The Shrewsbury and Telford Hospital NHS Trust

Paper 11iii

| | |
|---|---|
| **Recommendation**<br>☑ **DECISION**<br>☑ **NOTE** | **The Trust Board is asked to:**<br>• **Discuss** the current performance in relation to key quality indicators as at the end of October 2017<br>• **Consider** the actions being taken where performance requires improvement<br>• **Question** the report to ensure appropriate assurance is in place |
| **Reporting to:** | **Trust Board** |
| **Date** | 30 November 2017 |
| **Paper Title** | Quality Performance Report |
| **Brief Description** | The purpose of this report is to provide the Board with assurance relating to our compliance with quality performance measures during October 2017 (month seven 2017/18).<br>Key points to note:<br>The Trust is compliant with a number of quality measures however:<br>• 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.<br>• We have reported 18 C Diff infections against an annual target of no more than 25.<br>• We reported ten Serious Incidents in October, one of which was a Never Event in Ophthalmology<br>• Whilst we have made an improvement in training compliance for Prevent, we will not, on current trajectory, achieve 85% compliance by the end of March 2018.<br>Also attached is the Quarterly Quality Performance Report that was received by the Quality and Safety Committee on 17 October 2017. The themes within this paper are similar to those noted above but the paper gives greater detail of the quarter's activity.<br>This paper is provided to the Board for information. |
| **Sponsoring Director** | Deirdre Fowler, Director of Nursing and Quality |
| **Author(s)** | Dee Radford, Associate Director of Patient Safety |
| **Recommended / escalated by** | Quality and Safety Committee |
| **Previously considered by** | Quality and Safety Committee |
| **Link to strategic objectives** | **Patient and Family** – through partnership working we will deliver operational performance objectives<br>**Safest and Kindest –** delivering the safest and highest quality care causing |

| | |
|---|---|
| | zero harm |
| **Link to Board Assurance Framework** | RR561<br>RR951<br>RR1185 |
| **Equality Impact Assessment** | ○ **Stage 1 only (no negative impacts identified)**<br>◉ **Stage 2 recommended (negative impacts identified)**<br>○ negative impacts have been mitigated<br>○ negative impacts balanced against overall positive impacts |
| **Freedom of Information Act (2000) status** | ○ **This document is for full publication**<br>○ **This document includes FOIA exempt information**<br>○ **This whole document is exempt under the FOIA** |

The Shrewsbury and Telford Hospital NHS Trust

Paper 11iii


# Quality Performance Report

# November 2017

## Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of October 2017 (Month seven 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.

## Contents

## Section one: Our Key Quality Measures

| Measure | Year end 16/17 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | April 17 | May 17 | June 17 | July 17 | Aug 17 | Sep 17 | Oct 17 | Year to date 2017/18 | Monthly Target 2017/18 | Annual Target 2017/18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |
| Clostridium Difficile infections reported | 21 | 2 | 2 | 0 | 1 | 3 | 4 | 3 | 1 | 3 | 1 | 3 | 3 | 18 | 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 | 0 | 0 | 2 | 1 | 0 | 1 | 1 | 0 | 6 | 2 | 3 | 13 | None | None |
| E. Coli Bacteraemia Infections | 31 | 7 | 1 | 0 | 3 | 1 | 1 | 1 | 1 | 3 | 3 | 1 | 2 | 12 | None | None |
| MRSA Screening (elective) (%) | 95.2 | 91.2 | 94.8 | 95.0 | 95.8 | 95.5 | 95.4 | 95.9 | 95.9 | 95.6 | 95.6 | 95.5 | 95.7 | 95.6 | 95% | 95% |
| MRSA Screening (non elective) (%) | 94.4 | 94.7 | 94.7 | 95.0 | 94.2 | 95.2 | 96.3 | 95.0 | 96.1 | 96.1 | 97.0 | 97.2 | 96.5 | 96.3 | 95% | 95% |
| | | | | | | | | | | | | | | | | |
| Grade 2 Avoidable | 35 | 2 | 2 | 5 | 0 | 6 | 2 | 2 | 2 | 4 | 2 | 1 | 2 | 15 | 0 | 0 |
| Grade 2 Unavoidable | 112 | 13 | 9 | 4 | 9 | 9 | 10 | 19 | 5 | 11 | 9 | 4 | 2 | 60 | None | None |
| Grade 3 Avoidable | 9 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 1 | 5 | 0 | 0 |
| Grade 3 Unavoidable | 9 | 0 | 0 | 1 | 4 | 1 | 0 | 1 | 2 | 4 | 3 | 0 | 2 | 12 | None | None |
| Grade 4 Avoidable | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Grade 4 Unavoidable | 2 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | None | None |
| | | | | | | | | | | | | | | | | |
| Falls reported as serious incidents | 5 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 2 | None | None |
| | | | | | | | | | | | | | | | | |
| Number of Serious Incidents | 61 | 5 | 2 | 4 | 3 | 1 | 2 | 4 | 6 | 1 | 4 | 4 | 10 | 31 | None | None |

