure that their staff do feel able to speak out and do not fear victimisation or reprisal for doing so. We are concerned about the degree to which we receive reports of staff feeling bullied or harassed, or feeling that they have been intimidated because they spoke out.
Teamwork is essential to the delivery of safe, good quality care. This is not always given the priority it needs. Many of our investigations featured serious failures in teamwork, both between managers and clinicians and between clinical groups. Clinical staff have a responsibility to work together – nurses, doctors, midwives, allied health professionals and those involved in social care.

2. Management and targets
Targets or outcome measures are an integral feature of a modern 21st century healthcare system, and have resulted in measurable improvements for patients in some important areas.

NHS managers have always had to deal with conflicting priorities. The vast majority do it successfully. Our investigations have looked at how managers tackle these potential conflicts and our overriding message has always been that it is not acceptable – nor is it necessary – for the safety of patients to be compromised by any other objectives, no matter how compelling these may seem, at the time, to be. In fact, if a trust takes the view that meeting a target may put the safety of patients at risk, it may, according to the rules of the annual health check, apply to the Healthcare Commission for some form of special treatment in relation to the target. This will allow it to deal with the matter of safety without affecting its annual assessment inappropriately.

We have seen different approaches taken by managers in these challenging environments, and in some investigations have noted that there is a fine distinction between what some perceive as a firm management style, and what appears to others as the suppression of uncomfortable messages or bullying.

Our investigations always try to take full account of the realities and pressures faced by managers in today’s health service, but we remain concerned that, too often, management styles are perceived as being autocratic. This can discourage the open reporting of serious incidents, thereby restricting a trust’s ability to learn from failure and make necessary improvements.

3. Governance and the use of information
We have been surprised at the extent to which some large, complex organisations have not had adequate systems in place to ensure that the board is properly informed about trends or potential issues at ward level or in specialist services. The collection and proper use of data on outcomes is essential for every trust, for board members to assure themselves about the quality of services for which they are responsible. Trusts should have clear structures and experienced staff making sure this happens properly. Boards must satisfy themselves that they have this information.

However, we have seen examples where the information generated within trusts was either not sufficiently detailed to identify the serious problems that we subsequently revealed, or the information was merely collected on a regular basis and not used to inform decisions. Apart from exposing patients to unnecessary risk, these situations can have the added danger of providing a ‘false assurance’ within the trust, because board members take comfort in the knowledge that data is collected and that no concerns have been raised. This false assurance may also inappropriately reassure the strategic health authority responsible for managing the performance of the trust, and the primary care trust commissioning the service in question.

Every NHS board member has a responsibility to ensure they understand the data they are given. What is more, they need to challenge or
question information whenever it appears unclear, so that they can provide a genuine assurance that patients are receiving safe, appropriate care.

4. The impact of mergers and other organisational change

Services to patients can often be improved by reorganising the strategic delivery of health services, or by merging organisations.

Changes are inevitable over time, but clearly effecting organisational change presents real challenges to the leadership team. Our investigations show that, if not carefully managed, the process of change can divert management from delivering a good quality of service.

One of the Healthcare Commission’s predecessors, the Commission for Health Improvement (CHI), published a report that considered the triggers for an investigation and identified risk factors for serious service failure. The report noted that: “Many investigated organisations had been the subject of a recent merger or major structural change, and this change was often difficult. Organisational change is a common feature of the NHS, but the effects are exacerbated when there is poor leadership and a lack of strategic capacity and direction.”

In our investigations, a history of recent and/or difficult mergers or restructures is a common feature. In these organisations, we considered that structural change had not been implemented successfully at the time of the investigation.

For example, the Mid Yorkshire Hospitals NHS Trust was formed after two difficult mergers: the first in 1997 and the second in 2002. We found that concerns about the quality of clinical care had been poorly handled by the successive management teams. The legacy passed on to the Mid Yorkshire Hospitals NHS Trust was one of unanswered questions and deteriorating relationships. Faced with implementing a contentious and complex merger, the Mid Yorkshire board failed to establish a regime of clinical governance capable of resolving difficult issues.

The consultation prior to the merger in 2002 identified a number of benefits of bringing the trusts together. These included clinical benefits through the reconfiguration of clinical services, made possible by reaching sufficient critical mass to permit specialisation. However, few services had been integrated. This resulted in an inequitable service for patients and, in some cases, placed them at risk.

