Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	07 November 2019		

Report Title:	Safety and Effectiveness of Services at the Weekend			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
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Executive Sponsor (presenting):	Dr C Blanshard			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the higher than expected weekend HSMR and the probable causes. It is also asked to note concerns about safety and workload at weekends, and the measures which the executive team are taking in order to address these issues. .

Executive Summary:
Over the period August 2018 to May 2019 the Hospital Standardised Mortality rate for patients admitted at the weekend has been steadily rising, and for the most recently available twelve month period, ending May 2019 is 127 and significantly higher than expected. Over the same period of time junior doctors have raised concerns about the intensity of the workload in the evenings and weekends. In September the Clinical Governance Committee received a report on the safety and effectiveness of services at weekends. This paper describes the actions the executive team are leading to address these issues, including working with partners to reduce inappropriate admissions, review of clinical pathways, uplifts in staffing in key areas, improving deployment and utilization of existing staff and improved documentation and coding. Even if the uplifts in staffing and better deployment of staff will impact on the weekend HSMR, there will be a lag time of at least 6 months before any change is apparent. However they will make a measurable impact on junior doctor wellbeing and Keogh standard 4 (patients having a daily senior review). The work with community partners is more likely to have an impact on HSMR, but will take time, and experience from other Trusts who have undertaken work to reduce HSMR suggests that improved diagnostic coding is the most important factor. Board is asked to continue to monitor the impact of these actions through the Quality Indicator Report, seven day board assurance framework, learning from deaths report and guardian of safe working report.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

Safety and Effectiveness of Services at the Weekend

Background

Over the period August 2018 to May 2019 the Hospital Standardised Mortality rate for patients admitted at the weekend has been steadily rising, and for the most recently available twelve month period, ending May 2019 is 127 and significantly higher than expected. The HSMR for patients admitted on a weekday is showing a slow decline and is in the expected range. The SHMI is 101.4 and within the expected range. About 8.2 % of all patients admitted as an emergency at the weekend die compared to 5.9% of those admitted during the week. Compared to other local Trusts we have the second highest weekend mortality and the widest gap between weekend and weekday HSMR.

REGION (acute)	weekday HSMR	Weekend HSMR
All	98.2	107.7
NORTH BRISTOL NHS TRUST	85.9	97.5
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	98.4	97.6
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	115.2	125.7
ROYAL CORNWALL HOSPITALS NHS TRUST	88.3	94.3
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	93.3	117.0
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	100.1	110.1
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	107.9	113.0
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	100.6	91.2
TAUNTON AND SOMERSET NHS FOUNDATION TRUST	101.7	110.5
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	91.3	113.1
POOLE HOSPITAL NHS FOUNDATION TRUST	101.7	113.3
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	101.2	118.7
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	86.0	92.7
SALISBURY NHS FOUNDATION TRUST	102.1	133.0
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	115.5	111.5
NORTHERN DEVON HEALTHCARE NHS TRUST	120.0	139.9
WESTON AREA HEALTH NHS TRUST	82.8	96.1

With the help of Dr Foster we have undertaken an in-depth analysis to look at the reasons for this and also carried out a case note review of 78 patients who were admitted at the weekend and subsequently died. The factors we have identified as potential causes for the high HSMR can be summarised as:

- Patients nearing the end of their life being admitted to the acute site in extremis particularly on a Sunday afternoon, including those with secondary malignancy as an admitting diagnosis
    - Lack of availability of alternatives to admission e.g. community palliative care for new referrals, intermediate care beds
    - Patients with community Treatment Escalation Plans saying not for admission being admitted anyway
    - Patients known to be near the end of their life not having a community treatment escalation plan
    - Care homes lacking confidence and capability in managing dying patients, or pressure from families to admit. Nationally about a third of patients who are acutely admitted from care homes die in hospital

- Patients with pneumonia or sepsis as an admitting diagnosis who have often been unwell for some time
- Poor capture of comorbidities – patients with between 1 and 5 comorbidities being given a Charlson score of 0. During this time our upper quartile comorbidity coding as an index of national decreased from 99 to 96, the lowest level we have recorded. The “weekend” notes review recently undertaken showed the comorbidity checklist was rarely completed and in a small minority of cases the quality of the junior doctor clerking was poor.

Over the same period of time junior doctors have raised concerns about the intensity of the workload in the evenings and weekends, via the GMC regional adviser, the GMC trainee survey, the Hospital at Night Board and exception reports to the Guardian of Safe Working. The Clinical Governance Committee (CGC) commissioned a review of the safety and effectiveness of hospital services at weekends, and this paper demonstrated a reduction in clinical and non-clinical staffing levels at weekends, reduced compliance with Keogh safety standard 4 (daily senior review – down to 80% of those needing it in the Q2 7 day serviced Board Assurance Framework) and concerns raised by patients regarding access to some services at weekends, notably some diagnostics, therapies and medical reviews. These have been analysed and described in papers submitted to CGC in September 2019 and Workforce Committee in October 2019. Whilst it is difficult to identify a causal relationship between these factors and the high weekend HSMR (patients typically die 1-2 weeks after admission, with no particular day of the week a higher risk) this paper summarises the actions the executive team are taking to address both matters.

Action Plan

Objective	Action	Delivery date	Lead
Reduce potentially avoidable admissions at the weekend particularly of patients nearing the end of their life	• Ask primary care colleagues to identify improvements in the pre-hospital care of patients admitted at the weekend	complete	MD
	• Establish a local clinical and care board to work on pathway improvements	December 2019	MD
	• Promote and support initiatives to improve clinical support for care homes	April 2021	CCB and CCG
	• Engage with Medvivo to increase confidence in managing patients in the community	Q3 2020	CCG and Medvivo
	• Support the roll-out of the ReSPECT process across the STP	Q4 2019-20	Resus committee
	• Extend OPAL service into the weekends subject to identifying a source of funds and recruitment	April 2020	COO
	• Development of outreach service to avoid admissions with PCNs and WH+C	March 2019	COO
Expedite admissions of patients with sepsis and pneumonia at the weekend	• Work with Medvivo and SWAST to pre-alert patients with a view to giving pre-hospital treatment and expedited transfer	April 2020	Lead clinician ED, CD medicine, SWAST, Medvivo
Increase the number of patients being discharged at the weekend	• Expand early supported discharge team subject to identifying a source of funds and recruitment	April 2020	COO
	• Develop a pathway for patients to go to Shaftesbury beds once commissioned for Wiltshire patients	January 2020	COO/DOF
	• Consider partnering with WH&C to respond to a tender for intermediate care beds	November 2020	DOF
Continue to undertake structured judgement reviews where a diagnostic category shows higher than expected mortality,	• Pneumonia	Complete	MSG
	• Septicaemia	Complete	MSG
	• GI bleeding	Complete	MSG
	• Fractured neck of femur	November 2019	MSG
Make improvements in the clinical pathways identified by SJRs, quality indicators and audits	• Pneumonia	Complete	LC respiratory
	• Septicaemia	Ongoing	Sepsis steering group
	• GI bleeding	Q4 2020	LCs gastro and endoscopy

	• Fractured neck of femur • Stroke	Q2 2020 Q3 2020	LC orthopaedics LC stroke and stroke SCN
Reduce the time between a death and sharing the learning	• Introduce medical examiners • Ensure all deaths where concerns are raised have a structured judgement review within two weeks	January 2020 April 2020	MSG Medical Examiners
Improve capture of comorbidities	• Pilot a coder attending post take ward rounds at weekends • Improvements to the electronic discharge summary to "pull through" comorbidities recorded in previous admissions	January 2020 April 2020	DoT DoT/CIO
Where possible bring forward the staffing uplifts in the winter plan	• 7/7 Consultant ward round cover on all specialties • Additional F1/F2 ward cover Saturday and Sunday • Additional Trust Grade weekend cover (0900-1400) • Additional x 5 SHO agency cover doctor across medicine • Pharmacy support to MAU at weekends • Additional twilight and weekend ward clerk cover on MAU • Additional therapy support across medicine • Additional B5 in AMU night shift	1st January 2020 Mid Dec 2019 Mid Dec 2019 January to March January to March January to March January January	CD- medicine Chief pharmacist COO Head of therapies HoN - medicine
Improve the deployment of current clinical staff	• Ensure a weekend plan is included in the notes of all patients • Ensure specialty consultants check in with the H@NT F2 during the evening or before retiring • Bring forward the bleep co-ordinator role to 5pm on weekdays and introduce it from mid-afternoon at weekends • Change the weekend model in medicine so that the Trust Grade does the cover round with an F1, leaving the consultant to support the admissions whilst the registrar can deal promptly with emergencies • Plastics registrar to take calls out of hours • Include ENT F2 on H@NT rota • Improve doctor job planning, rostering and leave	January 2020 Immediate January 2020 Q4 19/20 October 2020 August 2020	HImp team and "steady"working group CDs for Surgery and MSK COO CD medicine DME, LC plastics DME, LC ENT

	management • Introduce e-rostering where appropriate • Explore increase in consultant hours at the weekend with weekday time off.	April 2020 April 2021 April 2020	CDs Head of Medical workforce, MD CD-medicine
Ensure junior doctors are rested, hydrated and refreshed to improve clinical decision making and well-being	• Utilise the £60k allocated by the BMA for improving the working lives of junior doctors, to be spent on a dedicated rest, quiet study and refreshment facility in the main hospital.	April 2020	Deputy MD
Improve infrastructure support to clinical staff releasing time for clinical activity	• Ward clerk on SAU at weekends • Increase Medical Assistant hours • Replace bleep system with modern message paging • Improving digital maturity	Jan 2020 April 2020 March 2021 ongoing	CD-Surgery DC-CSFS Head of Facilities DoT, CIO

Risks

The actions to reduce avoidable admissions are dependent on the support and engagement of community partners and likely to require additional resource invested into community and primary care.

Bringing forward the staffing changes in the winter plan will incur considerable cost, currently being worked through by finance , as it will for the most part rely on bank, agency or additional locum shifts from existing staff. The changes will not be sustainable without additional recruitment. Changing the job plans of consultants to provide more weekend hours with fewer weekday hours is likely to meet with some opposition both from the consultant body and the BMA, as non-emergency work at the weekend remains optional in the 2003 consultant contract. Changes in junior doctor work patterns require approval by the Deanery and need to start with a new rotation.

The digital immaturity of the Trust has a significant impact on clinical safety, recruitment and retention of doctors as well as on workload. To quote one consultant: *"To see one patient on call (or indeed during the week) at the minute you need to log in to the front end of the computer plus then into Review, PACS and POET as a minimum (plus sometimes EDS) – several computers on the wards don't work properly and Review etc often don't open as expected. Especially for POET time to 'time-out' is too short. I was on call this weekend and it took between 5 -10 minutes from arriving on a ward to logging in to all systems and being actually ready to see the first patient – over the 2 days this added 2-3 hours of non-value added time to the ward rounds"* . However we address this, we will need to invest considerable time, expertise and money and until then we are reliant on paper work-arounds – Friday stickers, printed patient lists, comorbidity checklists, COPD care bundle stickers etc.

It is by no means certain the uplifts in staffing and better deployment of staff will impact on the weekend HSMR, and even if they do there would be a lag time of at least 6 months before any change is apparent. However they will make a measurable impact on junior doctor wellbeing and Keogh standard 4. The work with community partners is more likely to have an impact on HSMR, but will take time, and experience from other Trusts who have undertaken work to reduce HSMR suggests that improved diagnostic coding is the most important factor.