| Measure | Year end 16/17 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 | April 17 | May 17 | June 17 | July 17 | Aug 17 | Sep 17 | Oct 17 | Year to date 2017/18 | Monthly Target 2017/18 | Annual Target 2017/18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |
| Never Events | 5 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 |
| | | | | | | | | | | | | | | | | |
| Harm Free Care (%) | 94.17 % | 96.33 | 93.54 | 95.49 | 92.54 | 93.9 | 94.31 | 94.81 | 93.48 | 91.15 | 92.09 | 89.91 | 90.86 | 92.37 | 95% | 95% |
| No New Harms (%) | 97.94 % | 99.27 | 98.16 | 98.62 | 96.77 | 97.16 | 98.47 | 98.18 | 97.49 | 95.24 | 96.59 | 96.83 | 96.34 | 97.02 | None | None |
| | | | | | | | | | | | | | | | | |
| WHO Safe Surgery Checklist (%) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | | | | | | | | | | | | | | | |
| VTE Assessment | | 95.64 | 95.31 | 95.66 | 95.34 | 95.96 | 95.6 | 95.5 | 95.4 | 95.2 | 95.4 | 96.4 | | 96.4 | 95% | 95% |
| | | | | | | | | | | | | | | | | |
| MSA including ITU discharge delays>12hrs | 361 | 31 | 39 | 27 | 33 | 30 | 26 | 17 | 37 | 39 | 31 | 37 | 33 | 188 | None | None |
| | | | | | | | | | | | | | | | | |
| Complaints (No) | 424 | 41 | 31 | 47 | 45 | 49 | 44 | 56 | 42 | 61 | 50 | 45 | 45 | 298 | None | None |
| Friends and Family Response Rate (%) | 23.8% | 23.5 | 20.7 | 20.0 | 22.0 | 23.8 | 32.2 | 22.5 | 23.3 | 19.5 | 20.1 | 18.3 | 15% | 20.1 | None | None |
| Friends and Family Test Score (%) | 96.6% | 96.0 | 96.5 | 96.6 | 96.7 | 96.6 | 97.1 | 96.7 | 97.0 | 96.2 | 97.1 | 97.2 | 96.1 | 97.1 | 75% | 75% |

## Section Two: Key Messages by exception

### Infection Prevention and Control

There were three new cases of C Difficile infection in October 2017. This means that we continue to be over our internal targets of no more than two per month and are in danger of breaching our target of no more than 25 in the year as at month seven we have reported 18.

Many cases are not preventable and cross Infection is rare. However the main issues are failure to send samples pre antibiotics to allow narrowing of antibiotic therapy, failure to follow antibiotic policy or to review antibiotics within 72 hours, and overlong courses of antibiotics. There have also been delays in isolating patients when required. All of these issues are raised at governance meetings across the Trust and medical and nursing staff reminded of the need for regular review of antibiotic prescriptions.

In September there was a postive MRSA bacteraemia affecting a patient in the Trust. A comprehensive post infection review was carried out with CCG colleagues present following which the Trust submitted an appeal for the bacteraemia to be allocated to a third party due to significant input to the patient's care whilst at home between admissions from other care providers. This decision has been upheld by the national review panel. The last MRSA bacteraemia case apportioned to the Trust was in August 2016.

There were three post 48 hour cases of MRSA on ward 27 at RSH during September which have now been typed by the laboratory. A post infection review was held but prior to the final typing being confirmed. This has now been received and it was found that two patients had the same type (the most common type of MRSA) and one was different. The review found that there were no specific connections between the patients who were in different parts of the ward. The ward has been cleaned and regular walk rounds are carried out by the Infection Prevention and Control team with the matron and ward manager to ensure that the ward areas remain clean.

### Learning from in service pressure ulcer incidence

In October we reported that two grade two and one grade three pressure ulcers were avoidable and attributable to our care.

For the grade three pressure ulcer, preliminary findings indicate that while there is evidence that the patient declined repositioning, there is a paucity of evidence to confirm whether the appropriate care was delivered in line with guidance. The investigation is ongoing and will endeavour to provide more evidence of avoidability and learning.

