NHS LOTHIAN

Board Meeting
4 February 2015

Medical Director

SUMMARY PAPER - QUALITY REPORT

This paper summarise the key points in the full paper.

The relevant paragraph in the full paper is referenced against each point.

	Para
• The number of formal complaints remains fairly stable (excluding prisons Graph 3). Graph 4 shows a subset of these complaints which are prison complaints which account for a large number of the overall complaints. The response rate at 20 days and 3 days remains a challenge (graphs 1 & 2).	3.1.1 and Graphs 1-4
• HSMR – None of the three acute hospitals are a statistical outlier; all are below one and have seen reductions from the October-December 2007 baseline.	3.1.2 and Graphs 7-9
• Staff absence levels (Graph 6) are over 4% (4.8%) which appears to reflect seasonal variation.	3.1.3 and Graph 6
• The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (see graphs 11&12). Healthcare Associated Infection is a separate agenda item and paper.	3.1.4 and Graphs 11&12
• A number of reports on the Board agenda examine in more detail delayed discharges, A&E 4 hour waits, Cancer 62 day waits and compliance with stroke standards which remain a challenge.	3.1.5 and Graphs 5,17,18 & 19-21

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NHS LOTHIAN

Board Meeting
4 February 2015

Medical Director/Executive Nurse Director

QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for December 2014, to provide assurance on the quality of care NHS Lothian provides.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 Review the quality dashboard and exception reporting to inform assurance requirements, (context and technical appendix are set out in Appendix 1).

3 Discussion of Key Issues

3.1 Exception Reporting – Quality Dashboard

3.1.1 The number of formal complaints remains fairly stable (excluding prisons Graph 3). Graph 4 shows a subset of these complaints which are prison complaints which account for a large number of the overall complaints. The response rate at 20 days and 3 days remains a challenge (graphs 1 & 2).

3.1.2 Since December 2009, Information Services Division (ISD) has produced quarterly hospital standardised mortality ratios (HSMR) for all Scottish hospitals participating in the Scottish Patient Safety Programme (SPSP). The aim of the Scottish Patient Safety Programme is to reduce hospital mortality by 15% by December 2012 compared to baseline of 2007. This has been extended to a national aim of a 20% reduction by December 2015. The publication in November 2014 is for the period April to June 2014.

The HSMR is based on all acute inpatient and day case patients admitted to all specialties (medical and surgical). The calculation takes account of patients who died within 30 days from admission; that is, it includes deaths that occurred in the community (out of hospital deaths) as well as those occurring in-hospital. It excludes deaths that occur more than 30 days after admission whether in hospital or not.

Hospital Standardised Mortality Ratio (HSMR) = Observed Deaths / Predicted Deaths. The prediction is based on data from SMR01 returns. The purpose is to adjust observed mortality for the underlying risk of death at the time of admission.

Key Points:

- The current values and change from baseline are in Table 1 below
- None of the three acute adult hospitals is a statistical outlier and all are below 1.

Table 1

	HSMR Oct-Dec 2007	**HSMR Apr-June 2014**	**Change from baseline**
Scotland	1.00	0.81	-15.89%
RIE	0.87	0.63	-18.06%
St John's	0.88	0.75	-7.37%
WGH	0.74	0.59	-12.38%

3.1.3 Staff absence levels (Graph 6) are over 4% (4.8%) which appears to reflect seasonal variation.

3.1.4 The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (see graphs 11&12). Healthcare Associated Infection is a separate agenda item and paper.

3.1.5 A number of reports on the Board agenda examine in more detail delayed discharges, A&E 4 hour waits, Cancer 62 day waits and compliance with stroke standards which remain a challenge.

Quality Dashboard – December 2014 (dates for each data item stated in background charts)

This table shows a monthly summary of process and outcome quality measures. Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focussing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.
If you have an electronic version of this report, links to each measure chart have been embedded in the headings below.

