Shadow Oxfordshire Health and Wellbeing Board – 14 March 2013

Briefing Document for Themed Discussion

Considering the implications for Oxfordshire of the Francis Report on the Mid Staffordshire NHS Foundation Trust Public Enquiry

Current Clinical Assurance available in Oxfordshire

1. Introduction

The first Francis report on the Mid Staffordshire NHS Foundation Trust was published in 2010. It identified extremely poor care being delivered in a number of areas of the trust. The second report was published in February 2013. This report goes further and looks at the wider responsibility of the NHS. The report makes 290 recommendations. The Department of Health's response to this report is currently being prepared.

This paper sets out the systems and processes in place in Oxfordshire with which the commissioners monitor and manage the quality of provider services. Oxfordshire Clinical Commissioning Group (OCCG) is building on the systems developed by NHS Oxfordshire (the PCT).

There are three aspects of clinical quality; clinical effectiveness, patient safety and patient experience. Commissioners collect data and intelligence on each of these areas. The types of intelligence and the methods used are detailed below.

The primary responsibility for quality sits with service providers. OCCG has a duty to act with a view to securing continuous improvements in the quality of services for patients and in outcomes; with particular regard to clinical effectiveness, safety and patient experience. OCCG also has a statutory duty to assist and support the NHS Commissioning Board in securing continuous improvement in the quality of primary medical services.

Providing assurance of the quality of services is complex and no system is infallible. Systems are evolving all the time and information becomes more sophisticated. The uncovering of poor quality within NHS commissioned services frequently leads to increased scrutiny and changes in the way in which we seek to understand the quality of services.

It is the role of Boards to seek assurance on quality. As far as possible the systems we use provide this assurance. However, it is important always to be alert to the possibility of poor quality. The acknowledgement that things can and do go wrong is essential and constant vigilance is required.

2. Clinical effectiveness

In seeking to establish quality there is clearly a desire to look at things which can be measured. This is a relatively new science and methods are constantly changing and being updated.

2.1 Dr Foster, HSMR and SHMI

Oxfordshire commissioners have, since 2008, used Dr Foster software to monitor clinical outcomes at Oxford University Hospitals NHS Trust (OUH) (previously Oxford Radcliffe Hospitals). The clinical outcomes measured by this software are mortality, readmissions, length of stay and day case rates. Using an algorithm, the software determines whether the expected numbers of negative outcomes (e.g. for mortality, this would be death) are exceeded by the monitored number. When any of these outcomes is statistically significantly higher than expected, Dr Foster will produce a 'red bell'. The OUH has regular monthly meetings to discuss red bell alerts which a member of the OCCG Quality team attends.

In some areas commissioners rely on the providers' use of Dr. Foster. In Oxfordshire the commissioners have their own Dr. Foster package. This makes the system more robust in that it allows for direct scrutiny of local data.

Dr Foster measures the Hospital Standardised Mortality Ratio (HSMR). The HSMR is an indicator of healthcare quality that measures whether the death rate at a given hospital is higher or lower than would be expected. HSMR is one of the range of indicators regularly reviewed by OCCG when assessing the quality of the clinical services. The OUH has had higher than expected mortality. However, this difference is within the range of normal variation and is not therefore considered to be statistically significant. This means that the hospital has not been mentioned as a hospital with a high mortality rate in the Dr Foster Hospital Guide. The Department of Health has recently introduced an additional mortality measure, the Summary Hospital-level Mortality Indicator (SHMI). This measure also indicates that the OUH has a mortality rate within expected limits.

NHS Oxfordshire and now Oxfordshire Clinical Commissioning Group (OCCG) attends meetings with OUH at which mortality alerts and all red alerts are discussed. Commissioners continue to work with the OUH to improve the HSMR. The OUH and OCCG's ambition is to have one of the lowest mortality ratios in the country.

2.2 Audits

Clinical audit is a quality improvement process. It seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the subsequent implementation of change. In Oxfordshire, clinical audits are requested from providers via the contract to assure commissioners that National Institute for Clinical Excellence (NICE) guidance is followed. Performance in clinical audits is reviewed by the Quality Team of OCCG and the evidence from these reports is triangulated with other information collected.

3. Patient safety

There are established systems for reporting and reviewing patient safety incidents. All providers manage incidents internally. There is a nationally designated list of Serious Incident Requiring Investigation (SIRIs). These incidents must be reported to the commissioner. The provider must then conduct a root cause analysis. The commissioner manages the investigation process and incidents are only 'closed' when commissioners are satisfied that incidents have been thoroughly addressed, that lessons have been learnt and that steps have been taken to prevent recurrence.

Where themes emerge in the investigation of serious incidents providers are required to understand these and to demonstrate that they are being addressed.

Issues about the culture of organisations often emerge in the analysis of SIRIs, as well as in the response of trusts to the events. In these circumstances the commissioners may require action to be taken to address these issues, for example, through increased clinical leadership.

We can begin to understand the safety culture of a trust by looking at how they respond to incidents. The ideal culture is one in which staff feel able to voice their concerns, and where patients are always listened to and their concerns attended to promptly. Trusts should be able to receive information which shows that they may have issues with a willingness to understand and investigate further.

3.1. Safeguarding

Commissioners have a statutory safeguarding function. They are notified of safeguarding alerts relating to both adults and children and are instrumental in responding to alerts. This means that safeguarding information can be viewed alongside other quality information to alert areas where poor care may be causing harm.

4. Patient Experience

Patient experience is perhaps the fastest growing area of quality information. In order to be assured of quality we need to put feedback from patients at the centre. Patient experience is a good early indicator of where thing may be going wrong.

Patient experience is also the most difficult area to measure. Patient satisfaction can be collected through simple scoring - as in the new 'Friends and Family test', but experience is not measurable. Methods of looking at experience include scrutinising complaints, PALs and MPs' letters. It is not sufficient to simply look at the number of complaints. The content of the complaint also needs to be understood in order to detect themes and possible trends. We also look at PALs queries as these give an indication of areas which patients are finding difficult and provides us with an indication of how well providers respond to patients' concerns. Crucially, we look at how trusts use the information they receive in

complaints to inform the way in which they deliver services and to make improvements.

There is a close correlation between overall patient experience and the quality of nursing care. In both Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Trust the quality of nursing has been a focus for improvement. We continue to work with them on developing leadership in this area.

4.1 Patient and Staff Surveys

The views of patients are frequently sought through local and national surveys. The national acute inpatient survey is conducted every year and allows comparison between trusts and within trusts over time. There are also more specific surveys, for example the cancer patient survey and the maternity survey, which provide a view of patients' experiences of individual services. The OUH generally scores well in the national inpatient survey.
It is well known that the well being of staff has a direct impact on the experience of patients. For this reason we look at the results of the staff survey in conjunction with those of the patient survey.

5. Contracts: Schedule 3 part 4

Commissioners receive monthly indicators on performance activity and quality. This range of indicators is set out in schedule 3 part 4 of the contract held between the commissioner and the provider. The contents of this schedule are agreed as a part of the contract negotiation. It sets out the quality markers expected from providers and includes limits for healthcare acquired infections such as MRSA bacteraemias and clostridium.difficile. It includes national targets relating to, for example A&E, cancer waits and 18 weeks referral to treatment times. It also includes relevant local indicators such as radiology turnaround times.

For the main providers schedule 3 part 4 is scrutinised monthly at performance meetings. Quality is discussed at the same meeting as activity. In this way it is given the same weight as performance and the impact of each on the other can be understood.

6. Quality Information system

OCCG uses a risk management software package called Datix. This enables a range of quality data to be stored. Datix includes data on complaints, PALs, MP letters, and incidents. Importantly Datix permits users to search for data – for example to see whether there has been a number of complaints about a particular area.

In 2012 the Datix system was expanded to provide GPs with direct access. They use this to report to the commissioners directly concerns they have about the quality of services. This facility provides the commissioners with a rich source of timely information which can be addressed rapidly to ensure quality is improved. Since being established in June 2012 we have received well over a thousand

reports through this system, all of which have been or are currently being followed up.

7. Whistleblowing

The PCT has, on occasion, received 'whistle blowing' allegations. When this has happened we always follow up allegations by conducting investigations.

8. Action to address quality concerns

When there are concerns about the quality of services a number of steps are taken. The first step would usually be to raise the issue locally, formally at a contract meeting. The provider is then expected to produce a detailed rectification plan. If the commissioner receives an inadequate action plan or the plan is ineffective then a contract query will be issued. If this approach fails or the concerns are significant then the commissioner will issue a performance notice. If OCCG believes a service to be dangerous it will suspend the service immediately. In parallel to this process provider executive directors and the Chief Executive would be informed.

OCCG also has the option of commissioning an external review of quality from national experts such as the Royal Colleges. This facility has been used by the PCT on a number of occasions to seek additional information and advice on issues of concern.

OCCG has a structure which puts quality at the heart of commissioning. It has established a formal sub committee of the board to focus on quality and performance. The group is chaired by a lay member of the governing board and has a lay member in attendance.

The Francis report identifies a number of recommendations for commissioners. OCCG will review these and agree a programme of implementation. We look forward to the establishment of the local Healthwatch, which will build on the achievement of the LINks, to help strengthen the patient perspective. We are developing the website to enable direct patient feedback to OCCG. The GP feedback (Datix) system is a recommendation which we are already using to good effect.

9. Conclusion

Where possible we use validated tools to measure the quality of commissioned services. These are not, on their own, sufficient to provide assurance of quality. We also use the 'soft intelligence' we receive. Where there have been extreme cases of poor quality, culture is usually cited as a cause. While it may not be the cause of the poor quality itself, it is a culture of acceptance and of secrecy which prevents the issues being tackled.

It is essential that providers are open in their reporting and consideration of quality issues. The quality team has built good working relationships with provider trusts. This means that we can work together to understand and address potential

quality issues while crucially maintaining the critical distance which scrutiny and assurance requires. Importantly, data which suggests poor performance and data which indicates good performance should be afforded the same degree of scrutiny.

Seeing the organisation or service as a whole is also crucial. Indicators when viewed on their own may not be the cause for a high level of concern. When viewed in the context of a range of other information a high level of concern may be indicated. This whole picture view is achieved through close working within the quality team and across the organisation.

This paper sets out the range of tools, methods and intelligence which are currently in use in Oxfordshire to provide commissioners with assurance of the quality of the services they commission. OCCG has intentionally placed quality at the centre of the organisation. The Quality team work closely with providers and have developed a relationship where they are expected to challenge. When necessary decisive action is taken to address situations where quality fall below the standard we would expect.

Sula Wiltshire, Director of Nursing & Quality, Oxfordshire & Buckinghamshire PCT Cluster

February 2013