

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
Trust Board 28th July 2011

Quality Report

EXECUTIVE RESPONSIBLE	Vicky Morris, Director for Quality and Safety/Chief Nurse
AUTHORS	Vicky Morris, Director for Quality and Safety/Chief Nurse Justin Barnes (Medical Performance Manager) Sara Biffen (Divisional Manager)
STRATEGIC DOMAIN	C. Quality and Safety
ORGANISATIONAL OBJECTIVE	<p>This paper relates to all objectives within the Quality and Safety Domain of our Strategy:</p> <p>C1. Ensure that we learn from mistakes and embrace what works well C2. Design care around patient needs C3. Provide the right care, right time, right place, right professional C4. Deliver services that offer safe, evidence-based practice C5. Meet regulatory requirements and healthcare standards C6. Ensure our patients suffer no avoidable harm</p>
SUMMARY	<p>The strategy of The Shrewsbury and Telford Hospital NHS Trust is based on the central principle of Putting Patients First. Putting Patients First means giving the best patient experience we can, doing so safely (patient safety) and using the evidence of what works best to inform our practice (clinical effectiveness).</p> <p>The Board has put in place systems and processes to report on progress and provide assurance on patient experience, patient safety and clinical effectiveness. This includes:</p> <ul style="list-style-type: none"> • The monthly Strategic Performance Report, which tracks performance on key areas of Quality reflecting the six organisational objectives listed above. • The Quality Account, which provides an annual review of quality in the Trust, focusing on progress and challenges in the previous year and setting priorities for the year ahead • The Quality and Safety Committee, which focus on the agreed priorities and reports to the Board on a monthly basis. • Quality Reports, which provide a regular opportunity to share key issues with the Board across the three dimensions of Quality. <p>This Quality Report provides more detailed information on current issues affecting patient experience, safety or clinical effectiveness in the Trust. This includes the current waiting list challenges in the Trust and the impact of this on our patients, prevention of venous thromboembolism, continued progress to reduce in-hospital mortality, and the findings and recommendations of recent quality reviews.</p> <p>The Board has received regular updates on quality and safety at previous meetings, for example through the Quality Account approved by the Trust Board on 30 June 2011, through the most recent Quality Report on 26 May 2011, through the Quality and Safety Committee meetings and minutes and through the mortality updates to the Trust Board.</p>
RECOMMENDATION	The Trust Board are asked to NOTE the Quality Report and the actions being taken to improve patient experience, patient safety and clinical effectiveness.

Quality Report
July 28th 2011

1.0 Introduction

The strategy of The Shrewsbury and Telford Hospital NHS Trust is based on the central principle of Putting Patients First.

Putting Patients First means giving the best **patient experience** we can, doing so safely (**patient safety**) and using the evidence of what works best to inform our practice (**clinical effectiveness**).

The Board has put in place systems and processes to report on progress and provide assurance on patient experience, patient safety and clinical effectiveness. This includes:

- The monthly Strategic Performance Report, which tracks performance on key areas of Quality reflecting our organisational objectives
- The Quality Account, which provides an annual review of quality in the Trust, focusing on progress and challenges in the previous year and setting priorities for the year ahead
- The Quality and Safety Committee, which was established to provide a formal process for the Trust to focus on the all three dimensions of Quality, understand trends and themes and brief the Board on key areas of concern.
- Quality Reports, which provide a regular opportunity to share key issues with the Board across the three dimensions of Quality.

