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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS' MEETING

HELD ON 18 JULY 2012

Subject	Healthcare Governance Summary
Supporting TEG Member	Professor Mike Richmond, Medical Director
Author	Sandi Carman, Head of Patient and Healthcare Governance
Status[1]	Note

PURPOSE OF THE REPORT

To update the Board of Directors on aspects of Healthcare Governance recently reviewed by the Trust, outline the current position and where appropriate provide an update on performance.

KEY POINTS

This summary aims to provide the Board of Directors with an overview of the significant Healthcare Governance matters reviewed by the Trust over the last month, these include:

1. External Visits, Accreditations and Inspections Update
2. Care Quality Commission Compliance
3. Patient Incidents, Concerns, Claims and Inquests
4. Patient Experience
5. Staff Incidents and Claims
6. Directorate Healthcare Governance Performance
7. Hospital Mortality
8. Management of Controlled Drugs
9. Trauma, Orthopaedic and Plastic Surgery Services
10. Complaints and Feedback

The Trust has in place an annual Healthcare Governance work plan that ensures regular review of all aspects of Governance and covers the essential requirements of the Care Quality Commission and NHS Litigation Authority.

IMPLICATIONS[2]

	Aim of the STHFT Corporate Strategy 2012-2017	Tick as Appropriate
1	Deliver the best clinical outcomes	✓
2	Provide Patient Centered Care	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATIONS

The Board of Directors are asked to note the contents of this report.

APPROVAL PROCESS

Meeting	Presented	Approved	Date
Trust Executive Group	Dr David Throssell		11 July 2012
Board of Directors	Dr David Throssell		18 July 2012

1. EXTERNAL VISITS, ACCREDITATIONS AND INSPECTIONS

The Trust reviewed the recommendations received during the previous month following visits to the Trust:

- Fire Authority Audit
- Human Tissue Authority Inspection
- CQC Termination of Pregnancy Inspection
- BSI Quality System Audit of Stereotactic Radio-surgery
- CPA Surveillance Visit to the Protein Reference Unit and Immunology

Any areas for improvement are addressed with an action plan. The Trust tracks progress against the action plans that have been received. The plans are removed from the tracker once the time-limited actions have been completed.

2. CARE QUALITY COMMISSION COMPLIANCE

a) Quality and Risk Profile: CQC have not published a Quality and Risk Profile (QRP) for May 2012.

b) Provider Compliance Assessments: The CQC Compliance Review Group met on 8th May. The Provider Compliance Assessments (PCAs) for Essential Standard Outcomes 9, 17 and 21 were considered and the Group felt that sufficient evidence was available to provide assurance of compliance.

c) Inspection Programmes: The Quality Governance Inspection Programme commenced in May 2012. This programme has been designed to simulate CQC methodologies. Internal performance data is triangulated to identify triggers for unannounced internal inspections.

An inspection team consists of 3 or 4 people led by a member of the Patient and Healthcare Governance Department. The team includes both corporate and directorate governance specialists. Each inspection explores performance on one selected ward or department. Follow-up inspection will be conducted if areas for improvement are identified.

The first internal inspection looked at falls prevention on Hadfield 6 and considered compliance with Outcome 4, care and welfare of people who use services. The inspection team was impressed by their observations and received positive comments from staff and praise from patients. One area for improvement was identified relating to clear documentation of falls assessment and care planning. The findings will be shared with the falls work stream. Local improvements will be led by the directorate risk lead. An inspection team will re-visit in approximately 3 months time to find out if improvement has been achieved.

d) Mortality Alert: CQC wrote to the Trust on 3rd May 2012 regarding a new mortality outlier alert for emergency admissions coded to Healthcare Resource Group (HRG) H89 “other neck of femur fracture without complications or co morbidities”. CQC had identified a mortality outlier for this HRG during their automatic scanning of hospital episode statistics data.

CQC have conducted an analysis of this alert and concluded that they do not need to undertake any investigation at this time. They will publish this as a closed case and do not require the Trust to provide an action plan. The purpose of the letter was to share the outlier alert with the Trust for information.

The Trust responded to this letter requesting further information on the nine outlier cases identified. Patients admitted to hospital with a primary diagnosis of fractured neck of femur can be mapped to one of several HRG codes depending on the treatment provided and on whether complications or co-morbidities are present and recorded. CQC analysed outcomes for the primary diagnosis and found that mortality at the Trust was within acceptable limits.

The Orthopaedic Directorate has been provided with the information received from CQC and have commenced their investigation. An update will be provided in a future CQC Compliance Report. Early indications show that these patients may have been coded to the wrong area, therefore reflecting an unusual set of outcomes for the patients concerned.

3. PATIENT, INCIDENTS, CONCERNS, CLAIMS AND INQUESTS

Information and data for the period January – March 2012 was reviewed to understand any themes and ensure appropriate action is been taken to address any areas for concern.

The following work streams and actions have been developed from key themes identified during the previous and current time period

- During the previous quarter (Oct – Dec 2011) the wards involved in the falls work stream implemented 'intentional rounding'. This is a formal check undertaken every 2 hours on each patient on the ward to ensure that they are positioned correctly, their personal needs are met and the patients' equipment is in easy reach. It is anticipated that the benefits of this work will result in fewer falls, fewer pressure ulcers and improve the patient experience. Evidence from other international sources also shows that it helps staff organise their workload and provides more systematic and reliable care. Anecdotal evidence from the 4 wards indicates that the patients are not operating their call buzzers as often as their needs are being satisfied. The data from this project will require further analysis over the coming months to determine its effectiveness

- A systematic review of the whole pathway for treating patients on the various anti-coagulation protocols is being undertaken, following a Coroners Rule 43 letter to a neighbouring Trust. This review will include input from the healthcare governance department, pharmacy, service development and patient safety

- Steroid replacement cover for patients undergoing surgery with pre-existing adrenal insufficiency is being reviewed, as during preparation for an inquest it was identified that there were no national guidelines. The coroner has alerted various Royal Colleges via a Rule 43 of the lack of National Guidelines. Feedback from the Royal Colleges is awaited, however the Trust has decided to progress with local guideline development as an interim solution.

- Medicines related incidents continue to be reviewed by the Medicines Safety Committee. Improvement work is currently being undertaken by a work group led by Dr Des Breen, Associate Medical Director.

4. PATIENT EXPERIENCE

Information on all aspects of experience has been reviewed. Where poor experience is reported, actions are taken to ensure improvements are made. Information sources include:

- National Surveys
- Frequent Feedback
- Website Feedback
- Comments Cards
- Complaints
- Clinical Assurance Toolkit (CAT)
- Service Improvement Projects
- Governor and LINk Visits

Using all methods of information available enables the Trust to better understand the patient's experience of the services offered and delivered, and is beneficial to help prioritise where to focus efforts on action planning.

National Surveys - Results from the 2011 National Outpatient and Inpatient Surveys were published by the Care Quality Commission (CQC) during this quarter. STH performed well in the 2011 outpatient survey compared to other Trusts. Key areas for further improvement have been identified and priorities for improvement action will be reviewed and agreed as part of the Outpatients Service Improvement Project.

The Trust also scored well in the Inpatient survey. Over 95% of patients rated their care as either excellent, very good or good. Just under 3 % said their care was fair and 2% reported that they had received poor care.

The key area for improvement identified in the Inpatient Survey Report for Trust-wide improvement relates to improving the quality of information included in letters sent between the hospital and family doctors so that they are written in ways that patients can understand. This improvement target is reflected in one of the Trust's Quality Priorities for 12/13.

5. STAFF INCIDENTS AND CLAIMS - January to March 2012

a) Staff and student incidents: Insignificant, Minor and to a much lesser extent Moderate incidents are the usual grades for staff incidents.

In this quarter the number of moderate incidents has reduced significantly from the last quarter.

This quarter there were 2 major staff incidents reported which is unusual as normally there are none. They were both slip fall incidents on ice which resulted in a fractured arm of a staff member walking on a side delivery road and a fractured neck of femur of a staff member who was asked to grit a path. Both incidents were in relation to inclement weather. Snow had fallen at the weekend which had been cleared and the paths then gritted by Estates Department as per procedure.

The two incidents were both investigated, the gritting of the paths had been undertaken by Estates but due to extreme weather, had begun to refreeze. Staff on the Unit involved have been reminded that the procedure is to report potentially unsafe paths to the Estates Helpdesk as soon as they can and not to undertake gritting themselves. There is a risk assessment in place, which is reviewed annually by Estates in relation to the gritting of our premises. Gritting is undertaken in a prioritised manner.

In response to other incidents reported there will be a new focused group set up to review all exposure incidents which will include needle/sharps incidents. The group aims to analyse in detail the numbers and types of exposure incidents, make recommendations in the use of safety devices and any changes to practise to reduce incidents.

b) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Reported for Staff Incidents

This quarter there was a total number of 16 RIDDORs reported to the Health and Safety Executive (HSE)

This quarter the HSE have investigated a RIDDOR which was reported last quarter in relation to a fall on an emergency escape route in a Corporate Department. The HSE recommendations have now been completed and the HSE have closed the investigation.

One of the Moving and Handling RIDDORs reported this quarter has been investigated by HSE. It is in relation to a staff fall whilst assisting a patient in a toilet. The HSE visited the Trust, two inspectors, (one general inspector and his manager) met with the Trust Occupational Safety Manager, the Matron and Ward Sister and the Governance Coordinators for Specialised Cancer, Medicine and Rehabilitation. The inspectors discussed what

happened on the day of the incident and what had been undertaken since the incident. They also visited the ward area and the toilet where the incident happened.

The HSE and were pleased with the work that has been carried out on the ward by the staff, (risk assessments, moving and handling issues and follow up support) However, the inspectors requested further information on the planned work which had already been identified for the area. The Trust have now ring-fenced the funding from the financial budget year 2013/14 and the work will be factored into the prioritised Estates work programme and a scheme should be ready to go in early 2013. The HSE have been notified of this plan. It is expected that the HSE will be in contact at some point and the investigation remains open.

c) Claims

Of the 15 opened cases, 7 relate to slips/trips, 2 of which were associated with icy conditions. There were 3 moving and handling cases, 2 non-clinical and 1 clinical. There were 2 needle stick injury claims. Other claims related to being struck by lift door, suffering an electric shock and there was an industrial disease case alleging hearing loss.

Of the 23 closed cases 21 were settled. Of the settled cases, 7 were related to moving and handling incidents (3 clinical, 4 non-clinical), 5 needle-stick injuries, 3 defective equipment, 3 slips/trips, 2 injuries to due problems with the lifts, 2 scalds when handling hot water/food and there was 1 electric shock.

Key areas leading to claims are therefore slips/trips, moving and handling and needle-sticks.

All opened and closed claims are discussed at the quarterly Personal Injury Claims Review Group. The importance of the reporting and investigation of incidents at the time they occur has been taken back to the directorates as really this key to early assessment of the defensibility of claim and sufficient evidence to defend them where appropriate.

6. DIRECTORATE HEALTHCARE GOVERNANCE PERFORMANCE

Two new programmes for monitoring directorate governance performance have been introduced in 2012.

- The Quality Governance Inspection Programme monitors performance relating to CQC standards and will be reported through the CQC Compliance Report to the Committee.

- The Healthcare Governance Risk Management Audit Programme monitors performance relating to 50 high risk criteria identified by the NHS Litigation Authority. These include incident and complaints management, mandatory training and directorate Healthcare Governance meetings. Progress will be reported through a new Directorate Healthcare Governance Performance Report to the Committee.

A thorough review has been undertaken to ensure that the measures included in the previous Directorate Dashboard report are all still reported through the papers in the Healthcare Governance work plan and the Performance Management Framework.

The new programmes will provide assurance about local governance practice. They will also seek out areas for improvement and identify if this is specific to one small area or if it is a common issue across the Trust. The issues that are identified will be addressed locally and shared through the Healthcare Governance Operational Group.

7. HOSPITAL MORTALITY

The Trust has reviewed two current measures of mortality – the established Hospital Standardised Mortality Ratio (HSMR) and the new Summary Hospital-level Mortality Indicator (SHMI).

Hospital Standardised Mortality Ratio (HSMR)

The HSMR is an *indicator* of healthcare quality that measures whether the death rate *at a hospital* is higher or lower than you would expect. We access this information through Dr Foster's Real Time Monitoring Tool (RTM).

The HSMR compares the expected rate of death in a hospital with the actual rate of death for those patients with diagnoses that most commonly result in death i.*e. it covers the top 56 diagnoses from which 80% of all deaths occur.* When calculating the expected death rate severity of illness, age, sex, deprivation and other factors are taken into account.

The number of expected deaths is compared with the number of observed (actual) deaths and if the number is the same the HSMR score is a value of 100. If the number of observed deaths is less than expected the HSMR value is below 100; if observed deaths are higher than expected then HSMR is greater than 100.

All hospitals in England are included in the model so that a national benchmark can be calculated. The current benchmarking data in RTM is based on the 2010/11 financial year's Secondary User Services (SUS) data.

Dr Foster reports the annual HSMR in their Hospital Guide to enable comparison of mortality rates across all hospitals in England for any particular year. Table 1 indicates the rolling 12 months HSMR as it currently stands.

The HSMR for 2011/12 of **89.3** for All Admissions is "significantly lower than the national benchmark". The rebased value STH NHSFT for 20011/12 is anticipated to be 98 (within expected range) and we await confirmation of this from Dr Foster in September 2012.

STH NHSFT	**Rolling 12 months HSMR April 2011 - March 2012**
All Admissions	**89.3** (85.8 – 93.0)
Elective Admissions	74.1 (58.9 - 92.0)
Non Elective Admissions	89.9 (86.3 – 93.7)

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is an *indicator* of healthcare quality that measures whether the death rate at a hospital *and up to 30 days from discharge* is higher or lower than expected.

It is a ratio between the actual (observed) number of deaths at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated there. The value produced is evaluated as to whether the mortality within the trust can be described as either 'as expected', 'lower than expected' or 'higher than expected'. One SHMI value is calculated for each trust. The baseline SHMI value is 1.

Developed by the NHS Information Centre (IC) with an industry-wide panel of experts the SHMI methodology is similar to the Dr Foster HSMR but with 3 key differences;

- The SHMI measures in-hospital deaths and deaths outside of hospital for a period of up to 30 days where HSMR measures in-hospital deaths only
- The SHMI uses 100% of diagnosis groups whereas HSMR uses only 56 groups that account for approx 80% of deaths
- The SHMI does not take into account Palliative Care whereas the HSMR does

SHMI is the standard indicator for reporting hospital mortality across the NHS (http://www.ic.nhs.uk/services/SHMI) and reported quarterly on NHS Choices.

The most recent information from the IC, published 24 April 2012, covers the period 1 October 2010 to 30 September 2011. The IC SHMI value for STH is **0.90** (0.88 – 1.13) for an expected 3945 deaths.

The Trust continues to monitor and review mortality rates at a sub-speciality level, any areas of concern are flagged to the Medical Directors Office and review work initiated.

8. MANAGEMENT OF CONTROLLED DRUGS

There has been a decrease in the number of Datix reported Controlled Drugs related incident this quarter, with a marked decrease in the number of balance irregularity incidents and a more even split between other incident types than in previous quarters. This could in part be as a result of more accurate descriptions being entered onto Datix thus making classification easier.

The Trust noted:

- There were 40 incidents involving controlled drugs in the quarter 1st January to 31st March 2012
- Of these 40 incidents, 19 were classed insignificant, 19 as minor and 2 as moderate.
- All incidents were fully investigated at the time or have been followed up later.
- No incidents were reported to the police.
- No incidents have been reported from Community Services.

9. TRAUMA, ORTHOPAEDICS AND PLASTIC SURGERY SERVICES

This Trust received an update on the actions taken following the recommendations made by a service review in March 2008 into Trauma / Orthopaedic and Plastic Surgery services at the Northern General Hospital. As clinical reconfiguration has now concluded, it was agreed timely to revisit the original recommendations to ensure that all actions have been completed.

The original report was accepted and the recommendations progressed through an action plan overseen by the Healthcare Governance Committee. Although most actions were completed at the time, there were a number of outstanding actions that were to be completed at the point of clinical reconfiguration.

All the recommendations have now been addressed. Reconfiguration was a major part of the work undertaken following this review and had had a significant impact on these services.

Further changes may now be required as a result of the Trust achieving designation as a Major Trauma Centre, this work is progressing.

10. COMPLAINTS AND FEEDBACK

The number of new complaints received in April fell slightly from previous months. The reduction is however consistent with the same period last year reflecting the impact of bank holidays over the Easter period. The level of other feedback received remains low and the Patient Partnership Department are working with Clinical Directorates, Governors and Volunteers to look at ways of encouraging more patients to give us their feedback.

The following items were noted

- 99 new complaints were received by the Trust in April.
- One area received more complaints than expected and the reasons for this are being investigated by the Nurse Director.
- 4 departments had peaks in the numbers of complaints received. These have been investigated and no specific themes or trends have been identified.
- The Trust responded to 87% of complaints within 25 working days during April.

The Trust reviewed data on the number of Patient Services Team (PST) enquiries that have been dealt with during April. A process of recording and responding to Patient Services Team (PST) enquiries was introduced in December 2011 to try to deal with minor concerns and enquiries in a more timely manner and to avoid the need to initiate the complaints process where appropriate. If calls, emails or face to face enquiries are received by the PST that staff feel can be dealt with quickly by direct action or be putting the enquirer in touch with an appropriate member of staff such as a Matron or Service Manager, contacts are made and the enquiry is recorded on the complaints database. If the concern or issue is not dealt with within 2 days, or if the enquirer remains concerned, the issue is re categorised as a complaint and processed accordingly.