North East Quality Observatory Service

Independent review of transfers from West Cumberland Hospital (WCH) to Cumberland Infirmary (CIC)

22 March 2016

Undertaken by:
Dr Gerry Morrow
Dr Anna Mushi
and
Mr Tony Roberts
Joint Deputy Director
North East Quality Observatory Service

On behalf of:
Northern Clinical Senate for Cumbria CCG

Ridley House │Henry Street │Newcastle upon Tyne │NE3 1DQ

www.neqos.nhs.uk

Tel: 0191 245 6708

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Summary

The aim of this review is to evaluate the quality and findings of internal reviews in the North Cumberland University Hospital Trust audit report regarding the transfer from West Cumberland Hospital to Cumberland Infirmary

Specific objectives

Evaluate if the transfers were

- In line with the transfer protocols;
- Timely;
- Clinically appropriate;
- Followed the clinical pathways;
- Well managed;
- Supported by appropriate clinical staff; and,
- Communicated effectively with patients and receiving staff.

Methods

Since April 2015 NCUHT undertook an internal review of 10% sample of transfer from a six month period, which amounted to 85 transfers. They concluded that whilst some of these patients are not on the agreed clinical pathways for transfers the transfers were 'clinically understandable'.

NEQOS have re-reviewed a 14% sample of these 85 transfer cases (12 cases) to confirm accurate entering of the data into the spread sheet (the original proposal aimed at a minimum of a 10% sample).

NEQOS have re-analysed the whole spreadsheet to quality assure that the conclusions found by NCUHT are substantiated by the collected data. There are about 15 data items for each review.

Results

Eight case notes did have the transfer checklist, seven had the SBAR document for transfer and four did not have transfer checklist or SBAR documents.

Patients met the transfer pathway criteria. Three patients from our cohort were in this 'undefined category'. In each of these cases there was a good clinical indication for transfer.

Eleven transfers were considered unavoidable.
Twelve transfers definitely had a positive impact on the patient's quality of life. Three of 12 received a surgical intervention.

Nine transfers were considered to be well managed. Three were considered to be poorly managed, because of poor documentation of care.
Seven files had no evidence of documentation of the grade of clinician referring the patient.

There was a delay of transfer of a patient with a NSTEMI. However, he was assessed and transferred on the following day. It was not clear why this delay occurred.

There were no deaths in the cohort of transfers analysed.

The results of the Final Audit from NCUHT showed that significant majority of transfers were clinically appropriate and unavoidable.

However, it has been identified that there are patients who are being transferred between sites without appropriate adherence to Trust policy on communication and co-ordination to transfers between the two sites.

Conclusions

Overall the results are consistent with those presented in the NCUHT transfer report.

On the evidence of our random sample it seems that the transfers we reviewed were made for clinically appropriate reasons.

The main issue identified was the poor/lack of documentation of transfer list/SBAR hence raising questions about the safety of transfers as well as communication between patients, relatives and clinicians.

A re-audit in six months after the introduction of the new Transfer checklist and SBAR is recommended.

NEQOS believe that the audit process undertaken by the Trust was reasonable, accurate and robust and that the CCG can us their audit as a basis for decision-making.

Background

Transfers of patients between hospital sites are a regular occurrence for most NHS acute trusts and it is essential that these transfers are safe and well managed.

Cumbria CCG has requested and recently received from NCUHT a breakdown of the transfers between WCH and CIC as the CCG was concerned at the sheer numbers of and increasing numbers of patients being transferred. The numbers from the CCG perspective could not be accounted for by the pathway changes that had been agreed. The information we have had from NCUHT is that over 80% of the transfers are on pathways and the others are clinically understandable.

The CCG are aware from the SI reporting system of a small number of incidents involving the transfer of patients none of which have been related to any deaths during transfer. Concern has also been raised by members of the public save our services and most recently staff from NCUHT through the BBC North West 'Inside Out' programme about the transfers of patients between WCH and CIC. These concerns also include allegations of patients coming to harm because of this transfer process.

The CCG has as part of its response to these concerns has written to the BCC and received confirmation that the BBC has no evidence of patients coming to any harm through the transfer process.

The CCG has previously procured a small independent survey of patients transferred which was completed in 2014 and showed a good level of satisfaction with the service they received. The Friends and Family surveys from the trust departments involved particularly trauma cardiac and general surgery also show high levels of satisfaction. There is also an ongoing process of getting feedback from patients who have recently been involved in the cardiac and GI bleeding pathway and too date the feedback has been positive.

NCUHT is in special measures and this is due to the inadequate rating for Acute Medicine on the WCH site. NCUHT is in the success regime one of 3 in the country for health care economies with longstanding difficulties.

NCUHT is undertaking its own internal review of 85 records of patients transferred; this is a 10% sample of the transfers undertaken since April 2015. Data from this case record review has been entered on to database and findings have been summarised in a report made available to the CCG.

The CCG has requested that NEQOS undertakes an independent review of this work in the first instance to assist them in evaluating the quality of both the process of the internal review as well as the findings that have been presented in the report.

This review is designed to provide Cumbria CCG with assurance that the transfers occurring between sites are safe in line with the transfer protocol, timely, clinically appropriate, and covered by appropriate clinical pathways, well managed, supported by appropriate clinical staff, and communicated effectively with the patients and with the receiving staff

Scope of Work

Since April 2015 NCUHT undertook an internal review of 10% sample of transfer from a six month period, which amounted to 85 transfers. They concluded that whilst some of these patients are not on the agreed clinical pathways for transfers the transfers were 'clinically understandable'.

NEQOS have re-reviewed a 14% sample of these 85 transfer cases (12 cases) to confirm accurate entering of the data into the spread sheet (the original proposal aimed at a minimum of a 10% sample).

NEQOS have re-analysed the whole spreadsheet to quality assure that the conclusions found by NCUHT are substantiated by the collected data. There are about 15 data items for each review.

NEQOS, NCUHT and Cumbria CCG will determine if further work is required based on this first phase and where a further sample of transfers is taken and to perhaps include patients who were not transferred.

Methodology

Retrospective re-audit of case records was conducted on a random sample (random numbers generated using www.random.org.uk) of 12 patients transfers from WCH to NCUHT audited by the Trust. The Trusts made case records available for re-audit on 8th March 2016. Retrospective Case Record Review was conducted by Dr Morrow and Dr Mushi. Where necessary discussion was used to achieve consensus.

Data was collected on a spread sheet similar to that which was used by the NCUHT audit team. Answers to each questions were either 'yes', 'no' or 'unable to comment'.

The team of two auditors also reviewed the hospital pathways to see if the transfers met the hospital pathway criteria. In addition they used clinical judgement to ascertain whether the transfer was clinically appropriate.

The spreadsheet used to capture data by the Trust was also checked to ensure that the summary findings were consistent with the data in this spread sheet. Although the spreadsheet provided was not the final one used by the Trust in their report it was possible to check that summarizing was accurate and NEQOS can confirm that this was the case (details in Appendix A).

Inclusion criteria

Any transfers from WCH to NCUHT between April - October 2015. Of these 85 transfers were audited by NCUHT. The NEQOS sample was drawn randomly from these 85.

Transfer pathways included Trauma and Orthopaedics, General Surgery, Respiratory, Gastroenterology and ACS.

There were 13 patients identified as transfers outside the five clinical protocols. These patients were designated as being 'clinically appropriate' to be transferred. The NEQOS random cohort included three patients from this category.

Data fields contained in the spread sheet	YES/NO
Was it a definite transfer	
Transfer checklist in patients file	

Data fields contained in the spread sheet	YES/NO
SBAR for transfer in patients file	
Pathway transferred under	
Clinical reason for transfer	
Clinical appropriate transfer	
Received surgery	
Patient died	
Transfer positively influenced the patients outcome	
Could it be avoided	
Was the transfer well managed	
Was the decision to transfer risk assessed	
Undertaken by appropriately skilled staff	
Communicated effectively between the two sites	

Results

Twelve case notes were clearly transfers from WCH to NCUHT

Pathways of the 12 transfers were

- 2 surgical
- 3 ENT
- 1 trauma
- 1 Cardiology
- 1 respiratory
- 1 gastroenterology
- 3 orthopaedics

Eight case notes did have the transfer checklist, seven had the SBAR document for transfer and four did not have transfer checklist or SBAR documents.

Patients met the transfer pathway criteria. Three patients from our cohort were in this 'undefined category'. In each of these cases there was a good clinical indication for transfer.

Eleven transfers were considered unavoidable. One orthopaedic transfer who was discharged on the following day, in the medical record the following note was found 'With Out-patients or following morning orthopaedics review'? This patient had chronic back pain and presented with leg weakness and numbness. There was limited documentation in the notes regarding the clinical findings on neurological examination and on review at CIC there was no focal neurological deficit noted.

Twelve transfers definitely had a positive impact on the patient's quality of life. Three of 12 received a surgical intervention.

Nine transfers were considered to be well managed. Three were considered to be poorly managed. The reason for this conclusion is that there was a lack of documentation. In one case note there was no evidence of either SBAR or a Transfer Checklist, however, there was clear documentation of the patient's risk assessment and evidence of communication between the two sites.

Seven files had no evidence of documentation of the grade of clinician referring the patient.

There was a delay of transfer of a patient with a NSTEMI. However, he was assessed and transferred on the following day. It was not clear why this delay occurred.

There were no deaths in the cohort of transfers analysed.

The results of the Final Audit from NCUHT showed that significant majority of transfers were clinically appropriate and unavoidable.

However, it has been identified that there are patients who are being transferred between sites without appropriate adherence to Trust policy on communication and co-ordination to transfers between the two sites.

Audit Question	Response from re-reviewing the notes Yes ' Y ' unless stated otherwise	Comment
Transfer check list in patients file	8 (out of 12)	
SBAR for transfer in patients file	7 (out of 12)	
Pathway transferred under	9 (out of 12)	Clinically the three transfers were appropriate. But there is no transfer pathway for ENT.
Clinically appropriate transfer	11 (out of 12)	Unable to comment one patient due to limited documentation on physical assessment.
Patient received surgery	3 (out of 12)	
Transfer positive for patient	12 (out of 12)	
Transfer avoidable	?1 (out of 12)	There was no documentation on physical findings to support the transfer for an orthopaedic review.
Transfer well managed	9 (out of 12)	No documentation
Risk assessed	9 (out of 12)	No documentation
Appropriately skilled staff	5 (out of 12)	Poor documentation with lack of information relating to the grade of the referring clinician.
Effective communication between sites	8 (?9) (out of 12)	Some notes had statements referring to the states discussed but no evidence of SBAR or checklist, others had no documentation at all.
Timing	11 (out of 12)	One patient with a NSTEMI was referred on the following day, Not clear from the notes why this happened.

The spreadsheet provided by the Trust with details for their audit was examined. Although it was found that the spreadsheet provided was not the final one used by the Trust in their report it was possible to check that summarizing was accurate and NEQOS can confirm that this was the case (details in Appendix A).

Conclusion

Overall the results are consistent with those presented in the NCUHT transfer report.

On the evidence of our random sample it seems that the transfers we reviewed were made for clinically appropriate reasons.

The main issue identified was the poor/lack of documentation of transfer list/SBAR hence raising questions about the safety of transfers as well as communication between patients, relatives and clinicians.

A re-audit in six months after the introduction of the new Transfer checklist and SBAR is recommended.

NEQOS believe that the audit process undertaken by the Trust was reasonable, accurate and robust and that the CCG can us their audit as a basis for decision-making.

Appendix A

The analysis presented in the interim report relates to 61 cases with 53 transfers whereas the spreadsheet received from the trust contained 92 transfers. Presumably the difference relates to patients who were audited after the interim report was produced. Since the number of transfers is greater in the spreadsheet it has only been possible to check the analysis produced by the trust for consistency and not confirm its accuracy.

The key question in relation to the transfers for the Trust is whether the current level of transfers is appropriate and whether these patients are on a transfer pathway or not. In order to examine this the Trust decided to audit 10% of the transfers for April to October 2015.

The activity is broken down by the Pathway Transferred under which includes 'Not on a pathway'; of the 13 transfers in this category all were considered to be clinically appropriate. The trust intended to do further work to examine these cases.

The table below summarises the findings for the 92 transfers. These findings appear to be consistent with those presented in the interim report for the 53 transfers.

Audit question	Response = 'Y' unless stated otherwise
Transfer checklist completed	26 (out of 92)
SBAR for Transfer	23 (out of 92)
Clinically appropriate	89 (out of 92)
Patient received surgery	49 (out of 92)
Transfer a positive for the patient	77 (out of 92)
Transfer avoidable	17 (out of 92) includes 5 ?s
Well managed process	60 (out of 92)
Risk assessed	51 (out of 92)
Appropriately skilled staff	39 (out of 92)
Effective communication	Y = 36; N = 28

The NEQOS analysis also gave some consideration to the pathway of the 92 transfers
- 29 could be categorised as GS: General Surgery, Surgery, Surgical
- 20 could be categorised as T&O: Orthopaedics + T&O
- 12 for Cardiology: Cardiac, cardiology and NSTEMI
- 13 Not on a pathway (all appropriate)

These findings appear to be consistent with those presented in the interim report for the 53 transfers with the exception of Cardiology where there has been no increase (12 transfers). It is possible that the Cardiologists conducted their audit more quickly than the Orthopaedic Surgeons or that these notes were easier to retrieve and so the initial audit captured all of these patients.

Data fields contained in the Excel spreadsheet

Patient Identifier	
Date of Transfer	
Definite transfer from WCH to CIC	
Transfer Checklist in patient file	
SBAR for transfer in patient file	
Pathway Transferred under (GS, Cardiology, … etc)	
Clinical reason for transfer	
Clinically Appropriate transfer?	y/n
	Comments
Received surgery?	y/n
	Comments
Patient Died?	y/n
	Comments
Transfer positively influenced on patient quality? (meaning outcome/safety/experience)	y/n
	Comments
Could this transfer have been avoided?	y/n
	Comments
Was the transfer well managed?	y/n
	Comments
Was the decision to transfer risk assessed?	y/n
	Comments
Undertaken by appropriately skilled staff (at least a middle grade)	y/n
	Comments
Communicated effectively between sites (if no SBAR or Transfer checklist is there other evidence of effective communication)	y/n
	Comments
Original pathway identification (based on ICD-10)	
In Hours / Out of Hours transfers	
Procedure code in PAS	

Appendix B

Staff conducting this project were:

Tony Roberts is Joint Deputy Director of the North East Quality Observatory Service (NEQOS) and Deputy Director (Clinical Effectiveness) at South Tees Hospitals NHS Foundation Trust. He is also the Patient Safety Collaborative Interim Programme Lead for the North East and North Cumbria Academic Health Science Network.

Tony has a research background and a Masters in Philosophy of Mind and Health Services Research. He has worked in the NHS in acute hospital, primary care and health authority roles, always with a focus on measurement of quality and safety of care.

Dr Gerry Morrow is an established local GP with 20 years' experience. Gerry's interests are in evidence based medicines and patient involvement care. Gerry is the Medical Director for Clarity Informatics, who develop solutions that lead to radical improvements in clinical safety and quality. Gerry has worked with Tony for a number of years around standardising clinical case note reviews for the Regional Mortality Review.

Dr Anna Mushi is a Specialty Registrar in Medicine. Anna completes her final ARCP on 9 February 2016 and will be signed off as having completed her full training; she has passed all exams and is already MRCP. She is currently working with County Durham and Darlington NHS Foundation Trust.

Mr Michael Walkley is a very experienced Data Analyst working full time for NEQOS and carried out the verification of the spreadsheet provided by the Trust.

DOCUMENT GOVERNANCE	
Document name	Independent review of transfers from West Cumberland Hospital (WCH) to Cumberland Infirmary (CIC)
Document type	Report
Version	Final
Date	21st March 2016
Document Classification	
Prepared on behalf of	Northern Clinical Senate for Cumbria CCG
Created by	Dr Gerry Morrow, Dr Anna Mushi and Mr Tony Roberts
Approved by Epidemiologist	Mr Tony Roberts
Approved by Project Director	Helen Ridley
Peer Reviewed by (if appropriate)	Michael Wakely
Originating organisation	North East Quality Observatory Service (NEQOS)
Website of originating organisation	www.NEQOS.nhs.uk
Contact email address	NEQOS@nhs.net
Public file location	
Internal file location	\\ottowa1\neqossnh$\ProjectManagement\ProjectMgt15-16\Independent Review of Transfer

VERSION CONTROL				
Version	Document Type	Date	Amendments	By
1	DRAFT 1	14/3/16	First draft	A Mushi
2	DRAFT2	16/3/16	Comments and amendments from G Morrow	A Mushi
3	DRAFT3	17/3/16	Format/grammar	J Watson
4	DRAFT4	17/3/16	Comments and amendments from T Roberts	T Roberts
5	DRAFT5	21/3/16	Comments and amendments from G Morrow and T Roberts	G Morrow T Roberts
6	FINAL	22/3/16	Final proofing followed by sign off by T Roberts	T Roberts
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