Similarly, our investigation at Buckinghamshire Hospitals NHS Trust revealed an organisation that had faced a challenging agenda since a merger in April 2003. As well as bringing together two disparate organisations, the leadership had to deliver a major reconfiguration of services and a new hospital building, funded by a private finance initiative. In the meantime, services at the trust’s Stoke Mandeville Hospital had to be delivered from poor and in part dilapidated buildings.

It is important to recognise that, while mergers and other organisational changes will continue to be necessary in some situations, there is clear evidence that they also bring with them a high degree of risk, if not handled appropriately by senior leaders.

5. Safeguarding vulnerable adults

The investigations of Cornwall Partnership NHS Trust and Sutton and Merton Primary Care Trust threw into sharp relief the importance of maintaining effective systems for safeguarding vulnerable adults. In Cornwall in particular, the
safeguarding systems were shown to be inadequate both within the trust and between the trust and the local authority. However this failing, in our experience, is not an isolated example. There appears to be poor understanding of adult protection procedures among the NHS healthcare providers that we have looked at, and of their responsibilities under the *No Secrets* guidance.

*No Secrets* was issued as a local authority circular and as such is binding on health bodies as it is on local authorities. Adults who are vulnerable deserve no less care and attention to their safety and wellbeing than do children, but the systems are not always as clear or well developed.

In part, this is due to the higher profile of child protection by virtue of the Children Act, which places a statutory duty on public authorities to keep to child protection procedures. A number of high profile cases have also heightened awareness of the need for effective systems and partnership working. All NHS trusts have a designated child protection officer and invariably a director holds lead responsibility. That is not the case for adults.

Local authority adult protection coordinators have told us that some NHS trusts do not routinely check that incidents may include adult protection issues meriting referral to the local authority under *No Secrets* guidance. NHS trusts, they report, have a tendency to deal with matters under the system attached to the label and so something that is reported as an ‘incident’ gets dealt with under the incident reporting procedure; likewise a complaint.

In the main, healthcare staff and the safeguarding system – health providers, local authorities and the police – recognise sexual assault as abuse. They usually recognise serious physical assault as abuse too – although there is far too great a tendency to tolerate a high level of patient-to-patient assault in mental health (especially older people with dementia) and learning disability settings, particularly where people live together in what should be viewed as their home.

Too often incidents, which in the home would be viewed as domestic violence, are accepted as customary in some NHS settings. They are excused on the grounds that the person committing the assault did not do so intentionally, or could not help themselves, because the behaviour is part of their condition. While that may be true, it does not follow that the person living with the perpetrator must endure it. High rates of assaults and other serious incidents often seem to be accepted as an inevitable consequence of low staffing levels, and something that must be accepted because staff are trying their best.

We cannot observe this without asking whether our society genuinely finds it acceptable, or tolerable, for those who are mentally unwell, or old, or who have a disability – who cannot exercise full control and choice over their lives – to be hit or hurt on a regular basis.

Members of NHS boards must make themselves aware of, and challenge, the repeated occurrence of such incidents on this basis: if they were a patient on that ward, or in that home, how often would they expect to be hit or hurt during a given period? In one mental health ward we examined, incident rates over a six-month period were as follows:

- Violence from patient-to-patient, involving injury: 129 (34 involving the same patient)
• Violence from patient-to-patient, not involving injury: 286 (34 involving the same patient)
• Violence from patient-to-staff, involving injury: 91
• Violence from patient-to-staff, not involving injury: 90.

Patients on an acute ward would not, we suggest, find it acceptable to be hit once, still less regularly, while lying in their beds or walking around the ward.

Institutional abuse also poses a problem for the safeguarding system. Staff become used to ways of working that they do not readily recognise as institutional abuse. It can be difficult for new staff to challenge or for unqualified staff to recognise it as poor practice. It is essential that those responsible for services for vulnerable patients maintain their skills and keep up to date with best practice.

Institutional abuse also presents a challenge to local authorities. Cornwall County Council found it difficult to address institutional abuse through its existing adult protection procedures and we are aware of healthcare providers and our own staff experiencing resistance from local authorities when they try to report it. It may be that further examination of the safeguarding systems for adults needs to be undertaken to ensure that they are fit for their intended purpose.

6. Poor care of patients on general wards

The relatively small number of our investigations of acute hospitals has revealed worryingly similar stories of poor care for patients on general wards.

Older or otherwise vulnerable patients were most at risk, since they were most dependent on good nursing care and not always able to express their needs. We saw examples of patients who had received good care in a specialist part of the hospital followed by a dramatic reduction in the standard of care once the patient was transferred to a general ward.