QUALITY AMBITION

PERSON-CENTRED - Process Measures
20-day Complaints Response Rate *
3-day Complaints Response Rate *
Delayed Discharges and Average Length of Stay *

PERSON-CENTRED - Outcome Measures
Number of Complaints (excluding HMP Healthcare) *
Number of Complaints for HMP Healthcare *
Staff Absence Levels *
Patient Experience
Staff Experience

SAFE – Outcome Measures
Hospital Standardised Mortality Ratios for RIE, WGH & St. John's *
Incidents with harm *
C. Difficile Numbers *
Staph. Aureus Bacteraemia Numbers *
Number of Cardiac Arrests *
Rate of Cardiac Arrests *
Inpatient Falls with Harm *
Inpatient Pressure Ulcers Grade 2 or above *

EFFECTIVE – Process Measures
A&E 4 Hour Wait *
Cancer Waits 62 Days from Diagnosis to Treatment *
Admission to stroke unit on day or day after admission *
Stroke Treatment Measure: CT Scan *
Stroke Treatment Measure: Swallow Screen *

Additional Quality Measures

Hospital Scorecard: January – March 2014

Indicator	Lothian Rate (Per 1000 admissions)	Scottish Rate
Standardised Surgical Readmission rate within 7 days	23.83	21.73
Standardised Surgical Readmission rate within 28 days	43.30	40.22
Standardised Medical Readmission rate within 7 days	48.36	51.88
Standardised Medical Readmission rate within 28 days	115.19	112.69
	Lothian	**Scotland**
Average Surgical Length of Stay – Adjusted	0.95	1.00
Average Medical Length of Stay – Adjusted	1.10	1.00

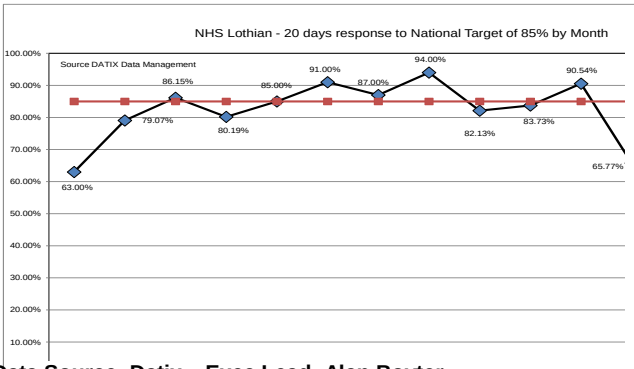
Person-Centred

"Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making."

Title:	20-day Complaints Response Rate (Graph 1)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	85% of complaints responded to within 20 days

Process Measure

20-Day Response Target across NHS Lothian

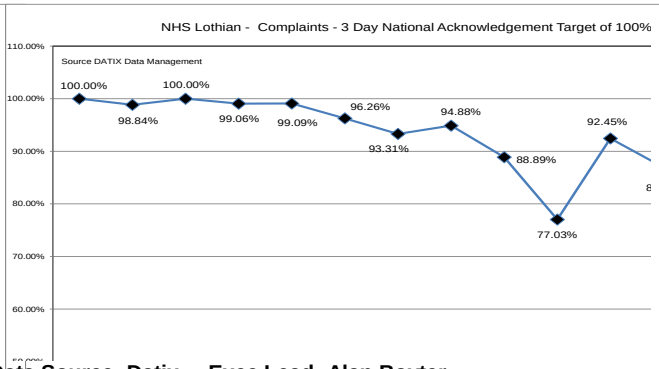


Data Source: Datix Exec Lead: Alan Boyter

Title:	3-day Complaints Response Rate (Graph 2)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	100% formal acknowledgement within 3 working days

Process Measure

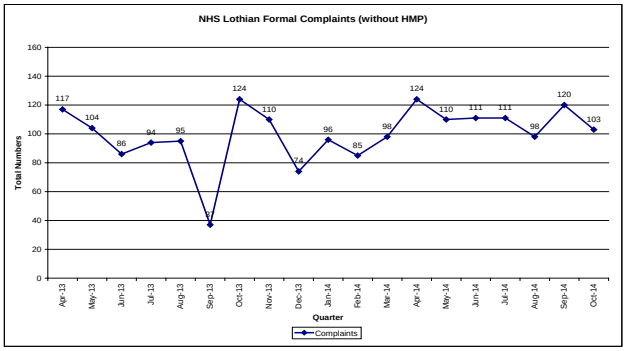
3-Day Response Target across NHS Lothian



Data Source: Datix Exec Lead: Alan Boyter

Title:	Number of Complaints (excluding Prison Complaints) (Graph 3)
Numerator:	Total number of complaints
Goal:	Reduction in number of formal complaints

