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## **REVIEW INTO THE QUALITY OF CARE AND TREATMENT PROVIDED BY 14 HOSPITAL TRUSTS IN ENGLAND**

### **TERMS OF REFERENCE**

On 6 February, the Prime Minister announced that he had asked Professor Sir Bruce Keogh to review the quality of care and treatment provided by those NHS Trusts and NHS Foundation Trusts that are persistent outliers on mortality indicators. 14 hospital trusts will be investigated as part of this review on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Indicator or the Hospital Standardised Mortality Ratio.

The investigations will seek to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these Trusts.
- Identify:
  - i) whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken;
  - ii) any additional external support that should be made available to these Trusts to help them improve; and,
  - iii) any areas that may require regulatory action in order to protect patients.

Professor Sir Bruce Keogh will publish a public report summarising the findings and actions resulting from the 14 investigations before the summer.

### **KEY PRINCIPLES**

The review will be guided by the NHS values set out in the NHS Constitution and underpinned by the following principles:

- **Patient and public participation.** Patients and members of the public will play a central role in the overall review and the individual investigations, working in partnership with clinicians. The views of patients in each of the 14 hospitals, either directly or through representatives, will be sought by the teams and reflected in their reports. Further details will be set out shortly as to how patients and members of the public will be able to feed information and concerns into the investigation (by email, letter or phone).
- **Listening to the views of staff.** Staff in each of the 14 hospitals will be supported to provide frank and honest opinions about the quality of care and treatment provided to patients in their hospital. These will be reflected in the rapid responsive review team reports.

- **Openness and transparency.** All possible information and intelligence gathered to support the investigations, as well as the reports produced by the rapid responsive review teams and Risk Summits, will be made publicly available.
- **Cooperation between organisations.** The overall review and the individual investigations will be built around strong cooperation between the different organisations that make up the health system, placing the interests of patients first at all times.

## METHODOLOGY

The individual investigations will follow a three stage process:

- Stage 1: Gathering and analysing the full range of information and data available within the NHS** to develop key lines of enquiry. This will include, amongst other things, examining data relating to clinical quality and outcomes as well a patient and staff feedback and views.
- Stage 2: Rapid Responsive Review-** a team of experienced clinicians, patients, managers and regulators will, following training, go into each of the 14 hospitals and observe the hospital in action. This will involve walking the wards and interviewing patients, trainees, staff and the senior executive team. The review team will then meet to discuss and share their opinions before producing a report. Should the review team identify any serious concerns about the quality of care and treatment being provided to patients that they believe requires rapid action or intervention, the Chief Executive of the Trust and the relevant regulator(s) will be notified immediately.
- Stage 3: Risk Summit-** this will bring together a separate group of experts from across health organisations, including the regulatory bodies. They will consider the report from the Rapid Responsive Review, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned. A report following each Risk Summit will be made publicly available.

Professor Sir Bruce Keogh will establish a National Advisory Group to guide the overall review process and ensure a robust and consistent approach is taken to conducting the investigations. This group will be comprised of patient representatives, senior clinicians from the regulatory bodies and other national organisations, professional bodies and other experts in healthcare quality.

## LIST OF HOSPITAL TRUSTS COVERED BY THE REVIEW

- Basildon and Thurrock University Hospitals NHS Foundation Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Burton Hospitals NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- The Dudley Group NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- George Eliot Hospital NHS Trust
- Medway NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

- Sherwood Forest Hospitals NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust