

Paper 12

Recommendation <input type="checkbox"/> DECISION <input checked="" type="checkbox"/> NOTE	The Trust Board is asked to: <ul style="list-style-type: none"> • Discuss the current performance in relation to key quality indicators as at the end of August 2017 • Consider the actions being taken where performance requires improvement • Question the report to ensure appropriate assurance is in place
Reporting to:	Trust Board
Date	28 th September 2017
Paper Title	Quality Performance Report
Brief Description	<p>This report will provide the Board with assurance relating to our compliance with quality performance measures during August 2017 (month four 2017/18).</p> <p>Key points to note:</p> <p>The Trust is compliant with a number of quality measures however:</p> <ul style="list-style-type: none"> • We are not compliant with Mixed Sex Accommodation (MSA) requirements due to the number of patients that wait for more than 12 hours to be transferred from our critical care units. • We have reported five serious incidents in August • We saw a decrease in the number of additional patient episodes in August 114 compared to 158 in July.
Sponsoring Director	Deirdre Fowler Director of Nursing, Midwifery and Quality
Author(s)	Dee Radford, Associate Director of Patient Safety
Recommended / escalated by	
Previously considered by	Quality & Safety Committee Clinical Governance Executive Committee Clinical Quality Review Meeting
Link to strategic objectives	Patient and Family – through partnership working we will deliver operational performance objectives Safest and Kindest – delivering the safest and highest quality care causing zero harm
Link to Board Assurance Framework (see over)	RR561 RR951 RR1185
Equality Impact Assessment	<ul style="list-style-type: none"> ● Stage 1 only (no negative impacts identified) ● Stage 2 recommended (negative impacts identified) <ul style="list-style-type: none"> ● negative impacts have been mitigated

	<ul style="list-style-type: none">● negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	<ul style="list-style-type: none">● This document is for full publication● This document includes FOIA exempt information● This whole document is exempt under the FOIA

Strategic Objectives 2017/18

PATIENT AND FAMILY - Deliver a transformed system of care (VMI) and partnership working that consistently delivers operational performance objectives

SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm

SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach

HEALTHIEST HALF MILLION ON THE PLANET – Build resilience and social capital so our communities live healthier and happier lives and become the healthiest 0.5 million on the planet through distributed models of health

INNOVATIVE AND INSPIRATIONAL LEADERSHIP - Through innovative and inspirational leadership achieve financial surplus and a sustainable clinical services strategy focussing on population needs

VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce

BAF Risks

If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (RR 561)

If we do not work with our partners to reduce the number of patients on the Delayed Transfer of Care (DTC) lists, and streamline our internal processes we will not improve our 'simple' discharges (RR 951)

If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to patients (RR 1134)

If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage (RR 1204)

If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185)

If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186)

If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (RR 668)

If we are unable to resolve the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties & address the modernisation of our ageing estate & equipment (RR 670)

If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients (RR1187)

If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve (RR 423)

Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859)



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Quality Performance Report

September 2017

Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of August 2017 (Month five of 2017/2018). The report will provide assurance to the Quality and Safety Committee that we are compliant with key performance measures and that where we have not met our targets that there are recovery plans in place.

The report will be submitted to the Quality and Safety Committee as a standalone document and will then be presented to Trust Board as part of the Integrated Performance Paper for consideration and triangulation with performance and workforce indicators.

The report will be submitted to our commissioners (Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group) to provide assurance to them that we are fulfilling our contractual requirements as required in the Quality Schedule of our 2017-2018 contract.

From July 2017 we provide a quarterly detailed report to the Committee relating to a number of metrics as reported here but with the additional detailed triangulation with patient experience metrics such as complaints and PALS and further detail relating to incident reporting down to Care Group level.

This report relates to the Care Quality Commission (CQC) domains of quality – that we provide safe, caring, responsive and effective services that are well led, as well as the goals laid out within our organisational strategy and our vision to provide the safest, kindest care in the NHS.

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Section one: Our Key Quality Measures

Measure	Year end 16/17	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	April 17	May 17	June 17	July 17	Aug 17	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
Infection Prevention and Control																
Clostridium Difficile infections reported	21	3	2	2	2	0	1	3	4	3	1	3	1	12	2	25
MRSA Bacteraemia Infections	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia Infections	9	1	1	1	0	0	2	1	0	1	1	0		2	None	None
E. Coli Bacteraemia Infections	31	0	6	7	1	0	3	1	1	1	1	3		6	None	None
MRSA Screening (elective) (%)	95.2	95.1	95.8	91.2	94.8	95.0	95.8	95.5	95.4	95.9	95.9	95.6	95.6	95.7	95%	95%
MRSA Screening (non elective) (%)	94.4	93.9	94.2	94.7	94.7	95.0	94.2	95.2	96.3	95.0	96.1	96.1	97.0	96.1	95%	95%
In Service Pressure Ulcer Incidence																
Grade 2 Avoidable	31	1	6	2	2	4	0	3	2	2	2	2	1	9	0	0
Grade 2 Unavoidable	112	7	9	13	9	5	9	8	10	19	5	10	7	51	None	None
Grade 3 Avoidable	9	0	3	2	1	0	0	0	0	0	1	0	1	2	0	0
Grade 3 Unavoidable	9	0	1	0	0	1	4	1	0	1	3	2	4	10	None	None
Grade 4 Avoidable	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grade 4 Unavoidable	2	0	0	0	0	1	1	0	0	0	1	0	0	1	None	None
Patient Falls																
Falls reported as serious incidents	5	0	0	1	1	0	0	0	0	0	1	0	1	2	None	None
All Serious Incidents Reported																
Number of Serious Incidents	63	5	7	6	2	4	3	1	2	4	6	1	5	18	None	None

Measure	Year end 16/17	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	April 17	May 17	June 17	July 17	Aug 17	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
Never Events																
Never Events	5	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0
NHS Safety Thermometer Point Prevalence Trust Level Data																
Harm Free Care (%)	94.17%	93.56	94.9	96.33	93.54	95.49	92.54	93.93	94.31	94.81	93.48	91.15	92.09	93.17	95%	95%
No New Harms (%)	97.94%	97.81	98.58	99.27	98.16	98.62	96.77	97.16	98.47	98.18	97.49	95.24	96.59	97.20	None	None
Safer Surgery																
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Venous Thromboembolism (VTE) Risk Assessment																
VTE Assessment		95.74	96.01	95.64	95.31	95.66	95.34	95.96	95.6	95.5	95.4				95%	95%
Mixed Sex Accommodation (MSA)																
MSA including ITU discharge delays>12hrs	361	25	32	31	39	27	33	30	26	17	37	39	31	150	None	None
Patient, Family and Carer Experience																
Complaints (No)	424	24	37	41	31	47	45	49	44	56	42	61	50	253	None	None
Friends and Family Response Rate (%)	23.8%	26.5	20	23.5	20.7	20.0	22.0	23.8	32.2	22.5	23.3	19.5	20.1	20.1	None	None
Friends and Family Test Score (%)	96.6%	96.2	95.8	96.0	96.5	96.6	96.7	96.6	97.1	96.7	97.0	96.2	97.1	97.1	75%	75%

Section Two: Key Messages by exception

Infection Prevention and Control

We are currently above trajectory for the year at 12 cases (should be no more than ten against our internal targets) and for the month (target of no more than two).

All cases have a Post Infection Review led by the clinical teams caring for the patient to look for any lapse in care. Not all cases are preventable.

Most cases are caused by antibiotic use. Cross infection is now rare. Although SaTH are lower users of antibiotics on average compared with other trusts we are less good at reviewing antibiotic prescriptions within 72 hrs.

Learning from in service Pressure Ulcer Incidence

In August 2017 we found that one grade two pressure ulcer was considered to be avoidable. This related to the lack of evidence of repositioning of this patient who was compliant with the care provided.

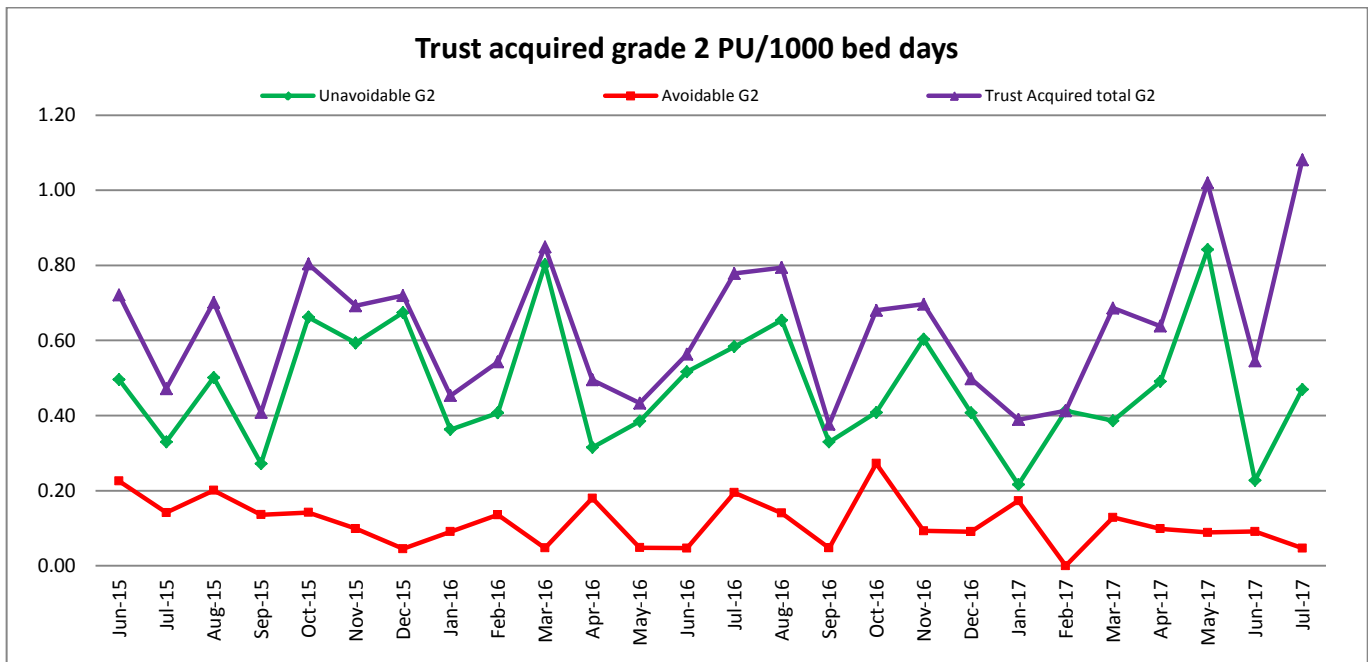
As the Committee is aware, significant patient safety incidents that did not meet the revised Serious Incident Framework are managed as High Risk Case Reviews (HRCR). Therefore, some grade three and four pressure ulcers and some falls resulting in fractures will not be reported as serious incidents but will be reviewed to ensure any learning is recognised and shared in order to observe trends and potential actions which may reduce risk going forward. There were three HRCR pressure ulcer incidents in August as shown in table one below:

Table one: HRCR Pressure Ulcers August 2017

Combination G3/Moisture Lesion	W23OH	Incident relates to an oncology patient who had recently suffered significant weight loss. Small grade 3/moisture lesion. Reasonable care provision and escalation when noted. Patient did not experience pain from this skin damage which was very small in size. Reviewed by Tissue Viability Nurse – considered not attributable to our care.
Grade 3 PU	WD 7	Following discussion and advice from the TVN team it has been decided that this was unavoidable. The rationale for this decision is due to the patient having full capacity and when informed of the potential risks of not repositioning the patient still declined to comply. This gentleman has numerous co-morbidities and was provided with an appropriate mattress when a possible DTI was noted on admission. Nursing documentation notes attempts to reposition but no compliance from the patient, this has also made assessment and applying dressings difficult
Grade 3PU	WD 24	TVN confirms unavoidable. Well recorded compliance issues.
Grade 3PU	WD 26	TVN confirms unavoidable. Well recorded compliance issues, patient fully aware of risks.

Chart one below shows that in July the number of in service grade two pressure ulcers increased.

Chart one: Trust acquired Grade 2 Pressure ulcers per 1000 bed days



Patient Falls

Chart two shows that the number of reported patient falls per 1000 bed days has reduced slightly

Chart two: Patient Falls per 1000 bed days July 2017

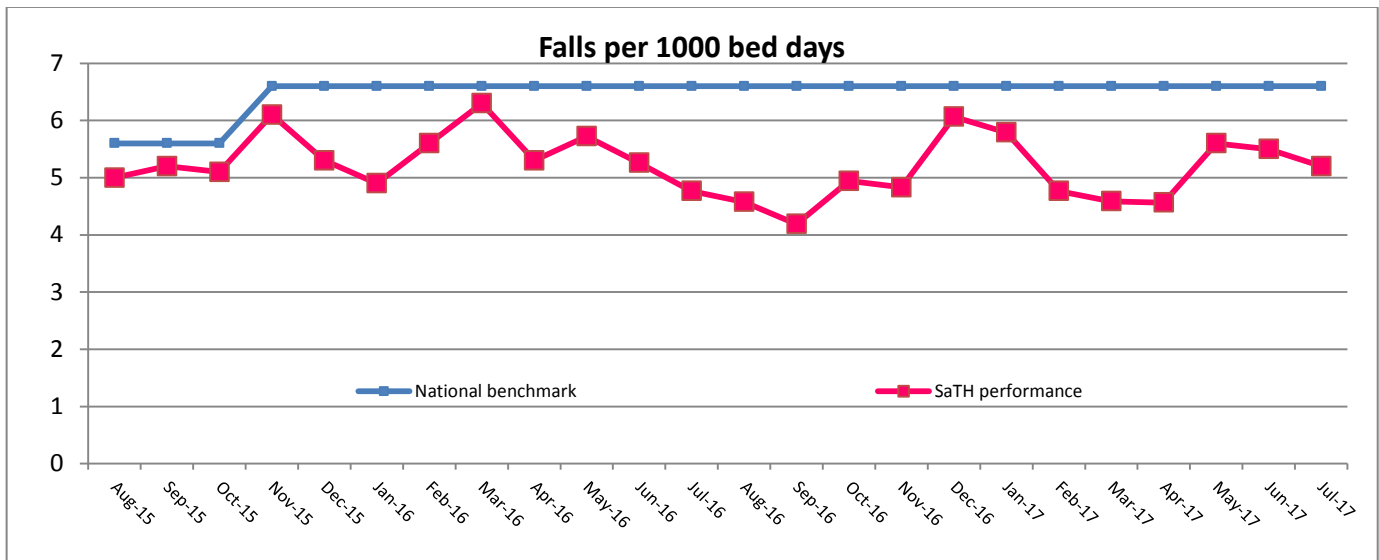
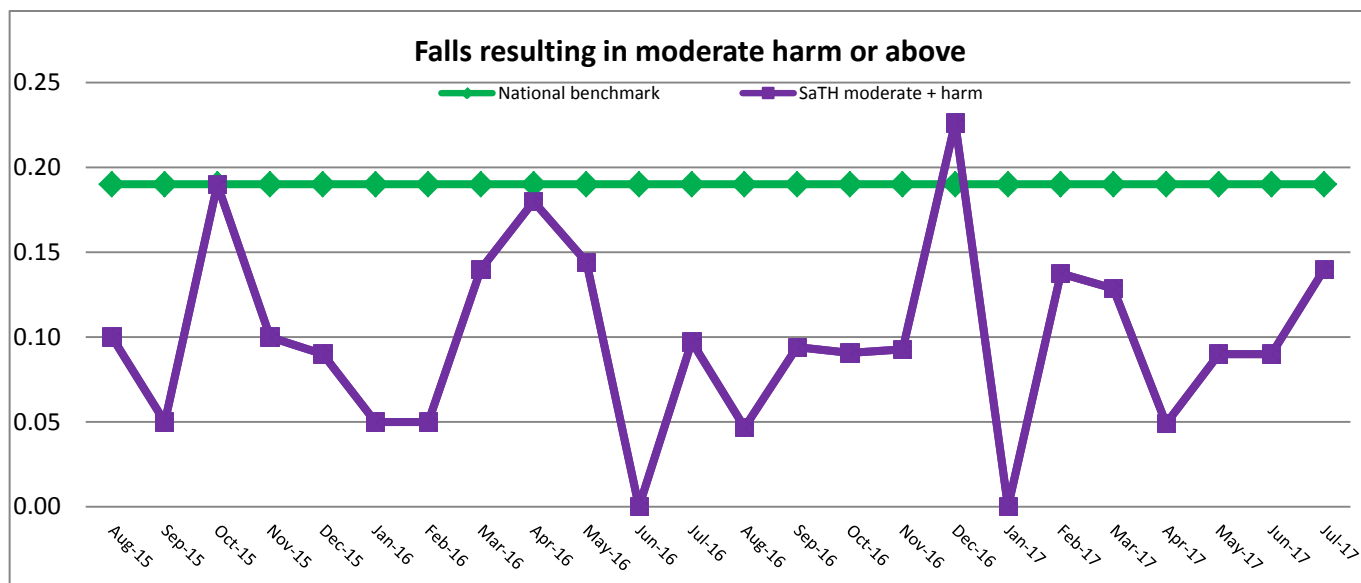


Chart three shows that the number of patient falls reported as resulting in moderate harm or above has increased slightly but remains below the national benchmark.

Chart three: Falls reported as resulting in moderate harm or above July 2017



There were no falls reported as HRCR in August 2017.

Learning from Moderate and Serious Incidents

At the Trust Board meeting on 29 June 2017 the Director of Nursing, Midwifery and Quality was required to provide further information about how patient safety incidents were graded and how HRCR were identified.

The reporting criteria for Serious Incidents changed during 2015/16 due to the release of the revised Serious Incident (SI) Framework (2015). The Revised Framework reporting was amended to report only those incidents which met the definition of severe harm linked to those where act or omission directly contributed to the outcome.

HRCR are a subset of incidents which are not externally reportable as they do not match the revised SI framework for level of harm linked to act or omission. However, in some cases there remains some concern regarding the incident which requires further high level review as the level of learning may be significant.

As with serious incidents, HRCRs can be identified through Datix incident reporting, verbally or potentially through the complaints process. Examples of HRCR are:

- When severe harm or death occurs but where an act or omission was not directly linked to the outcome but during rapid review or preliminary investigation, that there are some learning outcomes which may improve services.
- When moderate harm where act and/or omission have contributed to the outcome.
- When an increase/cluster in reporting of a specific category of incident which has the potential to lead to moderate or severe harm if left unaddressed and may need to be considered for higher level review.

HRCRs are managed in accordance with the Trust Incident Reporting Policy directly by the Care Groups. Any potential learning, relevant to the Trust as a whole, should be shared through appropriate internal networks, structures and governance groups.

Serious Incidents are still recognised as events in healthcare where the potential for learning is so great that they warrant allocating significant resources into understanding the circumstances and root causes of how and why they occurred in order to affect significant learning and change within organisations.

With the changes to the SI Framework there is an emphasis on incidents matching both level of harm and act or omission criteria and the removal of the focus away from 'mandatory' categories which have previously been reported. For example prior to the release of the revised SI framework the Trust would report all grade three or four pressure ulcers, many infection related concerns, and all falls resulting in a fracture.

Following the revision to the framework when the outcome meets the definition of severity of harm or unexpected death, consideration is given as to whether an act or omission was directly contributory to this event, there is recognition that upsetting outcomes are not always the result of error, acts and/or omissions in care.

However, if there is a lack of clarity as to the impact of any act or omission then the framework recommends that this can be discussed with the commissioners to ascertain agreement on the appropriate and proportionate response. This may lead to escalation of a case to a serious incident, but if the investigation confirms no act or omission directly contributed to the outcome then a request for a downgrading/ removal from StEIS may be made.

In the majority of cases it will be immediately clear that a serious incident has occurred and further investigation will be required, further guidance below:

Serious incidents in the NHS include:

- Unexpected or avoidable death of one or more people, this includes:
 - Suicide/self-inflicted death and
 - Homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent death or serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
 - Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring
 - Where abuse occurred during the provision of NHS funded care

This includes above that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS-funded care caused or contributed to the incident.

- An incident (or series of incidents) that prevents, or threatens to prevent, on organisations ability to continue to deliver an acceptable quality of healthcare services; (examples of which can be found in the SI Framework)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare within an organisation

“Serious incidents can also include those where patients could have been seriously harmed but, for a stroke of luck or heroic action on the part of an individual, this was avoided. Where very significant consequences may have resulted and there is a strong likelihood that the incident could be repeated, it may be justified to declare a serious incident in order to ensure the incident is learned from”.
(Serious Incident Framework - frequently asked questions March 2016)

Serious or Severe Harm are defined as:

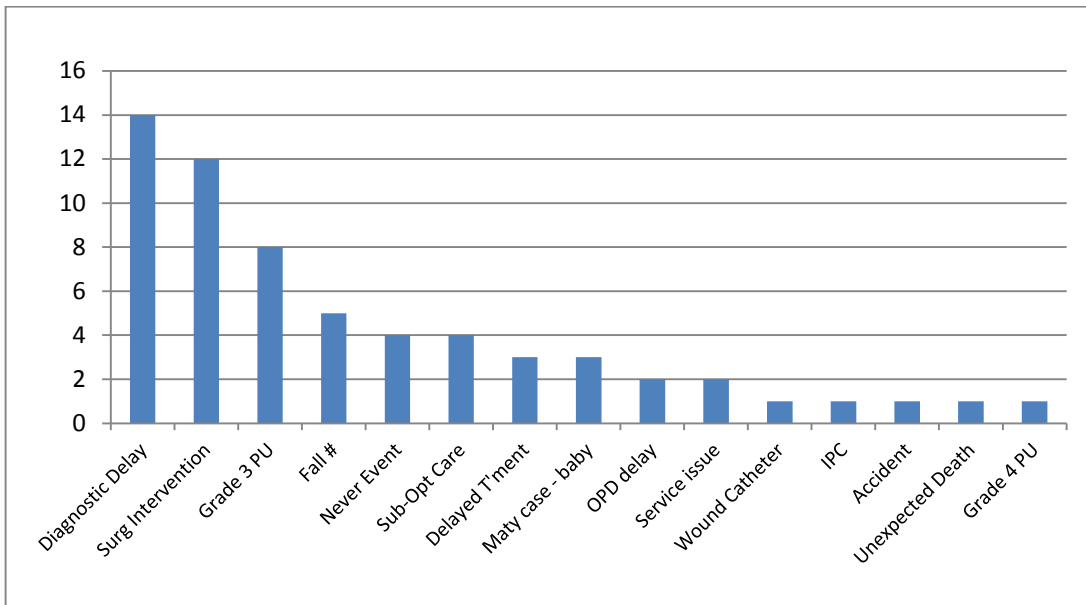
- A patient safety incident which resulted in permanent harm to one or more persons receiving NHS-funded care.
- Chronic pain – continuous long term pain of more than 12 weeks or after the time that healing would have been through to have occurred in pain after trauma or surgery
- Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary.

Moderate Harm is defined as:

Any unexpected or unintended incident which resulted in further treatment, possibly surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm to one or more persons.

In 2016-2017 the Trust reported the following 63 Serious Incidents:

Chart Four: Serious Incidents 2016-2017



In terms of trends, there were three diagnostic delays in ophthalmology but causes were both system and process and some had causal human factors.

The Board will be aware of the four Never Events that were reported and have received additional assurance relating to the actions that have been taken since to prevent recurrence.

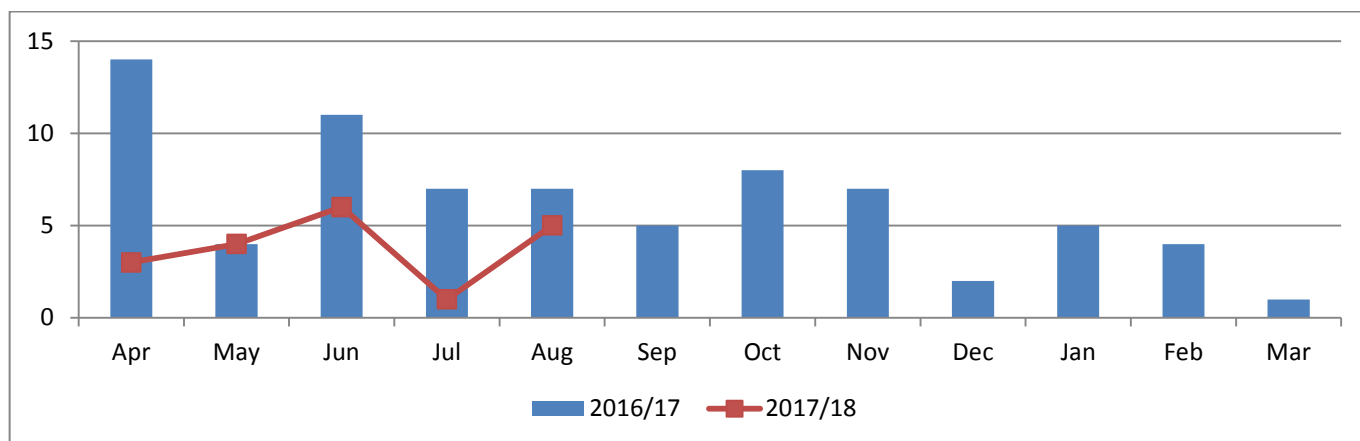
There were no specific trends in relation to the HRCR that were carried out during the same period. Some pressure ulcers (15) and patient falls (22) were managed as HRCR during 2016-2017.

The Board will be aware that we are taking steps to improve how we share learning in the Trust. This includes a weekly Executive Rapid Review meeting which reviews the moderate and severe harm reports of the previous week and also complaints received in the same time. Further detail below.

Additionally the launch event for Values Stream #5 utilising the well tested methodologies of the Virginia Mason Institute was held on 19 September 2017. The Values Stream will concentrate on processes related to Patient Safety and will enable the Trust to strengthen and embed our processes for sharing learning.

During August we reported five serious incidents. All are in the process of being reviewed at present.

Chart Five: Serious incidents reported compared to 2016-2017



Executive Rapid Review Meeting

The first meeting of the regular (usually weekly) rapid review meetings was held on 08 September. The Terms of Reference were discussed and will be formally approved at the next meeting. The meeting reviewed five moderate and serious harm incidents from the previous fortnight along with seven formal and two pending complaints. The meeting sought assurance that the incidents were correctly graded and if confirmed as moderate or severe that Duty of Candour requirements had been complied with. Complaints were reviewed to ensure that no immediate actions were required and further detail was requested where appropriate.

The Executive Rapid Review Meeting will report to the Quality and Safety Committee through the Clinical Governance Executive.

Safeguarding Children, Young People and Adults

In August there were nine safeguarding adults concerns raised involving the Trust, five raised by the Trust and four against our services. All are being investigated.

There were three safeguarding children concerns raised by our services during August.

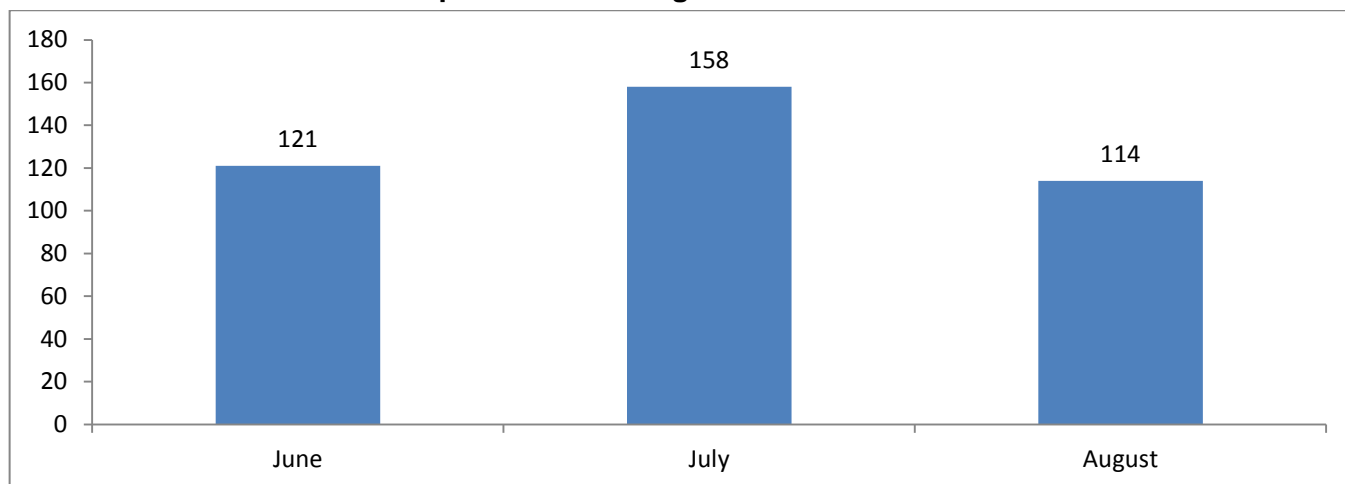
Mixed Sex Accommodation Breaches

There were 31 patients who waited more than four hours to leave our intensive care areas once deemed well enough to do so.

Additional Patients on our wards

In August we recorded 114 additional patient episodes on our wards. The chart bellows shows the total numbers since June. A risk assessment is carried out before any additional patient is placed on a ward.

Chart Six: Additional Patient episodes as at August 2017



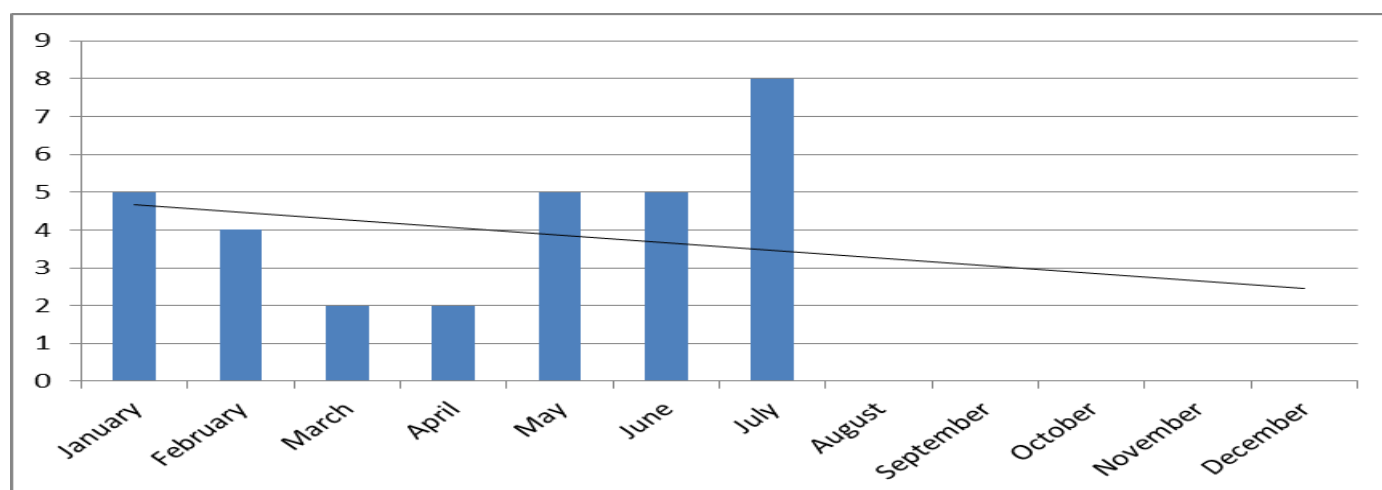
Patients waiting more than 104 days for Cancer Treatment (July data)

In August we reported eight patients who received their first definitive treatment for cancer after 104 days (the target for referral to treatment being 62 days) over three specialties (Colorectal, Lung and Urology).

In accordance with the Trust’s procedure, a harm proforma and an RCA will be requested from the clinician / operational team responsible for each individual patient. On completion, both the harm proforma and RCA will be reviewed and signed off by the Cancer Board prior to sharing with the CCG (in line with NHS England Guidelines).

It is our aspiration to eradicate any 104+ day breach linked to capacity at SaTH. We will also ensure that any action plans generated as a result of RCA are reviewed by the Cancer Board and any learning points / action are followed up to ensure compliance with the action plan in the relevant clinical / operational area.

Chart seven: 104+ day breaches - year to date (January 2017 onwards)



Patient, Family and Carer Experience

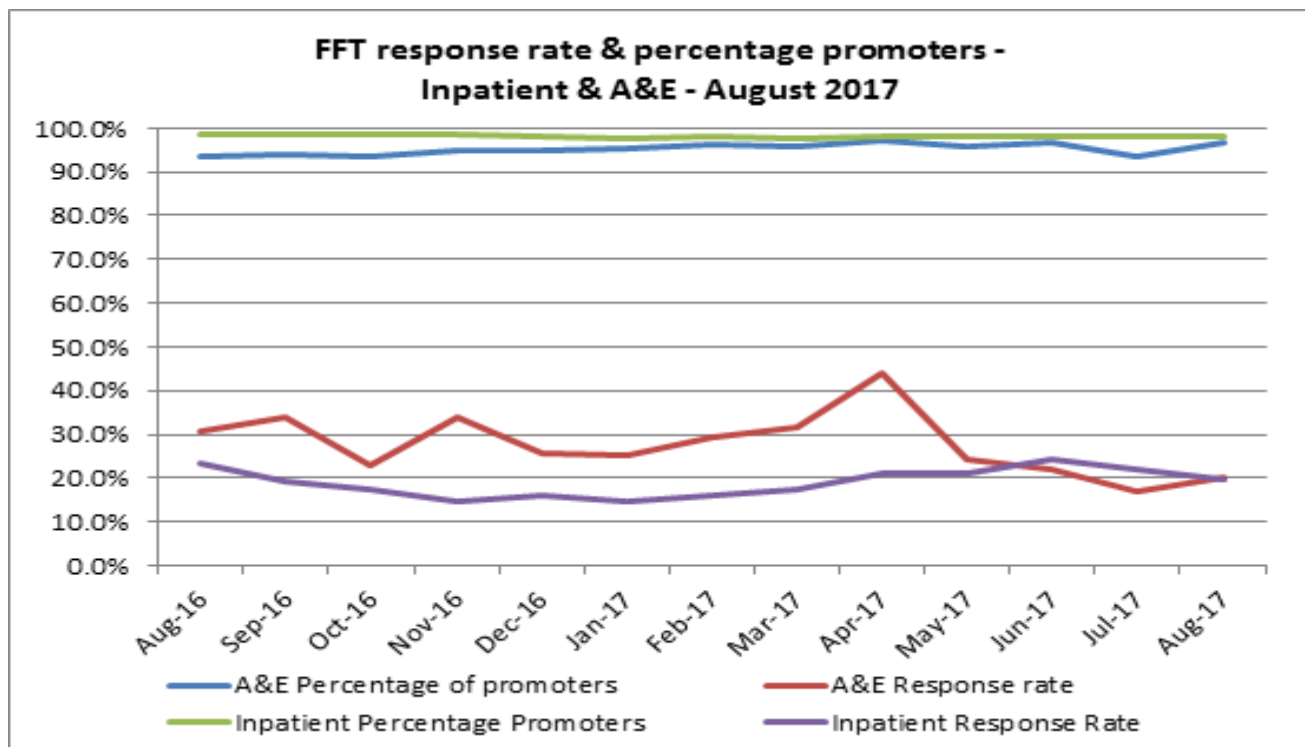
Friends and Family Test (FFT)

The overall percentage of patients who would recommend the ward they were treated on to friends and family, if they needed similar care and treatment, was 97.1%. This was an increase on July’s

results. Individually, Maternity and A&E increased; inpatients remained the same and Outpatients declined, but only by 0.1% compared to July.

The overall response rate was 20.1% which was an overall increase compared to July response at 19.5%. Individually, Maternity and A&E improved, however inpatients' response rate declined as July was at 22%.

Chart eight: FFT Response Rate



Complaints and Patient Advice and Liaison Service (PALS).

Fifty formal complaints were received in August 2017. Unscheduled Care continues to receive the most complaints, which is in line with levels and nature of activity. Complaints in Women and Children's Care have decreased slightly from previous months.

Clinical treatment and communications remain the top subjects with complaints that cover a range of issues and specialties. Inadequate discharge planning continues to be an issue raised in a number of complaints. There have been fewer complaints about staff attitude this month.

Outpatients continue to receive the most complaints; these are mainly about the quality of the appointment rather than waiting times. 123 PALS contacts were received in August. The majority of contacts related to problems with communication and appointments, including cancellations and waiting times. Outpatients and Bookings continue to see the most PALS contacts; these are mainly linked to appointments.

Section three: Recommendations for the Trust Board

The Trust Board is asked to:

- **Discuss** the current performance in relation to key quality indicators as at the end of August 2017
- **Consider** the actions being taken where performance requires improvement
- **Question** the report to ensure appropriate assurance is in place

Serious Incidents– July 2017

Reported Date	Care Group	Description of Incident (StEIS category with additional explanation)	Update 01 Sep 2017
18 Jul 2017	Scheduled Care	<p>Retained Wound Catheter Part of a wound catheter retained post operatively</p> <p>This does not fall into the category of a Never Event because:</p> <p>This object was not subject to a formal counting/checking procedure and the catheter was intentionally left in for a period post operatively</p>	Investigation on track for completion in timescales

Serious Incidents – August 2017

Reported Date	Care Group	Description of Incident (StEIS category with additional explanation)	Update 01 Sep 2017
03 Aug 2017	USC	<p>Major Incident/Emergency Preparedness/Resilience Decision to report and escalate to SI to support wider learning</p>	RCA in progress and remains in timescales
03 Aug 2017	USC	<p>Information Governance – Missing Notes Following an appointment an inpatients notes were found to be missing</p>	RCA in progress and remains in timescales
11 Aug 2017	USC	<p>Grade Three Pressure Ulcer Pressure ulcer developed whilst patient in hospital</p>	RCA in progress and remains in timescales
22 Aug 2017	WCC	<p>Delayed Diagnosis – Gynae Retrospective review reported as an SI.</p>	RCA in progress and remains in timescales
30 Aug 2017	USC	<p>Patient Fall Patient fell and sustained a sub capital fracture of neck of femur.</p>	RCA in progress and remains in timescales