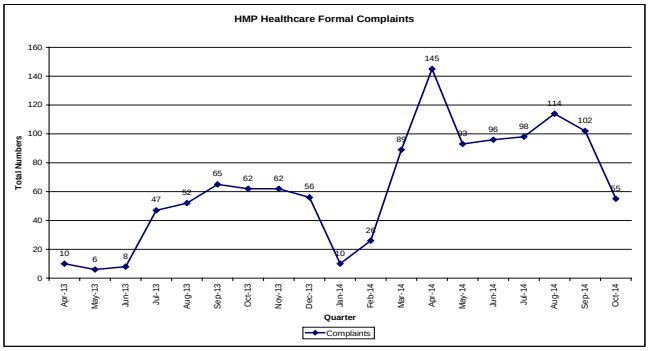
Outcome Measure



Data Source: Datix Exec Lead: Alan Boyter

Title:	Number of Prison Complaints (Graph 4)
Numerator:	Total number of prison complaints
Goal:	Reduction in number of formal complaints

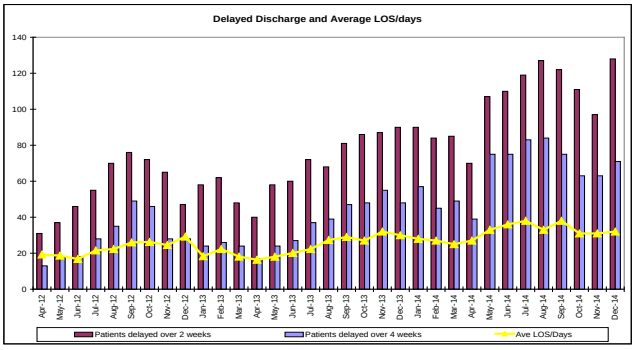
Outcome Measure



Data Source: Datix Exec Lead: Alan Boyter

Title:	Delayed Discharges & Average Length of Stay (Graph 5)
Goal:	No patient waiting longer than 2 weeks for discharge, by April 2015

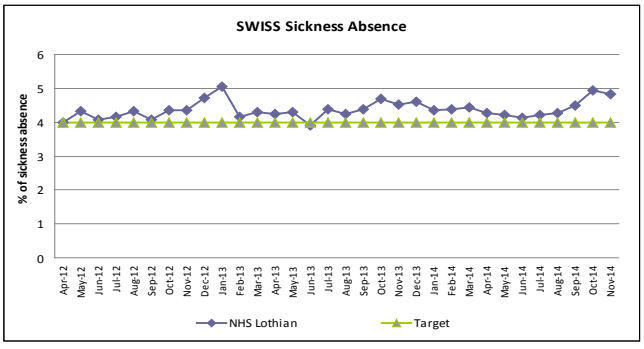
Process Measure



Data Source: Local data captured on EDISON shared data with Health & Social Care Exec Lead: Melanie Johnson

Title:	Staff Absence Levels (Graph 6)
Numerator:	Total staff hours lost
Denominator:	Total staff hours available
Goal:	4% or less

Outcome Measure



Data Source: Scottish Workforce Information Strategic Systems (SWISS) Exec Lead: Alan Boyter

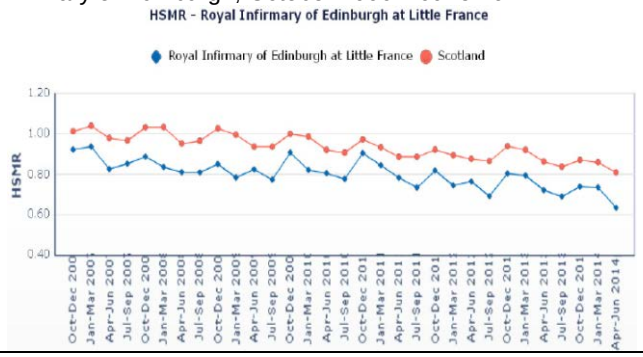
Safe

"There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times." Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, HAI indicators, arrest calls, falls with harm and pressure ulcers.

