**NAG 1st Meeting**

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

**NATIONAL ADVISORY GROUP**

**MINUTES**

**11th MARCH 2013**

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<td>Bruce Keogh (Chair)</td>
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<td>David Behan</td>
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<td>Paul Husselbee</td>
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**Agenda**

1. Welcome and Introduction (Paper Ref: NAG(01)(01))
2. Background to the review and role of the National Advisory Group (Paper Ref: NAG(01)(02))
3. High Level Methodology & Timetable (Paper Ref: NAG(01)(03))
4. Information & Intelligence Framework (Paper Ref: NAG(01)(04))
5. Rapid Responsive Reviews- Operating Model (Paper Ref: NAG(01)(05))
6. Patient & Public Participation and Transparency (Paper Ref: NAG(01)(06))
7. Any Other Business & Next Steps
ITEM 1: WELCOME AND INTRODUCTION

BRUCE KEOGH (Chair, and Head of the Review) welcomed members to the first meeting of the National Advisory Group. He explained that, in response to the publication of the Mid Staffordshire NHS Foundation Trusts Public Inquiry report, the Prime Minister had asked him to review the quality of the care and treatment provided by those hospital trusts (NHS and NHS Foundation Trusts) that were persistent outliers on mortality statistics. 14 hospital trusts in total fell within the scope of the Review - five of which had been outliers on the Summary Hospital-Level Mortality Index (SHMI) for the last two consecutive years and a further nine which had been outliers on the Hospital Standardised Mortality Ratio (HSMR) over the same period.

Continuing, he said that the Review presented an important opportunity to leave a legacy that reached well beyond the 14 trusts in question through helping to establish a new approach to analysing hospital performance on quality and developing a new methodology for carrying out hospital investigations. As such, the Review had significant potential to help shape the new ‘Chief Inspector of Hospitals’ role, which would be located within the Care Quality Commission, and the hospital inspection regime which would sit underneath this person going forward.

Concluding his opening remarks, he said that he hoped members of the advisory group would provide him with both guidance and assistance in taking forward the 14 investigations in a rigorous, transparent and fair way as well as providing advice on how best to ensure the overall Review left a wider and more enduring legacy for the NHS.

ITEM 2: BACKGROUND TO THE REVIEW AND ROLE OF THE NATIONAL ADVISORY GROUP

Introducing item 2, JOHN STEWART (Review Secretariat) explained that the supporting paper (NAG(01)(02)) was principally for information and intended to bring advisory group members up to speed with progress in establishing the Review and clarifying the fixed points. More specifically, the paper set out the published terms of reference for the Review and some core principles that were intended to underpin it, the rationale for how the 14 trusts had been selected and a description of the role of the National Advisory Group, which Bruce Keogh had also touched upon in his opening remarks.
BRUCE KEOGH invited general comments from members of the National Advisory Group.
The following points were made in discussion:

a. the establishment of the advisory group was welcome. It would be important to
harness the opportunity presented by the Review and the broad expertise around the
table to establish a robust methodology for assessing hospital performance on quality
which could be deployed beyond the completion of the discrete investigations into the
14 hospitals;

b. the Review needed to link with the more theoretical piece of work that the Nuffield
Trust had been commissioned to undertake around developing aggregate ratings of
provider performance. Professor Don Berwick’s work on introducing a culture of zero
harm across the NHS was also relevant;

c. the principle around ensuring strong patient and public participation in the Review
was paramount. However, this needed to be taken forward in a way that added value
and was sensitive to the fact that many patients and members of the public would
already have provided feedback or raised concerns about the hospitals under
investigation. To guard against this principle becoming tokenistic, it would be vital to
gather and analyse the feedback and insight that patients and members of the public
had already supplied. In doing so, the Review would be able to demonstrate a
genuine commitment not just to listening but to actually hearing and understanding
what people were saying about the quality of the services being provided;

d. the Review should engage with the 14 trusts in a positive manner and maintain a
strong focus on supporting improvement. Whilst understandably anxious about the
investigations, contact to date with the NHS Confederation had revealed that, rather
than adopting a defensive stance, the trusts were generally wanting to embrace the
Review and the insight and support it might bring;

e. consideration should be given to the impact the Review might have on junior doctors’
rankings of their choice of hospital;

f. although not represented on the advisory group it would be important to ensure that
the professional regulatory bodies were actively engaged with the Review and able to
feed in their hard and soft intelligence; and,

g. in diagnosing any potential problems and offering up a prescription, the review teams
would need to look beyond the boundaries of the organisations being investigated.
An appreciation of how broader factors facing local health and care economies, such
as the quality and availability of primary, community and social care provision, might
be impacting on hospital mortality rates would be crucial.
Summing up the discussion, **BRUCE KEOGH** said he was grateful for the advisory group’s enthusiasm for the *Review* and the appetite amongst members to use it to make a more fundamental and lasting contribution to the complex issue of assessing provider quality. He said that it was critical for the *Review* to strike the right tone from the outset and the key message had to be one of support and improvement rather than fear and blame. Using the language of ‘review’ rather than ‘investigation’ or ‘inspection’ would help with this. Getting the approach to patient and public participation right was also vital and he hoped he could look, in particular, to National Voices, the Patients Association and Healthwatch England for help and support with this.

**ITEM 3: HIGH LEVEL METHODOLOGY AND TIMETABLE**

Introducing paper NAG(01)(03), **JOHN STEWART** (*Review* Secretariat) said that a three stage process for the *Review* had been proposed. Stage 1 involved gathering all the available information and intelligence held across the system and analysing it in order to develop key lines of enquiry for the 14 trusts covered by the *Review*. Stage 2 involved Rapid Responsive Review teams conducting site visits and scrutinising the quality of services being provided, informed by the analysis from stage 1. Stage 3 then involved the convening of a formal Risk Summit meeting for each of the 14 trusts in order to make system wide judgements about the quality of care being provided and agree what additional action might be needed to support further improvement or, if necessary, to safeguard patients. Stage 1 was provisionally timetabled to complete towards the end of April with stages 2 and 3 scheduled to be taken forward during May and June. This timetable aimed to bring the *Review* to a close during July with the publication of an overarching summary report.

Continuing, he said that the timetable attempted to strike the right balance between allowing sufficient time to conduct a rigorous process on the one hand with the need for pace on the other, recognising the importance of providing patients and members of the public with rapid but not false assurance.

**BRUCE KEOGH** invited comments on the proposed high-level methodology. The following points were made in discussion:

1. it was unclear from the terms of reference or the proposed methodology whether a key objective of the *Review* was to establish the actual number of avoidable deaths in the 14 trusts when compared with the higher than expected mortality rates revealed by the SHMI and HSMR measures. Not tackling this issue would be difficult
to explain to the public, particularly given the investigations had been triggered by mortality measures;

i. conducting retrospective case note reviews in each of the 14 trusts would be the only way to establish actual avoidable deaths. Whilst an ideal model might be to review random case notes in each trust and then compare these against a control group it would be very challenging to complete this in the timeframe proposed for the Review;

j. a number of trusts now conducted their own internal case note reviews. One approach might be to ask the 14 trusts in question to undertake case note reviews themselves, with a 10% sample submitted for external review and validation. Such an approach would be similar to a proposal being considered by the Outcomes Framework Technical Advisory Group in relation to developing a new NHS Outcomes Framework indicator to measure hospital deaths attributable to problems in care;

k. although there was a need to understand the relationship between avoidable mortality and SHMI / HSMR, this could potentially divert attention from the primary purpose of the Review which was to determine the current state of the quality of care and treatment being provided in the 14 trusts across all three dimensions of quality-patient experience, patient safety and clinical effectiveness; and,

l. leaving to one side the pros and cons of conducting retrospective case note reviews, the review methodology could be considerably strengthened and have more academic rigour if the 14 trusts were compared against a control group, for example of 14 ‘matched pairs’ that were performing well against the SHMI and HSMR measures.

Summing up the discussion, BRUCE KEOGH said that he was clear that the Review was not intended to be retrospective but contemporary. The primary objective was to assure patients and members of the public about the current state of quality in the 14 trusts and to establish whether any additional action or intervention was needed to support improvement. As such, conducting retrospective case note reviews to establish the extent of avoidable deaths in the past did not necessarily help meet this objective. However, he said that he understood the importance and value of developing a better understanding of the relationship between SHMI / HSMR and avoidable hospital mortality. Addressing this fitted with the advisory group’s desire to make a more fundamental and enduring contribution to understanding provider performance on quality. As such, he said he would reflect on this further and let the group know how intended to proceed.
ITEM 4: INFORMATION AND INTELLIGENCE FRAMEWORK

