

Commission for
Health Improvement
Investigations

Lessons from CHI Investigations 2000–2003

March 2004





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Contents

1	Introduction	2
	What the report considers	2
	Summary of key findings	2
2	Risk factors for serious service failure	3
	Understanding service failure	3
	Findings from investigations	4
	Findings from fast track clinical governance reviews	8
	Risk factors for serious service failure	8
3	Impact of CHI investigations	10
	National impact	10
	Local impact	11
	Results of telephone interviews	12
	Conclusions about CHI investigations	13

Appendices

1	List of CHI investigations	15
2	Emergent themes from investigations	16
3	List of organisations that participated	19
4	Authors	20
5	Evaluating the impact of CHI's investigations	21

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First published 2004

ISBN 0 11 703372 3

Lessons from CHI Investigations 2000–2003

Introduction

Since April 2000 the Commission for Health Improvement (CHI) has carried out and published 11 independent investigations of serious system failures in the NHS. Since producing this report CHI has published its investigation into mental health services at Pembrokeshire and Derwen NHS Trust. The findings of this investigation are not included in this report. CHI's investigations are set up to establish the facts surrounding the service failure, to clarify accountability and to learn from the events which led to the failure. They provide an opportunity to resolve issues surrounding the failure, to spark action and to provide the impetus for change. This helps to rebuild public confidence in the NHS, and in the organisation and particular clinical area, through agreeing actions to be implemented.

The investigations have been analysed to find if there are common features across the organisations investigated by CHI. This may lead to the identification of risk factors for serious service failure. If such features were to be identified, this could potentially enable healthcare organisations at risk of service failure to be identified before such incidents occur.

The ultimate purpose of investigations is to bring about improvement, so it is important to assess the impact of the process and what has happened as a result. CHI investigations have had a considerable impact on the healthcare services and the health organisations it has investigated. In some instances, CHI's investigations have had a wider impact on the NHS.

What the report considers

The report considers the types of events that triggered an investigation and identifies the risk factors for serious service failure at three levels: operational or clinical speciality level, strategic or trust wide level, national/health community level.

It then considers the extent to which CHI investigations have made an impact at a local and national level, in improving services and enabling the service to implement change.

Summary of key findings

Risk factors for serious service failure occur at three levels: operational or clinical specialty level, strategic or trust wide level and national/health community level.

At an operational service level, key common findings in failing services include severe and sustained staffing shortages, poor team working within a closed organisational culture, and inadequate risk and clinical effectiveness arrangements.

At a strategic level within a trust, the risk factors identified include a recent history of mergers or major structural change, and inadequate leadership which has often been both unable to set and implement a clear vision and strategic direction, or instigate a robust framework for performance monitoring and effective risk management systems.

The analysis showed how vulnerable services are disproportionately drawn from service areas that appear low in terms of national priorities, and do not directly feature in the Government's target setting agenda or performance monitoring framework. They often have staff shortages that are reflected nationally and are subject to ambiguous accountability arrangements in the health community, and there's often a failure by appropriate external organisations to monitor quality.

It may be possible to develop a model based early warning system to highlight where organisations and services are most at risk of service failure.

CHI investigations have had a considerable impact both nationally and on the performance of those organisations investigated. There has been wider NHS impact, for example on Department of Health guidance, and further local impact from the perspectives of NHS trusts, stakeholder organisations and strategic health authorities.

Lessons from CHI Investigations 2000–2003

Risk factors for serious service failure

Since its inception in 2000, CHI has published 11 investigation reports and three further investigations are underway. The list of published investigations is in appendix 1. There are clear patterns of findings that occur in the reports that indicate common risk factors. These factors could potentially be used by healthcare organisations, strategic health authorities, the Department of Health and the Commission for Healthcare Audit and Inspection, CHI's successor body, to predict organisations or systems at risk, and even to intervene to reduce the risk of serious service failure.

Understanding service failure

There has been an increasing awareness of patient safety and avoidance of health service failure within the last 10 years. Lessons from the aviation industry and elsewhere have shown that a focus solely on individual human error gives only part of the picture; it is essential to look to the overall systems of delivering health care. As well as active failures such as the unsafe acts committed by individuals, there are latent conditions in the organisation that contribute to the likelihood of failure – eg staff shortages, resource constraints, closed cultures and the distracting effects of constant organisational change. Human error can contribute to serious error but there are also underlying systemic factors at work. Likewise, organisations themselves do not exist in a vacuum. Health policy, priorities and the prevailing culture can all impact, as can relationships in the local health community.

Methods of investigation

Investigations undertaken by CHI can be grouped into three categories of failure based on the precipitating event:

- abuse (or suspected abuse) of vulnerable patients – failure to protect patients
- concerns regarding unexpected deaths or other suspected poor clinical performance – clinical failure
- administrative service failure

Lessons from CHI Investigations 2000–2003

Risk factors for serious service failure *continued*

The investigations considered are set out in table 1 below:

Table 1

Type of service failure	Details	Example
Failure to protect patients or service users – abuse of vulnerable people	Older people with mental health problems	North Lakeland Healthcare NHS Trust November 2000 and Manchester Mental Health and Social Care NHS Trust September 2003
	Young people	Loughborough GP (Peter Green) August 2001
	Older people	Gosport War Memorial Hospital July 2002
	People with a learning disability	Bedfordshire and Luton Community NHS Trust April 2003
Clinical failure – unexpected patient deaths or suspected poor clinical service	Removal of wrong kidney	Carmarthenshire NHS Trust November 2000
	Histopathology – poor practice in employing locums	Swindon & Marlborough (and other trusts) (Dr Elwood) May 2001
	Concerns about outcomes after heart and lung transplants	St George's Healthcare NHS Trust September 2001
	Maternity unit – concerns about outcomes (perinatal mortality rates)	Ashford and St Peter's Hospitals NHS Trust March 2003
Administrative service failure	Breast screening – failure to recall women	West of London Breast Screening Service, Hammersmith April 2002
	Ultrasound – referrals not actioned	Barnet and Chase Farm Hospitals NHS Trust November 2002

(For full trust titles, see appendix 1)

Findings from investigations

It is important to look wider than the key organisation where the service failure was located, to include both the health community in which the failing organisation was located and indeed beyond.

Serious system failure is usually a result of complex interrelated factors. This report is based solely on the findings from CHI's first 11 investigations. Not all factors identified would apply equally to all service sectors or all types of investigation. Analysis is complicated because the causal factors are not independent of each other and are not readily able to be separated into distinct categories.

Lessons from CHI Investigations 2000–2003

Risk factors for serious service failure *continued*

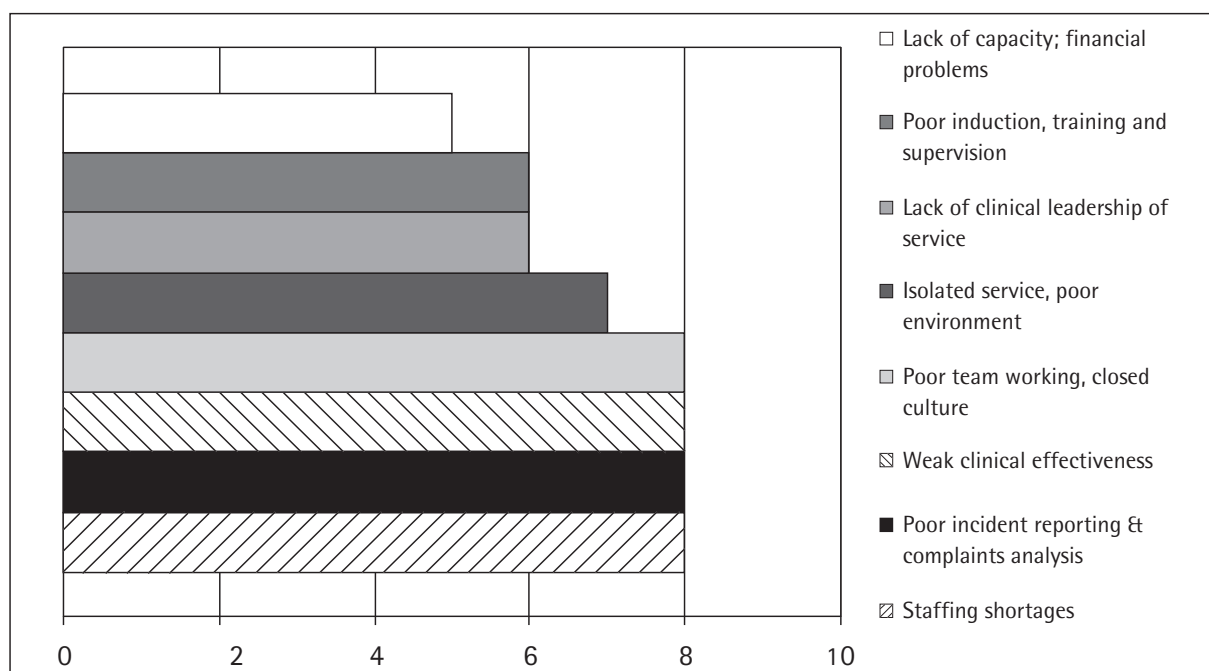
Service operational level

At service/operational level the eight key factors identified are:

- 1 severe staffing shortages with a strong reliance on bank, agency and locum staff
- 2 ineffective risk management including inadequate incident reporting, complaints systems and awareness of risk
- 3 inadequate arrangements for clinical effectiveness with lack of agreed policies/guidelines and audit
- 4 poor team relationships with a closed culture and lack of true multidisciplinary working
- 5 inadequate clinical leadership of the service concerned, often accompanied by a lack of vision or agreed model of care, or adherence to outdated patterns of care
- 6 lack of capacity and/or financial problems in the service*
- 7 inadequate training and supervision for clinical staff
- 8 the service is likely to be isolated either geographically or clinically, often with a poor quality of environment

*CHI makes no judgement on the adequacy of resources

Table 2: Frequency of Key Features at Service Level



Lessons from CHI Investigations 2000–2003

Risk factors for serious service failure *continued*

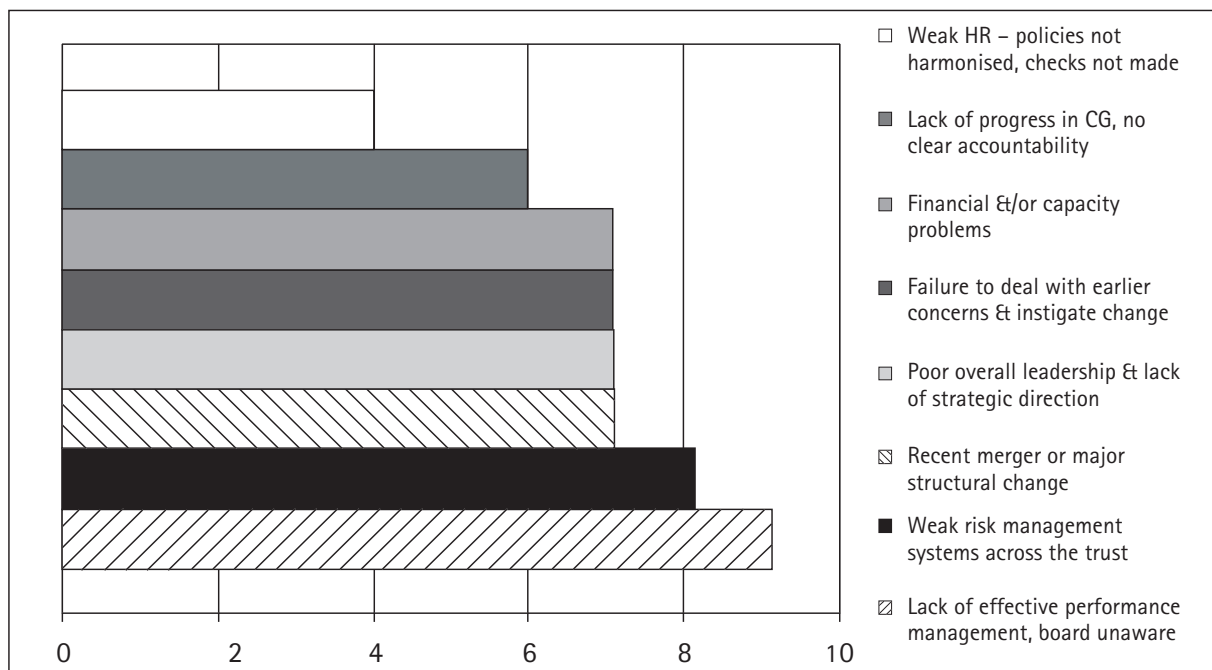
The most common factors at operational level are chronic and severe shortage of staff, failure of risk management, inadequate arrangements for clinical effectiveness and poor team relationships, often in a closed culture with elements of harassment and bullying. These were all found in eight out of 11 investigations. Issues such as a closed and inward looking culture may exist either in relation to an isolated service or be part of a wider malaise across an organisation.

Strategic level

The key factors identified at strategic level in the main organisation being investigated include:

- 1 lack of a robust performance management framework associated with inadequate information systems leading to the trust board being unaware of problems
- 2 poor overall executive leadership and lack of strategic direction, combined with poor communication with staff
- 3 history of recent and/or difficult merger(s) or restructure
- 4 poor risk management systems across the organisation
- 5 failure to deal with earlier concerns arising from complaints, incidents and serious untoward incidents and to instigate change from them
- 6 lack of progress in implementing a framework for clear accountability for clinical governance combined with weak clinical leadership at trust level
- 7 serious financial and/or clinical capacity difficulties
- 8 poor human resources (HR) input at strategic level

Table 3: Frequency of Key Features at Strategic Level



Lessons from CHI Investigations 2000–2003

Risk factors for serious service failure *continued*

The factors most frequently involving all organisations at strategic level are lack of effective performance management, combined with inadequate information systems and a board generally unaware of the performance of the organisation.

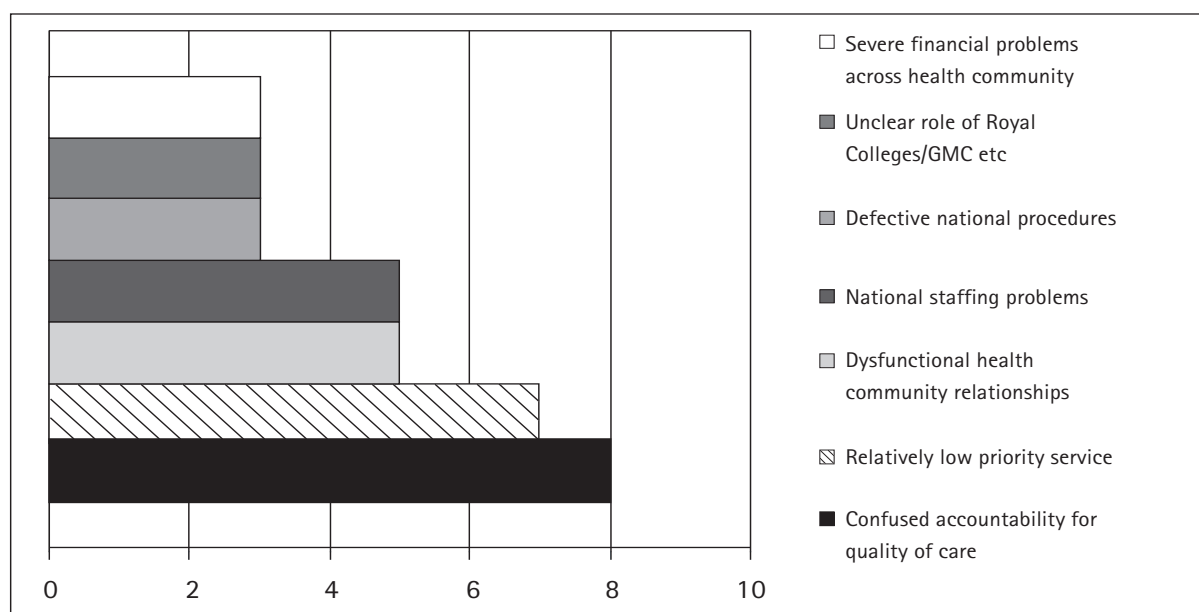
A high proportion of investigations involved organisations that have had a major organisational change or merger. In these organisations, structural change was considered to have been unsuccessfully implemented or integrated at the time of the investigation. Similarly, at operational level, weak risk management arrangements are common; there is a failure to have robust systems in place for risk assessment, incident and near miss reporting, and complaints handling across the organisation. Other important recurring features are poor executive leadership with lack of strategic direction, serious financial or capacity concerns and failure to deal with earlier problems.

Health community and national policy level

External factors in the wider health community and wider NHS, including policy areas, that are identified in the analysis of the investigations include:

- confused accountability for the quality of care and lack of adequate external performance monitoring of quality
- at national level and in policy terms, the service may be relatively low profile and low priority
- evidence of severe national staffing problems in similar services or clinical specialties
- different organisations and agencies within the health economy not working well together and lack of agreement on the way forward, accompanied by poor decision making arrangements and sometimes conflict
- sustained financial pressures
- national procedures for quality assurance that are missing or defective

Table 4: Frequency of Key Features at National/Health Community Level



Lessons from CHI Investigations 2000–2003

Risk factors for serious service failure *continued*

The most common factors at health community level appear to be confused accountability for the quality of care and corresponding lack of external performance monitoring of quality.

At national level, in seven out of 11 cases, the subject of investigations were services with low profiles and services perceived to be of lower priority. Serious national staffing shortages may also play a part as they have appeared in five out of 11 investigations to date.

Findings from fast track clinical governance reviews

When the CHI investigations and fast track programme board receives a referral which is not felt to require a full investigation, one option is to ask for the routine clinical governance review to be brought forward and for the area of concern to be reviewed as one of the chosen clinical teams. Reports from six fast track clinical governance reviews were also considered in order to provide an additional perspective into organisations perceived to be at risk of failing.

In the areas that were initially referred for investigation, a common finding was lack of leadership and poor team working.

Conclusions about risk factors for serious service failure

At operational service level, the key risk factors appear to be serious sustained staffing shortages, poor team working often in a closed culture, poor incident reporting, poor handling and learning from complaints, and inadequate arrangements for ensuring clinically effective services. These factors should not be viewed in isolation without considering their complex relationship with one another.

Chronic staffing shortages, combined with other resource constraints, are likely to create pressure, and reduce safety margins and the capacity to deal with unexpected events. Staffing pressures may restrict access to training and supervision opportunities and also impact on the capacity to report incidents and handle complaints. Investigations occurred in a number of places where the stability of the service was undermined by the proportion of temporary staff. Staff frequently referred to the added pressures of working with other staff who were unfamiliar with the unit. Where patients are in long term care, for example people with a learning disability or some older age patients, pressure is again added as only permanent or long term agency staff will be able to build long term relationships with patients.

A poor physical environment and inappropriate facilities may also be symptomatic of underlying financial pressures. In just under half of the investigations, serious financial and capacity issues were identified. Where financial issues dominate management thinking, less attention is given to other factors that can have significant impact on the quality of patient care.

Services that are the subject of an investigation often have been identified as lacking clinical leadership. This can contribute to a lack of clarity or detail as to the model of service. Inadequate clinical leadership may mean there is not enough focus on providing high quality up to date services, and may cause a decline in largely unmonitored standards of care.

At strategic level, the factors associated with service failure are a lack of effective performance management arrangements and a failure by the board to be sufficiently aware of the quality of services, and therefore of problems in clinical services. This failure is often associated with incomplete information systems and a failure to use available information. Information tends to focus on finance and activity, rather than services, quality and outcomes, and the board and executive team may focus

Lessons from CHI Investigations 2000–2003

Risk factors for serious service failure *continued*

on financial issues to the detriment of quality of care. Occasionally, major breakdown occurs when senior managers have not instituted adequate reporting systems and do not know what is happening, while staff in middle and junior levels, try to cope with increasingly difficult situations.

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. Management time may be diverted away from service quality issues.

Risk management systems across the investigated organisations are almost universally weak. Earlier warnings or actual incidents have not led to change and improvement. This feature is generally indicative of a lack of progress in implementing sound and comprehensive clinical governance, often without clear accountability arrangements.

Another identified problem at strategic level is under capacity in human resources (HR) or ineffective HR. This may lead to poor HR practices; failure to produce and implement standardised key policies such as handling bullying and harassment; lack of attention to effective and equitable recruitment; poor handling of staff sickness and failure to deal with disciplinary and grievance issues.

The national focus on access targets in acute services can lead to other services receiving less attention. These services have generally not been subject to high profile Government targets or close performance monitoring, even when national service frameworks are in place. Most of CHI's investigations to date have taken place in services that may be perceived to have a relatively low profile and are either supporting services, or may be considered to be the "Cinderella services".

At health community level, investigations are common in those services where direct accountability for the quality of care is particularly unclear. Often, this is as a consequence of complex, ambiguous accountability arrangements set nationally. Due to this ambiguous accountability, nobody is assuming direct responsibility for the quality of care and for monitoring the service effectively. This situation is often accompanied by dysfunctional relationships between the key stakeholders and a failure to agree to a strategic direction for the service in question. This is likely to be exacerbated if there are serious financial problems in the health economy (no judgement is being made on the adequacy of resources).

An additional factor in some cases is the perceived overlap, and potential confusion of roles of different regulating and accrediting organisations, as well as bodies such as the transplant organisations and national specialist commissioning structures. As with accountability in the health economy, the lack of clarity can lead to a failure of direct responsibility to resolve issues.

Nearly half of the investigations have occurred in services that have severe national staffing problems. This in turn, leads to a reliance on bank, locum and agency staff who are often subject to less rigorous performance management arrangements and have less access to training, which could impact on the quality of care.

There has only been one investigation in primary care. Until recently there has been no overall system of performance management and an absence of robust mechanisms to identify and deal with under performing, negligent or criminal primary care practitioners. However, the creation of primary care trusts and introduction of the new GP contract may help to clarify the accountability arrangements.

Lessons from CHI Investigations 2000–2003

Impact of CHI investigations

National impact

Several of CHI's published investigations have contained recommendations or suggestions that extend beyond the organisation being investigated. Recommendations have referred to the health authority, regional office, strategic health authority, and Department of Health. Other bodies such as the General Medical Council (GMC) have been invited to consider suggestions.

In direct response to the recommendations in the report in 2001 on cardiothoracic transplantation at St George's Hospital NHS trust, the Government gave responsibility for commissioning, designation and performance monitoring of heart and lung transplantation to the National Specialist Commissioning Advisory Group.

Furthermore, commissioning of adult heart and lung transplantation will be based on common standards covering staffing levels and qualifications, retrieval arrangements and outcomes such as survival and rejection rates. Following widespread consultation, the UK Transplant Cardiothoracic Advisory Group in 2002 approved and published national protocols for assessment of transplant patients, a donor retrieval process and national standards on documentation for cardiothoracic transplant patients.

CHI's published investigation in 2001 into the abuse of patients by a Loughborough GP and its accompanying recommendations have had a national impact in a number of areas.

The new GP contract requiring GPs to participate in appraisal and audit was influenced by the report. Primary care bodies are now required to provide incident information to the national patient safety agency. The interagency inspections of children's safeguards published in October 2002 was partly influenced by this report, drawing on the common issues between the protection of children and vulnerable adults.

A revised alert letter system was issued in 2002 by the Department of Health to ensure NHS bodies properly record and share concerns relating to individual healthcare professionals. The investigation report was part of the information used by the department of health to reconfigure the NHS complaints process. The Advisory Council on the Misuse of Drugs has recommended to the Home Office that the sedative drug Midazolam be rescheduled to reduce the risk of inappropriate use. The Academy of Medical Sciences is looking at the development of a system to help organisations detect and reduce misconduct and fraud. The GMC have acted to ensure cases at the extreme end of professional misconduct are dealt with swiftly. Procedures are now in place to identify problems at an earlier stage and institute interventions that are appropriate both to the practitioner involved and the allegations in question.

Following the Loughborough investigation and concerns about how the help line had operated, CHI published national guidelines for the NHS in March 2003, on establishing and running rapid response NHS helplines. CHI's national programme of clinical governance reviews now check that organisations have a whistle blowing policy and whether staff are aware how to use it.

In 2002 the Department of Health revised the set of rules (code of practice) for trusts employing locum doctors and other temporary staff, in order to safeguard the quality of care. This tightening of procedures followed the publication of the Dr Elwood investigation in 2001 into poor practice in the employment of locum doctors by Swindon and Marlborough trust and others.

Lessons from CHI Investigations 2000–2003

Impact of CHI investigations *continued*

Other related actions included planned improvements to workforce planning, the establishment of the NHS Professionals agency and the development of Occupational Health Smart Cards. Action was already being planned but the investigation gave impetus to its implementation. There is some indication from clinical governance reviews that this investigation has encouraged NHS trusts to be more careful in the employment of locum consultants and temporary staff and to comply with the code of practice.

In part as a consequence of the Elwood investigation, the Royal College of Pathologists developed guidelines for trusts on the appointment of career grade locum pathologists in 2001 and on dealing with substandard professional performance in 2002. The college recommends that consultant pathologists are on the GMC specialist register and that they should fulfil compulsory continuing professional education requirements.

Following the investigation into the West of London Breast Screening service in 2002, the NHS Breast Screening Programme agreed to revised guidance in 2003 on the correct processing and issuing of results from breast screening mammograms. These procedures now must be audited by the service and the visiting regional quality assurance team. Changes have been made to monitoring and reporting of QA visits to ensure that, for example, required timescales are included in the executive summary. The NHS Breast Screening Programme has also developed a list of publications on its website.

The Gosport investigation in 2002 raised concerns about the care of older people and confusing terminology within levels of care. The Department of Health agreed to promote understanding through the national service framework for older people. Work is well advanced to develop a protocol for the NHS to share information on patient safety with the police.

One of the recommendations of the Ashford and St Peter's investigation published in March 2003 into maternity services was that a model information pack should be developed for pregnant women. In May 2003, the Government announced a better information service for mothers via centrally funded local maternity guides across the country. Following the 2003 publication of the report into learning disability services in Bedfordshire and Luton, the Government has given a commitment to consult widely on proposals to regulate support workers including health care assistants in the NHS.

The care of older people with mental health problems has been given increased priority following the report into the care in Rowan ward in Manchester Mental Health and Social Care Trust in 2003. A summit held at the Department Of Health involved the National Clinical Directors for mental health, older people emergency care and primary care with professional organisations, carers and patient representatives and policy leads. The National Clinical Directors for older people and mental health will take forward a national review of inpatient services for older people with mental health problems. The chief executive of the NHS has alerted all trust chief executives to the issues raised. Several strategic health authorities have contacted CHI to confirm they are auditing and/or inspecting their older people mental health units.

Local impact

The local impact was assessed via a retrospective evaluation of the 10 investigations that CHI published prior to May 2003. The evaluation was conducted through semi structured telephone interviews, chosen to increase participation and to allow collection of qualitative as well as quantitative data. The evaluation focused on processes rather than specific examples of change.

Lessons from CHI Investigations 2000–2003

Impact of CHI investigations *continued*

The survey included all chief executives of trusts that had an investigation by CHI, all Strategic Health Authority chief executives where a trust in their area had had an investigation, and all CHCs where a trust had been investigated. In total, 36 interviews were carried out.

The data provided is based on the perceptions of the individual participants and many respondents started the interview with that proviso.

Results of telephone interviews

In order to assess the impact of investigations, five broad dimensions or issues were identified, around which the questionnaire was designed.

The identification of issues surrounding the systems failure

Generally respondents considered that the investigation had been successful in identifying the issues at the heart of the systems failure. Often the factors surrounding a systems failure can be both complex and interrelated. As a consequence it may be that only an external assessment and examination can successfully identify and highlight these.

There was also consensus among all groups of respondents that the investigations have value. It was remarked that the investigation provided "a framework" and "a new approach" towards facilitating organisational change, and that it "highlighted shortfalls" and "clarified facts" at the heart of the breakdown in care.

The investigation as a driver for change for patients and improvement to services

Among those surveyed, there was a strong perception that since the investigation, the patient experience at the trust has either slightly or significantly improved. Almost half attributed this primarily to the investigation.

It was a widespread comment that the investigation resulted in a considerably greater level of patient involvement, with responses such as, "patients are more widely involved, as well as friends and volunteers links with a lot of the PALS work"; "clients are now involved in care and quality improvement", and "patients are involved in improving things from clinical issues to signposting".

The investigation as a general driver for change within the organisation

There was a widespread perception that the investigation had acted as a general driver for change within the organisation. The proportion of respondents specifying that the investigation provided a significant impact was highest among the trusts investigated and their commissioners.

Furthermore, as well as facilitating change, it was also expressed that the investigation had provided either some, or a significant contribution to, the resolution of complex issues.

The impact of the investigation as a driver for organisational change was assessed in relation to leadership and internal performance monitoring arrangements, to risk management arrangements, and to staffing, staff management and multidisciplinary team working.

More than three quarters of all respondents said that since the investigation, trust leadership, including trust board and executive team functioning, had improved either slightly or significantly. Once more, this perception was most marked among the trusts surveyed and their commissioners. However most of these changes were only partly attributed to the investigation.

Lessons from CHI Investigations 2000–2003

Impact of CHI investigations *continued*

Most respondents perceived that internal performance monitoring had improved since the investigation; nearly half said the changes were primarily due to the investigation.

There was an almost universal perception amongst respondents that risk management arrangements within the trust have been strengthened.

The majority of respondents said that multidisciplinary team working had improved since the investigation, but the outlook was considered less consistently positive with regards to staffing and staff management arrangements. Respondents recognised that the importance of staffing and staff management had been acknowledged as a result of the investigation. In most cases, additional resources were considered necessary to address staffing issues including training and continuing professional development. However, it was suggested frequently that the investigation may have damaged staff morale.

More than three quarters of respondents agreed that strategic plans have been developed since the investigation. However, few felt that this was principally due to the investigation. The investigations had served to reprioritise the development and quality of strategic plans that may have been already started. It was commented by a trust that "the investigation has caused us to review our strategic plans with commissioners", that strategic plans are "good and strong" and "really developed", and that "huge strategic developments" have been made.

The extent of progress with action plan implementation varied according to the length of time that had passed since the investigation was conducted. Among the investigations published at least 12 months prior to this evaluation, more than two thirds reported action plans either mostly or fully implemented. For those investigations that were published within 12 months of this evaluation, 70% of respondents indicated that the action plan was being implemented.

The investigation as a driver for change within the health economy

Following the investigation, relationships have improved within the health economy. External performance monitoring mechanisms have also improved. Almost two thirds of CHCs and many patient organisations reported that relationship with other health and patient organisations has improved since the investigation, although not all credited this to the investigation itself. All trusts stated that external performance monitoring mechanisms have either slightly or significantly improved since the investigation. Some respondents said that the action plan helped both the process of external performance monitoring and the improved relationships: "the action planning brought us together ... we have a common focus now", and "an action planning monitoring group" has been instigated.

Public confidence

Trusts perceive at least a short term negative effect on public confidence. The view of CHCs and patient representative organisations on the impact of investigations on patient confidence, was less pessimistic.

Conclusions about the impact of CHI investigations

One of the statutory functions of CHI is to investigate serious service failures in the NHS. It is clear that the CHI investigations have a considerable impact nationally and on the performance of those organisations investigated, and the impact is largely positive.

Lessons from CHI Investigations 2000–2003

Impact of CHI investigations *continued*

The consensus among those questioned is that the investigation served as a catalyst for change, and provided a direction for the change that was, in some cases, already being developed. This is the case both locally and nationally.

In many areas the consensus shows a definite improvement locally, in large part attributed to the investigation. These include the significant areas of patient experience, internal performance monitoring, risk management, multidisciplinary team working and health community relationships. Leadership, external performance monitoring and strategic planning were also reported to have improved although this was not so clearly attributed to the investigation. Respondents expressed satisfaction with the extent to which investigations were considered to have established the facts, and also contributed to some degree, to both learning from the events and the clarification of accountabilities.

In some areas, particularly staffing and public confidence, there was a perception of both positive and negative effects, especially among trusts and strategic health authorities. This is consistent with findings on impact by other regulatory bodies.

The accuracy of these perceptions is difficult to ascertain. It could be tested for example, by a substantial local staff or patient and public survey, before and after the investigation, but this might shift focus away from the investigation itself.

Long term public confidence in the NHS, locally and nationally, is likely to be served by properly addressing the issues that CHI investigations are set up to tackle. It would be a mistake to confuse damage to public confidence arising from those issues coming to light, with any damage arising from the process of the investigation or its recommendations.

Clearly, among those surveyed, it is perceived that the investigation has acted as a driver for organisational change, most particularly with the development of systems and processes for safeguarding clinical care, and the clarification of accountabilities; factors acknowledged to be at the heart of clinical governance.

Some respondents are concerned about the impact on staff morale. These views may represent accurately the views of chief executives, but we have no evidence of actual morale levels throughout the organisations where investigations have taken place. It remains CHI's view that in the long term, staff morale can only be enhanced by the resolution of problems. In any case, short term impact on staff morale cannot be allowed to override benefits to the quality of patient care brought about by each investigation.

Lessons from CHI Investigations 2000–2003

Appendix 1: List of CHI investigations

<i>Investigation Carried Out</i>	<i>Matters Investigated</i>	<i>Publication</i>
North Lakeland Healthcare NHS Trust	Abuse of older patients with mental illness	November 2000
Carmarthenshire NHS Trust	Environment in which a major surgical error occurred	November 2000
Swindon & Marlborough NHS Trust and three others (Matters arising from the employment of Dr Elwood)	Poor practice in employment of locum doctors	May 2001
Loughborough GPs (Dr Peter Green)	Failure of the primary care systems in one community to prevent sexual abuse of patients by Dr Peter Green	August 2001
Heart and lung transplantation at St George's Healthcare NHS Trust	Increase in deaths following heart and lung transplants	September 2001
West of London Breast Screening Service at Hammersmith Hospitals NHS Trust	Failure to recall women for assessment following mammograms	April 2002
Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital	Quality of care of older patients, including prescribing	July 2002
Barnet and Chase Farm Hospitals NHS Trust	Unreported ultrasound referrals	November 2002
Ashford and St Peter's Hospitals NHS Trust	Maternity services	March 2003
Bedfordshire and Luton Community NHS Trust	Issues regarding treatment of individuals with learning disabilities	April 2003
Manchester Mental Health and Social Care NHS Trust	Alleged abuse of older patients with mental illness	September 2003

Other appendices on the web publication only, with reference at the back of the hard copy publication

Lessons from CHI Investigations 2000–2003

Appendix 2: Emergent themes from investigations

Table 1: Operational issues at service level

Category		Lack of effective clinical leadership of service, no vision, unclear accountability	Staffing shortages much bank, agency, locum use.	Poor induction, training, supervision, CPD	Poor team relationships, cultural issues – eg <i>bullying</i> . Weak MD working	Poor clinical effectiveness – absence of clinical protocols or guidelines or failure to follow them	Poor incident reporting and complaints handling and analysis. Record keeping weak	Isolated service geo/prof, poor environment working conditions	Lack of capacity and/or financial problems, poor information
Failure to protect – suspected abuse of vulnerable people	North Lakeland Healthcare NHS Trust	✓	✓	✓	✓	✓	✓	✓	✓
	Manchester Mental Health and Social Care NHS Trust	✓	✓	✓	✓	✓	✓	✓	✓
	Loughborough GP Peter Green				✓		✓		
	Gosport War Memorial Hospital			✓		✓			✓
	Bedfordshire and Luton Community NHS Trust	✓	✓		✓	✓		✓	✓
Clinical failure – unexpected deaths or suspected poor clinical service	Carmarthenshire NHS Trust		✓			✓	✓		
	Dr Elwood		✓	✓				✓	
	St George's Healthcare NHS Trust	✓			✓	✓	✓	✓	
	Ashford and St Peter's Hospitals NHS Trust		✓	✓	✓		✓	✓	
Administrative service failure	West of London Breast Screening Service at Hammersmith Hospitals NHS Trust	✓	✓	✓	✓	✓	✓	✓	
	Barnet and Chase Farm Hospitals NHS Trust	✓	✓		✓	✓	✓		✓

Note: Whilst 11 investigations have been considered, it is important to acknowledge that not all of the factors outlined above are potentially applicable to all service sectors and types of investigation. Additionally the presence of ticks indicates that at least one aspect of the category was found to apply within the investigation, although not necessarily all aspects as detailed above

Lessons from CHI Investigations 2000–2003

Appendix 2: Emergent themes from investigations *continued*

Table 2: Strategic capacity issues within organisation

		Poor overall leadership and lack of strategic direction, poor internal communication	Recent merger or major structural change or uncertain service future	Ineffective internal performance management and weak info systems, TB not informed	Financial problems and/or capacity problems	Lack of progress in CG, no clear accountability for CG overall and components, weak clinical leadership	Weak HR – policies not harmonised etc, checks not made, training poor, D&G weak	Poor RM eg incident reporting and complaints systems across trust	Failure to deal with earlier concerns and instigate change
Failure to protect – suspected abuse of vulnerable people	North Lakeland Healthcare NHS Trust	✓	✓		✓			✓	✓
	Manchester Mental Health and Social Care NHS Trust	✓	✓	✓	✓	✓	✓	✓	
	Loughborough GP Peter Green		N/A	✓		✓		✓	✓
	Gosport War Memorial Hospital		✓						✓
	Bedfordshire and Luton Community NHS Trust	✓	✓	✓	✓			✓	
Clinical failure – unexpected deaths or suspected poor clinical service	Carmarthenshire NHS Trust	✓	✓	✓	✓	✓	✓		✓
	Dr Elwood		N/A	✓	✓		✓		✓
	St George's Healthcare NHS Trust			✓		✓		✓	
	Ashford and St Peter's Hospitals NHS Trust	✓	✓	✓	✓	✓		✓	
	West of London Breast Screening Service at Hammersmith Hospitals NHS Trust	✓		✓		✓	✓	✓	✓
Administrative service failure	Barnet and Chase Farm Hospitals NHS Trust	✓	✓	✓	✓			✓	✓

Note: Whilst 11 investigations have been considered, it is important to acknowledge that not all of the factors outlined above are potentially applicable to all service sectors and types of investigation. Additionally the presence of ticks indicates that at least one aspect of the category was found to apply within the investigation, although not necessarily all aspects as detailed above

Lessons from CHI Investigations 2000–2003

Appendix 2: Emergent themes from investigations *continued*

Table 3: Health community and national issues

		Confused accountability for quality of care in health community, lack of external performance management of quality	Health community relationships dysfunctional, agencies not working together, no agreed future, poor decision making	Financial problems across economy, serious cost constraints	Relatively low profile/priority service	National staffing problems in specialty or service	National procedures for quality risk management defective or not applied	Unclear role of Royal Colleges/ GMC or other bodies such as NSCAG
Failure to protect – suspected abuse of vulnerable people	North Lakeland Healthcare NHS Trust	✓			✓			
	Manchester Mental Health and Social Care NHS Trust	✓	✓	✓	✓	✓		
	Loughborough GP Peter Green	✓					✓	
	Gosport War Memorial Hospital				✓			
	Bedfordshire and Luton Community NHS Trust	✓	✓	✓	✓			
Clinical failure – unexpected deaths or suspected poor clinical service	Carmarthenshire NHS Trust	✓	✓					
	Dr Elwood			✓	✓	✓	✓	✓
	St George's Healthcare NHS Trust	✓					✓	✓
	Ashford and St Peter's Hospitals NHS Trust					✓		
Administrative service failure	West of London Breast Screening Service at Hammersmith Hospitals NHS Trust	✓	✓		✓	✓		✓
	Barnet and Chase Farm Hospitals NHS Trust	✓	✓		✓	✓		

Note: Whilst 11 investigations have been considered, it is important to acknowledge that not all of the factors outlined above are potentially applicable to all service sectors and types of investigation. Additionally the presence of ticks indicates that at least one aspect of the category was found to apply within the investigation, although not necessarily all aspects as detailed above

Lessons from CHI Investigations 2000–2003

Appendix 3: List of organisations that participated in telephone interviews about the impact of CHI's investigations

Organisation	Investigation
National Childbirth Trust	Ashford and St Peter's Hospitals NHS Trust
North West Surrey CHC	Ashford and St Peter's Hospitals NHS Trust
Surrey and Sussex SHA	Ashford and St Peter's Hospitals NHS Trust
Ashford and St Peter's Hospitals NHS Trust	Ashford and St Peter's Hospitals NHS Trust
Chief Officer – Enfield CHC	Barnet and Chase Farm Hospitals NHS Trust
Barnet CHC	Barnet and Chase Farm Hospitals NHS Trust
North Central London SHA	Barnet and Chase Farm Hospitals NHS Trust
Barnet and Chase Farm Hospitals NHS Trust	Barnet and Chase Farm Hospitals NHS Trust
Bedfordshire Advocacy Alliance	Bedfordshire and Luton Community NHS Trust
South Bedfordshire CHC	Bedfordshire and Luton Community NHS Trust
North & Mid Beds CHC	Bedfordshire and Luton Community NHS Trust
Bedfordshire Joint Commissioning Agency	Bedfordshire and Luton Community NHS Trust
Bedfordshire and Hertfordshire SHA	Bedfordshire and Luton Community NHS Trust
Bedfordshire and Luton Community NHS Trust	Bedfordshire and Luton Community NHS Trust
Llanelli CHC	Carmarthenshire
Carmarthenshire Health Board	Carmarthenshire
Carmarthenshire NHS Trust	Carmarthenshire
Swindon and District CHC	Dr Elwood
Avon, Gloucestershire and Wiltshire SHA	Dr Elwood
Swindon and Marlborough NHS Trust	Dr Elwood
Portsmouth and Hampshire CHC	Gosport War Memorial Hospital
East Hampshire PCT	Gosport War Memorial Hospital
Hampshire and Isle of Wight SHA	Gosport War Memorial Hospital
Fareham and Gosport PCT	Gosport War Memorial Hospital
Carlisle MIND	North Lakeland Healthcare NHS Trust
CHC East Cumbria	North Lakeland Healthcare NHS Trust
Cumbria and Lancashire SHA	North Lakeland Healthcare NHS Trust
Eden Valley CHC	North Lakeland Healthcare NHS Trust
North Cumbria Mental Health & Learning Disabilities NHS Trust	North Lakeland Healthcare NHS Trust
Leicester CHC	Loughborough GP Peter Green
Leics, Northants and Rutland SHA	Loughborough GP Peter Green
Wandsworth CHC	St George's Healthcare NHS Trust
South West London SHA	St George's Healthcare NHS Trust
St George's Healthcare NHS Trust	St George's Healthcare NHS Trust
North West London SHA	West of London Breast Screening Service, Hammersmith Hospitals NHS Trust
Hammersmith Hospital NHS Trust	West of London Breast Screening Service, Hammersmith Hospitals NHS Trust

KEY CHC = Community Health Council
SHA = Strategic Health Authority
PCT = Primary Care Trust

Lessons from CHI Investigations 2000–2003

Appendix 4: Authors

Dr Heather Wood, CHI Investigation Manager

Debbie Murdock, CHI Investigations Manager

David Harvey, CHI Senior Analyst, Investigations

Ann Goodridge, CHI Analyst, Investigations and CHI's analytical team

Jo Lambourne, CHI Investigations Coordinator

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews

Q1) What was the impact of the investigation in providing the impetus for change?

Results by group	No impact	Some impact	Significant impact	Unsure/Don't know
Total (36)	5.6%	19.4%	66.7%	8.3%
Trusts (10)	10.0%	20.0%	70.0%	
CHC/Patient org (14)		21.4%	64.3%	14.3%
SHAs (9)	11.1%	22.2%	55.6%	11.1%
Commissioners (3)			100.0%	

A key finding from the overall results is that 67% of those who responded to this survey said that investigations had a significant impact in providing an impetus for change. The details of this will be examined further as the individual responses to questions are addressed in turn below. One respondent described the investigation as "near the top of the Richter scale as far as earthquakes go". Another described it as a shock wave. Several respondents said that where some change had started already, the investigation process was an impetus that drove necessary change.

Other comments included:

- "there was a lot of adverse press prior to the investigation"
- "the investigation acted as a catalyst for change"
- "it made everybody in the trust think about what was going on and what needed to happen"
- "the change began even before the investigation started"
- "it's too early to say what the real impact is. CHI highlighted problems that were widely known anyway and all that has happened is they've been published in local papers"
- "it provided a significant impact to get on and do something"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q2) How would you describe the impact of the investigation on staffing and staff management?

This is an example of where some respondents felt unable to confine their comments to just one of the options on the rating scale, since the investigation was perceived to have been both positive and negative. It was agreed that they could rate in two areas. As a result of this many of the percentages for this question add up to more than 100.

Results by group	Significant negative impact	Some negative impact	No impact	Some positive impact	Significant positive impact	Unsure/ don't know
Total (36)	19.4%	38.9%	2.8%	33.3%	11.1%	13.9%
Trusts (10)	20.0%	50.0%		40.0%	30.0%	
CHC/Patient org (14)	7.1%	35.7%		35.7%	7.1%	35.7%
SHAs (9)	33.3%	44.4%	11.1%	22.2%		
Commissioners (3)	33.3%			33.3%		33.3%

Many comments in this section referred to the positive and negative effects of the investigation. It is noticeable in the "total" row, that investigations have a slightly higher negative impact. Some see the impact initially as negative but as a necessary process to go through to get to the stage where you can move forward. Statements were made such as: "It is a necessary trough to go through". However CHI needs to be aware that trusts feel there are long term negative effects. One respondent said that, "some of the senior nursing staff are still unable to talk about this period without crying and even now cannot discuss this," and "the emotional impact on the staff and patients has been deleterious in that they haven't been able to complete their grieving." In contrast another respondent said, "We made up our minds we were going to use it positively and use the outcomes developmentally, there was a high level of commitment once the process started".

Other comments included:

- "money has been released for training"
- "the negative impact was that it really reduced morale"
- "there was significant positive impact but not immediately such as the effects of senior staff changes"
- "the investigation did have a very negative impact but the CGR follow up had a positive impact and did point to progress"
- "significant positive impact, it resulted in additional resources being provided to address skill deficits and staffing issues"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q3) Leadership (including board and executive team functioning) has changed since the investigation

Results by group	Got significantly worse	Got slightly worse	No change	Got slightly better	Got significantly better	Unsure/ don't know
Total (36)	2.8%		5.6%	52.8%	25.0%	13.9%
Trusts (10)			10.0%	50.0%	40.0%	
CHC/Patient org (14)				57.1%	14.3%	28.5%
SHAs (9)			11.1%	55.6%	33.3%	
Commissioners (3)	33.3%			33.3%		33.3%

The majority of respondents said that leadership had got slightly or significantly better since the investigation and 22% said that they felt that this was principally due to the investigation. Others stated that changes were happening anyway and it was difficult to say what was specifically due to the investigation. Examples of changes provided included staffing changes such as changes of chairman, chief executive, new trust board members, changes in directors and other managers. Changes in organisational structures were also reported. Statements included:

- "there are now new ways of working including a different attitude and approach"
- "the HR and Medical Directors work more closely and are more aware of clinical governance now"
- "policies and procedures are more robust"
- "complaints are acted on effectively now"
- "all are more aware of clinical governance and accountability"
- "a new structure has now been introduced"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q4) Relationship with other health and patient organisations have changed

Results by group	Got significantly worse	Got slightly worse	No change	Got slightly better	Got significantly better	Unsure/ don't know
Total (36)	5.6%	2.8%	27.8%	30.6%	27.8%	5.6%
Trusts (10)		10.0%	30.0%	20.0%	40.0%	
CHC/Patient org (14)			35.7%	42.9%	21.3%	
SHAs (9)	11.1%		11.1%	22.2%	33.3%	22.2%
Commissioners (3)	33.3%		33.1%	33.3%		

There is a mixture of views in response to this question with some respondents saying there had been no change, the majority of others reporting that relationships were slightly or significantly better and a few saying relationships had deteriorated. On some occasions where no change was reported, this was because relationships were described as being good prior to the investigation. Where change was identified, 38.9% said this was principally due to the investigation. Some of the examples given include:

- "the action planning brought us together and we have a common focus now"
- "much more information is given now to allied organisations and they are empowered to ask questions"
- "we have easier access to senior managers now"
- "from a CHC perspective they have got better in terms of complaints management and patient representatives are more involved"
- "there were fairly good relationships with stakeholder organisations anyway"
- "some people who I have contacted felt that nothing has changed"
- "no real change because we had a good relationship with the chief executive"
- "greater confidence is generated in voluntary organisations, user groups and CHCs because they see a new value base and a board prepared to tackle difficult issues that have been avoided in the past"
- "a multiagency review group was established and our complaints officer sat on that"
- "it has not really had a great deal of impact in that there were and still remain effective relationships"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q5) Since the investigation internal performance monitoring mechanisms have changed

Results by group	Significantly worse	Slightly worse	No change	Slightly better	Significantly better	Unsure/ don't know
Total (36)		2.8%	2.8%	33.4%	47.2%	13.9%
Trusts (10)			10.0%	20.0%	70.0%	
CHC/Patient org (14)		7.1%		28.6%	35.7%	28.6%
SHAs (9)				33.3%	55.5%	11.1%
Commissioners (3)				100.0%		

A clear majority of respondents rated internal performance monitoring as being slightly or significantly better since the investigation. Almost half (47.2%) said that where change had occurred, it was principally due to the investigation. Others reported that change was happening anyway and that the investigation was a catalyst that spurred things along. CHC and patient organisations found this question difficult to comment on and many responded by saying they did not know or they were unsure. Examples referred to with regards to internal performance monitoring were:

- "the Chairman of the CHC has observer status on the trust board"
- "there is a strong clinical governance team now"
- "reporting mechanisms to the board are stronger"
- "specific clinical directorates have been set up"
- "significantly better whistle blowing policy"
- "complaints management has improved"
- "generally a much stronger performance management ethos"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q6) Since the investigation external performance monitoring mechanisms have changed

Results by group	Significantly worse	Slightly worse	No change	Slightly better	Significantly better	Unsure/ don't know
Total (36)			13.9%	50.0%	19.4%	16.7%
Trusts (10)				70.0%	30.0%	
CHC/Patient org (14)			28.6%	35.7%		35.7%
SHAs (9)			11.1%	44.4%	44.4%	
Commissioners (3)				66.7%		33.3%

The majority of participants rated external performance mechanisms as being slightly or significantly better since the investigation and no one reported a deterioration. Twenty eight percent of respondents said that this improvement was principally due to the investigation. Most of the comments were about change being partly due to the investigation. One respondent said that there was a culture of openness and change would have developed anyway, with another saying that the investigation report was valuable and reinforced the importance of external performance monitoring. Examples of other statements include:

- "the PCT takes a closer interest now in the services"
- "an action plan monitoring group regularly checks progress on implementation"
- "quality assurance got worse initially and then better"
- "after the investigation other NHS agencies were keen to demonstrate that they were responding positively to the report and action plan, and that it put the trust under a very big spotlight particularly from the regional office and health authority"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q7) Risk management measures are more robust since the investigation

Results by group	Strongly disagree	Disagree	Agree	Strongly agree	Unsure/ don't know
Total (36)	2.8%		41.7%	36.1%	19.4%
Trusts (10)			40.0%	60.0%	
CHC/Patient org (14)			21.4%	35.7%	42.9%
SHAs (9)			66.7%	22.2%	11.1%
Commissioners (3)	33.3%		66.7%		

The majority of respondents either agreed or strongly agreed with this question and 41.7% said that the more robust risk management measures were principally due to the investigation. Comments ranged from:

- "people seem a bit obsessed by risk now"
- "there are risk management plans which we are now able to see"
- "a fulltime risk manager has been appointed"
- "there is a proper structure with reporting mechanisms"
- "the openness about untoward incidents is much better"
- "significant changes have been made to the organisational structure"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q8) Strategic plans have been developed since the investigation

Results by group	Strongly disagree	Disagree	Agree	Strongly agree	Unsure/ don't know
Total (36)		11.1%	52.8%	25.0%	11.1%
Trusts (10)		10.0%	60.0%	30.0%	
CHC/Patient org (14)		14.3%	57.1%	21.4%	7.1%
SHAs (9)		11.1%	44.4%	11.1%	33.3%
Commissioners (3)			33.3%	66.7%	

Again, the majority of respondents either agreed or strongly agreed with the statement that strategic plans have been developed since the investigation. However only 19.4% said that this change was principally due to the investigation and others referred to plans being developed anyway. Other comments include:

- "a five year clinical governance strategy has been introduced"
- "a clinical governance strategy is now developed as well as an organisational development strategy since the investigation"
- "good strong strategic plans would have been developed regardless of the investigation"
- "huge strategic developments, some of those influenced by CHI"
- "some of the strategy development was happening anyway"
- "we had been working on reconfiguration prior to investigation"
- "disagree because strategic things were happening anyway"
- "the clinical governance strategic plan has really developed as well as an organisational development strategy emerged since the investigation"
- "good and strong strategic plans which they would have been doing regardless of the investigation"
- "we have seen no plans from the practice or the PCT"
- "some of the strategy development was happening anyway"
- "not principally due to investigation because we have been working on reconfiguration for a while"
- "the investigation has caused us to review our strategic plans with commissioners"
- "it facilitated the development of a strategic service plan"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q9) Internal communications have improved since the investigation

Please note that some respondents felt unable to confine their comments to one option of the rating scale. It was therefore agreed that they could rate in two areas. As a result of this, some percentages for this question add up to more than 100.

Results by group	Strongly disagree	Disagree	Agree	Strongly agree	Unsure/ don't know
Total (36)		13.9%	44.4%	8.3%	33.3%
Trusts (10)		20.0%	70.0%	20.0%	
CHC/Patient org (14)		7.1%	21.4%	7.1%	57.1%
SHAs (9)		11.1%	44.4%		44.4%
Commissioners (3)		33.3%	66.7%		

Of those expressing a view, the majority of respondents other than patient organisations/CHCs, agreed or strongly agreed that internal communications have improved since the investigation. 27.8% of respondents reported that this change was principally due to the investigation.

Comments included:

- "I didn't see any signs of improved communication then. They have now appointed a Director of Communications"
- "we still receive the internal communication leaflet but cannot really comment"
- "communications is an issue that the trusts are grappling with"
- "some slight impact because of the investigation but not principally due to the investigation"
- "new communications department in place now"
- "there have been personnel changes but everything together has produced beneficial changes in terms of communication"
- "they were effective anyway"
- "basically it resulted in a top to bottom review of the terms of engagement with staff, users, carers, staff side reps and the introduction of new ways of working"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q10) Multidisciplinary team working has improved since the investigation

Results by group	Strongly disagree	Disagree	Agree	Strongly agree	Unsure/ don't know
Total (36)		8.3%	47.2%	11.1%	33.3%
Trusts (10)		20.0%	70.0%	10.0%	
CHC/Patient org (14)			35.7%	14.3%	50.0%
SHAs (9)			44.4%	11.1%	44.4%
Commissioners (3)		33.3%	33.3%		33.3%

The majority of respondents agreed or strongly agreed that multidisciplinary team working has improved since the investigation; 39.1% reported that this change is principally due to the investigation.

Comments included:

- "conflict between clinicians including doctors never really tackled"
- "most critical section in the report was the working of some of the senior medical staff. The investigation really has helped with that"
- "not convinced it has significantly improved"
- "there was a tradition of multidisciplinary work but now got an allied health professionals forum"
- "action plan monitoring group multidisciplinary"
- "significant development working between various clinical staff on joint protocol"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q11) The patient experience has improved since the investigation

Results by group	Strongly disagree	Disagree	Agree	Strongly agree	Unsure/ don't know
Total (36)		5.6%	55.6%	16.7%	21.2%
Trusts (10)			90.0%		10.0%
CHC/Patient org (14)		7.1%	50.0%	28.6%	14.3%
SHAs (9)			33.3%	22.2%	44.4%
Commissioners (3)		33.3%	33.3%		33.3%

The majority of respondents agreed or strongly agreed that patients' experience has improved since the investigation; 41.7% reported that this is principally due to the investigation.

Comments include:

- "there are a number of initiatives to improve staffing levels and the patient experience"
- "it does not seem to have improved. Their experience is that nothing has changed"
- "there were immediate changes as a result of the CHI investigation"
- "as far as we can tell it has not changed a lot but then most patients were satisfied with the service"
- "a lot of patients welcomed the CHI investigation and the patients suddenly realised that they could talk if they felt things were not right"
- "patients are much more widely involved as well as friends and volunteers and there are links with a lot of the PALS work"
- "waiting times have fallen so much now and was that due to the incident and the investigation - partly both"
- "they have worked very hard at getting clients involved in care and in quality improvement"
- "we have got different work streams set up, eg privacy and dignity of Muslim women, how people would like reception areas designed"
- "the CHC undertook a survey which showed very good results"
- "we did a lot of work around essence of care benchmarking standards and there is a huge customer focus to these"
- "there is a lot more rigorous system of clinical governance now and they have broken down some of the professional boundaries and patients are involved in improving things from clinical issues to signposting"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q12) Progress on action plan

The table below summarises the respondents' views on the progress made on action plans following investigations.

Publication year (number of respondents)	Only just commenced	Partly implemented	Mostly implemented	Fully implemented	Unsure/ don't know
2000 and 2001 (16)		6.3%	68.8%	6.3%	18.8%
2002 (10)		20.0%	80.0%		
2003 (10)	20.0%	40.0%	30.0%		10.0%

As would be expected, more progress has been made on action plans for earlier investigations. Overall, the majority of respondents stated that action plans following the investigation are either mostly or partly implemented.

Comments included:

- "one of the main areas of concern is the absence of signs of improvement between the trust and the PCT"
- "the action plan has only just been published but everyone is committed to it"
- "it is implemented in those areas where the trust is the sole agency involved but no progress has been made in those areas where commissioners need to spend significant resources. We have estimated that the total net cost of the implementation is about 1.7m per annum so there needs to be further negotiations about commissioning"
- "there were aspects of the action plan which are inappropriately expressed"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q13) Did the investigation establish the facts?

Results by group	Not at all	Partly	Mostly	Completely	Unsure/ don't know
Total (36)		25.0%	47.2%	16.7%	11.1%
Trusts (10)		20.0%	20.0%	50.0%	10.0%
CHC/Patient org (14)		21.4%	64.3%		14.3%
SHAs (9)		33.3%	44.4%	11.1%	11.1%
Commissioners (3)		33.3%	66.7%		

The majority of respondents reported that the investigation either mostly or completely established the facts.

Comments included:

- "it went some of the way to establish some of the facts but it didn't follow through"
- "most because it was about two separate organisations"
- "it highlighted shortfalls but not necessarily everything"
- "there will always be some things we don't know"
- "how do you get people to come forward that have had positive experiences as well as negative to ensure a more balanced picture?"
- "it is a bit difficult because the facts are still disputed to a certain extent"
- "we had produced reports but the CHI investigation clarified facts"
- "CHI identified systems and an observation of what was happening but it did not help on why it was happening. Really need to focus much more on why"
- "question mark about some of the statistical information and the wider context"
- "because it is like an onion: things have still been peeled off since the investigation"
- "it made no reference to the problem of the inadequate resource base"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q14) Did the investigation contribute to learning from the events that triggered the investigation?

Results by group	Not at all	To some degree	Significant contribution	Unsure/ don't know
Total (36)	8.3%	36.1%	52.8%	2.8%
Trusts (10)	10.0%	20.0%	70.0%	
CHC/Patient org (14)	7.1%	42.9%	42.9%	7.1%
SHAs (9)	11.1%	44.4%	44.4%	
Commissioners (3)		33.3%	66.7%	

The majority of trusts and commissioners reported that the investigation contributed significantly to learning from the events that triggered it; the majority of CHCs / patient organisations and strategic health authorities reported that the investigation either contributed to some degree or significantly.

Comments included:

- "a lot of learning had been done in some areas already but what hadn't happened was people learning about their own responsibility and that was useful"
- "I think it sped up the learning and gave a framework that made it easier to implement the required changes"
- "the learning was happening before the investigation started"
- "brought people together, made them look hard at practices, processes and communication"
- "not really because they had been investigated before CHI and responded to"
- "we learned many of the lessons prior to CHI having done the investigation, no real surprises"
- "the most significant thing was that it enables a totally new approach to be taken to develop an open culture and move away from a blame culture"
- "it was able to draw out some of the management failures that were organisational behaviour. That was helpful to show how it could happen in other services too"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q15) Did the investigation provide an impetus for the resolution of complex issues?

Results by group	Not at all	To some degree	Significant contribution	Unsure/ don't know
Total (36)	2.8%	52.8%	33.3%	11.1%
Trusts (10)		60.0%	40.0%	
CHC/Patient org (14)		35.7%	35.7%	28.6%
SHAs (9)	11.1%	77.8%	11.1%	
Commissioners (3)		33.3%	66.7%	

The majority of trusts and strategic health authorities reported that the investigation provided an impetus for resolving complex issues to some degree. The majority of commissioners thought the investigation provided a significant contribution, and CHCs / patient organisations said that the investigation either provided some, or a significant contribution.

Comments included:

- "the team working, the medical staffing problem and also links with other hospitals is much better now"
- "it made people think what they were doing and how it was affecting others and that has definitely brought about a change in the culture"
- "it has helped particularly with partnership working"
- "they do seem to have complex issues with consultant staff"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q16) How would you describe the effect of the investigation on public confidence?

Most respondents gave more than one answer with many saying that there were some positive and some negative effects of the investigation on public confidence, so most rows add to over 100%. It seems reasonable to expect both outcomes although further work may demonstrate that the initial effect is negative but that in the longer term there is a more positive outcome.

Results by group	Significant negative effect	Some negative effect	No effect	Some positive effect	Significant positive effect	Unsure/ don't know
Total (36)	11.1%	50.0%	8.3%	38.9%	8.3%	11.1%
Trusts (10)	20.0%	80.0%		40.0%	10.0%	
CHC/Patient org (14)		42.9%	14.3%	42.9%	14.3%	7.1%
SHAs (9)	22.2%	22.2%	11.1%	33.3%		33.3%
Commissioners (3)		66.7%		33.3%		

Apart from CHCs / patient representative organisations, the majority of respondents reported that the investigation had either a negative or no effect on public confidence. This finding is particularly marked for trusts. Where CHCs / patient representative organisations offered a view, they were split equally between some negative or no effect, and some positive or significant positive effect on public confidence.

Comments included:

- "the local organisation for a long time thought there was something wrong and were very pleased that the investigation was happening so you could say there was some positive effect"
- "one of the local newspapers carried out a campaign that could be seen as negative. Whenever there is a problem now they dig out all the press from the investigation"
- "the BBC have been invited to make a film about patient experience now"
- "I feel the public are waiting for something else to happen"
- "there is a lack of trust still"
- "lots of people do have positive experiences but they are not the ones that become public"
- "initial reaction was nothing because people were used to reading bad news about the trust"
- "it did help restore public confidence in the trust"
- "it caused a fuss at the time but people have moved on to new issues, eg waiting times"
- "we have had letters of support and letters of concern"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

- "it had a significant negative effect for a temporary period only"
- "generally it had some negative and some positive but the two probably evened each other out and had no effect"
- "we did notice a drop in bookings around the time of the publication of the investigation report but bookings are going up again now so it was only temporary"
- "it was significantly negative to start with, and that may have been presentational, but in the long term significantly positive"
- "it is a mixture. It has positive and a negative effect depending on where you sat as a stakeholder"
- "two effects: the short term one on the reputation, and then the contradictory effect of an investigation by an independent body. The fact that an independent body criticises helps restore public confidence. What is missing is the follow up to say that it has been done. A half day review on the Strategic Health Authority is needed"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q17) Did the investigation assist with clarifying accountability?

As some respondents felt unable to confine their comments to one of the options on the rating scale it was agreed that they could rate in two areas. As a result of this, some percentages for this question add up to more than 100.

Results by group	Did not assist	Assisted to some degree	Significantly assisted	Unsure/ don't know
Total (36)	11.1%	50.0%	38.9%	2.8%
Trusts (10)	10.0%	50.0%	50.0%	
CHC/Patient org (14)	7.1%	57.1%	28.6%	7.1%
SHAs (9)	22.2%	33.3%	44.4%	
Commissioners (3)		66.7%	33.3%	

The majority of respondents reported that the investigation either assisted to some degree or significantly assisted with clarifying accountability.

Comments included:

- "not sure that it was entirely fair that the chief executive was held responsible and that they left. However it did not fully explain where the accountability lay"
- "but what it has done is it has made clear to a lot more people who is accountable – it is a lot more transparent"
- "the accountability within the trust is clearer with the new structures"
- "made it clear who is responsible for what and the trust is much more clear about this"
- "the lines of accountability were clear but not operating effectively"
- "it certainly raised everyone's awareness and reminded everyone of their personal accountability"
- "this was done before the investigation"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Q18) What could / should be different in future investigations?

Many of the comments that were provided in response to the above questions, have been detailed below. The primary themes that can be extracted from the feedback are the methodology, the timeliness of investigations, the perceived focus on the investigation on the negative aspects of the trust's systems the need for more robust ways of ensuring change and concerns about communication, and the content of the press release around publication of the report. Additionally, it is worth noting that one respondent was concerned that insufficient attention is given to the cost of implementing the recommendations.

Comments are grouped below and include:

Methodology

- "the evidence seemed to lead to a flawed comment or recommendation"
- "too much weight on negative evidence"
- "interview a wide enough group of people to validate statements"
- "there has to be a rigorous and objective system, to recognise that it's a challenge, to develop open philosophy"
- "there is a real problem with the [CHI] triangulation methodology"
- "the impression I have is that you readily gave credence to people with a gripe or a grudge and those negatives outweighed many of the positives"
- "you gave too much weight to those who has a bad experience and didn't balance it enough. For example a thorough analysis of compliments on good practice, not just complaints"
- "I think that it could be improved if it became more scientific"
- "change to say could you come forward if you have positive or negative things to say"
- "key overall comment is about the need for root cause analysis and the investigation needs to look at not only who did what when but need to go further than that in order to learn"
- "in future investigations continue to involve users and carers and make them the first port of call because they are more free to say things"
- "there are concerns about the [CHI] triangulation process of evidence"
- "need root cause analysis – should be a key technique within it"
- "methodology has to be absolutely watertight"
- "going in and doing root cause analysis"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

Timeliness

- "the time delay between the incident and the investigation was an issue"
- "the length of time between the investigation and the report coming out is a problem"
- "once report had been done, it was a long process to get it published and it lost some of its impetus. People lost the will, things went off the boil because it took so long"
- "the speed of setting up an investigation needs to be looked at, you need it next week and patient safety is an issue"
- "response time is really important, even if it means calling people in from elsewhere and purchasing consultancy time"
- "intensive investigation needed with a short timescale and clear expectation of when report will be produced"
- "perhaps doing this kind of exercise a lot closer to this event so that we are not having to look back two years and rely on distant memory so much"

Investigation perceived to be too negative and punitive, not sufficiently developmental

- "how does it ensure the information is accurate especially when there is a very critical local press?"
- "how can CHI look at things with a view to how things can be done better – it seems like an attitude thing"
- "try to bring about a development approach"
- "needs to not be held up as a rod, as a punishment"
- "they need to make it more explicit that they are trying to establish the facts and not blame"
- "we should congratulate the organisation on any progress made"
- "give equal measure to positive and the negative – not just in press release but also in the wording of the report"
- "there is a feeling that when it becomes CHAI that it will be more inspectorial than developmental"

Improvement to action planning, follow up and ensuring change

- "don't just rely on action plans when people tick boxes"
- "ensure you involve staff and go back and ask them the impact"
- "need to be clear about who signs off action plan and when"

Lessons from CHI Investigations 2000–2003

Appendix 5: Evaluating the impact of CHI investigations: results of telephone interviews *continued*

- "is there a standard monitoring process?"
- "maybe there was a need to do a follow up from the investigation a year or 18 months on"
- "positive reassurance that things have moved on and be able to draw a line in the sand"
- "there needs to be a sign off from CHI and there is mileage in doing something a bit more substantial than what currently happens"
- "build in a check and balance with the strategic health authorities monitoring of the action plan"
- "need to be more concerned about outcome than about paperwork"

Concern about press release and communication at time of publication

- "lack of communication between the SHA and CHI just before publication"
- "the press release probably caused most of the negative impact on public confidence that eliminated some of the positive impact of having an investigation in the service"

Other

- "being clear about when an investigation is required and when something else is needed from an significant untoward incident. For example a review that looks at structures and processes"
- "sometimes there are issues within the service about fear of CHI coming to investigate and the loss of stars"
- "there is a view that CHI is a bit inflexible but that is a wider view not just about investigations. It needs to work on listening to feedback"
- "we have estimated that the total net cost of the implementation is about 1.7m per annum so there needs to be further negotiations about commissioning"

Commission for
Health Improvement

Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG

Telephone 020 7448 9200
Text phone 020 7448 9292

www.chi.nhs.uk