Title:	Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Graphs 7 – 9)
Numerator:	Total number of in-hospital deaths and deaths within 30 days of discharge from hospital
Denominator:	Predicted total number of deaths
Goal:	20% reduction against 2006/07 baseline by December 2015

Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – June 2014

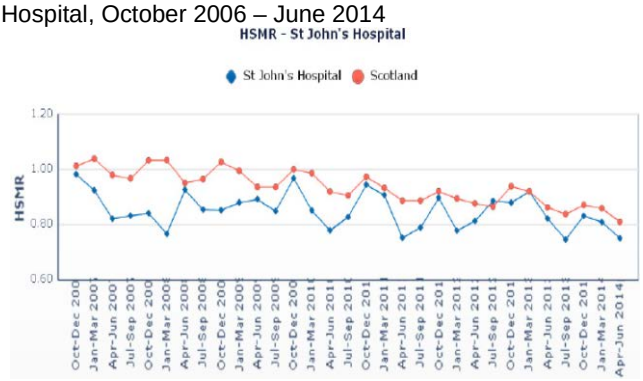


Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – June 2014

Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in St John's Hospital, October 2006 – June 2014



Data Source: ISD (Quarterly) Exec Lead: David Farquharson

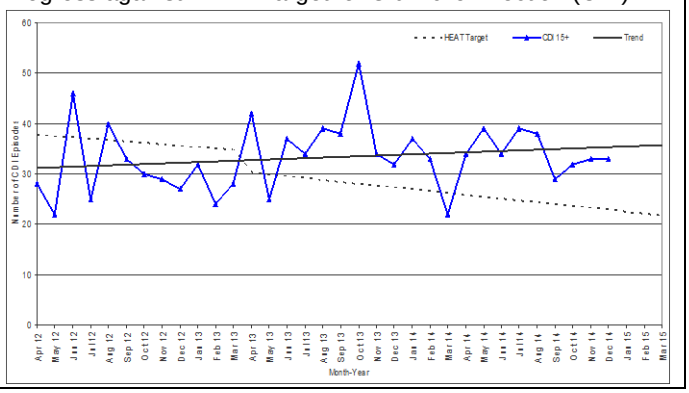
Title:	Incidents with harm (Graph 10)
Numerator:	Number of incidents associated with serious harm reported per month in NHS Lothian (Dec 2011- Nov 2013)
Goal:	There are specific goals for reductions in Falls & Pressure Ulcers. See separate graphs for progress against these.

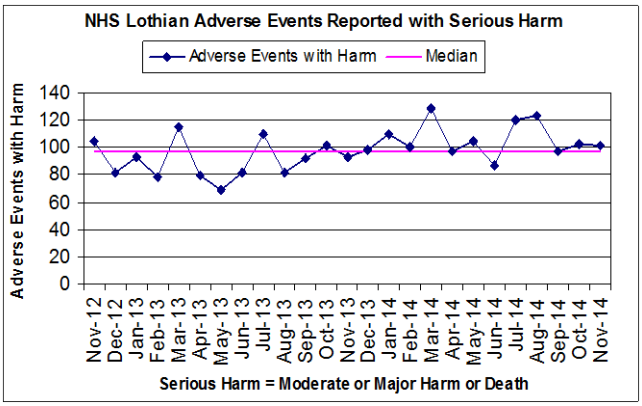
Outcome Measure

Title:	C. difficile associated disease against HEAT Target 2012-13 (Graph 11)
Numerator:	Total number of patients aged 15 and over with C.difficile toxin positive stool sample (CDI)
Goal:	NHS Lothian is to achieve 262 or fewer CDI by March 2015 as shown by trend line.

Outcome Measure

Progress against HEAT Target for *C.difficile* Infection (CDI)





Data Source: Datix Exec Lead: David Farquharson

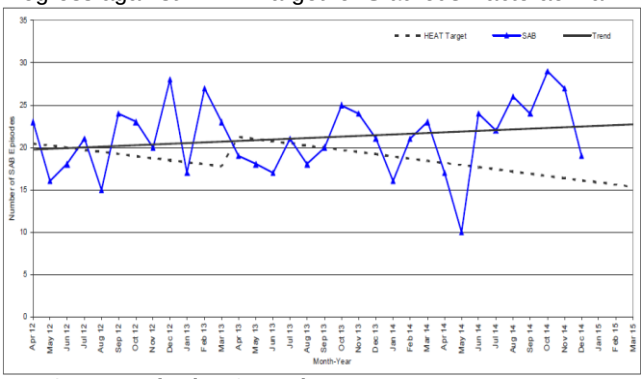
Data Source: Infection Control Team Exec Lead: Melanie Johnson

Safe (cont'd)

Title:	Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Graph 12)
Numerator:	The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)
Goal:	NHS Lothian is to achieve 184 or fewer SABs by March 2015 as shown by trend line.

Outcome Measure

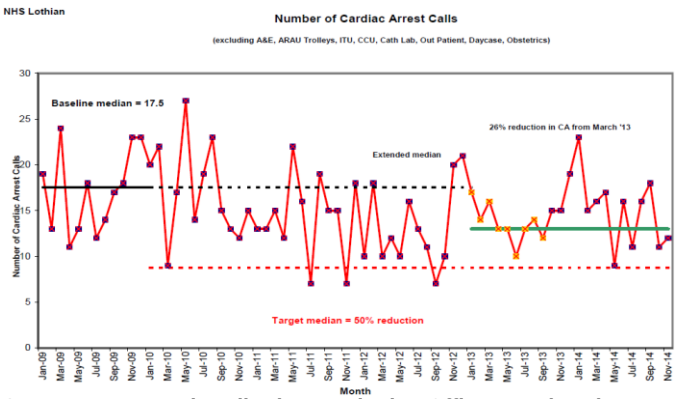
Progress against HEAT Target for *S.aureus* Bacteraemia



Data Source: Infection Control Team
Exec Lead: Melanie Johnson

Title:	Number of Cardiac Arrests (Acute Wards) (Graph 13)
Numerator:	Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

Outcome Measure



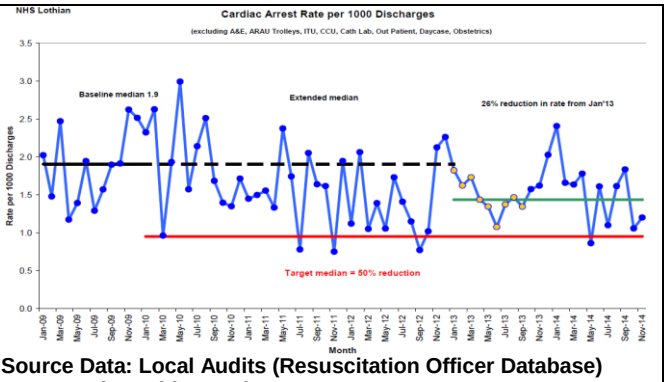
Source Data: Local Audits (Resuscitation Officer Database)
Exec Lead: David Farquharson

Title:	Rate of Cardiac Arrests (Acute Wards) (Graph 14)
Numerator:	Arrest – Rate of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

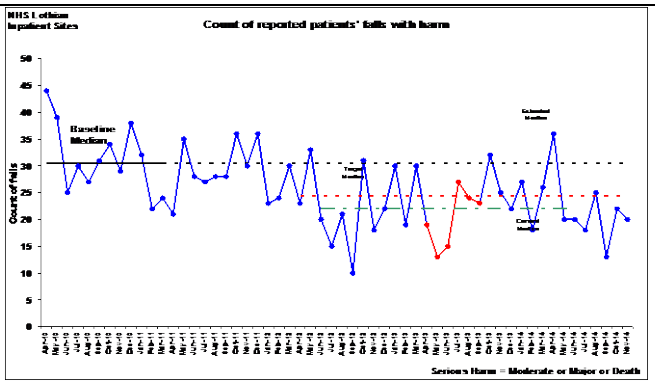
Outcome Measure

Title:	Patient Falls with Harm (Graph 15)
Numerator:	Number of falls reported resulting in moderate or major harm or death (define moderate/ major). Data for NHS Lothian inpatient sites
Goal:	20% reduction in inpatients falls and associated harm by December 2015

Outcome Measure



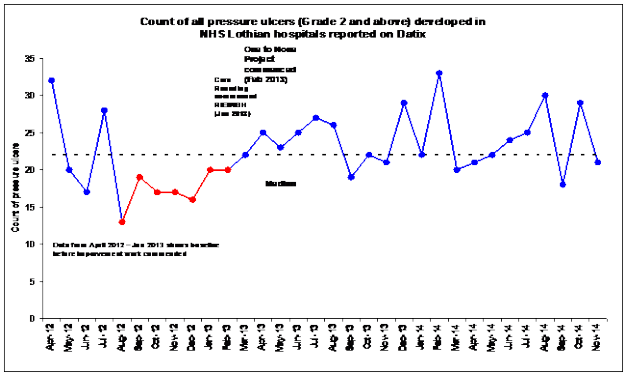
Source Data: Local Audits (Resuscitation Officer Database)
Exec Lead: David Farquharson