Patients were not always helped with eating or cutting up their food. There were examples of patients who had suffered a stroke, having their food placed on their paralysed side. Some families told us that they found themselves having to feed not just their own relative but other patients as well, and that when patients rang the call bell because they were in pain or needed to go to the toilet, it wasn’t answered, or not in time.

We found examples of tablets or nutritional supplements not being given on time and of medication being missed. Charts of what the patient had eaten or of fluid intake and output were not completed properly, so were of no effective use. Patients were moved from one location to another because of the pressure on beds, sometimes late at night or in the early hours of the morning.

In some cases there were too few nurses on the wards for the needs of the patients they were looking after, or the proportion of qualified staff was low. Nurses themselves were distressed at the standard of care patients were receiving. We spoke to some nurses who had raised concerns and filled in incident forms but nothing appeared to have happened. These concerns appeared either to have not filtered through to the level of the trusts’ boards, or to have been disregarded.

In the small number of trusts that we investigated where these problems occurred, the boards seemed ‘insulated’ from these events, and the systems of governance were simply not effective.
We are concerned that patients are put at risk because of the way in which some struggling organisations have interpreted their priorities, and our experience in this area, which is also reflected in themes arising from NHS second stage complaints managed by the Commission, will lead us to keep a close watch on similar situations arising in different parts of the country.

Specific themes

1. Poorly-performing maternity services
After finding worrying similarities in major investigations into deaths at three maternity units (Northwick Park Hospital in London, New Cross Hospital in Wolverhampton and Ashford St Peters Hospital in Chertsey), we identified five themes that suggest that a maternity unit may be in difficulties:

- Weak risk management with poor reporting of incidents and handling of complaints.
- Poor working relationships and poor working in multidisciplinary teams.
- Inadequate training and supervision of clinical staff.
- Poor facilities and services isolated geographically or clinically.
- Shortages of staff coupled with poor management of temporary employees.

In a national statement we called on NHS trusts to start assessing their maternity services against these themes, and primary care trusts, which commission the services of maternity units in hospitals, to use them to assess the performance of these units.

Since this statement, we have worked closely with individual trusts, and nationally with health professionals through the Royal Colleges, to build their confidence in addressing governance issues and using data effectively to monitor and improve performance. There is now widespread awareness of this work and a significant number of maternity units have developed action plans addressing the findings from our investigations.

We have also carried out a review of maternity services in England, the results of which are due to be published in 2008.

2. Foetal heart monitoring
The investigations team managed 10 referrals regarding maternity issues in the year to April 2007 alone. A common theme in some of these referrals is concern over foetal heart monitoring and cardiotocograph (CTG) interpretation, either brought to our attention by the referrer or evident from a review of documentation relating to serious untoward incidents.

If staff fail to recognise and act upon signs of distress on the CTG traces, this can lead to serious complications and, ultimately, could lead to the death of the baby.

The investigation team reviewed staff training programmes and checked attendance records to ensure staff are appropriately trained to identify signs of distress. Serious untoward incidents are also reviewed to ensure that any learning has been identified and shared. Any concerns are reported to the trust and a recommendation made for immediate action. The trust is then monitored until it has taken the actions needed.

Our maternity services review will create a set of indicators covering women's experience, clinical quality, and capability and efficiency. It will enable trusts and commissioners to
compare outcomes and benchmark their performance. The review asks trusts about their CTG training and maternity staff about how it is used in their trusts. A final report, with an interactive toolkit, should be available in 2008. Follow-up work with those trusts considered most in need of support will be undertaken with the involvement of our local staff.

3. Services for people with learning disabilities
The Commission has undertaken two major investigations and managed eight other referrals about services provided for people with learning disabilities. Although there were distinct differences in each investigation, we also identified some key similarities in the findings:

- The services were isolated, in terms of their management and often their location, and the models of care were outdated.
- Institutional abuse was occurring, but staff were often unaware that what they were doing constituted abuse.
- There was a lack of awareness about restraint and its appropriate use.
- Supervision arrangements and staff training were poor.
- There were deficiencies in record keeping and in the planning of care.
- The arrangements for governance did not allow for effective monitoring of the quality of the services.
- Historically, learning disability services had not been well resourced.
- The relatives of users of services and advocates were not involved sufficiently in the planning of care.
- The PCTs failed to commission safe services of good quality.
- The strategic health authorities failed to manage effectively the performance of the learning disabilities services.

There is no doubt that the combination of these factors has led to poor care and abuse of people with learning disabilities. We were encouraged to hear that some trusts reviewed their own practice in the light of the recommendations from these investigations.

