Appendix 1

Supporting Information and Links to Data Sources (Quality)

PATIENT SAFETY

Serious Incidents Requiring Investigation (SIRI) and Never Events

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure robust investigations are undertaken, which result in organisations learning to minimise the risk of the incident reoccurring. The terms 'serious incident requiring investigation (SIRI)' or 'serious incident (SI)' are often used interchangeably.
http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

A Framework for the management of serious incidents requiring investigation was published by the National Patient Safety Agency (NPSA) in March 2010. A revised framework was published in March 2013 by the NHS Commissioning Board Patient Safety Domain Team to help with the new commissioning system from April 2013. It is relevant to all NHS Funded care in primary, secondary and tertiary sectors.

When an incident occurs it must be reported to all relevant bodies. Serious Incidents are graded according to severity, with grade 0 being a potential issue pending investigation, grade 1 and grade 2 being an incident requiring investigation, with Grade 2 being the most serious.

There are 25 types of incidents that are considered to be never events, as detailed in 'The never events' list: 2013/14 update.
http://www.england.nhs.uk/wp-content/uploads/2013/12/nev-ev-list-1314-clar.pdf

The 'Never Events Policy Framework' was revised and updated in October 2012 to provide greater clarity about never events and the response to them. The NHS Wiltshire CCG Policy has been written in support of national guidance. There are clear requirements in our provider contracts for the reporting of serious incidents and never events.

All providers are contractually obliged to inform WCCG of any Serious Incidents which occur, and enter onto STEIS, the national reporting database. For each Serious Incident, providers complete and submit a Route Cause Analysis (RCA) which is reviewed by WCCG at Serious Incident panels. Some (usually smaller) providers/contracts do not have access to STEIS, so they meet their reporting requirements by informing WCCG, who upload onto STEIS on the provider's behalf, this Serious Incident is then recorded as a 'Wiltshire CCG' Serious Incident. However, the provider retains the responsibility to investigate and complete and submit a RCA.

National Reporting and Learning System (NRLS)

The National Reporting and Learning System (NRLS) is a voluntary scheme for reporting patient safety incidents with the primary purpose of enabling learning across the NHS from these incidents. The NRLS is a dynamic reporting system, and therefore it is anticipated that the number of incidents reported will continue to increase as the reporting culture of an organisation matures. Therefore, any increase in reporting of incidents should not be viewed as an indication of worsening patient

safety but rather as an increase in awareness of safety issues and a more open and transparent culture across the organisation.
As a voluntary scheme, the NRLS are unable to provide a definitive number of the patient safety incidents occurring in the NHS. Furthermore, there are number of known data qualities issues such as accuracy (high vs low / safe vs unsafe reporting) and comparability (seasonality, changes to mandatory reporting requirements). However, NRLS can offer an indication of how many, and what types of incidents are being reported across healthcare.

Healthcare Associated Infection (HCAI)

The term HCAI covers a wide range of infections. The most well-known include those caused by Methicillin-Resistant Staphylococcus Aureus (MRSA), Methicillin-Sensitive Staphylococcus Aureus (MSSA), *Clostridium difficile (C. difficile)* and Escherichia coli (E. coli). Healthcare-associated infections can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. HCAIs cover any infection contracted:

- As a direct result of treatment in, or contact with, a health or social care setting
- As a result of healthcare delivered in the community
- Outside a healthcare setting (for example, in the community) and brought in by patients, staff
- By visitors and transmitted to others (for example, Norovirus)

There are national and local reportable trajectories for MRSA and *C. difficile* infections, and national surveillance continues for MSSA Bacteraemia E. Coli Bacteraemia, GRE Bacteraemia, although there are currently no national or local trajectories (reducing targets).
HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result infection prevention and control is a key priority for the NHS.

National Patient Safety Thermometer (Harm Free Care)

Harm free care is a term derived from the former NHS Institute for Innovation and Improvement, adopted by the Department of Health as an umbrella term for a programme of work focusing on four common conditions or harms that can affect the patient as a result of healthcare provision. Harm Free care is captured monthly by providers as point prevalence data and recorded on the 'Safety Thermometer' and incudes

- Falls
- Pressure Ulcers
- Catheter Acquired Urinary Tract Infections (CAUTI)
- Venous Thromboembolism (VTE) (blood clots in limbs or chest)

These conditions affect over 200,000 people each year in England alone, leading to avoidable suffering and additional treatment for patients and a cost to the NHS of more than £400million. The programme supports the NHS to eliminate these four harms through one plan within and across organisations. The Department of Health in support of Harm Free Care launched the Patient Safety Thermometer as a national requirement from 2012.

The Safety Thermometer is designed to be used by frontline healthcare professionals to measure a snapshot of harm to patients once a month for each of the harms listed.

Safer staffing

Following the Mid Staffordshire and Stafford Hospital's investigation and the release of the publications, 'Francis Report' and 'Hard Truth's' each provider is now required to demonstrate that each ward has the correct establishment of registered and non-registered staff, in both planned actual hours. This provides transparency and openness of day to day establishments and providing an early indicator or warning sign to providers and commissioners.

Methicillin-resistant staphylococcus aureus blood stream infection (MRSA-BSI)

Where a MRSA-BSI is identified, Public Health England Data Capture System will automatically and provisionally assign an organisation with the responsibility for leading a Post Infection Review (PIR). If a blood specimen was taken from the patient on or after the third day of an admission to an acute trust, the acute trust will be assigned the case and be required to lead the PIR. For all other cases, where the blood sample is taken on admission to an acute hospital or if the sample was taken whilst the patient was being cared for in primary care the case is assigned to the CCG which is home to the GP practice where the patient is registered.
Reducing hospital-based MRSA bloodstream infections is a national healthcare priority and has met with considerable success in recent years.
Post infection reviews (PIR) for all MRSA-BSI forms part of the government's strategy for achieving 'Zero tolerance' to Healthcare Association Infection and was introduced to support the delivery of the zero tolerance on MRSA bacteraemia as set out by NHS England in the planning guidance Everyone Counts: Planning for patients 2014/2015.

Clostridium difficile infection (CDI)

C. difficile infection (CDI) causes serious gastric illness and outbreaks among hospital in-patients. Normally it affects the elderly, the debilitated and patients who have had antibiotic treatment and can result, if not treated early, in severe morbidity and mortality.

PATIENT EXPERIENCE

NHS Choices

NHS Choices provides a patient feedback portal via NHS UK website on their experience of NHS services, including hospitals, GPs, dentists and mental health trusts. Patient feedback enables patients, commissioners and providers to make informed decisions about health services and encourages healthcare providers to assess their services and make changes where necessary. Service providers are alerted when a comment has been left on their profile and they are given the opportunity to reply.

Patient Safety Indicators

In June 2014 a number of Patient Safety Indicators were published on NHS Choices and will be updated monthly. This increased openness and transparency includes information about local health providers. Hospitals are ranked red (poor), blue (OK) or green (good) by how they are performing in terms of infection control and cleanliness, CQC rating, safe staffing levels and patient safety reporting.
Any organisation with any red indicator will be given an overall red rating and any organisation with at least two green indicators and no red indicators will be given an overall green rating. All other organisations will be given an overall blue rating.

PALS and Complaints

The patient advice and liaison service (PALs) offers a confidential advice, support and information on health related matters. They provide aa point of contact for patients, their families and their carers

CLINICAL EFFECTIVENESS

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

National Institute of Health and Clinical Excellence (NICE)

NICE is guidance that is developed in conjunction with experts in their field, consulted on and published each month to provide a benchmark of evidence based and cost effective guidance for clinical practice. The aim is to promote health and wellbeing and prevent ill health in all spheres of health and social care for the public.