This Quality Report provides more detailed information on current issues affecting patient experience, safety or clinical effectiveness in the Trust. This includes:

Issue	Quality Dimensions	Section
The current waiting list challenges in the Trust and the impact of this on our patients	Patient Experience Patient Safety	See Section 2
Prevention of venous thromboembolism	Patient Safety	See Section 3
Continue progress to reduce in-hospital mortality	Clinical Effectiveness	See Section 4
Leading Improvement in Patient Safety	Patient Safety	See Section 5
Improvement Plan	Patient Experience Patient Safety Clinical Effectiveness	See Section 6
Findings and recommendations of recent quality reviews	Patient Experience Patient Safety Clinical Effectiveness	See Section 7

2.0 Update on Waiting Times and the Outpatient Improvement Programme (Patient Experience, Safety)

2.1 Introduction

The Board has received regular updates on the challenges facing the Trust in relation to waiting times, the impact of these challenges on patients and the work underway to ensure sustainable delivery of the 18 weeks Referral to Treatment Target (RTT), including the Outpatient Improvement Programme.

Performance in the Trust is currently significantly behind the national standards for seeing patients within 18 weeks from referral to treatment. The booking and appointment systems we have had in place in the Trust in the past have not provided a good service to patients. Our patients, our staff and the Trust as a whole will continue to see the impact of this until these issues have been resolved sustainably.

This is frustrating for patients who are waiting longer than expected to see a hospital specialist and receive definitive treatment (patient experience). It is important to note that whilst waiting for treatment – whether for one week, six weeks, eighteen weeks or longer - patients continue to experience the condition, concern or discomfort that has led to the referral (patient experience). In some cases the condition may worsen during the period until they are seen (safety). However, the significant reductions in waiting times over the last decade do mean that generally patients are seen much more quickly than ten years ago, and therefore risks in relation to both safety and patient experience have also reduced.

It is also frustrating for our staff, who aim to provide the right care in the right place at the right time, every time for every patient and who have found that the booking and appointment systems that the Trust has had in place in the past have not supported them to achieve this.

2.2 Reducing waiting times

Reducing waiting times requires co-ordinated action between the Trust, PCTs, GPs and other referrers (e.g. opticians, dentists). The Trust has worked with local NHS partners to review the position for each speciality and develop and agree a plan for sustainable achievement of the 18 week referral to treatment target.

Sustainability plans have been produced for each of the challenged specialties and are being implemented. Performance against these plans is monitored at the Trusts' weekly 18 week operational group and at the 18 week Local Health Economy Programme Board.

As expected, the Trust is not currently achieving the 18 week RTT target. This target will not be achieved until these plans have been delivered and the longest-waiting patients have been seen.

Waiting times data by speciality is published on the Trust website so that patients and communities are aware of potential waiting times and can make choices about potential treatment options on this basis.

2.3 Outpatient Improvement Programme

The Action plan to improve the systems and processes within the outpatient function is on schedule. Work completed to date is as follows:

- Booking staff recruited, will be in post mid August
- Key Performance Indicators agreed and Dashboard in place.
- Choose & Book being managed by PCT for 6 months who will train SaTH team.
- Standard Operating Procedures written and tested in outpatient and waiting list
- Standardisation and automation of appointment letters is ongoing, with a definitive position to be achieved by the end of September
- Scanning of new referral letters initially in Trauma and Orthopaedics introduced to improve safety and reliability of management of referrals
- Appointment telephone line in place initially for ophthalmology and cardiology follow up patients.
- Redesign of the Clinic Outcome Form process with accompanying awareness and education programme.
- Updated Access Policy, with 'drop in' awareness and training sessions beginning in August.

Further work is being undertaken in the way DNAs (patients who Did Not Attend) are managed within the Trust's Patient Administration System. An update on this work will be provided to the Trust Board in August.

2.4 Supporting patients who are still waiting for treatment

As mentioned above, this situation is frustrating for patients who are waiting longer than expected to see a hospital specialist and receive definitive treatment. It is not acceptable that patients are being inconvenienced because our appointment and booking systems have not worked effectively in the past. Through the plans outlined in Section 2.2 and 2.3 we aim to rectify this situation as soon as possible.