However, to be sure that serious failures are not occurring elsewhere, the Commission embarked on a comprehensive audit of specialised inpatient learning disability services, both in the NHS and the independent sector throughout England. This will improve the understanding of the key issues affecting people using learning disability services, and highlight what improvements providers can make. We published the results of this audit in December 2007.8

---

Cardiotocograph (CTG)

The cardiotocograph was introduced as a screening test in the 1970s to monitor pregnant women. It simultaneously measures foetal heart rate and uterine contractions, and produces a printout: the CTG trace. The baby’s heart rate is monitored throughout labour so stress can be detected early. The contractions are monitored so that the midwife and mother know when the contraction is occurring and to check for foetal distress during the contraction. The use of CTG monitoring in labour is recommended for women with identified risk factors.
4. The control of infection in hospital
We have now carried out two investigations into outbreaks of Clostridium difficile (C. difficile), one at Stoke Mandeville hospital, part of Buckinghamshire Hospitals NHS Trust, and the other recently completed at Maidstone and Tunbridge Wells NHS Trust.

The background to these investigations is the dramatic rise in the number of cases of C. difficile in the UK. The number of infections in patients over 65 reported to the Health Protection Agency in 2006 was 55,681, an increase of 8% on the previous year.

There has also been a rise in the number of deaths associated with C. difficile in the UK – the infection was cited on 3,807 death certificates in 2005 compared with 975 in 1999. Even if this is partly due to increased awareness, it is still a serious concern, particularly as our review of case notes at Maidstone suggested there was probably a considerable underestimate of the number of patients where C. difficile had contributed to their deaths.

The investigation into the outbreaks of C. difficile at Stoke Mandeville hospital found that the environment made controlling infection more difficult, since the buildings were dilapidated and there were few single rooms.

We also found that the trust failed to bring the second outbreak under control because it was too focused on meeting national targets and was not focused enough on clinical risk. Its determination to meet the target of four hours for a maximum waiting time in accident and emergency, led to some patients with diarrhoea being put on open wards rather than in isolation facilities. Clinical staff repeatedly raised concerns about moving patients to different wards, because of the likely spread of infection, but no effective action was taken to stop this.

In addition the shortages of nurses probably contributed to the spread of infection – staff on the wards were too rushed to take basic precautions such as washing their hands, wearing aprons, emptying commodes promptly and cleaning equipment properly.

C. difficile

C. difficile is the major cause of serious bacterial infectious diarrhoea acquired in UK hospitals. It cannot grow in the presence of air. To help it survive it produces spores, which are resistant to drying, chemical disinfectants, alcohol and stomach acid.

For a patient to get the infection, they must swallow C. difficile spores or bacteria. This could happen before they come into hospital, or at the hospital if the environment, equipment or clinicians’ hands or clothes are contaminated. The spores can remain in the patient and the environment for long periods, increasing the chance of cross-infection. Since the spores are resistant to alcohol, the alcohol gels used in hospitals are not an effective protection.

In most cases, recent treatment with antibiotics is a prerequisite for developing a C. difficile infection. Antibiotics destroy many of the normal healthy bacteria that live in our intestines, and their absence makes it easier for C. difficile to thrive. Broad-spectrum antibiotics, which act against a wide range of bacteria, are most often associated with the disease.
The investigation at Maidstone revealed a number of similarities with Buckinghamshire Hospitals. Both trusts had had difficult mergers, and were preoccupied with finances, a demanding reconfiguration agenda and new buildings funded through a ‘private finance initiative’, all of which consumed much management time and effort. They also had many older-style ‘Nightingale’ wards and few single rooms able to be used for isolation.

Additionally, financial pressures in both trusts led to low numbers of nurses and a cap on the use of bank and agency staff. In both trusts, we found an unrelenting pressure to take beds ‘out of the system’. Thus both trusts had very high occupancy levels, could not manage with fewer beds, and so had to open ‘escalation’ beds, often in unsuitable environments, without proper support in place.

In both trusts, there were many complaints from patients and relatives about the quality of care. These included patients not being fed, call bells not being answered, patients told to empty their bowels or bladder ‘in the bed’, poor hygiene practices, and general disregard for privacy and dignity.

It seems unlikely that these similarities are coincidental. We are concerned that where trusts are struggling with a number of problems that consume senior management time, and are under pressure to deliver on targets or outcomes, similar problems might be likely to develop.