NICE Quality Standards, Guidance and Technology Appraisals are designed to drive up standards and measure quality improvements within any given area and will be monitored by the WCCG on a monthly basis.

http://www.nice.org.uk/

Mortality Indicators

‘Dr Foster Intelligence’ produces five indicators of mortality. This report will utilise two to monitor mortality rates; the Hospital Standardised Mortality Rate (HSMR) and the Summary Hospital Mortality Indicator (SHMI);

- HSMR – The calculation takes deaths in hospital other than in Accident and Emergency departments, for the 56 most common medical conditions and divides the number of deaths it expects for the hospital, based on factors including age, gender, other medical conditions and local deprivation.(Patients who die after being transferred between two hospitals are counted twice, i.e. at both of the providers)

- SHMI – Calculated by the Health and Social Care Information Centre, includes all deaths in patients admitted to non-specialist hospitals and deaths within 30 days of discharge, divided by the number of expected deaths adjusting for age, gender and diagnosis, but does not make adjustments for deprivation or palliative care.

Mixed Sex Accommodation (MSA)

The Department of Health requires all providers of NHS-funded care to confirm that they are compliant with the national definition ''to eliminate mixed sex accommodation except where it is in the overall best interests of the patient or reflects the patient's choice. 'Mixed sex accommodation' refers not only to sleeping arrangements, but also to bathrooms or WCs and the need for patients to pass through areas for the opposite sex to reach their own facilities. As long as men and women are cared for in separate bays or rooms and have their own toilet facilities, then it may be appropriate for them on the same ward being cared for by the same team of doctors and nurses. NHS services are expected to eliminate mixed sex accommodation where it is in the best interests of the individual or reflects personal choice.

Clinical need must be judged for each individual patient. If a patient is admitted into a multi-bed room, then either all patients must be same gender, or mixing must be clinically justified for *all* patients in the room, not just the newly-admitted one.

Clinical Advisory Group

One of the key functions of the Clinical Advisory Group is to review, horizon scan, consider and disseminate evidence based practice through implementation and monitoring of the NICE guidelines, NICE policy and Quality Standards. Additionally, best practice tariff audits are also agreed and reviewed through the Clinical Advisory Group. The Clinical Advisory Group make recommendations and these are then ratified by the Quality and Clinical Governance Committee.

Commissioning for Quality and Innovation

The purpose of the CQUIN Panel is to ensure that the NHS Wiltshire CCG has a clear process in place to support the decision making for payment of CQUIN funding to providers against the achievement of milestones. The role of the panel is also to support the CCG in considering provider submissions in evidence of CQUIN achievement and to review, clarify and agree actions required under the CQUIN schemes by the Commissioner. The panel also provides final approval of CQUIN schemes for approaching financial years.

Hospital Intelligence Monitoring (HIM)

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals.

These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led?

The indicators are used to raise questions about the quality of care. The indicators will not be used on their own to make judgements. The CQC judgements will always be based on the result of an inspection, which will take into account the 'Intelligent Monitoring' analysis alongside local information from the public, the trust and other organisations.

Where an indicator has 'no evidence of risk' this refers to where the CQC statistical analysis has not deemed there to be a "risk" or "elevated risk". For some data sources these thresholds are determined by a rules-based approach - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

Sentinel Stroke National Audit Programme

The GWH risk associated with the Sentinel Stroke National Audit Programme (SSNAP) score has been highlighted by the HIM report because at the point of data capture, GWH was a 'D' rating (the SSNAP audit rates providers from A to E, level 'D' is a score of between 40 and 60 points out of 100).

Less than optimal case ascertainment or audit compliance for each SSNAP Domains 1-10 will result in a team receiving downwards adjustments. The size of the adjustments will vary depending on how low the case ascertainment or audit compliance band is. The resulting adjusted SSNAP score is then assigned a level:
A= over 80
B= between 70 and <80
C= between 60 and <70
D= between 40 and <60
E= less than 40

Staff Survey 2014

The NHS staff survey is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments or quality, safety, and delivery of the NHS Constitution. The survey collects the experiences and opinions of NHS staff on a range of matters such as job satisfaction, wellbeing and raising concern.

The annual survey saw over 255,000 responses from staff including doctors, nurses, healthcare assistants, ambulance workers and non-clinical employees. Nearly 290 NHS organisations from across the country took part.

Summary of overall national results:

Patient care – In 2014, slightly more staff reported that care of patients is their organisation's top priority (66% in 2013 to 67% in 2014) and more felt that senior managers are commmited to patient care (52% in 2013 to 53% in 2014).
Raising Concern – 93 percent of staff reported that they know how to raise any concerns they had about unsafe clinical practice.
Advocacy - 64 percent of staff would be happy with the standard of care provided by their organisation if a friend or relative needed treatment, down from 65 percent in 2013.

Health and wellbeing at work – Fewer staff said that they experienced physical violence at work from patients, their relatives or the public in 2014 (14 percent, 15 percent in 2013). Fewer staff also said that they experienced harassment, bullying or abuse from patients, their relatives or the public, down from 29 percent in 2013 to 28 percent in 2014.

For Wiltshire CCG providers, see information below:

SFT – 485 staff at SFT took part in the survey, a response rate of 57% (a reduction of 2% on the 2013 survey).

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RNZ_sum.pdf

RUH – 2579 staff took part in the survey, a response rate of 57% (a reduction of 3% on the 2013 survey).

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RD1_sum.pdf

GWH – 456 staff took part in the survey, a response rate of 55% (a reduction of 12% on the 2013 survey).

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RN3_sum.pdf

All three acute trusts were among the highest 20% response rate of acute trusts in England.

AWP – 1790 staff took part in the survey, a response rate of 51% (a reduction of 1% on the 2013 survey). AWP are in the highest 20% response rate for mental health/learning disability trusts in England.

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RVN_sum.pdf

SWAST - 1691 staff took part in the survey, a response rate of 42% (a reduction of 2% on the 2013 survey).

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RYF_sum.pdf

Serious Incidents and Never Events policy and framework.

The revised Serious Incident Framework and Revised Never Events Policy and Framework were released on 27 March 2015, along with frequently asked questions reference documents.

In order to simplyfy the process of serious incident management, two key operational changes have been made:

The removal of incident gradings (Grade 0, Grade1, or Grade 2) – Incidents were often graded without clear rationale, frequently causing debate and disagreement and increasing the risk of incidents being managed and reviewed in an inconsistent and disproportionate manner.

Under the revised framework all incidents meeting the threshold of serious incident must be investigated and reviewed according to the principles set out in the framework.

Time scale for Investigation reports: Previously time scales for completion of investigation reports varied according to the grade of incident, in the revised guidance a single timeframe of 60 working days has been agreed for the completion of investigation reports, allowing providers and commissioners to monitor progress in a more consistent way, and providing increased clarity for patients and families in relation to investigation completion dates.

http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

Never Events- The list of Never Events has been reviewed and a total of 10 previous never events have been removed or merged.

http://www.england.nhs.uk/ourwork/patientsafety/never-events/

Department of Health (England) Consultation on the Health and Social Care Act 2008: Code of Practice on the Prevention of infection control and related guidance. The ethos of the code remains the same with the exception of a significant proposed change to criterion 3 to include appropriate antibiotics use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance

2015/16 Clostridium difficile infection objectives and guidance (England) - NHS England has published Clostridium difficile infection (CDI) objectives for acute trusts and CCGs for 2015/16. The achievement against these objectives will be monitored by WCCG monthly.

LINKS TO DATA SOURCES

http://myhospitalguide.drfosterintelligence.co.uk/

http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/directory/

http://www.nhs.uk/Services/hospitals/ReviewsAndRatings/DefaultView.aspx?id=1661

http://www.hscic.gov.uk/catalogue/PUB13914
http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

http://www.cqc.org.uk/