Also, whilst waiting for treatment – whether for one week, six weeks, eighteen weeks or longer - patients continue to experience the condition, concern or discomfort that has led to the referral. In some cases the condition may worsen during the period until they are seen. As mentioned in Section 2.1, waiting times have significantly reduced in the last ten years. However, it is important that we ensure that risks are identified and addressed through a comprehensive quality review process involving:

- Ensuring that we see patients referred with suspected cancer within the much shorter waiting times standards for these conditions, and also giving priority to patients referred as urgent.
- Seeing patients who are waiting to be seen on the basis of clinical need and/or ensuring that those waiting longest are seen first.
- Identifying and reporting where a patient's condition may have worsened, and ensuring that this is discussed with them.

- GP-led and consultant-led review of the referral and/or notes of patients who have been referred and are waiting to be seen, so that we can review and confirm their priority to be seen and see them accordingly.
- Ensuring that there are systems in place to expedite appointments for patients in greatest clinical need.

The local Health Economy (including the Trust, PCTs, local GPs and other primary care practitioners) is working closely in partnership to minimise the impact of the Trust's capacity and demand challenges on our patients.

A weekly meeting is in place to review the systems and processes to manage the assessment of patients and the PCTs are currently working with GPs to assess the number of patients who may need to be seen on an urgent review basis.

3.0 Update on Venous Thromboembolism (patient safety)

3.1 Introduction

This is a short update on the progress and actions underway to achieve the national requirement that 90% of eligible patients receive assessment for venous thromboembolism (VTE), and intervention or treatment where appropriate (NICE guidance and also CQUIN target).

This Trust has not had effective systems for recording whether VTE assessments are taking place, and thereby to be assured that assessment is taking place consistently for all eligible patients. We have therefore strengthened our VTE reporting systems to include three approaches:

- VitalPAC
- A manual form for Day Surgery units, collated by Ward Clerks and reported through Clinical Audit
- Cohorts of low risk patients who are deemed to have been assessed as a group

3.2 Current Status

The current rate of reported VTE assessments across the Trust for June 2011 is 60.21%. This remains behind the national standard for 90% but is on track against the planned trajectory to achieve the target in September 2011.

This will not yet reflect improvements in the recording of VTE assessments following the Leading Improvement in Patient Safety programme week held in mid June. Snapshot reports now available from VitalPAC indicate that VTE recording for patients whose care and observations are recorded using the VitalPAC systems was 93.4% at midday on 15th July.

3.3 Issues and Ongoing Actions

A simple actions plan has been created to support the accurate reporting of VTE across the Trust. This is detailed below. The key issues are:

- **Areas of the Trust that are not reached through the three recording approaches**

It has been identified that a number of areas of the Trust have no formal way of recording that a VTE assessment has been completed. These areas are almost all providing care for day case patients. Our current assessment is that a cohort approach should be used for recording.

These areas are:

PRH	Cardiac Day Beds	RSH	Gastro Unit
	Haematology Day Beds		Cardiology Ambulatory Care
	Endoscopy Unit		Ambulatory Care Unit

- **Complex Cohort Groups**

Currently, the decision on whether patients are low risk and therefore recorded as a Cohort Group is made on the basis of Procedure Code. This process is complex and alternatives are being considered. A suggested list of cohort groups is being collated for consideration and approval by the Medical Director in August. If approved then this cohorting approach would be retrospectively applied.

It is anticipated that this approach will include the areas that are not reached through our current recording approaches (see above)

- **Discrepancies between the recorded VTE assessments on VitalPAC and the number of assessments reported**

There are some Patients that have been assessed and are recorded on VitalPAC, but are not reflected in the monthly report provided by the Trust Informatics department. This is being investigated by a member of the Continuous Improvement and Informatics team.

- **Consultant League Tables**

A weekly report of the assessment rates by Consultant is now being distributed within the Trust. This aims to support improvement across the Trust.

- **Surgical Assessment Suite**

The Surgical Assessment Suite currently has a manual process for recording VTE assessment. The VitalPAC system is being introduced shortly.

- **Policies and Procedures**

The next step in the plan is to review or develop relevant policies and procedures that support the cohorts of patients across the Trust.

4.0 An Update on Mortality (Clinical Effectiveness)

One of the Trust's quality priorities as set out in our Quality Account is to reduce deaths in our hospitals by 10% by June 2012 and a further 10% by June 2013. In addition, we aim to improve and sustain a Hospital Standardised Mortality Ratio (HSMR) at or below the national index of 100. This aims both to stimulate the NHS to provide more choice at the end of life for patients and carers, as well as to support frontline staff to maintain and improve standards of clinical effectiveness and safety. We monitor our progress through 2 key measures:

- **Crude Rate of Deaths** – This is the total in-hospital deaths. It is calculated on the basis of hospital activity information contained with the Trust's MedeAnalytics system.
- **HSMR** – This is a national measure that gives a risk based comparison of actual deaths with expected deaths for patients within 56 of the main diagnosis groups. It takes into account case mix and includes deaths in community hospitals if the patient is directly transferred from SaTH. It is calculated using the Real Time Monitoring system provided by Dr Foster Intelligence.

The baseline for our measures is the latest full year as reported in April 2011.

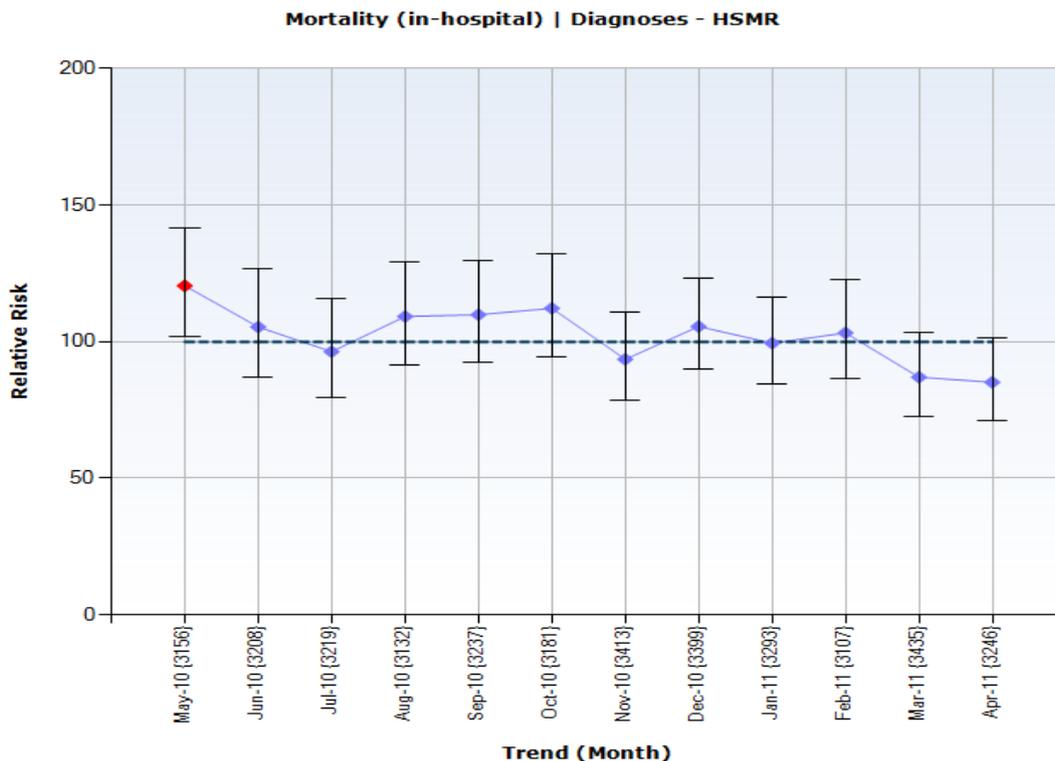
4.1 Current Status and Progress to date

The current status is set out below:

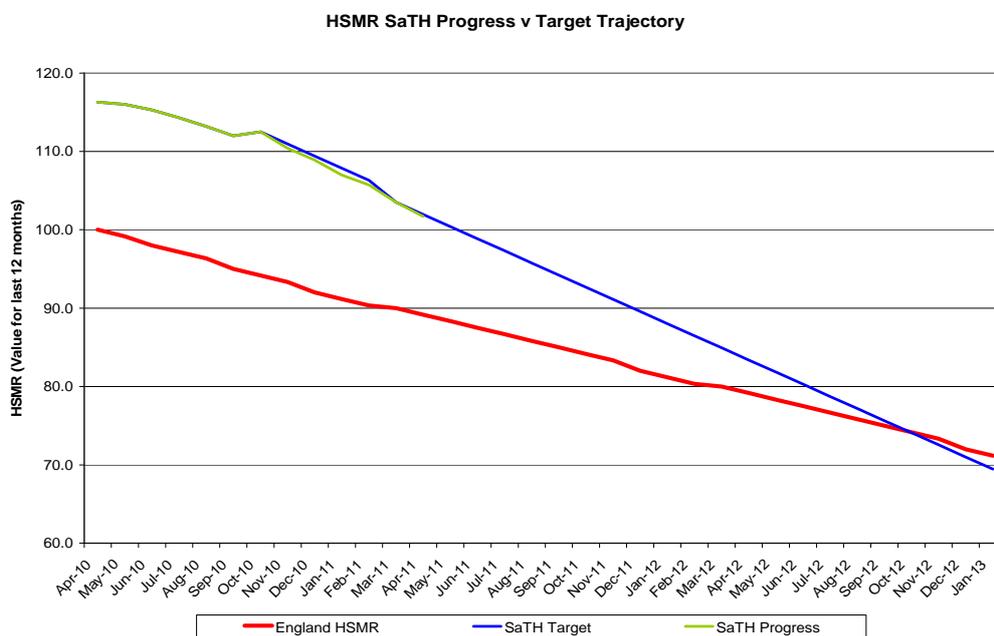
Baseline Year HSMR (rebased)	(Feb 2010 to Jan 2011)	116.2
Last 12 months HSMR (rebased)	(May 2010 to April 2011)	112.5
In Month HSMR – Trust	(April 2011)	96.0
In Month HSMR – PRH	(April 2011)	96.7
In Month HSMR – RSH	(April 2011)	92.1

The graphs overleaf show the trend in monthly HSMR (not rebased) to April 2011, and our proposed trajectory (not rebased).

HSMR Monthly Trend – SaTH (not re-based)



HSMR Trajectory and Progress Against Target



4.2 Key Points

Crude Rate of Deaths:

- The crude rate of death reduced by 10 compared with the equivalent period last year
- Further reductions in the crude rate of deaths can be achieved by supporting patients at the end of life (and their carers) to have greater choice around where they die (e.g. at home, nursing or residential home or hospice rather than in hospital) and through clinical improvements (e.g. through the Leading Improvement in Patient Safety programme).

HSMR:

- In-month HSMR is below (better than) the national index of 100 for the second month in a row, with a provisional HSMR (re-based) for April 2011 of 96.
- The Trust annualised HSMR continues to reduce at a faster (better) rate than the national index. The provisional re-based figure for the year to April 2011 is 112.5, reducing from 115 in the previous month.
- The in-month HSMR for April 2011 is similar for PRH and RSH. This reflects improvements in consistency between the two sites in the way that care is recorded.

5.0 Leading Improvement in Patient Safety

The Trust has embarked on a major programme, Leading Improvement in Patient Safety (LIPS), to support frontline staff to make changes that will improve patient safety. The LIPS programme focuses on supporting improvement in the following areas:

- Preventing Falls
- Preventing Pressure Sores
- Improving Hydration, Nutrition and Fluid Balance
- Reducing infections
- Responding to abnormal results
- Communication with patients and GPs
- Communication with and between staff
- Responding to deteriorating patients including through response to Early Warning Scores and reducing in-hospital cardiac arrest
- Medicines Management: improving drugs reconciliation and reducing medicines errors
- Improving Scheduled Care
- Improving Unscheduled Care

An update event was held on 21 July 2011. An oral update from this event will be provided to the Trust Board.

6.0 Improvement Plan for the Shropshire and Telford Health Community

The Shropshire & Telford Health Community has agreed a plan for improvement in performance, quality and safety across the local health community. This plan has approval from the commissioners and the Trust, and outline approval from other partners.

The plan commits to achieving the following national indicators:

- **Clinical Quality & Safety**
 - ✓ VTE actions will deliver the national indicator by September 2011
 - ✓ TIA indicators will have a full trajectory by October 2011
 - ✓ Achieve a rebased HSMR of 100 by December 2012
- **A&E Clinical Quality Indicators**
 - ✓ The action plan identifies that performance is expected to be at 95% by September 2011 and 96% by November 2011, and then maintained at that level.
- **Monthly Delayed Transfers of Care**
 - ✓ The action plan identifies that DTOC levels are expected to be at 5% (37 delays) by end of Q1 2011/12, aiming for 3.5% (26 delays) by end of Q2 2011/12 and then maintained at that level or below.
 - ✓ 80% of stroke patients will spend 90% of their time on a stroke award has been achieved.
 - ✓ Average length of stay across all wards to be 21 days by March 2012
- **Progress to date in reducing the 18wk RTT backlog**
 - ✓ By end of July 2011 no routine dental extractions will be referred from GDPs to SaTH.
 - ✓ By end of February 2012 all 18 weeks RTT targets will be met on a sustainable position across all specialties, i.e. 90% of admitted patients seen and treated within 18 weeks, 95 of non-admitted patients seen and treated within 18 weeks.
 - ✓ By February 2012, no patients placed on the pending list for a new outpatient appointment will be waiting beyond 2 weeks.

- ✓ By February 2012, no patient placed on the pending list for a follow-up outpatient appointment will be waiting beyond 4 weeks before the Consultants recommended 'to be seen by date'.
- ✓ By end of February 2012, SaTH will be able to cope with the recurrent demand for services across all specialties utilising in hour provision, at PbR tariff costs.

7.0 Quality and Safety Review Visit

A Quality and Safety Review Visit was undertaken jointly by the Strategic Health Authority, the West Mercia PCT Cluster, Shropshire County PCT and NHS Telford & Wrekin on 11 July 2011. This report outlines the feedback received and the areas identified for improvement or development.

The purpose of the visit was to review the safety and quality of the Trust's clinical services, including an assessment of patient experience. The visit also focused on leadership and clinical governance arrangements within the Trust. The visit involved a team of twelve people, the majority of whom were experienced clinicians and included several specialist advisers from other trusts.

The team visited the Princess Royal and the Royal Shrewsbury Hospitals and the review involved staff focus groups as well as visits to a significant number of clinical areas. The team paid particular attention to the impact of organisational management changes on clinical services. Information gathered through visits to clinical areas on both sites to meet patients and staff was triangulated with known intelligence about the Trust.

Overall the feedback has outlined that the visit went well and that staff should be praised for the way in which they engaged with the process. They displayed strong feelings of loyalty towards the Trust and a commitment to make improvements.

Staff spoke positively about the new Executive Team and the leadership being shown by the Chief Executive. They also commented about how refreshing it was to have a focus on patient care and safety. In essence, they appeared to welcome the new approach and accountabilities in the system. Consultant medical staff seemed keen to support reconfiguration but expressed a desire for a faster pace of change.

It was evident that investment is being made and staff acknowledged the efforts being made by the Board in this regard.

Three issues were identified for urgent attention:

1. Medical outliers require regular and systematic review. The current arrangements were reported to be ad hoc and pose a potential risk to patients.
2. Medical staffing at night, weekends and bank holidays requires review to mitigate the current risks particularly in acute medicine. Middle grade medical cover is a general concern.
3. VTE compliance needs to progress at a greater rate than is currently evident. The identification of a VTE champion to drive change must be put in place quickly. In addition medical staff need to be held formally to account for poor compliance.

Issues arising from visits to Clinical areas: for consideration

1. There was clear and repeated evidence of good patient care largely relating to nursing care. The review team met a number of patients and relatives and received consistently positive messages.
 - a. The use of patient information boards in public areas is not in line with best practice around patient confidentiality and needs to be reviewed.
2. Although it was generally reported that staffing levels continue to improve, the reliance on bank, agency and locum staff is of concern.
 - a. Steps need to be taken to improve the use of the Bank rather than agency staff and consideration given to the employment of permanent staff to avoid the disadvantages associated with temporary staffing.
 - b. Staff reported that recruitment is taking too long and it was recommended that the Trust should take stock of the internal processes to explore the scope for greater efficiency.
3. It was felt that staffing levels on the stroke rehabilitation unit at Telford, in particular, should be reviewed as a matter of urgency to ensure that the unit's rehabilitation role is adequately fulfilled.

4. The team noted the lack of an Emergency Medical Response Team in the Trust and defined how this is different to ITU outreach and could support/ prevent cardiac arrests. The SHA team outlined that this type of team is in place in many Trusts and it would be advisable to put this in place as soon as you can.
5. The team outlined that the review of HSMR and related data/intelligence should remain a priority for the Trust and a strong recommendation was made that the Trust should maintain an effective system for the review of all deaths to determine the avoidability of deaths and to generate regular reports for the Board. The team also recommended best practice from other organisations.
6. They observed that there was a lack of awareness about the Trust's serious incident policy from the discussions held, and therefore only limited assurance was gained about the reliability of reporting and associated follow through. The application of the WHO safe surgery checklist also requires attention to ensure the Trust is fully compliant and working to reduce clinical risks.
7. Staff reported concerns about the number of delayed discharges and their frustration at not being able to address the problem easily. The staff on the Medical Admissions Unit at Shrewsbury suggested that "up to 50% of admissions are inappropriate". This will need to be investigated further.
8. The work the Trust has done thus far to reduce patient falls was acknowledged but the pace of delivery requires attention to safeguard patients. Areas for particular attention were identified.
9. A number of wards were observed to be untidy and cluttered and staff commented on the lack of storage space for equipment such as mattresses and linen. The maternity unit at Shrewsbury was seen as a particular area of concern. This was deemed to be due in part to its age and the poor physical environment in clinical areas. However, there are also a notable number of staff vacancies on this unit and significant use of agency staff as a consequence. Opportunities to recruit student midwives due to qualify this year to substantive posts should be explored thereby reducing the requirement for agency cover.
10. There was no single sex accommodation available on the intermediate care unit at Shrewsbury (tier 1 service) and steps should be taken to address this issue.

In summary, from a quality and patient safety/ patient experience perspective, the review team found a number of issues of concern as outlined above. However, there was also evidence of good practice in a range of areas. Notwithstanding the general impression formed that the Chief Executive and the Executive Team had a grip on the issues the feedback identified that there is a need to step up the pace of delivery, particularly with regard to the safety issues which you are already aware of, including the backlog of appointments and associated issues.

Conclusions

The work undertaken to date to address these issues is supported by the SHA and they noted and appreciated the efforts being made to engage staff in the change process. Indeed the move to engage staff through Listening in Action and LIPS was applauded. It was acknowledged that the current reporting framework from the Trust to PCTs, the cluster and the SHA was complex and that the SHA, cluster and PCT should work together to streamline the process for ongoing review of performance against the improvement plan.

An oral update on how the Trust is responding to the recommended improvements and developments will be presented to the Trust Board on 28 July.

Director of Quality and Safety/ Chief Nurse
July 2011