Introducing paper NAG(01)(03), **RICHARD MURRAY** (*Review Secretariat*) emphasised four key points from the emerging information and intelligence framework which would underpin stage 1 of the *Review*:

- firstly, a vast quantity of data were being drawn together from a wide ranging set of data sources. For example, the Care Quality Commission’s Quality and Risk Profile alone included about 900 data items per provider. Analysing these different data sets and triangulating the information was a significant undertaking. The more time that could be dedicated to this stage of the review process the better equipped the review teams would be in terms pursuing key lines of enquiry;
- secondly, because patients and staff could lodge opinions or complaints with multiple agencies, it was not immediately clear that all the available intelligence in these areas would be captured. It was, therefore, proposed that two cross-cutting assessments of patient/public and staff opinion be carried out to check that, in combination, the various sources did draw on all available information;
- thirdly, it was proposed that two local information requests should be made to supplement the national data sources. One to the trusts themselves requesting that they provide their own data on quality and outcomes signed off by the relevant clinical service leads and another to the local clinical commissioning groups; and,
- fourthly, it was recognised that the analytical support to the *Review* would need to stretch well beyond the production of baseline information / data packs and key lines of enquiry for the 14 trusts. An ongoing, responsive analytical service was planned in order to support the Rapid Responsive Review teams in real time.

**BRUCE KEOGH** invited comments on the emerging information and intelligence framework. The following points were made in discussion:

m. although one of the key principles set out for the *Review* included a commitment to publish ‘all possible information and intelligence gathered to support the investigations’ this would need careful handling as the quality and validity of some of the data could be highly variable and not all of them would necessarily be in the public domain already;

n. it would be beneficial when publishing any data gathered as part of the *Review* to provide an indication of the validity and reliability of the data source;
o. there needed to be a recognition that some data would always be contested and that this should not divert attention from the fundamental purpose of the Review which was to establish whether there was a problem with the quality of care in the 14 trusts and to provide advice on how improvements might be secured;

p. whilst it was important for the Review to meet its commitment to openness and transparency it needed to do so in a way that did not lead to inappropriate claims being made. The way in which HSMR and SHMI had often been directly associated with the numbers of avoidable deaths was a case in point;

q. soft data, particularly that which related to quality governance arrangements within the 14 trusts, was as important and potentially more illuminating than some of the hard data. For example, an examination of board papers would enable the review teams to identify the extent to which the management prioritised the quality of care relative to other issues and what data sources they used to assure themselves of the quality of the care and treatment their organisation was providing;

r. looking at context data (i.e. financial context and operational context) could help identify any ‘inappropriate pressures’ the trust management may be under and the extent to which these might be contributing to or driving poor quality and poor outcomes;

s. while complaints data were useful they could paint an unclear picture. It would be more important for the review teams to understand how the trust management responded to complaints, the systems in place for acting on those complaints and how their processes—especially for engaging patients and family members—compared to the best practice;

t. the Review should look at other sources of potential information and insight to build a richer picture of trust governance. This might include engaging with Local Involvement Networks, the Patient Advice and Liaison Service within the trusts, Overview and Scrutiny Committees and conducting interviews with staff and, in the case of foundation trusts, governors;

u. care needed to be taken to ensure that the Review did not end up with so much data that key themes got lost. It would be better to focus in on a smaller amount of high quality data then to try and look at everything;

v. key contextual data, especially from primary care, would be extremely valuable for the review teams. When requesting local intelligence and insight from clinical commissioning groups it would, therefore, be important to ensure this captured the views of member practices; and,

w. Local Healthwatch groups would have archive data that could provide useful insight for the review teams.
Summing up the discussion, BRUCE KEOGH said that he agreed with the value of soft data and intelligence and that further consideration would be given to how best to capture this as part of stage 1 of the Review process. Understanding the governance arrangements for quality and the culture surrounding quality more generally within each of the 14 trusts was equally important and something that it would be essential for the Rapid Responsive Review teams to get underneath.

ITEM 5: RAPID RESPONSE REVIEWS – OPERATING MODEL

Introducing paper NAG(01)(05) JOHN STEWART (Review Secretariat) said that stage 2 of the high-level methodology involved Rapid Responsive Review teams conducting site visits in order to observe the trusts in action. It was proposed that the operating model for the review teams should be based on published guidance developed by the National Quality Board on ‘How to organise and run a rapid responsive review’. Advisory group members were invited to comment on the review team methodology in general and more specifically on the composition of the teams, how best to engage with patients and staff, the generic lines of enquiry that should be pursued for all trusts and the length of the review team visits.

BRUCE KEOGH invited comments on the proposed approach. The following points were made in discussion:

x. ensuring a highly consistent and standardised approach to the review team visits and their subsequent reports would be critical. Without this, there could be a significant risk of the review team findings being contested or judicially reviewed. Standardised processes and standardised assessors would greatly enhance the validity of the investigations, particularly amongst clinicians;

y. having 14 separate review teams was unlikely to help achieve the standardisation required. Consideration should be given to whether a single team could review each of the 14 trusts. An alternative approach might be to ensure cross over of membership between review teams, drawing on a pool of trained assessors who would then participate in more than one review;

z. the review team methodology and membership should be flexible in order to accommodate differences between the trusts. For example, depending on the key lines of enquiry identified for each trust, it may be appropriate to vary the length of the visits between the trusts or include more specialist expertise in certain review teams;
aa. it would be important for the review teams to add value and bring ‘a fresh pair of eyes’. One of the trusts had already been visited 9 times by the regulator and the issues were well understood by the trust board. It would, therefore, be important to establish the value of a 10th visit;

bb. it would be essential for the review teams to look beyond the trust walls if they were to really get to grips with what might be driving any poor quality and outcomes for patients; and,

c. Healthwatch England could potentially help contribute to sourcing a pool of lay assessors for the review teams

Summing up the discussion, BRUCE KEOGH said that the National Quality Board’s guidance provided a useful starting point for the rapid responsive review team methodology. However, in light of the discussion it was clear that it required further adaptation to both ensure its suitability for the task in hand and to support consistency in how the review teams conducted their visits. An updated methodology would be shared, via email, with members of the advisory group for further comment.

ITEM 6: PATIENT & PUBLIC PARTICIPATION AND TRANSPARENCY

Introducing paper NAG(01)(06) JOHN STEWART (Review Secretariat) said that two of the key principles underpinning the Review related to openness and transparency and ensuring patient and public participation was factored into the Review at every stage. The paper on information and intelligence had already set out how historical patient opinion and feedback would be captured and analysed and the paper on the operating model for Rapid Responsive Review teams proposed that patients / members of the public should form an integral part of the review teams. To further support these principles being met, the Review now had a web presence via the NHS Choices website. These web pages would be used to communicate progress with the Review and provide a single place where all information and reports relating to the Review, including all papers and minutes of meetings of the National Advisory Group, would be published. The web pages also set out how people could contact the review and raise concerns via email, letter or phone.

BRUCE KEOGH invited advisory group members to comment on the steps taken to date and to offer additional suggestions for how to promote openness and transparency and make it as easy as possible for people to engage with the Review. The following points were made in discussion:
dd. just having a website was not sufficient on its own. The Review needed to think about how it could raise awareness through local media, the use of social media and through national organisations such as National Voices and the Patients Association. It would also be important to engage with local Healthwatch around the purpose and nature of the Review;

e. platforms that enable ‘crowdsourced’ conversations (i.e. smart phone apps) could serve to provide both a rich source of data and a more convenient way for people to engage with the Review;

ff. it would be important to consider the ‘legacy issue’ of engagement from the Review, especially if a large volumes of people and information came forward. A feedback mechanism needed to be put in place so that patients and members of the public were kept fully abreast of developments in each of the trusts once the review teams had completed their investigations and reached conclusions about what needed to happen next; and,

gg. the intention of engagement must not be to seek only negative views of the trusts. Positive feedback and examples of high quality care experienced should equally be sort.

Summing up the discussion, BRUCE KEOGH said that further work was clearly needed to raise awareness of the Review and to make it as easy as possible for people to understand how they could engage, including through use of more innovative communications channels. This would be taken forward as a priority.

ITEM 7: ANY OTHER BUSINESS & NEXT STEPS

Concluding the meeting, BRUCE KEOGH thanked everyone for attending, especially at such short notice, and for contributing to such a rich discussion. He said that many very important points and excellent ideas had been raised which he would reflect upon and then update members on his proposed way forward, including on conducting retrospective case note reviews. He explained that Richard Murray and his team were continuing to work extensively through the data gathered to date and encouraged interested members to get involved in this important stage of the Review as it would be critical to the effectiveness of the Rapid Responsive Review teams. He said that he anticipated the group meeting in full a further two to three times before the Review concluded with ongoing engagement via email or on a one to one basis.

National Advisory Group Secretariat, March 2013