Data Source: Datix Exec Lead: Melanie Johnson

Title:	Number of Pressure Ulcers per month across NHS Lothian (Graph 16)
Numerator:	Number of Grade 2 or above pressure ulcers
Goal:	To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2015 (from one a day to none a day)

Outcome Measure



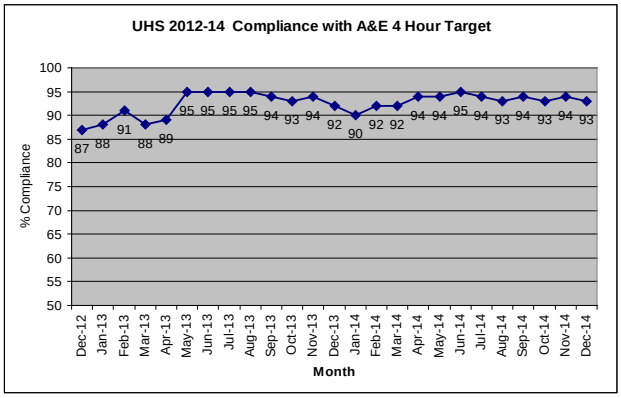
Data Source: Datix Exec Lead: Melanie Johnson

Effective

"The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated." Progress on this ambition is measured through clinical quality indicators and stroke care.

Title:	A&E 4 Hour Wait (Graph 17)
Numerator:	Number of patients waiting less than 4 hours from arrival to admission or discharge
Denominator:	Number of patients attending
Goal:	98% of patients waiting less than 4 hours from arrival to admission by March 2015

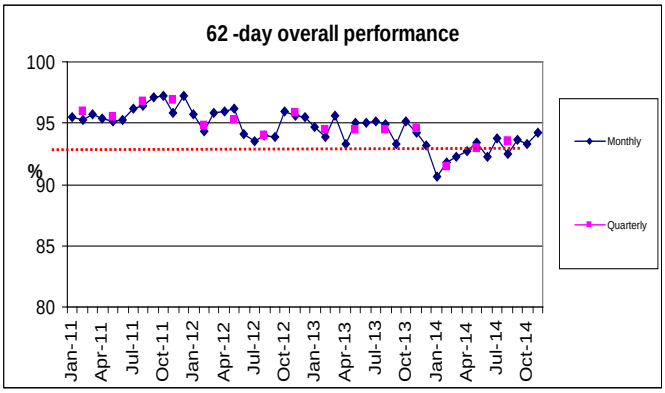
Process Measure



Data Source: Patient Administration System (TRAK)
Exec Lead: Melanie Johnson

Title:	Cancer Waits 62 Days from Diagnosis to Treatment (Graph 18)
Numerator:	Number of patients waiting 62 days to treatment Please note the scale
Denominator:	Number of cancer patients
Goal:	95% of patients from diagnosis to treatment wait no longer than 62 days

Process Measure

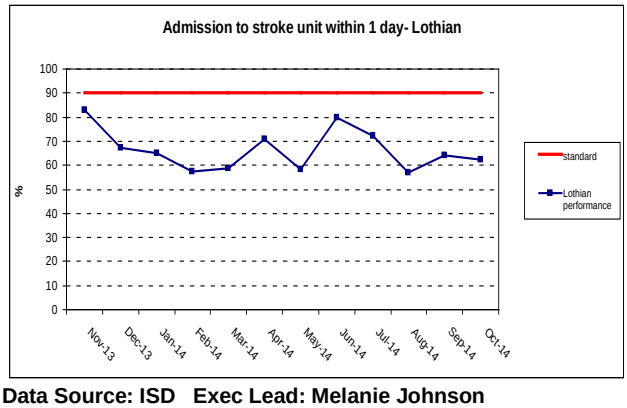


Data Source: SGHD Management Information
Exec Lead: Jim Crombie

Title:	Admission to Stroke Unit within 1 day of admission (Graph 19)
Numerator:	Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
Goal:	90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional

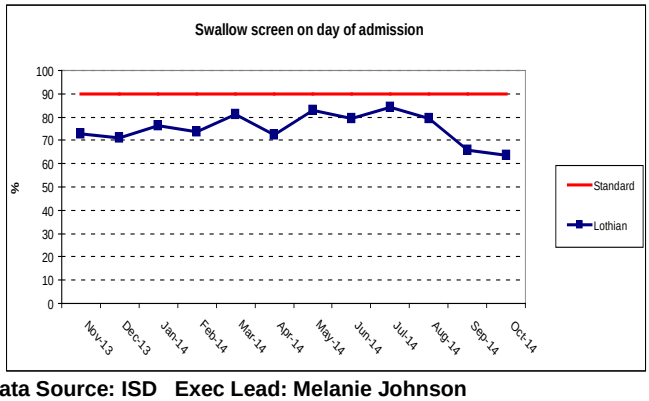


Data Source: ISD Exec Lead: Melanie Johnson

Title:	Stroke Treatment Measures (Graph 20)
Numerator:	Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional



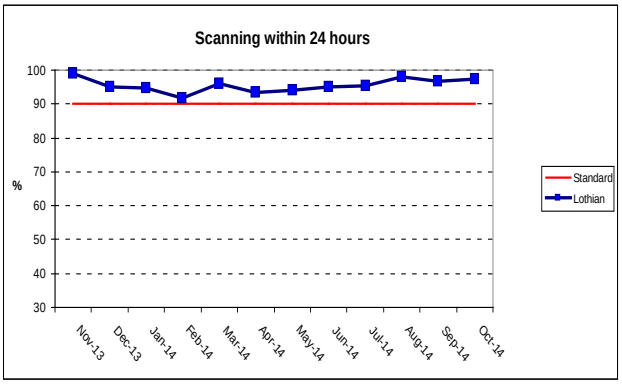
Data Source: ISD Exec Lead: Melanie Johnson

Effective (cont'd)

Title:	Stroke Treatment Measures (Graph 21)
Numerator:	Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional



Data Source: ISD Exec Lead: Melanie Johnson

4 Key Risks

4.1 Achieving the HAI HEAT target, complaints response times, stroke targets, delayed discharge target and cancer target.

4.2 This dashboard has been developed to ensure a range of measures that can be considered easily, all of which impact on the patient experience and outcome of care. These measures, however, do not reflect all aspects of care and need to be supplemented with condition-specific data, both qualitative and quantitative.

4.3 Failure to comply with national standards with potential impact on patient experience and outcomes of care, and external inspections.

5 Risk Register

5.1 Achieving HAI targets is also on the Corporate Risk Register (Risk 1076) and its risk grading has been increased to reflect that NHS Lothian is outwith HAI trajectory. Access to Acute Stroke Unit is on the University Hospital Services Risk Register – Medicine and Associated Services (Risk 2444). Compliance with stroke standards is captured in Unscheduled Care on the Corporate Risk Register. Patient Experience is also captured on the Corporate Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.

6.2 This paper combines elements of the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010) and the Scottish Patient Safety Programme (assessed in May 2009).

6.3 The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

7 Involving People

7.1 No service change.

8 Resource Implications

8.1 Work is ongoing to automate the production of this Dashboard, which is complex, as it uses data from a number of sources. This is within the Clinical Governance Workplan.

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13 January 2015
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List of Appendices

Appendix 1: Supporting Context and Technical Appendix

APPENDIX 1

Context and Technical Appendix

Quality Report Development

The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland's quality ambitions and across levels 1 to 3.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian's Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

Hospital Standardised Mortality Ratio (HSMR)

HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level 'warnings' for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

S.aureus Bacteraemia (SAB) rate

New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.

***C.difficile* Infection (CDI) rate**
New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

Incidents associated with harm
Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.

Surgical readmissions within 7 days
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Surgical re-admissions within 28 days
As for 7 day readmissions.

Medical Re-admissions Within 7 Days
This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.
The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Medical Re-admissions Within 28 Days
As for 7 day readmissions.

Average Length of Surgical Stay (Adjusted)
Ratio of 'observed' length of stay over 'expected' length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

Average Length of Medical Stay (Adjusted)
Ratio of observed length of stay over expected length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations.