Keogh report 14 hospitals

The results of a review of the quality of care and treatment provided by 14 hospital trusts in England have sparked widespread coverage in the press. The review, launched in February 2013, was led by Professor Sir Bruce Keoth, national nhs medical director in England. They analysed the quality of care and treatment provided by 14 trusts identified as having a higher than average death rate in the two years leading up to the review. Eleven of these trusts are to be subject to special measures to improve governance. The review revealed problems in care that were not previously exposed. Although the report states that immediate security problems have been resolved immediately, it also calls for coordinated efforts to improve care and accountability in the long term. Why was the Keogh review commissioned? The review was commissioned by Prime Minister David Cameron and Health Secretary Jeremy Hunt in response to the findings of a public inquiry in Mid Staffordshire. Its aim was to examine the quality of care and treatment provided by English hospitals with higher than average death rates over the past two years. While above-average death rates can often be taken into account by other factors (such as a hospital serving an older population), previous health scandals have shown that particularly unusual results in data (outliers) should never be ignored. 14 trusts were selected on the basis of higher than average results in one of two well-established mortality rates. These are: a standardised hospital mortality rate (HSMR), which compares the expected hospital mortality with the actual death rate, which compares the hospital-level mortality rate (SHMI), which compares hospital mortality rates The report sets out: whether there are any persistent deficiencies in the quality of care provided to patients in these 14 hospitals, which set out whether the trusts' efforts to improve quality are adequate and whether additional steps are needed to identify if any additional support should be made available trusts, identify areas that may require legal (regulatory) action to protect patients What data did the Keogh review address? The review was carried out in three stages and took into account the performance of hospitals in six main areas: deaths due to clinical staff experience and operational effectiveness leadership governance Stage 1 – information collection and analysis All information covering six key areas was collected for each trust and analysed. The results were then compared with average national standards. As part of the visit to the hospital, which was attended by a visit to the hospital, anxiety was carried out. Stage 2 – Teams responsive review have been trained to carry out scheduled and unannounced on-site visits to each of the 14 trusts for two or three days. These teams consisted of 15-20 people and included patients, patients, nurses, managers and regulators. Visits consisted of walking on wards and talking to patients, trainees, staff and senior management. The results were recorded in the Rapid Review Report. As part of the cultural assessment, individual interviews and around 70 focus groups were conducted. Step 3 – Risk Summit and Action Plan A meeting was held at the end of the reviews (risk summit to agree on a coordinated action plan with each trust, including support to accelerate improvements and determine who is responsible. What were the main conclusions of the keogh report? The report provides examples of good care, as well as areas where improvement is urgently needed. In the report, Professor Sir Bruce Keogh says: We have found pockets of excellent practice in all 14 peer-reviewed trusts. However, we have also found significant opportunities for improvement, each of which has had to deal with an urgent set of measures to raise standards of care. Key findings of the review include: Understanding that concepts such as excessive deaths and avoidable deaths are more complex than single-level summary death rates (the results of this review were based on two commonly used mortality rates). There are many different causes of high mortality and there is no magic solution. Mortality in NHS hospitals has been declining over the past 10 years and the improvement rate in the 14 hospitals under review has been similar to other NHS hospitals. It was often thought that factors associated with higher death rates (such as access to funding and poor health of the local population) were not statistically related to the performance of these hospitals. The accuracy of clinical coding (how hospitals record diseases, surgeries and other healthcare episodes) can affect the number of death rates. For example, the review says that coding patients to make them appear sick or identifying more multiple conditions can improve mortality, but it probably represents an attempt to fix the data. It is said that some hospitals do not respond to the signals that the figures identify because they thought they were incorrect, which is potentially a matter of concern. More than 90% of hospital deaths happen when patients are admitted in an emergency rather than in a planned procedure. The review says it is therefore not surprising that all of the 14 hospitals trusts had higher emergency care deaths, and only one trust (Tameside General Hospital) had a high death rate for scheduled procedures. Understanding the causes of higher death rates is said to be not about finding a rogue surgeon or problems occurring in one specialized area. The review says it is more likely to link the problems that all hospitals in the NHS experience, such as busy A&A; E departments treatment of the elderly, and the need to recruit and maintain excellent staff. Where areas of concern were immediate action was taken in any trust, including: immediate closure of operating rooms suspending out-of-hours services, which have addressed changes in staffing levels in relation to the backlog of patient complaints The review identifies areas of action over the next two years, as well as some common themes and barriers to providing high-quality care. These topics are: A limited understanding of how important and simple it can be to really listen to patient and staff feedback and engage them on how to improve service. The ability of hospital boards and leaders to use data to improve quality. This topic is hampered by how difficult it is to access data stored in different locations and in different ways in hospital systems. The complexity of applying and interpreting summary death measures (HSMR and SHMI). The review was widely reported in the media with various headline headlines and some inaccurate reports. The Guardian reports that Health Secretary Jeremy Hunt is sending troops to failed NHS trusts, while the Daily Mail reports that Hunt vows to fire hospital bosses if they reject sweeping changes to improve care. There is also widely cited data that NHS shortages have led to 13,000 unavoidable deaths. The figure was given by Professor Sir Brian Jarman, a member of the national review advisory group, in a BBC radio interview. At present, it is not clear from the media what evidence Professor Jarman used for these claims, but the media reports on this figure as a fact that emerged from the main review itself, when in fact the report does not give such a number. In another example Mail Online says: NHS medical director, Professor Sir Bruce Keogh, says there have been thousands of unnecessary deaths. In fact, Keogh said, although tempting it may be, it is clinically irrelevant and academically reckless to use such statistical means to quantified the actual number of avoidable deaths. The review noted that staff at the 14 trusts involved accepted the review, were open and honest and demonstrated a commitment to improving the quality of patient care. As you'd expect, many headlines had a political angle, with the Daily Mail reporting 20,000 additional NHS deaths on Labour's watch amid calls for inspectors on the ground, with The Telegraph saying: Thousands could die because of NHS job shortages. BBC News had the most accurate reporting of the review results. Request In a letter to the Secretary of State, Professor Keogh reports that the assessments of 14 hospital trusts were very rigorous and uncovered problems in care that had not been exposed before. Warns against hasty reactions and finger pointing of guilt. Any immediate security issues discovered are said to have been resolved. Professor Keogh says there needs to be a debate, as well as efforts to improve care, focusing on accountability in the future. The analysis carried out by the by NHS Website Jeremy Hunt vows to dismiss hospital bosses if they reject sweeping changes to improve care Daily Mirror, July 16, 2013 Labour cover-up in horror hospitals The Sun, July 16, 2013 NHS braced for hospital deaths report Channel 4 News, 16 July 2013 2013 20,000 additional NHS deaths on Labour watch amid calls for on-the-spot inspectors at the struggling Mail Online Hospital , July 16, 2013 Keogh's mortality review in the NHS is a plan, not a red alert. The Guardian, July 15, 2013 Hospital targets not to blame for the NHS scandal, says Andy Burnham The Daily Telegraph, July 16, 2013 Report today will highlight 13,000 unnecessary deaths in 14 NHS hospital trusts The Independent, July 16, 2013 Keogh Review: Hospital mortality BBC News, 16 July 2013 Further reading Keogh B. Review of the quality of care and treatment provided by 14 hospitals trust in England : review report (PDF, 1.19Mb) July 2013 2013