In relation to the two grade two pressure ulcers:

- While good repositioning is recorded on one, there was no evidence of floating the patient's heels and the patient developed a blister on his heel

- Good repositioning chart, however there was a delay in reporting the skin damage and no clear evidence of management other than repositioning.

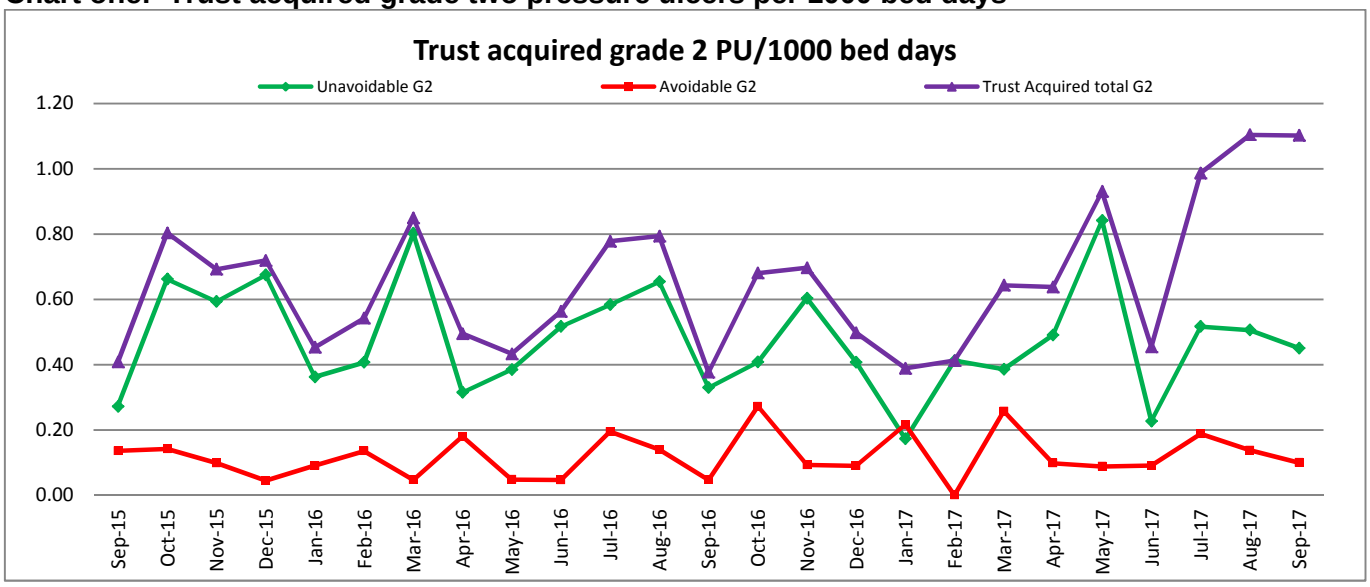
In addition there were two pressure ulcers that developed that did not meet the criteria for reporting as a serious incident and therefore will be reviewed as high risk case reviews. These are shown in the table below:

**Table one: High Risk Case Review (HRCR) Pressure Ulcers October 2017**

| | | |
|---|---|---|
| Grade 3 PU | W22SR | Transfer from UHNM with grade one pressure ulcer, despite best interventions and appropriate support, wound deteriorated to a grade two pressure ulcer, then to a grade three (7 days for deterioration). Reviewed by Tissue Viability Nurse – considered not attributable to our care. HRCR to be completed and shared with UHNM |
| Grade 3 PU | RSH/PRH ITUs | Patient admitted with moisture lesion to ED, direct transfer to ITU. Care provided within guidance, no breaches identified. Decision that unavoidable confirmed by TVN. HRCR to be completed. |

The numbers of pressure ulcers that we are reporting are shown in the table below. This indicates that the total number of grade two pressure ulcers reported has increased since June 2017 (to September 2017). There are still a number that require investigations to be carried out by the ward manager to identify whether these were avoidable.

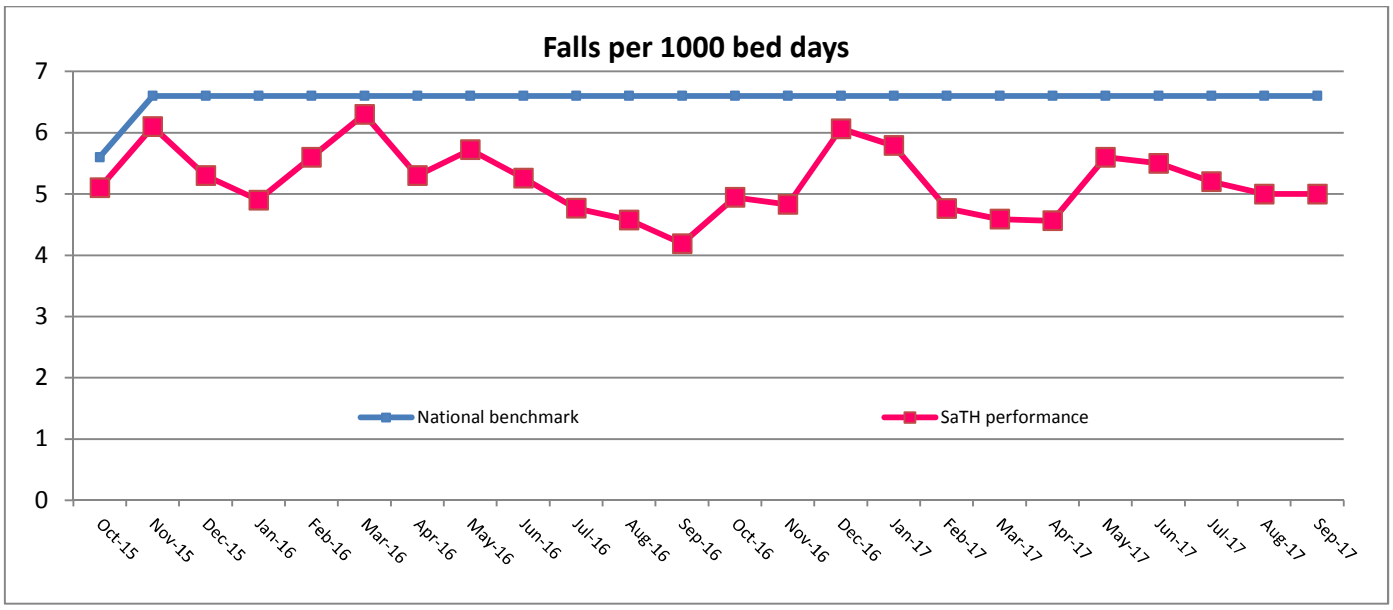
**Chart one: Trust acquired grade two pressure ulcers per 1000 bed days**



## Learning from falls

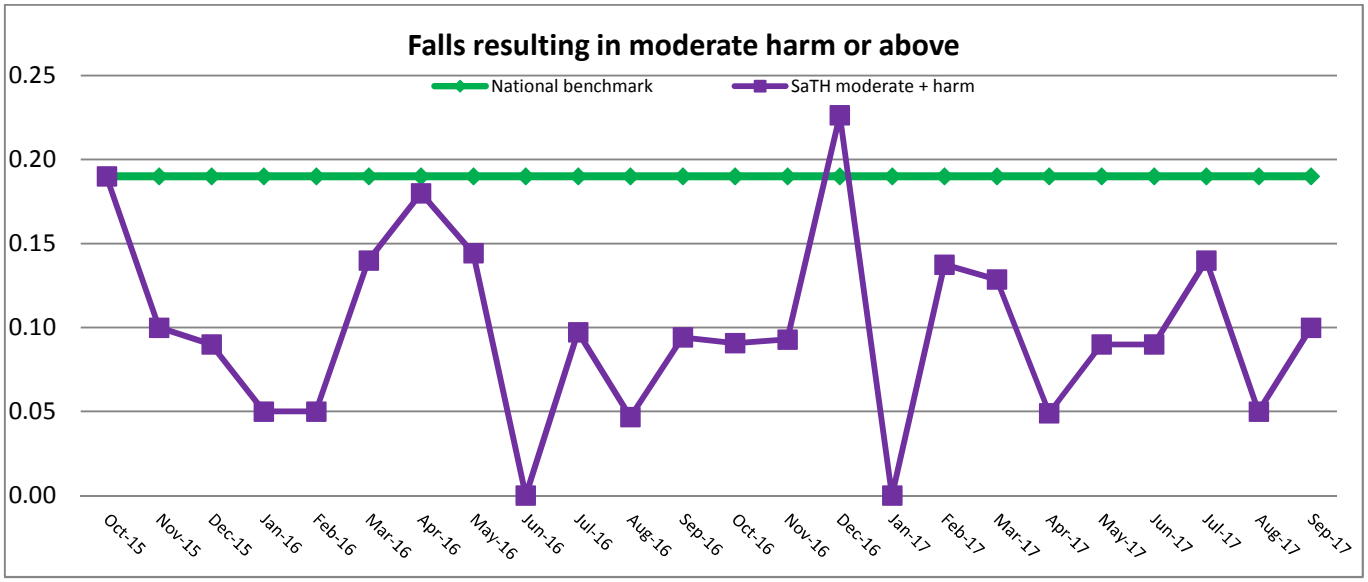
In October we did not report any falls resulting in fractures either as serious incidents or as HRCR. The Committee will receive a separate report relating to actions taken since 2011 to prevent falls in our hospitals. The chart below shows that we remain below the national benchmark for falls per 1000 bed days to September 2017.

**Table two: Falls per 1000 bed days**




The chart below shows that we also remain below the benchmark for falls resulting in moderate harm or above to August 2017.

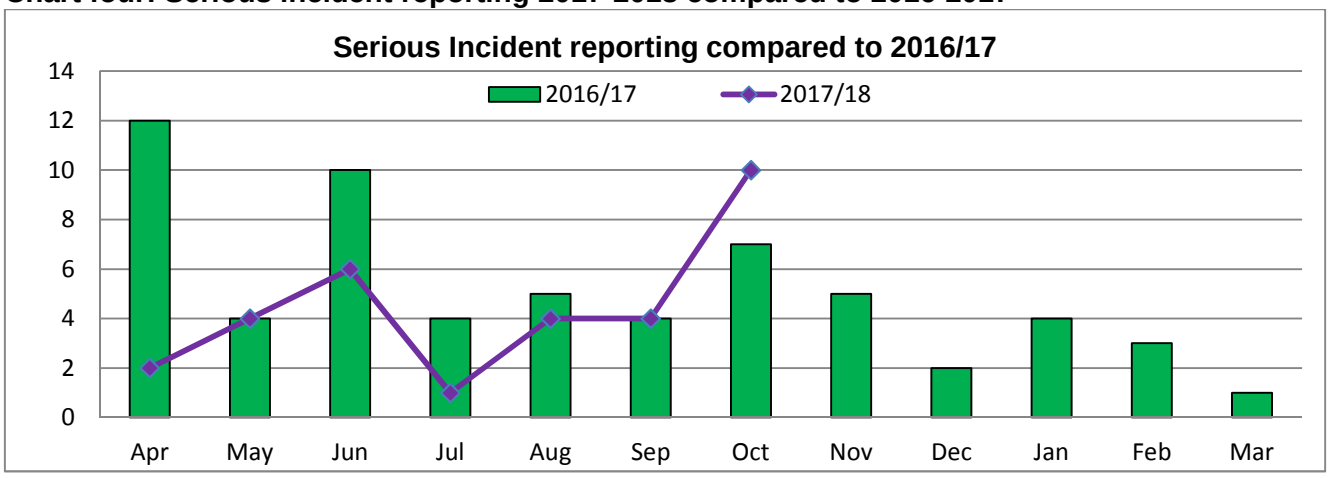
**Chart three: Falls resulting in moderate harm or above**



## Learning from moderate and serious incidents

In October 2017 we reported ten serious incidents as shown in chart four below.

**Chart four: Serious incident reporting 2017-2018 compared to 2016-2017**




The categories of incident are shown in table one below:

**Table one: Categories of incidents reported in October 2017**

| Category | Number |
|---|---|
| Delay in treatment/delayed transfer | 1 |
| Adult safeguarding | 1 (retrospective following mortality review) |
| Retained guidewire | 1 (retrospective reporting) |
| Delayed Diagnosis | 4 (two related to incidents in PRH ED, one in radiology and one in ED RSH |
| Grade 3 Pressure Ulcer | 1 |
| Complication of surgery | 1 |
| Incorrect Lens implant (Never Event) | 1 |
| **Total** | **10** |

All incidents will be investigated using the Trust processes for serious incident investigations and the reports submitted to the commissioners when complete.

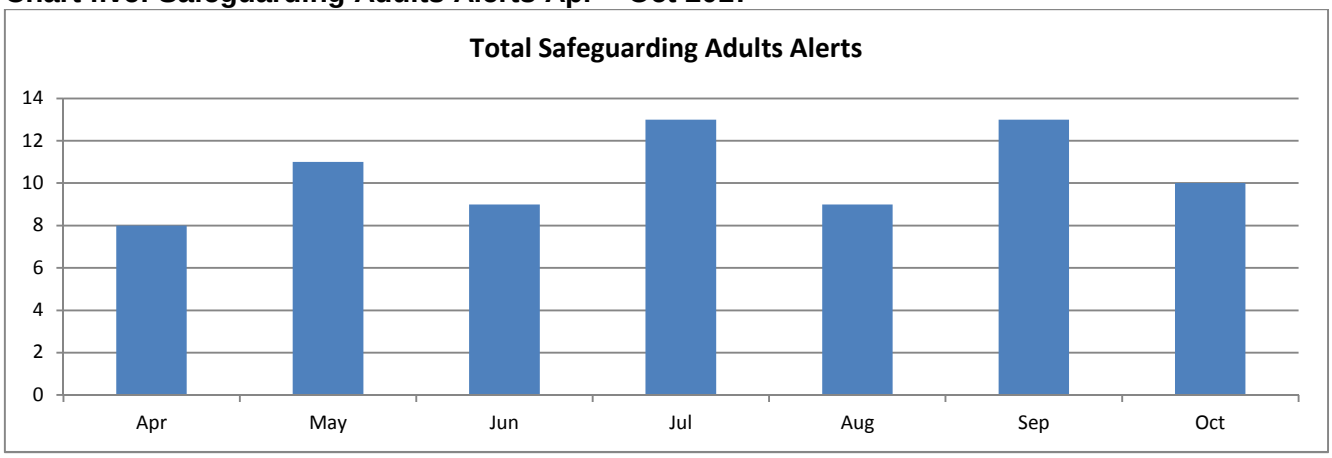
The Trust was contacted by the Healthcare Safety Investigation Branch (HSIB) to take part in a national review of Never Events, specifically around the incorrect insertion of intraocular lenses. As the Never Event we reported was the most recent reported nationally they were keen to visit us as soon as possible and have carried out a review during the week of 13 November. The team will be visiting other Trusts as part of this review and will publish their results in due course. Feedback received from the HSIB so far was that Trust staff had been open and welcoming to the team which they found extremely helpful.

**Executive Rapid Review Meeting**
The weekly reviews of moderate and severe incidents and formal complaints continues and has been agreed as an important way of triangulating concerns and identifying themes.

## Safeguarding Children, Young People and Adults

In October 2017 there were ten safeguarding alerts that involved the Trust – seven were made by the Trust against individuals or care providers and three were made against Trust services. Eight related to neglect or omission of care, one to financial issues and one potential physical assault. This compares to 13 such alerts in September 2017 and brings the total year to date to 73.

**Chart five: Safeguarding Adults Alerts Apr – Oct 2017**




There were no safeguarding concerns relating to children and young people in October 2017 that involved the Trust. We have been asked to contribute to a serious case review in Telford and Wrekin and have submitted our agency reports as requested prior to the learning event taking place in November.

We continue to train as many members of staff as possible in relation to Prevent – part of the Home Office counter terrorism strategy CONTEST. The requirement is for us to have trained 85% of appropriate staff by the end of March 2018. As at the end of October we had trained 19.6%. We have a recovery plan in place to meet this target and have identified the risk that we might not do so. We met with commissioners and NHS England in November to discuss this and make them aware of the significant effort that we are putting in to try and achieve this.

We will provide monthly updates to the committee on our progress.

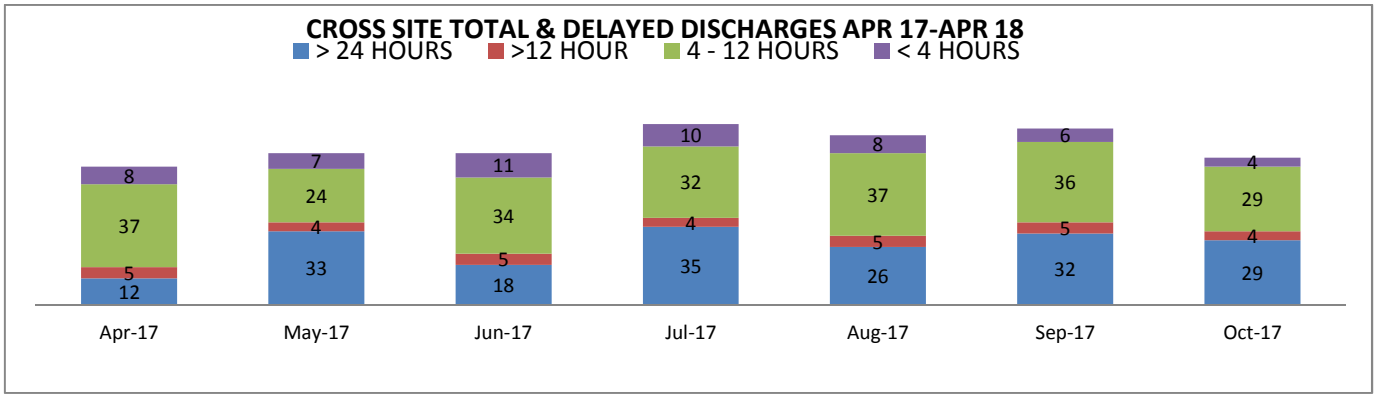
## Mixed Sex Accommodation Breaches

We continue to report delays in patients being transferred out of our intensive care areas once they are ready to be cared for on a general ward. In October the total number dropped slightly as shown in the table below.

Actions that are taken to expedite patient transfers include:

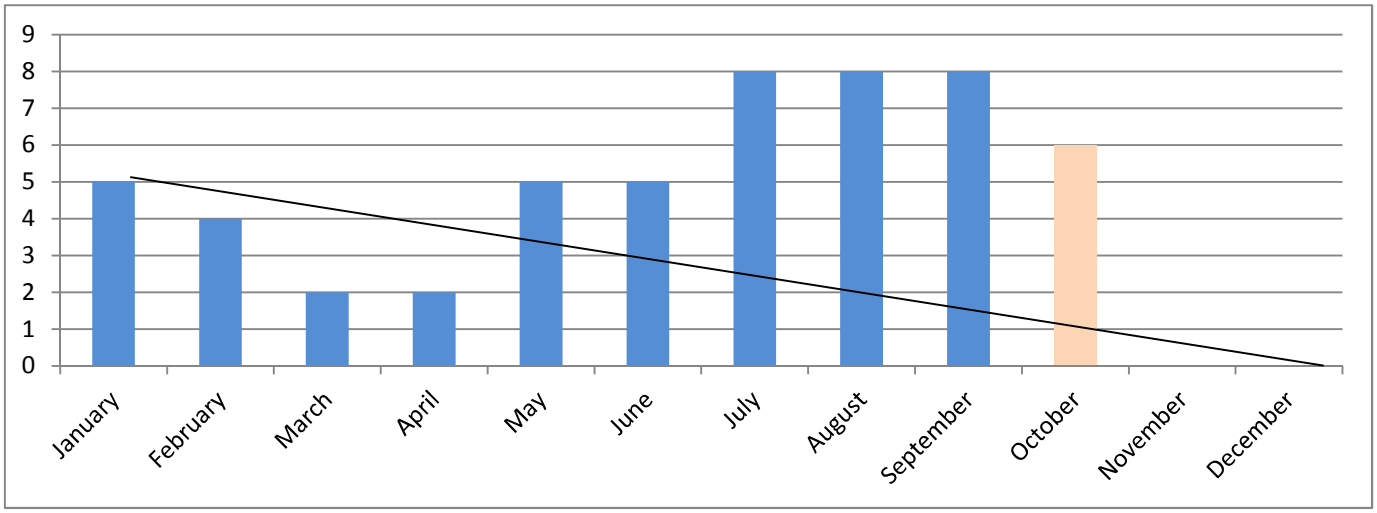
- Alerts are placed on the PSAG boards to enable wards to plan to receive patients from ITU when they can
- The matron for ITU visits all surgical areas to identify suitable wards for transfer of patients
- The Head of Capacity are informed on a daily basis of patients waiting to be transferred and these are included on the regular site reports and plans for the day.

**Chart six: Delayed Discharges from ITU**



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

**104 day breaches January 2017 onwards Trajectory of improvement** (October is a predicted figure unvalidated)




In order to achieve the recovery plan to reduce the number of patients who wait more than 104 days for cancer treatment, patients that are reaching day 63 are flagged to Operational Managers with request to confirm actions to be taken to avoid day 104 day breaches. These escalations are in addition to usual escalation procedure.

Patients that received their first definitive treatment for cancer after 104 days in September were within the following specialties: Colorectal (2), Lung (1), Sarcoma (1), Skin (2) and Urology (2).
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.

## Patient, Family and Carer Experience

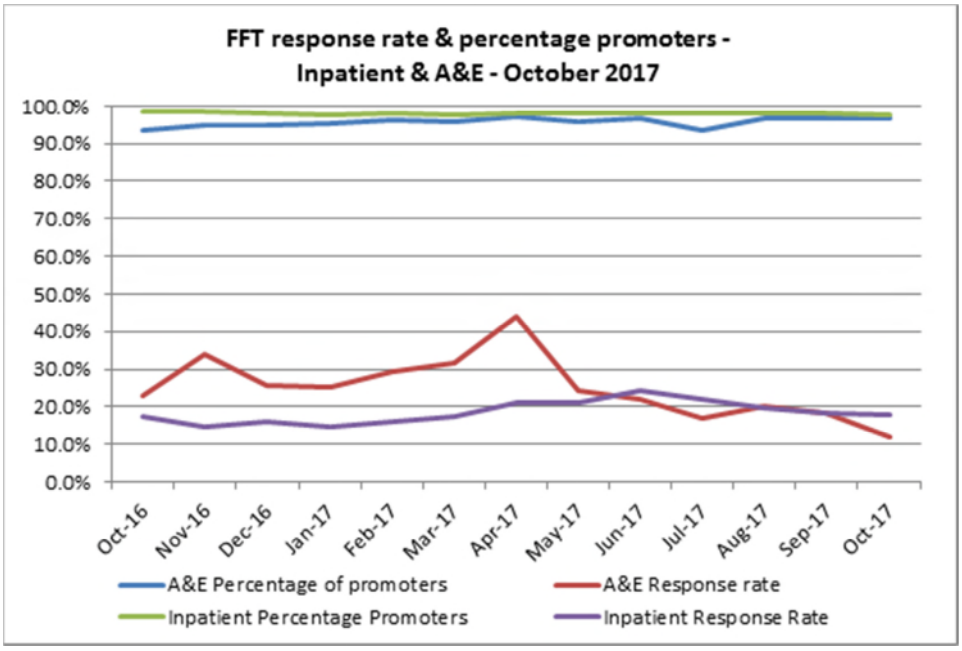
**Complaints and Patient Advice and Liaison Service (PALS).**
A total of 45 formal complaints were received in October 2017. There has been an increase in complaints about clinical care and patient care, as well as a slight increase in complaints about discharge. Complaints about staff attitude also continue to be high, but no trends have been identified within these complaints. A decrease in the complaints relating to Outpatients has been noted. A total of 115 PALS contacts were received in October; as in previous months, these relate mainly to problems with communication and appointments. Complaints are reviewed on a weekly basis at the Rapid Review meeting.

**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 96.1%. This was a slight decrease on September's results. Individually, Maternity saw an increase in patients who would recommend, however Inpatients, A&E and outpatients all decreased compared to last month.

The overall response rate was 15% which was a decline on September's response rate of 18.3%. Individually, Maternity birth saw an increase on their response rate for the second month running; however A&E and inpatients saw a decline in the percentage of completed FFT cards in October.

| | Percentage Promoters | Response Rate |
|---|---|---|
| **Maternity overall** | 99.5% | 11.2% (Birth only) |
| **A&E** | 96.6% | 12% |
| **Inpatient** | 97.8% | 17.9% |
| **Outpatients** | 94.5% | NA |




North Midlands Comparative FFT Data September 2017 is shown below to indicate the position of the Trust in relation to our reference acute Trusts:

| Trust Code | Trust Name | Total Responses | Total Eligible | Response Rate | Percentage Recommended | Percentage Not Recommended |
|---|---|---|---|---|---|---|
| England (including Independent Sector Providers) | | 230,468 | 910,933 | 25.3% | 96% | 2% |
| England (excluding Independent Sector Providers) | | 213,492 | 866,467 | 24.6% | 96% | 2% |
| Selection (excluding suppressed dat | | 14,122 | 57,144 | 24.7% | 97% | 1% |
| RK5 | SHERWOOD FOREST HOSPITALS NHS FOUNDATIC | 2,001 | 5,393 | 37.1% | 99% | 0% |
| RX1 | NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUS | 3,807 | 10,565 | 36.0% | 97% | 0% |
| RL1 | THE ROBERT JONES AND AGNES HUNT ORTHOPA | 342 | 1,193 | 28.7% | 99% | 0% |
| RJE | UNIVERSITY HOSPITALS OF NORTH MIDLANDS NI | 2,712 | 10,930 | 24.8% | 97% | 1% |
| RFS | CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATIC | 912 | 3,934 | 23.2% | 97% | 1% |
| RXW | SHREWSBURY AND TELFORD HOSPITAL NHS TRUS | 1,293 | 7,043 | 18.4% | 98% | 0% |
| RTG | DERBY TEACHING HOSPITALS NHS FOUNDATION | 2,481 | 13,968 | 17.8% | 97% | 1% |
| RJF | BURTON HOSPITALS NHS FOUNDATION TRUST | 574 | 4,118 | 13.9% | 96% | 1% |

## Section three: Recommendations for the Committee

**The Quality and Safety Committee is asked to:**

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