If waiting times are achieved and finances brought in balance, in some it is at the price of rushed handovers from accident and emergency, patients moving round the hospital and being cared for in inappropriate and sometimes unhygienic areas, with low numbers of nurses and many temporary staff. These are circumstances under which C. difficile is likely to thrive and outbreaks occur. In turn, not only can these have tragic consequences for patients but also they can lead, for those who recover, to longer lengths of stay, more pressure on waiting times and ultimately more closures of wards.

5. Mental health services
A consistently high proportion of cases managed by the investigations team relates to concerns about mental health services.

The nature of these varies from assaults and rates of suicide among users of services to allegations of abuse by staff and a lack of supervision. These are often accompanied by operational concerns, such as a lack of permanent staff, a lack of training and poor risk management procedures. These issues in turn can lead to intense work pressures and a reduction in the organisation’s capacity to report, investigate and take action.

A common theme in these referrals is a failure by trusts to learn from serious untoward incidents. Many people believe that serious incidents are more likely to occur – and some would even say inevitable – at mental health trusts, due to the nature of the service provided.

We do not believe that this should be used as an excuse for poor standards of safety. Trusts must learn from serious incidents. When we investigate, we look very closely at how the trust reports, investigates and takes remedial action to prevent incidents recurring. Our focus is not on the overall number of incidents reported. We are more concerned to understand the trust’s attitude to these incidents – the level of importance given to them by managers and whether there is evidence that lessons have been learnt and improvements made as a result.
A coordinated approach to protecting the safety of patients

It is clear that, in relation to service failure, “problems often occur at the borders between one organisation or team and another”. We have therefore put considerable effort into working jointly with other bodies: sharing information, referring or receiving concerns, and where appropriate working in partnership on investigations.

Working with other bodies

We continue to play our part in the Concordat and we cooperate with a range of bodies including the NHS Clinical Governance Support Team, the National Patient Safety Agency, the Health and Safety Executive, the General Medical Council, the Audit Commission, the Health Service Ombudsman and the Healthcare Inspectorate for Wales.

The Concordat

The Concordat is a voluntary agreement between organisations that regulate, audit, inspect or review elements of health and healthcare in England. It was launched in June 2004 by 10 organisations, led by the Healthcare Commission. There are now 20 signatories working together to coordinate their activities such as audits, reviews and inspections. By streamlining their activities, these bodies are supporting the improvement of health services for the public.

Cooperating with other organisations has helped to broaden the impact of our work. For example, in drawing up formal agreements with bodies like the Advisory Committee on Clinical Excellence Awards, the Independent Police Complaints Commission, the British Cardiovascular Society, the Department of Health and Monitor (the regulator of NHS foundation trusts), we share sensitive information in a considered way and help each other carry out our functions. It also reduces the burden on the health service and helps to avoid duplication of effort.

We have undertaken formal joint investigations with the Independent Police Complaints Commission and the Commission for Social Care Inspection. In each case, this has helped to build stronger working relationships between us, better understand each other’s perspectives and, as a result, further develop our own approach.

We have also made visits with the Mental Health Act Commission, resulting in joint recommendations and, again, an improved working relationship. We also undertook a joint national survey with the Health Protection Agency, the results of which were published in December 2005. We are working more closely with the Health and Safety Executive to share relevant information when referrals are first received.

Following up statistical ‘outliers’

We often have to analyse statistical data when we consider referrals for investigation. This is usually to review the mortality rates or other health outcomes of a particular service or consultant team, over a specified period.

This data, when compared with similar services or teams in other parts of the country, is an important guide in deciding whether further action is required. Sometimes these other services or teams, included in the analysis for the purpose of comparison, are themselves found to have extremely poor outcomes. These are referred to as statistical

48 Healthcare Commission Learning from investigations
Joint work with the NHS Clinical Governance Support Team

The NHS Clinical Governance Support Team (CGST) provides support to organisations facing significant challenges in the delivery of high-quality, safe and accountable healthcare, including those that have been the subject of investigation by the Healthcare Commission. The work is undertaken in partnership with clinical and managerial staff of the host organisation and often with external clinical experts, with the goal of developing local capacity, competence and resilience. The support focuses on those areas that consistently pose the greatest risk in challenged healthcare organisations: effective team working, strong leadership and management capability, and good communication.

In one such trust, following an unacceptable number of serious incidents in a maternity service, a Healthcare Commission investigation identified major problems with staffing levels, facilities and the use of evidence-based practice. The CGST undertook a whole-system intervention over 18 months that engaged all levels of the organisation, looking at poor working relationships between consultants and midwives, poor management of staff and unsatisfactory risk management.

Working with the service management team in maternity and the senior multidisciplinary team of consultants and midwives, roles were clarified to establish responsibilities and to review working relationships. The CGST enabled staff to introduce a systematic approach to handover at each shift change, which now includes summary feedback on incidents and complaints as well as the condition of patients.

At an organisational level, the CGST supported the development of a new trust-wide governance infrastructure, ensuring that local systems linked effectively into those of the organisation as a whole, so that both concerns and good practice were effectively communicated.

‘outliers’ but, clearly, each represents an actual organisation or team.

We have an agreed process for following up such outliers. This includes talking to other expert bodies (such as the Confidential Enquiry into Maternal and Child Health) and the healthcare providers themselves, to establish the quality of the data we have used in our analysis. If during this process, the investigations team has doubts about the information received back from the healthcare provider, or considers that there may be a serious risk to the safety of patients, the case can be escalated as a referral for investigation.

We have started to build even further on this experience and now deliberately search for statistical outliers, with the aim of identifying potential failure at the earliest possible stage. This requires a particularly thoughtful and sensitive approach, as data alone is unlikely to provide a complete insight into the complexities of healthcare. However, this is a potentially powerful means of highlighting problems – and addressing them before they build up into the sort of systemic failings uncovered in previous investigations.
Using investigative findings in our annual assessment of NHS trusts

The findings from investigations (and, where appropriate, initial considerations) are fed into the process of assessing NHS trusts against core standards.

This has been used to good effect. For example, for the year 2005/2006 one acute trust declared that it was meeting 43 of the 44 core standards and had “insufficient assurance” for the remaining standard.

The Commission was able to use evidence gathered as part of an investigation that was already underway at the trust. A comparison of this evidence against the criteria for achieving the core standards resulted in five of the standards being ‘qualified’ and the trust receiving two ‘penalty points’ for each standard when their score was calculated. This led to a rating under the core standards assessment of “not met”.

For the following year (2006/2007), the trust declared that it was compliant with 21 of the 44 core standards and was not meeting 23 standards. This seemed to be a more realistic assessment of its true performance, partly resulting from the scrutiny that the Commission was able to carry out during the previous year.
Conclusions

In our first three years, we have operated a professional and independent process for investigating failures in healthcare.

We have received requests from many different sources and we have handled them all using the same thorough procedure. Although only a relatively small proportion – around 6% – have required us to carry out a full investigation, these cases have by their nature been extremely serious and have captured significant attention from the national media. Many more have, after collection and consideration of detailed evidence, led to an agreed action plan for improvement. Sometimes the necessary action has already been taken by the trusts involved.

In each case, our primary concern has been for the safety of patients. We aim to work closely with trusts and stakeholders at all times and we very much adopt a proportionate approach. Those we work with generally find it is a constructive process, as some of the quotes within this document testify.

However, it is in the nature of healthcare that failure will occur from time to time. Our challenge is in minimising the risks, and thereby minimising harm to patients. This relies on the NHS learning from its mistakes. The Chief Medical Officer estimates that, currently in the UK, 10% of inpatient episodes lead to unintended harm;¹⁰ and around half of these are deemed by researchers to be preventable.

Through its investigation work, the Commission has uncovered evidence of serious, systematic failures. The resulting reports and actions plans have helped healthcare providers to learn about common problems seen elsewhere and how system improvements might be identified and implemented.

The Commission has already made an impact on a national scale, being instrumental in bringing about improvements in the safety of our maternity services, the care provided to people with learning disabilities and the management of infection in our hospitals. Our processes involve regular follow-up in trusts where we have carried out an investigation. The improvements made are striking.

It is clear that it is in the interests of patients and the public that our healthcare system has an independent regulator with strong investigative powers and functions.

The NHS

Within the National Health Service, there is a high degree of commitment and caring at the front line. However, we are concerned that where failure does happen, too often it is associated with recurrent themes, as set out in this report.

Our work requires us to ask questions of many trusts. Often the information that we are requesting is readily available – it is the same information that managers are using to assure themselves and the trust’s board that systems to protect the safety of patients are working. In most cases, we find that the trust is open and willing to work with us, with a view to identifying any improvement that may be necessary. But there are those trusts where an open attitude is not so evident, where systems for clinical governance are muddled or not given a high priority at the most senior level. In these cases, we have often been left with no alternative but to launch a full and exhaustive investigation.
We urge the NHS to take note of this and, as a basic requirement in every trust:

- Senior managers need to encourage a culture of openness and actively elicit the views of frontline staff on matters relating to safety.
- Every board member should make it their business to understand the nature of the incidents being reported in their organisation, and satisfy themselves that action is taken and improvements made.
- Systems for clinical governance must be ‘built in’ to the running of trusts, rather than being ‘bolted on’.
- Boards and senior management teams should regularly build in protected time, uncluttered by other priorities, to reflect on whether they are meeting the needs of their most vulnerable patients and how they can be assured that these individuals are safe from harm.

In addition, those bodies responsible for commissioning services and managing the performance of provider trusts need to pay particular attention to these points. They should actively check to make sure patients are protected from harm, rather than assuming this is someone else’s job.

Our role

At the Healthcare Commission we will continue to evaluate our work and improve our approach wherever possible, ensuring that it is proportionate and effective in improving healthcare and protecting the safety of patients.

Our challenge, leading up to the creation of the new health and social care regulator in 2009 and beyond, remains to ensure that healthcare providers learn from our investigations and continue to remember those lessons in years to come. We do not want to report another Cornwall or Northwick Park in five or 10 years’ time. We will develop our use of data to identify potential problems at an early stage, thus hopefully reducing the need for full investigations, continue to watch how trusts take action at a local level, and focus even more on achieving sustained improvement at a national level.
# Appendix: Overview of actions taken following our investigations

<table>
<thead>
<tr>
<th>Summary</th>
<th>Action plan agreed</th>
<th>Publication date</th>
<th>Assessment of progress against actions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation into the maternal services provided by Royal Wolverhampton Hospitals NHS Trust at New Cross Hospital</td>
<td>June 2004</td>
<td>16 June 2004</td>
<td>Assessment of progress showed improvements in the recruitment of appropriately skilled staff, a new committee structure was helping to provide information on risk, and positive reports had been received from women who had used the service.</td>
<td></td>
</tr>
<tr>
<td>Investigation into gastroenterology and related surgical services at Pinderfields Hospital, and subsequent public concern about the quality of care provided in the unit.</td>
<td>February 2005</td>
<td>16 December 2004</td>
<td>Special measures recommended by the Healthcare Commission were imposed at the time of publication, on the basis that the trust needed external support. Progress in all areas enabled special measures to be lifted in March 2006.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report title</th>
<th>Action plan agreed</th>
<th>Publication date</th>
<th>Assessment of progress against actions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation into Mid Yorkshire Hospitals NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report title</td>
<td>Summary</td>
<td>Action plan agreed</td>
<td>Publication date</td>
<td>Assessment of progress against actions</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-----------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Investigation into drug dependency services provided by Bolton, Salford and Trafford Mental Health NHS Trust</td>
<td>Concerns that had been brought to the Commission’s attention about the number of medication errors that had taken place within the inpatient service at Kenyon House since April 2000, and the alleged inadequacies of the procedures for reporting and investigating such errors.</td>
<td>February 2005</td>
<td>18 May 2005</td>
<td>March 2006</td>
</tr>
<tr>
<td>Review of maternity services provided by North West London Hospitals NHS Trust</td>
<td>Investigation into a number of adverse events in maternity services at Northwick Park Hospital. Significant failings were identified while the investigation was still underway, and special measures were imposed to cap the number of deliveries and to bring in external expert support.</td>
<td>May 2005</td>
<td>7 July 2005</td>
<td>May 2006</td>
</tr>
<tr>
<td>Allegations of bullying and harassment at Devon Partnership NHS Trust</td>
<td>A review was conducted following concerns that staff at the trust had experienced, or were still experiencing, bullying and harassment at work.</td>
<td>February 2006</td>
<td>12 January 2006</td>
<td>April 2007</td>
</tr>
</tbody>
</table>

Appendix: Overview of actions taken following our investigations
<p>| Investigation into allegations of bullying and harassment and the process for handling complaints at East Sussex Hospitals NHS Trust | Concerns were raised about management practices at East Sussex Hospitals NHS Trust. These included allegations of bullying, harassment and unfair treatment of some members of staff by their managers, and insensitivity in the handling of complaints from patients and members of the public. | 12 January 2006 | January 2006 | April 2007 | As a result of our investigation, a culture of ‘zero tolerance’ towards bullying and harassment had been promoted by the trust’s board, supported by training for staff and initiatives such as a checklist for good practice. Improvements in HR practices were also evident. |
| Investigation into Mid Cheshire Hospitals NHS Trust | In June 2004, a nurse was convicted of two separate charges of attempted murder of patients at the Mid Cheshire Hospitals NHS Trust. The Commission carried out an investigation into the systems and procedures that were in place in the trust at the time of the incidents and since to establish whether these were appropriate to protect the safety of patients. | 24 January 2006 | February 2006 | January 2007 | Following the investigation, nursing levels improved and the previous reliance on agency staff reduced. Clinicians were more engaged in leadership and management and frontline staff were supported to provide a better quality of care to patients on the wards. |
| Investigation into the care and treatment given to Christopher Alder by Hull Royal Infirmary and Humberside Ambulance Service NHS Trust prior to his death | The investigation, undertaken in collaboration with the Independent Police Complaints Commission, looked at the care and treatment given to Christopher Alder after he was assaulted outside a nightclub in Hull. | 27 March 2006 | June 2006 | August 2007 | Both NHS trusts have made the necessary improvements, and police and NHS representatives convened a national seminar to promote closer joint working. |</p>
<table>
<thead>
<tr>
<th>Report title</th>
<th>Summary</th>
<th>Publication date</th>
<th>Action plan agreed</th>
<th>Assessment of progress against actions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint investigation, with the Commission for Social Care Inspection, into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust</td>
<td>Concerns were raised about the quality of care provided by the trust to people with learning disabilities – including allegations of abuse. The Healthcare Commission invited the Commission for Social Care Inspection to join the investigation part way through to ensure that social care aspects were taken into full account.</td>
<td>5 July 2006</td>
<td>September 2006</td>
<td>October 2007</td>
<td>An external team was brought in by the strategic health authority during the investigation, leading to some improvements. Special measures were imposed in July 2006 to bring about further improvement. The investigation led to a national audit of services for people with learning disabilities.</td>
</tr>
<tr>
<td>Investigation into outbreaks of <em>Clostridium difficile</em> at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust</td>
<td>The Secretary of State for Health asked the Healthcare Commission to investigate following two outbreaks of <em>Clostridium difficile</em> at Stoke Mandeville Hospital in 2004/2005, associated with a number of deaths.</td>
<td>24 July 2006</td>
<td>July 2006</td>
<td>August 2007</td>
<td>The report concluded that there were significant failings in the management of the second outbreak and this was reported to the Secretary of State for Health.</td>
</tr>
<tr>
<td>Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005</td>
<td>Following the serious concerns uncovered during the Healthcare Commission’s earlier investigation, a further investigation was required into 10 maternal deaths at, or following delivery at, Northwick Park Hospital.</td>
<td>23 August 2006</td>
<td>Local actions already taken following our first Investigation</td>
<td>None outstanding</td>
<td>The report highlighted the need for the use of interventional radiology, resulting in national guidelines published by the Royal College of Obstetricians and Gynaecologists.</td>
</tr>
<tr>
<td>Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust</td>
<td>Outmoded, institutionalised care led to the neglect of people with learning disabilities. There were failures in management and leadership at all levels, from managers to the trust’s board.</td>
<td>17 January 2007</td>
<td>March 2007</td>
<td>Formal review scheduled for March 2008</td>
<td>The report highlighted the damage that institutionalised care can do to the lives of people with learning disabilities.</td>
</tr>
<tr>
<td>Investigation into cardiothoracic surgical services at Oxford Radcliffe Hospitals NHS Trust</td>
<td>The Commission looked into higher than expected rates of mortality and a history of problems in the cardiothoracic surgical services since the late 1990s. Detailed analysis showed the trust to be within acceptable statistical limits.</td>
<td>28 March 2007</td>
<td>July 2007</td>
<td>Formal review scheduled for June 2008</td>
<td>The report demonstrated the importance of trusts collecting and analysing their own data on mortality rates, as part of their standard assurance processes.</td>
</tr>
</tbody>
</table>
References


This information is available in other formats and languages on request. Please telephone 0845 601 3012.

如有需要，本信息还有其他格式和语言的版本，请致电0845 601 3012。

Arzu edildiği takdirde bu bilgi değişik formatlarda ve dillerde verilebilir. Lütfen 0845 601 3012 numaralı telefonu arayınız.

Tin tức này có bằng những hình thức và ngôn ngữ khác theo yêu cầu. Hãy gọi số 0845 601 3012

É possibile richiedere le presenti informazioni su altri supporti o in altre lingue. A tal fine, telefonare allo 0845 6013012.

Informacje te są dostępne na życzenie w innych formatach i językach. Prosimy zadzwonić pod numer 0845 601 3012