The Shrewsbury and Telford Hospital NHS Trust

Paper 11

Recommendation ☐ **DECISION** ☑ **NOTE**	**The Trust Board is asked to:** • **Seek Assurance** in relation to key quality indicators as at the end of December 2017 and approve the assurance and improvement process • **Consider** the actions being taken where performance requires improvement • **Question** the report to ensure appropriate assurance is in place
Reporting to:	**Trust Board**
Date	08 February 2018
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 December 2017. Key points to note: The Trust is compliant with a number of quality measures however: • Although we have exceeded our target of no more than 25 C Diff reported incidents in the year to date, not all have been associated with a lapse in care. We await the Qtr 3 panel decisions related to this. • During this quarter we have not been 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 and one episode of a breach in our Day Surgery Unit in Shrewsbury. • 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. • Detail is given in the report relating to how we care for additional patients during times of increased escalation. The Board receives a separate paper relating to staffing.
Sponsoring Director	Deirdre Fowler, Director of Nursing and Quality
Author(s)	Dee Radford, Associate Director of Patient Safety
Recommended / escalated by	None
Previously considered by	**No meeting has considered this report**
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	RR561 RR951

The Shrewsbury and Telford Hospital NHS Trust

Framework	RR1185
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	○ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

The Shrewsbury and Telford Hospital NHS Trust

Paper 11

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Quality Governance Report Quarter Three 2017-2018

October - December 2017

Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of December 2017 (Month nine for 2017/2018) and also for the third quarter of the year as a whole. The report will provide assurance to the Trust Board that we are compliant with key performance measures and where we are not, recovery plans are in place to improve our current position.

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 contracts.

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Section one: Our Key Quality Measures – how are we doing?

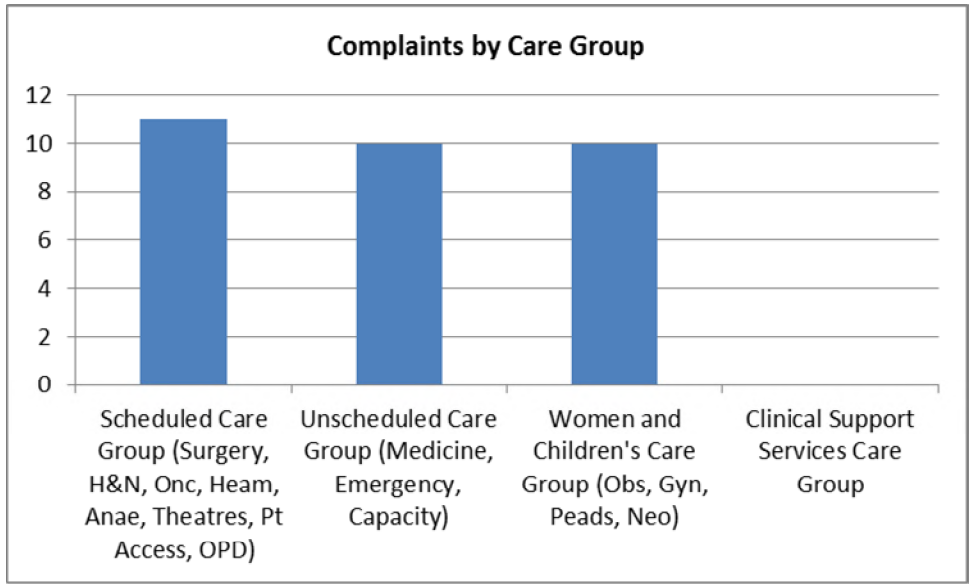
Measure	Year end 16/17	Jan 17	Feb 17	Mar 17	April 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
Clostridium Difficile infections reported	21	0	1	3	3	4	3	1	3	1	3	2	6	26	2	25
No lapse in care upheld by panel					1	1	0	1	0	1				4	None	None
Lapse in care upheld by panel					3	1	1	2	1	1				9	None	None
MRSA Bacteraemia Infections	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Bacteraemia Infections	9	0	2	1	0	1	1	1	6	2	3	2	4	20	None	None
E. Coli Bacteraemia Infections	31	0	3	1	1	1	1	1	3	3	1	4	2	17	None	None
MRSA Screening (elective) (%)	95.2	95.0	95.8	95.5	95.5	95.4	95.9	95.9	95.6	95.6	95.5	96.4	96.0%	96.0%	95%	95%
MRSA Screening (non elective) (%)	94.4	95.0	94.2	95.2	95.2	96.3	95.0	96.1	96.1	97.0	97.2	95.3	95.5%	95.5%	95%	95%
Grade 2 Avoidable	35	5	0	6	2	2	2	4	2	1	2	0	1	16	0	0
Grade 2 Unavoidable	112	4	9	9	10	19	5	11	9	4	2	3	7	70	None	None
Grade 3 Avoidable	9	0	0	0	0	0	1	0	1	2	1	3	0	8	0	0
Grade 3 Unavoidable	9	1	4	1	0	1	2	4	3	0	2	1	1	14	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	1	1	0	0	0	1	0	0	0	0	0	0	1	None	None
Falls reported as serious incidents	5	0	0	0	0	0	1	0	1	0	0	0	0	2	None	None
Number of Serious Incidents	61	4	3	1	2	4	6	1	4	4	10	7	3	41	None	None

Measure	Year end 16/17	Jan 17	Feb 17	Mar 17	April 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Year to date 2017/18	Monthly Target 2017/18	Annual Target 2017/18
Never Events	5	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
Harm Free Care (%)	94.17	95.49	92.54	93.9	94.31	94.81	93.48	91.15	92.09	89.91	90.86	90.45	89.06	89.06	95%	95%
No New Harms (%)	97.94	98.62	96.77	97.16	98.47	98.18	97.49	95.24	96.59	96.83	96.34	94.84	94.0	94.0	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.66	95.34	95.96	95.6	95.5	95.4	95.2	95.4	96.4	95.7	95.5	95.1	95.1	95%	95%
MSA including ITU discharge delays>12hrs	361	27	33	30	26	17	37	39	31	37	33	39	17	276	None	None
Complaints (No)	424	47	45	49	44	56	42	61	50	45	45	61	31	435	None	None
Friends and Family Response Rate (%)	23.8%	20.0	22.0	23.8	32.2	22.5	23.3	19.5	20.1	18.3	15%	14.3%	12.3%	12.3%	None	None
Friends and Family Test Score (%)	96.6%	96.6	96.7	96.6	97.1	96.7	97.0	96.2	97.1	97.2	96.1	96.8%	97.4%	97.4%	75%	75%

Section Two – Patient Experience

Complaints and Patient Advice and Liaison Service (PALS) Update –

There is a separate Quarterly report in relation to Complaints and PALS. Therefore the summary below shows complaints received and closed in December 2017.

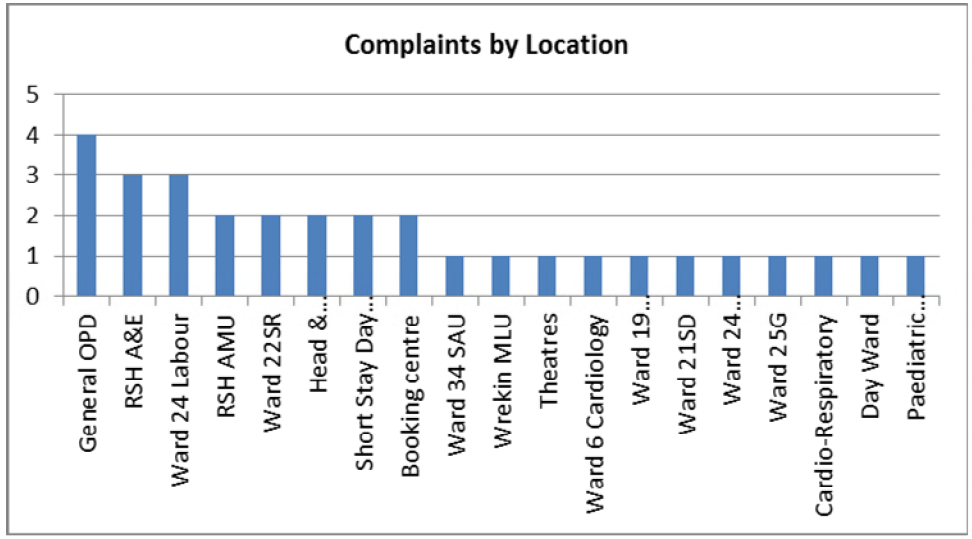


New Complaints

31 formal complaints were received December. This decrease is thought to be due to the Christmas period and we are anticipating an increase in January.

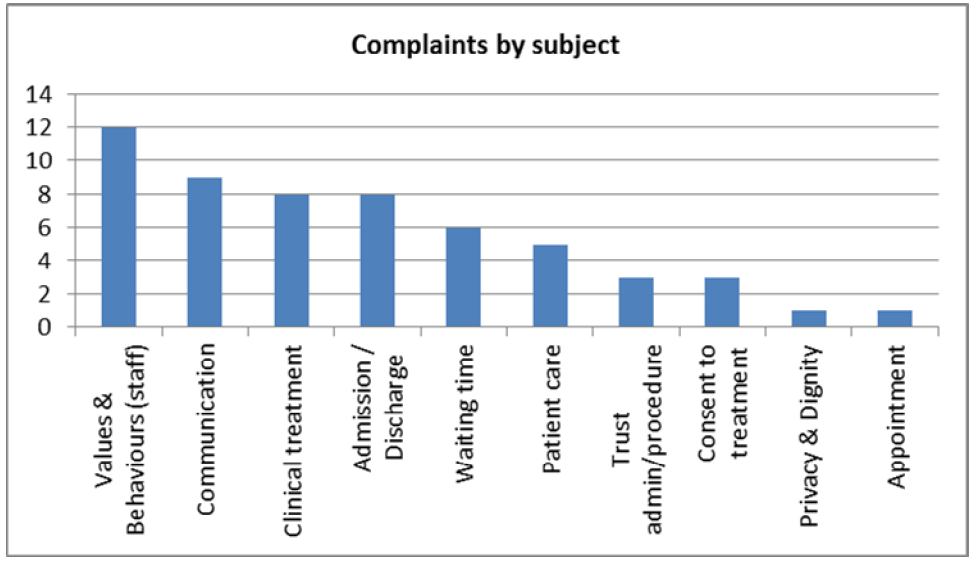
All complaints received an acknowledgement within three working days.

Complaints are reviewed on a weekly basis at the Executive Rapid Review meeting along with moderate and severe incidents reported to ensure that any potential incidents alerted as complaints are addressed appropriately.



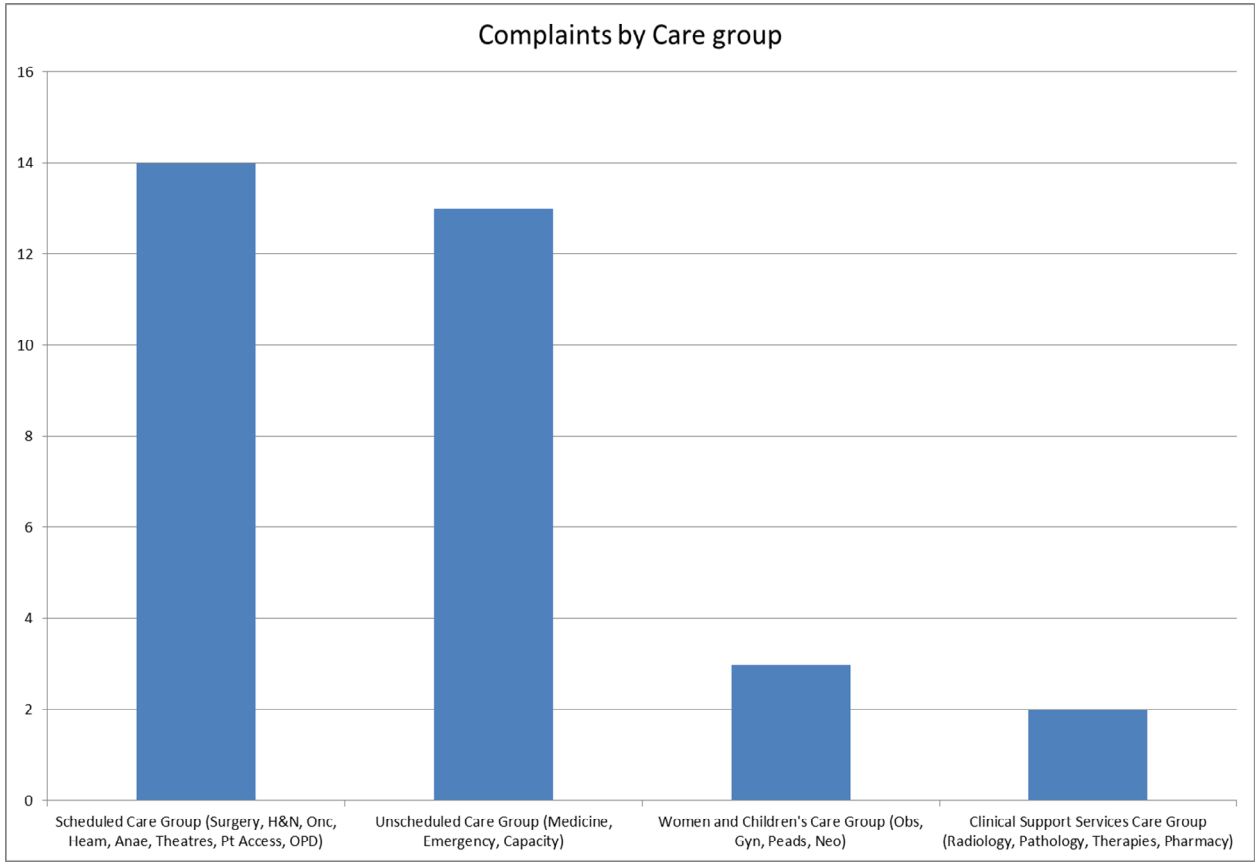
Top Locations of Complaints

A&E at RSH and Outpatients received the highest number of complaints; this is linked to the high levels of activities. There were also three complaints relating to the labour ward and management of labour; this will be monitored to see if further complaints are received in January.



Complaints by Subject

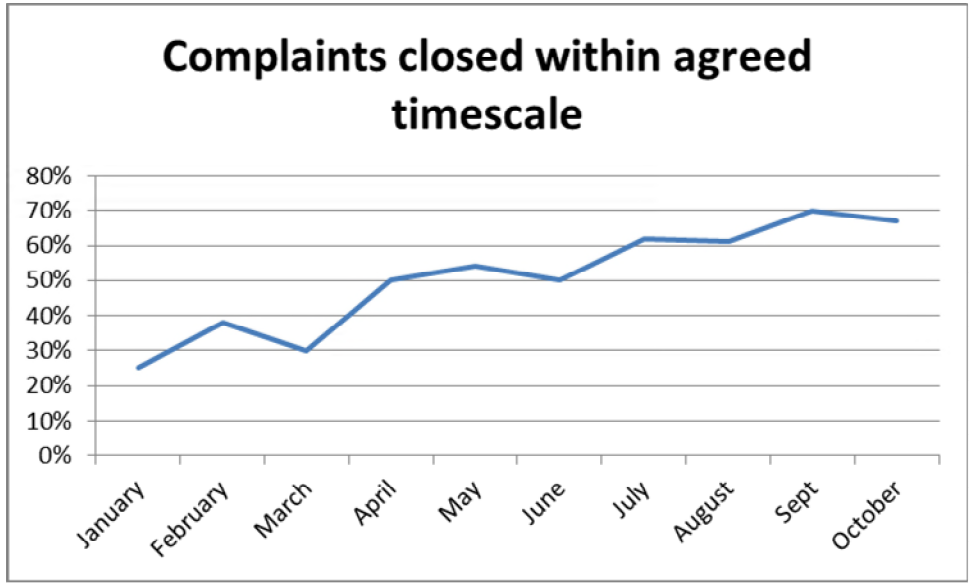
There continues to be a high number of complaints about staff attitude. This data will continue to be shared with the Workforce Directorate to feed into their work. In addition copies of responses relating to staff attitude of nursing/midwifery and medical staff are now being copied to the Director of Nursing and/or Medical Director for them to take action as needed.



Closed Complaints

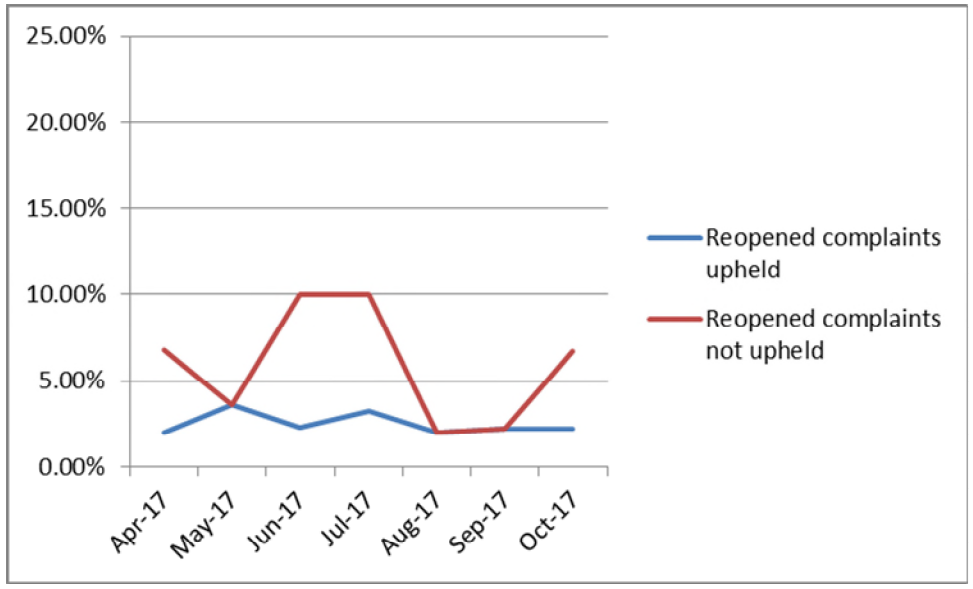
32 complaints were closed in December 2017.

The complaints team are continuing to work with Care Groups however winter pressures have resulted in delays in responses from care groups.



Complaints closed within agreed timescale

The number of complaints closed within timescale continues to increase overall; however as stated above, there has been an increase in the number of late responses received from the Care Groups – this is due to the current operational pressures on the Trust and it is anticipated that the response rates for November will be lower than those of September and October.



Reopened complaints

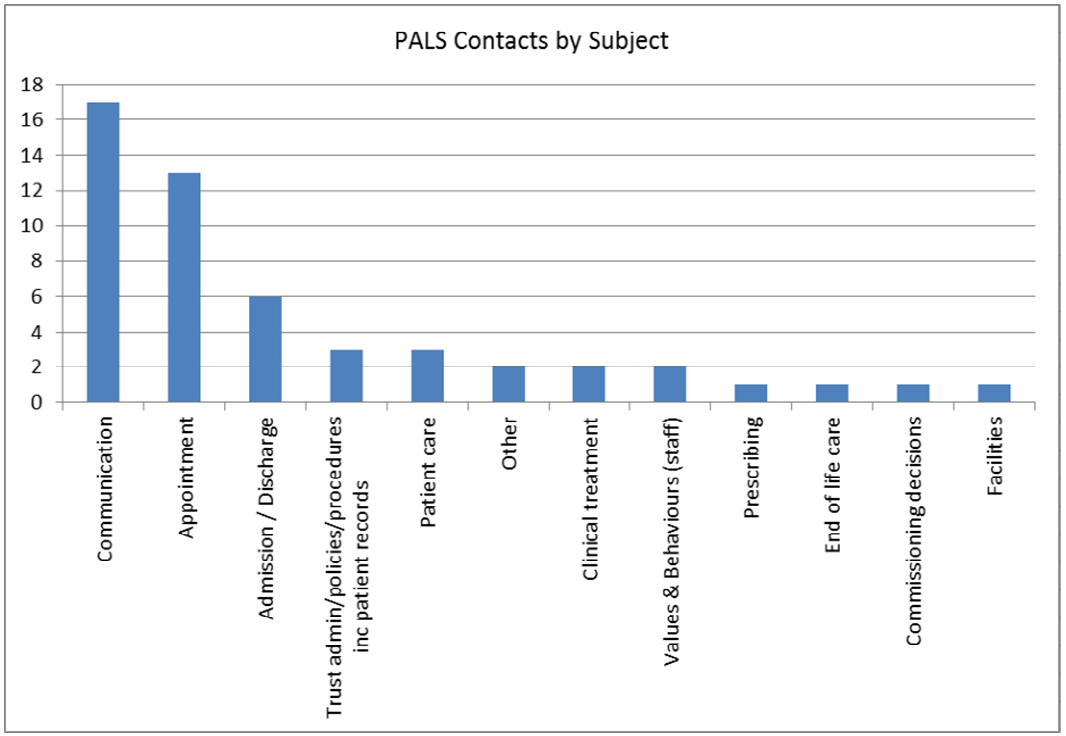
There were five complaints reopened in December. These related to complaints from November 2016, June 2017 and October 2017. Of these, one was upheld (i.e. the response had not fully answered all questions) and four were not upheld (i.e. the response had addressed all the questions, but the complainant wished to raise further issues not included in the original complaint or did not accept the findings of the investigation). The graph sets out the re-opened complaints from April 2017.

Parliamentary & Health Service Ombudsman (PHSO)

The Trust has not been advised of any new referrals or any closed cases by the Parliamentary and Health Services Ombudsman in December 2017.

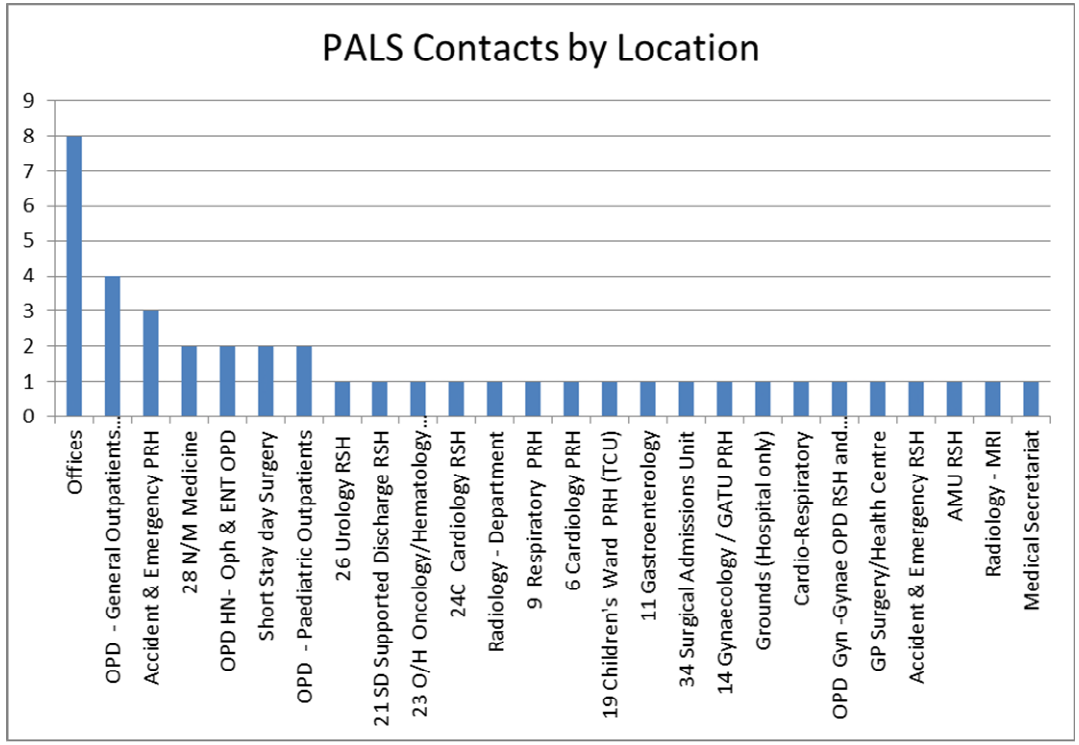
Patient Advice and Liaison Service (PALS)

The Trust received 68 PALS contacts in December 2017.



PALS Contacts by Subject

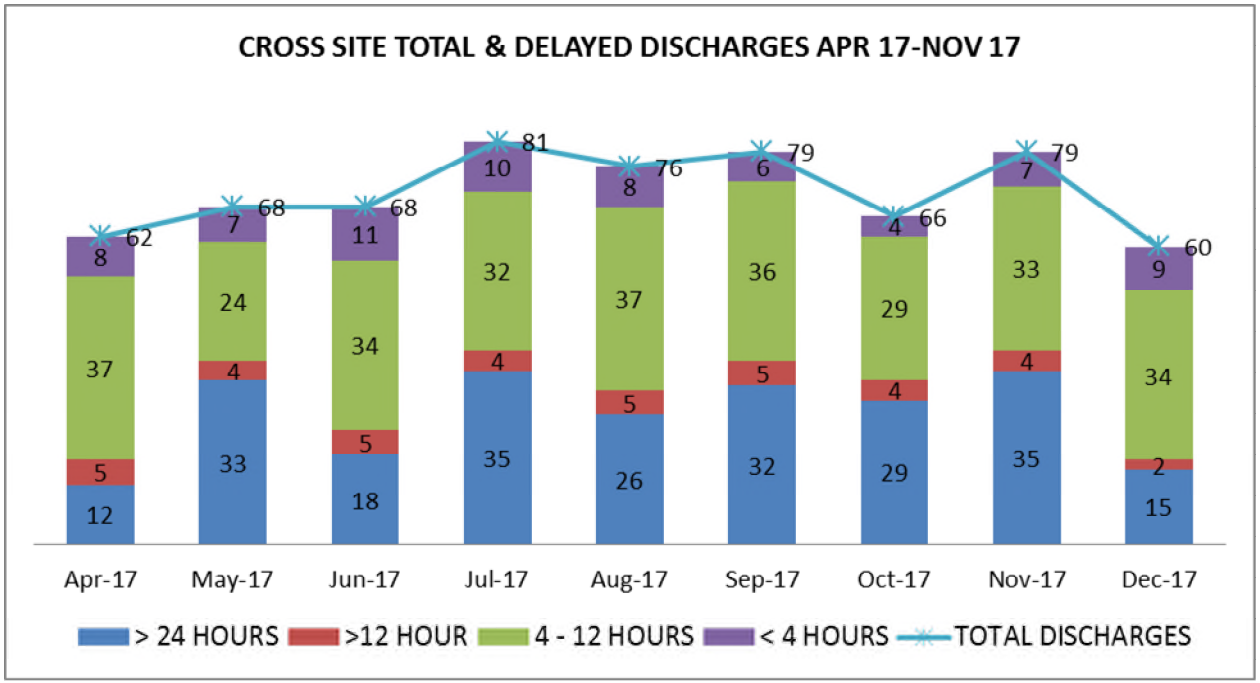
Contacts with PALS continue primarily to be about communication and problems with appointments.



Top Locations for PALS Contacts

In line with the main subjects, most PALS contacts related to the bookings office or outpatients.

Mixed Sex Accommodation Breaches (MSA)



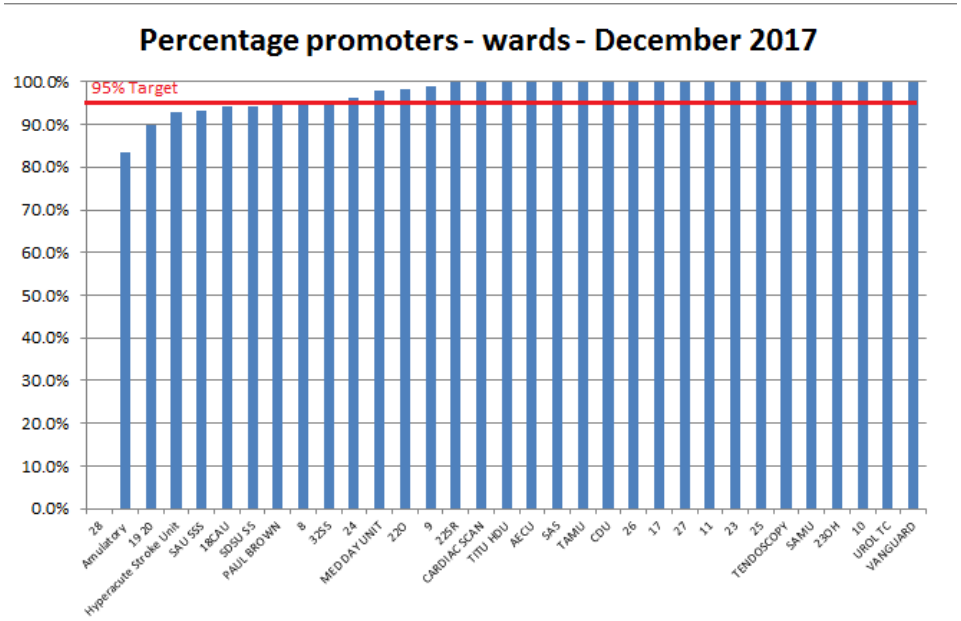
We continue to record patients waiting for more than four hours to be transferred from the high dependency areas (HDU) once they are well enough to do so.

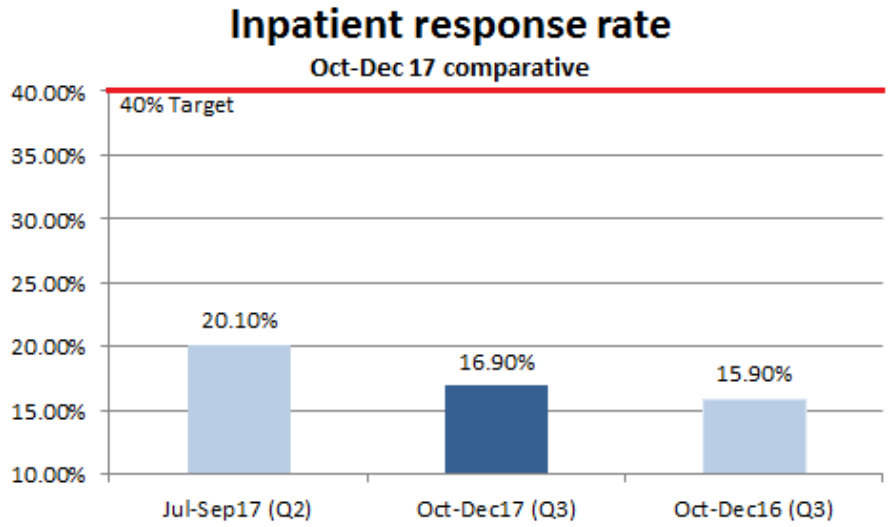
In December, across both sites, 15 patients waited for more than 24 hours to be transferred from HDU, 13 of them at RSH, 34 waited between four and 12 hours and nine less than four hours. In total during the month 51 patients across both sites experienced a delay greater than four hours.

There was one breach of MSA in the Day Surgery Unit at RSH during a period of escalation. The breach lasted 90 mins and affected four patients none of whom came to harm.

The incident was reported to the CCG and via UNIFY. A root cause analysis was completed to identify actions required to prevent this happening again,

Friends and Family Test Feedback (FFT)





Inpatient Summary

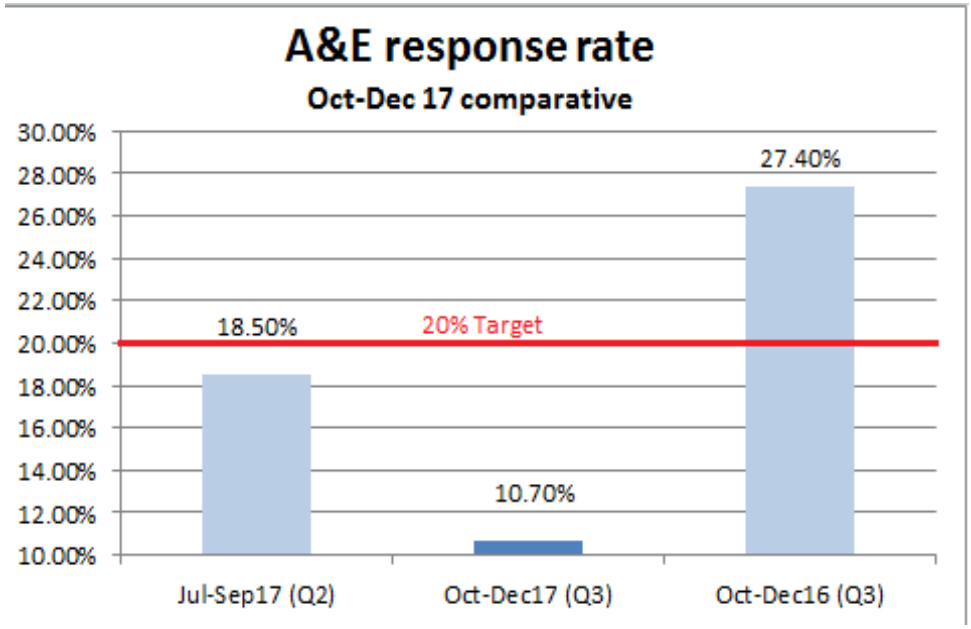
- The most recent National Inpatient promoter figures available are for Nov17 at 96%. SaTH exceeded this with a rate of 97.9% for inpatients in Nov17. SaTH has remained consistently high reaching 98% in Dec17.
- The majority of inpatient areas are achieving the Trust target of 95% for patients who would recommend the ward (percentage of promoters).
- The National response rate for inpatients in Nov17 was 25.5% which is higher than SaTH's response rate of 17.2%.
- This quarter (Oct-Dec17) has seen a decreased response rate compared to Quarter 2 of 2017 (Jul-Sep17). It has however improved compared to this time last year (Quarter 3, Oct-Dec16).
- Care groups where the response rate has fallen have been asked to produce action plans and an improvement trajectory.

Outpatients

SaTH has seen a steady increase across Quarter three in the percentage promoters in Outpatients. 94.5% in October 2017, 95.8% in November and 96.3% in December 2017.

These figures compare favourably to the available national results which were 93.7% in October and 93.9% in November 2017.

AE	TARGET	Oct-17	Nov-17	Dec-17
SaTH Response Rate	>=20%	12.0%	10.8%	9.3%
SaTH % Recommenders	>=95%	96.6%	97.1%	97.5%
National Response Rate	No Target	12.7%	12.9%	
National % Recommend	No Target	87%	87%	



A&E Summary

- The most recent national percentage of promoters figure for A&E is Nov17 at 87%, which SaTH exceeded with 96.8%. Although SaTH scored slightly lower in Oct17, the figure of 93.6% gave a ranked position of 13 out of 139 trusts.
- Results remain consistently high in Dec17 as SaTH reached 97.5%.
- The National response rate for A&E in Nov17 was 12.9%, which was slightly higher than SaTH's 10.8% response rate for Nov17.
- Overall, the 10.7% response rate for Quarter 3 doesn't reach the SaTH 20% target. It is also a decline on the previous Quarter 2 (Jul-Sep17) as well as results this time last year (Quarter 3, Oct-Dec16).
- We have introduced volunteers into ED who will have as part of their role the promotion of completing FFT cards.
- The patient experience apprentice from clinical audit team has been tasked with assisting the worst performing wards to improve their response rates.
- A review of the ED FFT card narrative will be reported in next month's report.

Maternity

- The most recent National percentage of promoters figures for Maternity was Oct17 which was 95.7%. It is therefore encouraging to see SaTH reach 99.5% in the same month.
- The response rate for Maternity only includes 'birth'. SaTH was 11.2% in Oct17 and more recently 4.3% in Dec17. These response rates remain considerably lower than the National birth response rates; the most recent figure available being Oct17 at 23.3%.

Healthwatch Shropshire published their report of the announced visit that they had carried out in October 2017 on Ward 22 TO at RSH. The purpose of the visits is to find out if patients are treated with dignity and respect, have privacy and that staff respond appropriately to meet care needs, including preparation for discharge. In summary the report was positive overall with the observations looking at the following domains , safety , engagement and general care. On the day of their visit the ward seemed clean and well-ordered but cramped which meant it did not feel like a very relaxing environment. The lack of space appears to be due to the number of patients but also the design and layout of the ward. They saw most staff treating patients with kindness, patience and sensitivity.

Healthwatch Shropshire are planning a further external announced assurance visit to ward 21 in December 2017 , a summary of the report will follow in due course but has not yet been received.

Additional Patients on our wards and ED Quality Target

We continue to have to admit additional patients to our wards at times of high escalation within the hospitals. We would only do this when other options have been used – for example, the use of escalation areas– which we would always use first. We have an updated Hospital Full Policy that clearly outlines where patients should be placed in times of extreme pressure. Whilst we have plans in place this does not prevent surges of activity in our Emergency Departments (EDs) and for this we must ensure that our patients are safe and well cared for until they can be placed in a more appropriate area.

Additional patients on wards remains an issue within our hospitals, patients are risk assessed and the most suitable patient will be designated as an additional patient on a ward. The additional patient is recorded and a Datix is completed to maintain a record of the number of patients that are additional on our wards and the length of time each ward has an additional patient. Matron visits the areas and apologises to each patient who is additional on the ward and seeks to assure staff, if extra staff are needed to support the ward in a range of activities this is sought. The Clinical and Operational teams work closely to move patients through the hospital to prevent the occurrence of additional patients, discharges daily are the key to maintaining flow and coping with surge capacity. Support from community colleagues and strengthened internal processes are vital to the reduction of the need for additional placement of patients in wards.

As part of the SAFER bundle, the Trust has designed, developed and implemented a process which has been supported by NHSi to review stranded patients which commenced In November last year. The definition of a stranded patient is anyone with a length of stay over six days. Originally the process commenced in Unscheduled care and has been further roll out to include Scheduled care wards and is now taking place on both sites on a weekly basis. Both care groups have adopted slightly different approaches due to the scale of the number of patients that fall into this category and following feedback from NHSi, the process have continued to develop, and currently all patients that fall into the 21 day plus length of stay are reviewed weekly by a senior clinician and actions taken to help expedite the patient journey. Weekly any patients that the reviewers feel are not progressing or need to be highlighted as complex are presented to the triumvirate. From this, patients are able to be escalated for further assistance in unblocking areas of concerns. This process has not only help to reduce the number of patients who are by definition ‘super stranded’ , it has also provided an opportunity to share good practice and highlight other areas which need some dedicated time and support to progress, or further service development with our partners e.g. community IV therapy service. Going forward, whist the stranded patient review process is working, impact has

been small, and further work is required to help adapt the process, to look at the whole of the patient journey a beneficial addition would be doctor peer review of patients with a length of stay of over 45 days plus.

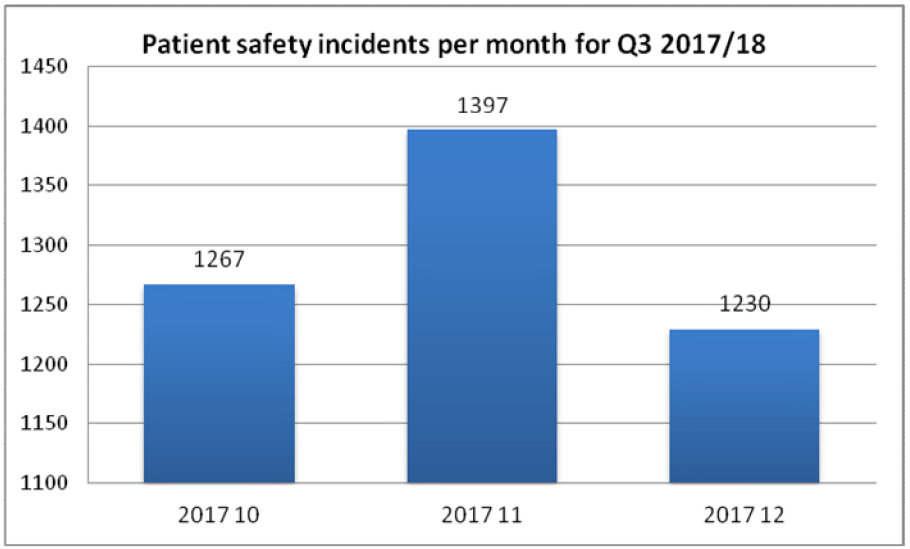
We know that patients wait more than four hours for treatment within our emergency departments. When the departments are particularly busy patients can be asked to wait on trolleys in the corridor rather than in cubicles. To ensure we are doing all we can to keep patients safe we undertake a clinical risk assessment on each patient waiting in ED for longer than four hours, this includes vital signs, comfort, risk of pressure areas and ensuing patients have a their nutrition and hydration needs met. Whilst we recognise that it is not ideal for patients to be situated in ED corridors we continue to maintain their needs, privacy and dignity and safety. We undertake audit to ensure that this is in place.

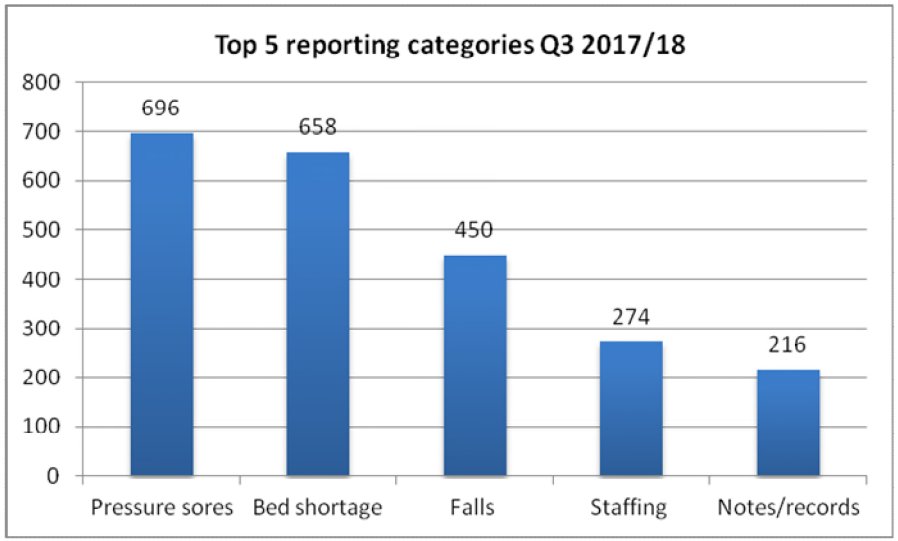
We make sure that we have a nurse that can take handover from the Ambulance Crews. The Ambulance Trust has provided a Hospital Ambulance Liaison Office (HALO) who works in ED along with the ambulance handover nurse to ensure that this process runs smoothly and patients are cared for appropriately.

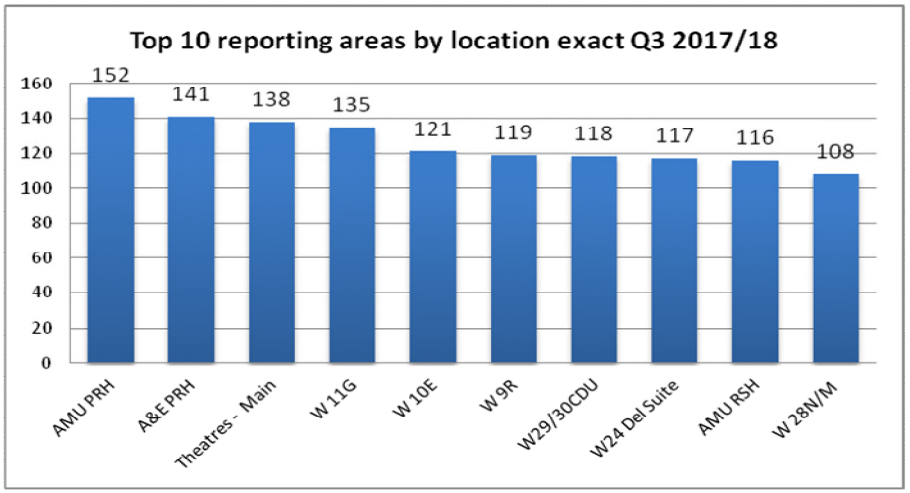
Volunteers have visited the ED to survey patients who have waited more than four hours, they were asked specifically if the care they received was the kindest and safest. The report will be available next month. Additional patients on five wards across both sites were surveyed to determine if their care had been the safest and kindest. This report will be available next month.

Section Three – Patient Safety

All Patient Safety Incidents







Patient Safety Incidents

A total of 3894 patient safety incidents were reported in Qtr 3 2017-2018 across the Trust. This compares to 2957 in the same quarter of 2016-2017. It is an increase from the 3504 reported in Qtr 2 of 2017-2018.

Top Five Reporting Categories/Top Ten Areas

It should be noted that of the 698 pressure ulcers reported, 470 were present on admission, 94 were skin conditions other than pressure ulcers, meaning that 134 potential pressure ulcers were reported as having occurred in our care. Following review and validation by the ward managers and, if required, the Tissue Viability Team, this number will reduce.

Patient safety incident management during Q3 2017/18	In holding area, awaiting review	Being reviewed	Awaiting final approval	Final approval	Total
Unscheduled Care Group (Medicine, Emergency, Capacity)	344	107	553	965	**1969**
Scheduled Care Group (Surgery, H&N, Onc, Heam, Anae, Theatres, Pt Access, OPD)	169	124	464	502	**1259**
Women and Children's Care Group (Obs, Gyn, Peads, Neo)	37	70	81	311	**499**
Clinical Support Services Care Group (Radiology, Pathology, Therapies, Pharmacy)	14	8	69	46	**137**
Resources Directorate (Estates, Facilities,Finance, IT,)	5	2	0	11	**18**
Corporate Governance Directorate (Legals, Security, H&S, Assurance, Gov, R&D)	8	0	1	0	**9**
Ambulance/ Patient first	0	0	2	0	**2**
Quality & Safety Directorate (Pat Safety, Pat Services, Infection Control)	0	0	0	1	**1**
Totals:	**577**	**311**	**1170**	**1836**	**3894**

The table above shows the detail relating to the status of the incidents that have been reported in the Quarter. The Trust Incident Reporting Policy requires managers to whom the incidents have been reported (the handler of the incident) to review and close the incident within specified timescales depending on the severity of the harm that may have occurred. Final approval is a process by which the relevant member of the Patient Safety Team reviews the actions and ensures that the Datix record is correct.

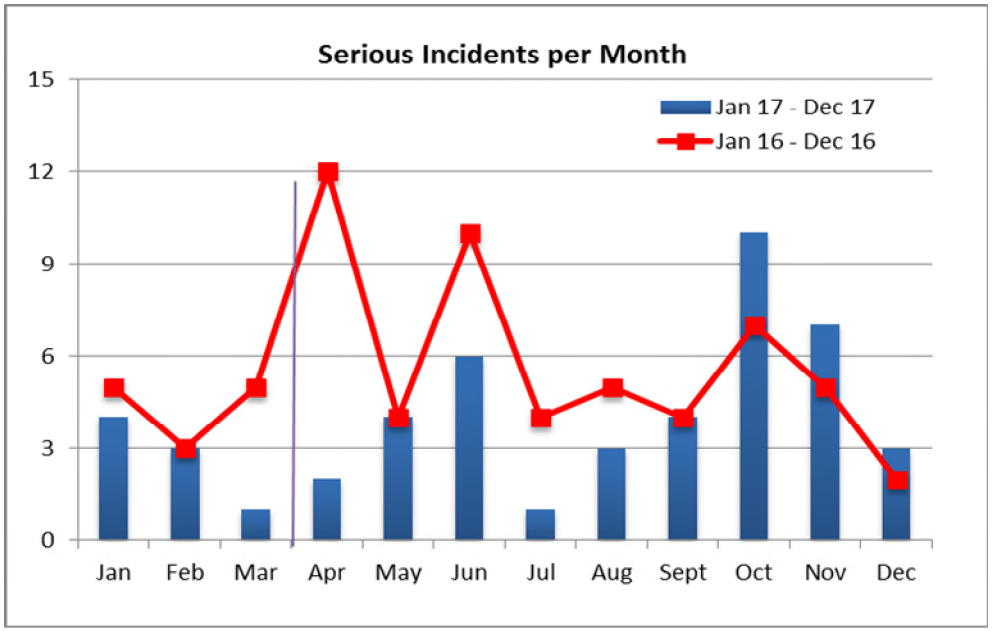
The Executive Rapid Review Meeting has met weekly since early September. The aim of the meeting is to provide assurance that immediate actions are taken in relation to serious and moderate incidents (clinical and health and safety) and complaints about patient care and that themes are identified and addressed. Also the group is to ensure that lessons to be learned are identified and allocated for action.

Care Group Heads of Nursing are required to attend as are the Patient Safety Advisors. The Heads of Nursing are to ensure that learning identified each week is shared through the quality processes within the care groups. Learning points that have been identified so far include ensuring that the requirements of the Duty of Candour have been fulfilled and the importance of reviewing, acting upon and closing Datix incidents within the timescales in the Incident Reporting Policy.

Additionally this group is considering the High Risk Case Reviews (HRCR) and serious incidents reported by the Trust to get an overview of incidents that are occurring, the themes that are emerging and actions that can be taken and shared

Serious Incidents Reported in Quarter Three 2017-2018

Type of Incident	Care Group	Date of incident
October:		
Delayed Treatment	USCG	Oct 2017
Vulnerable Adult	USCG/SCG	May 2017
Surgical Procedure	SCG	Sep 2017
Delayed Diagnosis	USCG	Sep 2017
Delayed Diagnosis	USCG	Oct 2017
Grade 3 Pressure Ulcer	USCG	Oct 2017
Surgical procedure	SCG	Oct 2017
Never Event	SCG	Oct 2017
Delayed Diagnosis	Support Services	Oct 2017
Delayed Diagnosis	USCG	Oct 2017
November:		
Other (Ophthalmology)	SCG	Sep 2017
Grade 3 Pressure Ulcer	USCG	Oct 2017
	SCG	Sep 2017
Obstetric (affecting baby)	W&C	Nov 2017
Grade 3 Pressure Ulcer	SCG	Feb 2017
Grade 3 Pressure Ulcer	USCG	Nov 2017
IG Breach	SCG	Nov 2017
December:		
Obstetric (mother only)	W&C	Dec 2017
Obstetric (affecting baby)	W&C	Dec 2017
Sub-optimal Care	SCG	Dec 2017
TOTAL		**20**



Serious Incident (SI) Reporting Status
The table below shows that there are 29 incidents open to investigation. Of these six have agreed extensions with commissioners due to complexities or factors affecting capacity to complete the investigation. There are eight SIs which have breached the external deadline due to a variety of internal and external factors. Progress on these is being managed via weekly Exec Rapid Review to ensure resolution as soon as possible.

Overall, 13 incident investigations have been completed with a request sent to commissioners to close them on the StEIS system; of the 18 incidents that remain open three require removal following evidence found that they did not meet the criteria of an SI.

Incident Status at 15 January 2018

	New Incidents for Q2	20
	Incidents being investigated	29
	Out of internal deadline (excludes external deadline & RCAs with extensions)	5
	Out of external deadline with CCG/CSU (excludes RCAs with extensions)	8
	CCG/CSU have been asked to close/remove incident	13

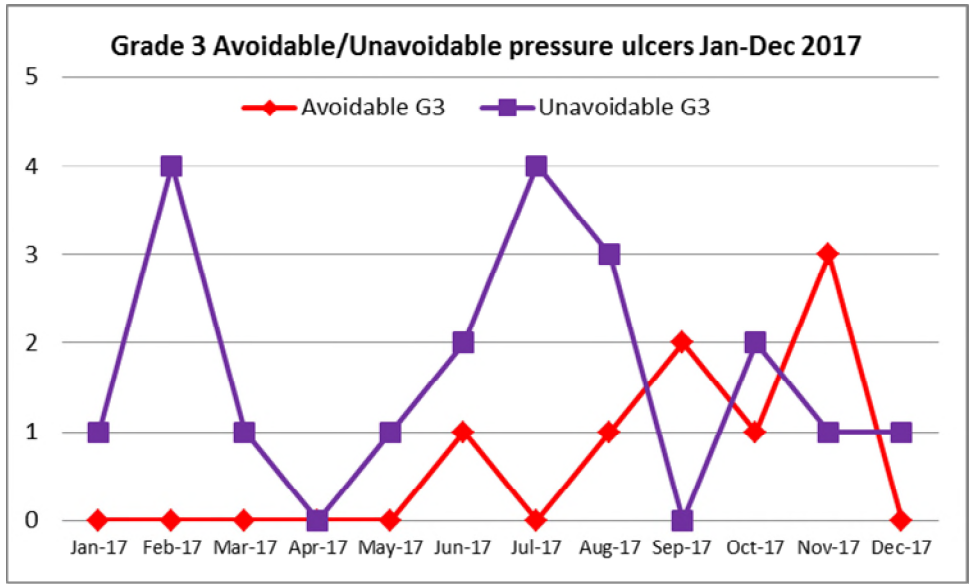
Action plan completion status
There are 16 RCAs action plans out of date for 2016/17, with two closed since the last report. There are nine RCA action plans out of date for 2017/18 with one closed since the last report. Overall the total number of RCA action plans going out of deadline remained the same. Work continues with operational teams to support that action plans completed in a timely manner.

Serious Incidents submitted to the Clinical Commissioning Groups in Quarter Three 2017-2018 with learning identified

StEIS No	Type of Incident	Clinical Area	Learning identified
2017/15952	Delayed Treatment	Ophthalmology	Process to ensure that patient who are requiring appointment within 6 weeks are appropriately recorded on SEMA.
2017/16078	Grade 3 Pressure Ulcer	Medicine	More vigilance with pressure area care, remembering the vulnerable pressure points on faces also ie device related PUs, particularly for patients with long term NIV. Adopting ITU documentation
2017/12473	Delay in Treatment	Emergency Care /CAMHS	Lack of clarity and agreement regarding the Service Level Agreement between Powys CAMHS and Shropshire CAMHS Internal process clarified to support care and management.
2017/15257	Fall resulting in head-injury	MSK	Raise awareness about the ease with which the new bedside tables move across the floor and potential risk to patients who may lean on the table
2017/15968	Delayed diagnosis	Surgery	Escalation process for unreported x-rays. Local learning regarding risks of specific conditions. Standardisation of handover processes.
2017/21581	Fall	Medicine	Improved multi-disciplinary approach to patient management where fluctuating capacity is identified.
2017/23957	Grade 3 Pressure Ulcer	Medicine	More vigilance with pressure area care, remembering the vulnerable pressure points on faces also, particularly for patients with long term NIV. Adopting ITU documentation

StEIS No	Type of Incident	Clinical Area	Learning identified
2016/30136	Obstetric incident (affecting baby)	Maternity	Improvements to of clarity and agreement regarding Service Level Agreement between Powys and Trust in relation to frequency of scanning. Improvements to standards of assessment and documentation at triage.
2017/18024	Surgical issue	Surgery	Medical device failure; improved processes regarding recording any issues with devices
2017/27069	Surgical incident	Critical Care	Develop local guidance for the insertion of chest drains. Improvements to consideration for ceiling of care prior to surgery for high risk patients
2017/20117	Grade 3 Pressure Ulcer	Medicine	Local improvements for the correct use of oxygen masks
2017/22604	Surgical incident	Surgery	Develop a care pathway for Jejunostomy feeding tubes including post-operative guidance and follow up. A business case is in place for a Nutrition Nurse who would be able to support patients and their families receiving enteral nutrition
2017/22713	Surgical incident	Surgery	Seeking advice if scope of surgery more complex than anticipated

Avoidable Hospital Acquired Pressure Ulcers



We reported one avoidable Grade three pressure ulcer in October, three during November and none in December 2017. The incident from October has breached completion deadlines and has been escalated accordingly. Two incidents from November has been investigated, and one is still in the process of investigation.
We have not identified or reported any avoidable Grade four pressure ulcers in 2017-2018 to date.

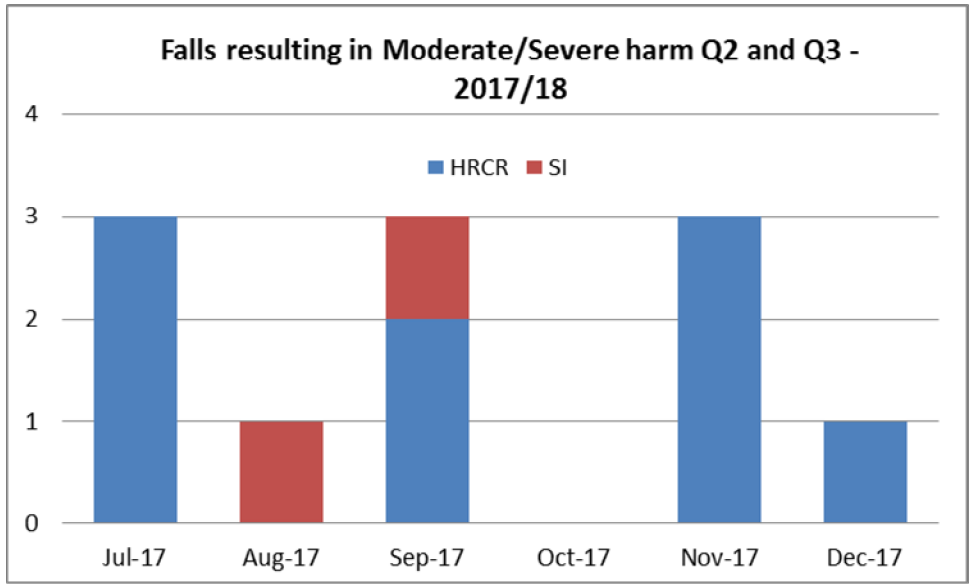
We identified six avoidable Grade two pressure ulcers during quarter 3 2017/18. RCAs have been completed and appropriate actions identified and shared with the ward staff. The learning related to the regular reassessment of potential skin damage, implementation of some risk reduction strategies and the monitoring of any areas of concern.

We have now had 23 avoidable grade two pressure ulcers in the financial year to date.

During December there was one Grade three pressure ulcer classified as unavoidable

Pressure Ulcer Site	Rationale for not reporting as an SI
Ears (device related)	All appropriate care, assessment and management in place. The patient required essential NIV treatment. Different masks and risk reduction strategies were attempted to reduce risk. Once dependency on NIV reduced; ears began to heal.

Patient Falls

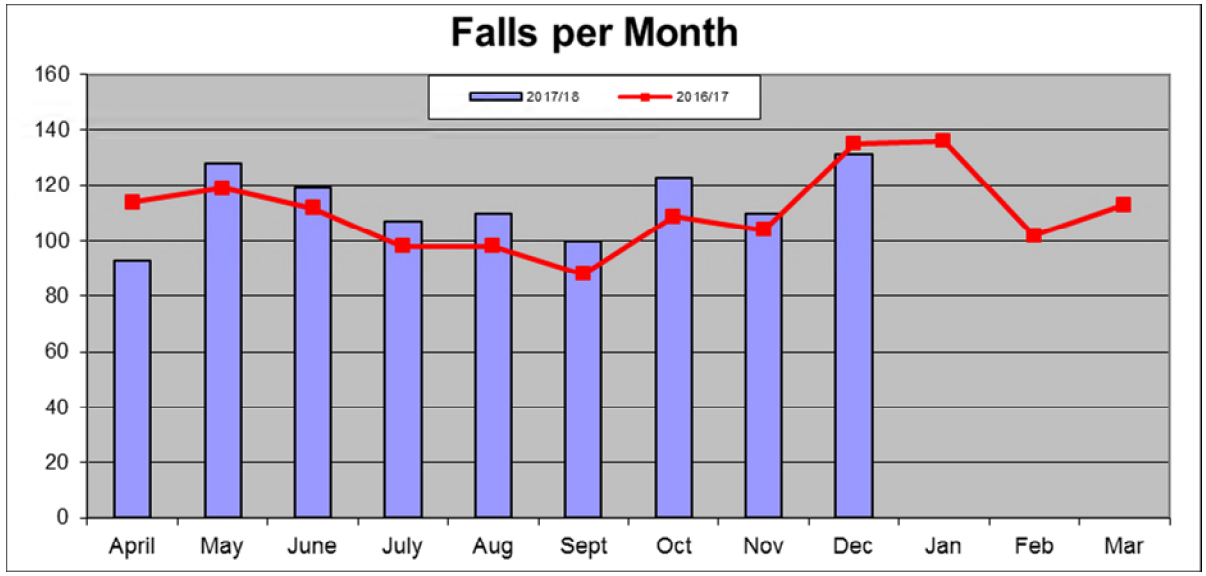


Patient falls resulting in severe harm

In Quarter three four patient falls resulting in moderate to severe harm were reported. None of these met the criteria for reporting as Serious Incidents and are being managed as high risk case reviews.

During December there was one fall resulting in a fracture which did not meet the criteria for reporting as serious incidents:

Fall fracture site	Rationale for not reporting as an SI
Fractured Left hip	All relevant risk assessments in place. Patient assessed as independently mobile by therapy and nursing staff. Patient had full capacity Nurse in bay saw patient stumble, but unable to reach patient in time to prevent fall Not RIDDOR reportable, classed as unpreventable

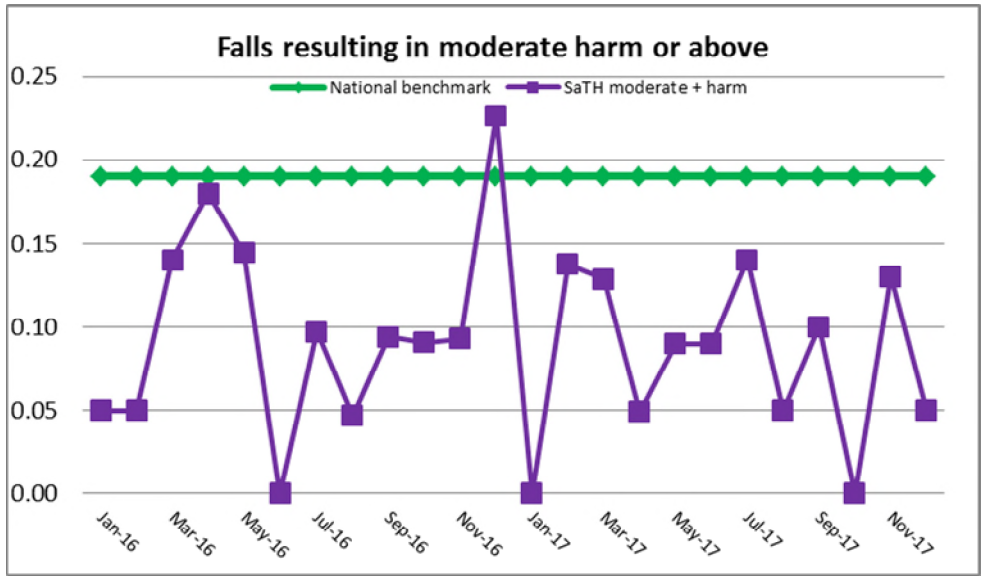


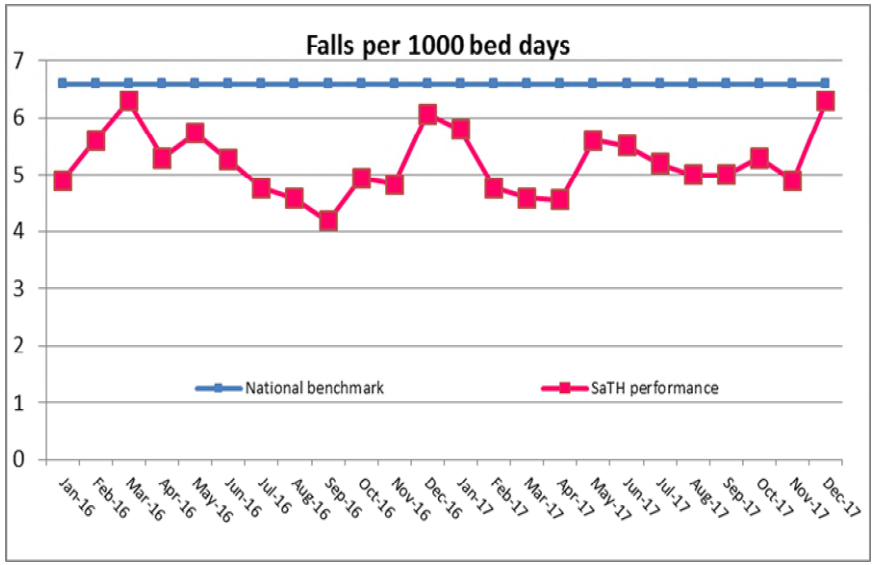
Patient Falls

The chart indicates the number of patient falls reported per month compared to 2016-2017. As may be seen with the exception of April we have reported more falls per month than the same period last year.

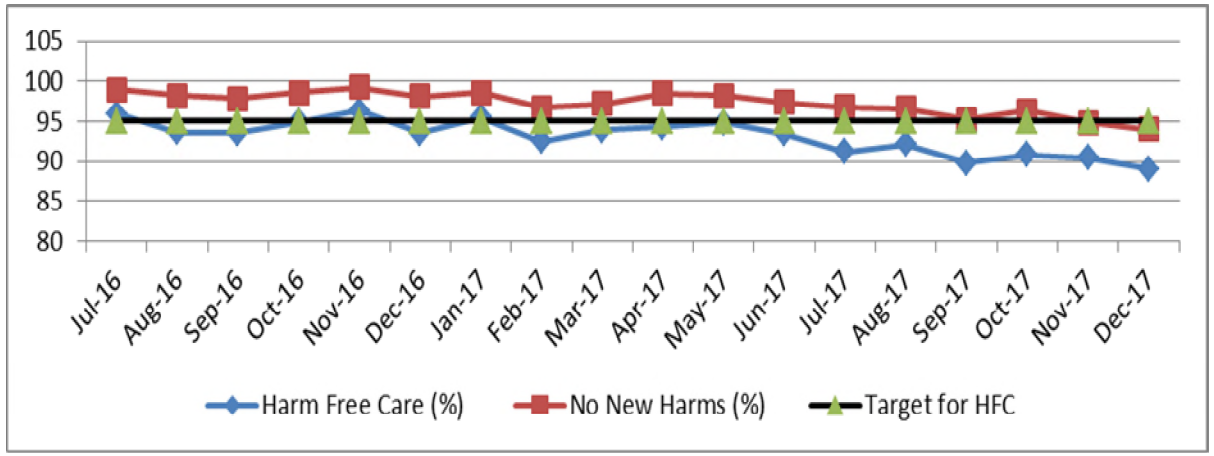
We have recently contributed to the National Audit for Inpatient Falls data collection for 2017 – the report is expected later this year and the results will be brought back to the Committee.

The charts below show the falls per 1000 bed days compared to the national benchmark.





NHS Safety Thermometer



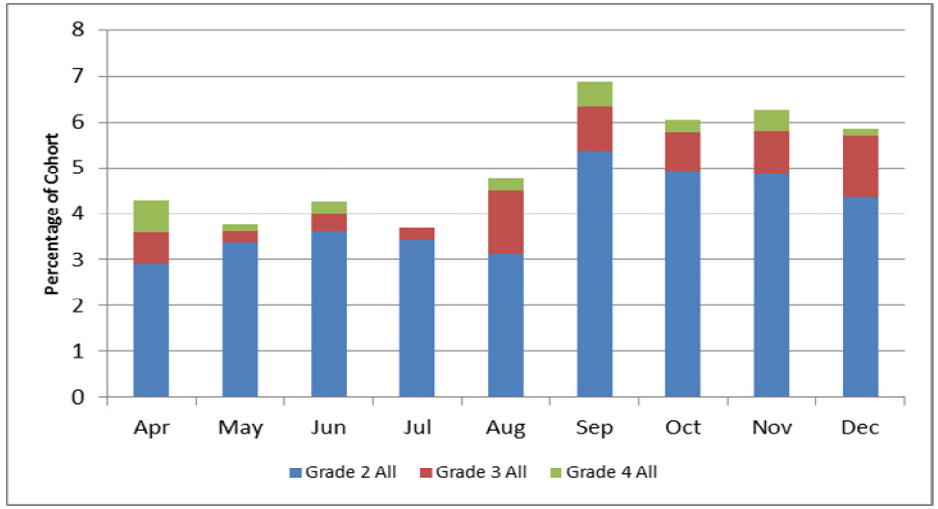
The NHS Safety Thermometer is a point prevalence audit carried out on a specific day across services providing NHS services.

The data collection measures whether a patient has one or more of four specific "harms" as detailed below.

Harms as described as new – those that occurred whilst in our care or old – those that were present when the patient was admitted to our care.

The data that was collected during December 2017 included 667 patients that were in our inpatient areas on the day of the data collection.

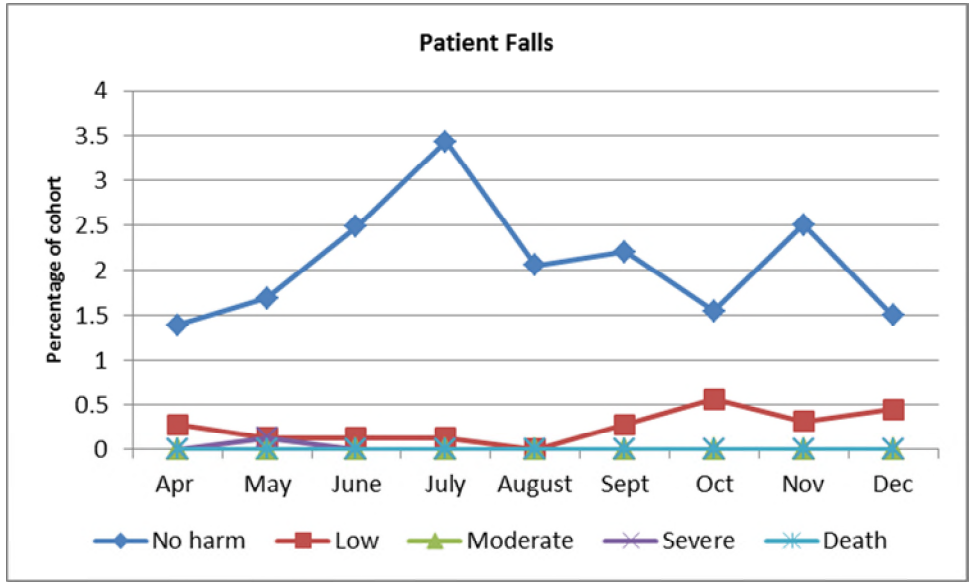
Overall, we recorded that 89.06% of the patient cohort on the day were free from any of the four harms measured in the data collection. We also found that 94.0% were free from any harm that occurred whilst in our care. The charts below indicate the trends shown by the data collection.



Pressure Ulcers The collection measures the grade and whether the pressure ulcer was old (was present on admission or developed within 72 hours of admission) or new (developed when a patient had been in our care for more than 72 hours).

The data collection in December showed that there were 39 pressure ulcers recorded on the day – 32 old (occurred outside our care) and 13 new (occurred in service). Of the new ones, ten were grade two and two were grade three and one grade four. It should be noted that this figure will always differ from the number of incidents recorded as it measures prevalence on the day and also the grading may not have been verified.

Further detail relating to incidence and actions relating to pressure ulcers is given elsewhere in this report.



Patient Falls
For the purposes of this audit, a fall is recorded if it occurred within 72 hours of the data collection day.

A total of 13 patient falls were recorded affecting 0.45% of the total cohort during December. Ten were reported as resulting in no harm to the patient and three resulted in low harm (defined as the patient required first aid, minor treatment, extra observation or medication).

Catheters and UTI
In December a total of 114 patients were recorded as having a urinary catheter in situ on the data collection day, 95 of which had been in situ for less than 28 days.

Of these, six patients were recorded as having a new UTI as well as a catheter.

Safeguarding

Safeguarding Vulnerable Adults

In Qtr 3 2017-2018 there were 36 safeguarding concerns raised that involved the Trust (compared to 35 in Qtr 2 and 28 in Qtr 1). Of these, 27 were raised by the Trust against other agencies and nine raised against the Trust during the period compared to eight in Qtr 2 and five in Qtr one.

Concerns initiated by the Trust (27) mostly related to concerns about paid carers.

Deprivation of Liberty Safeguards (DOLS)

There were 13 DOLS applications made by the Trust in Qtr three compared to 22 in Qtr 2 and 19 in Qtr one.

Safeguarding Children

During Quarter three 2017-2018 there were two Safeguarding Children alerts involving the Trust bringing the total for the year to 20. All were raised by Trust staff and none were made against the Trust services.

The Trust continues to contribute to Serious Case Reviews when our services have been involved in the care of children.

Prevent

Prevent is part of the Government counter-terrorism strategy CONTEST and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.

Prevent focuses on all forms of terrorism and operates in a 'pre-criminal' space'. The Prevent strategy is focused on providing support and re-direction to individuals at risk of, or in the process of being groomed /radicalised into terrorist activity before any crime is committed. Radicalisation is comparable to other forms of exploitation; it is a safeguarding issue that staff working in the health sector must be aware of.

The Prevent Duty 2015 requires all specified authorities including NHS Trusts and Foundation Trusts to ensure that there are mechanisms in place for understanding the risk of radicalisation. Furthermore, they must ensure that health staff understand the risk of radicalisation and how to seek appropriate advice and support. Healthcare staff will meet, and treat people who may be vulnerable to being drawn into terrorism. The health sector needs to ensure that healthcare workers are able to identify early signs of an individual being drawn into radicalisation.

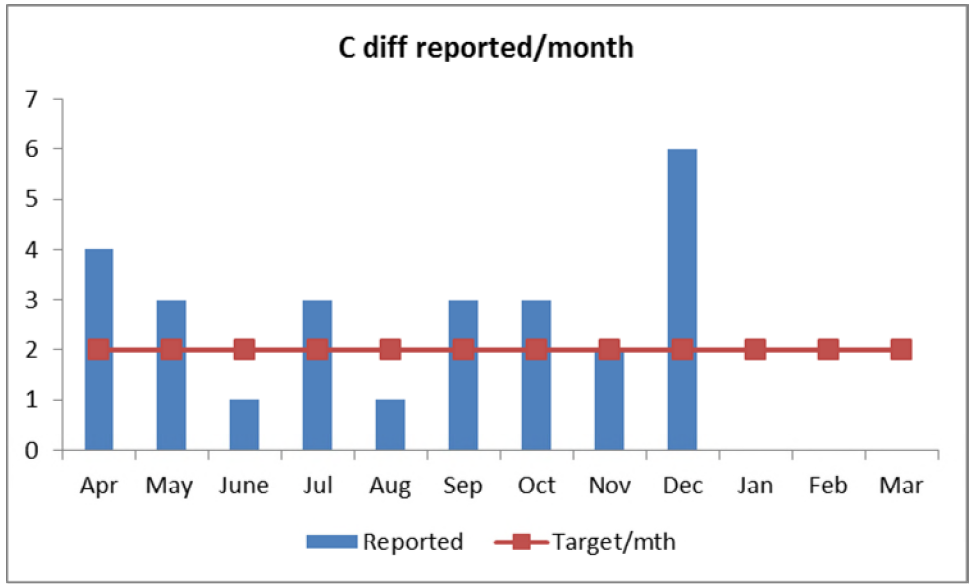
Staff must be able to recognise key signs of radicalisation and be confident in referring individuals to their organisational safeguarding lead or the police thus enabling them to receive the support and intervention they require.

There are two levels of training:

- Basic Awareness Training – we provide this to all staff on Corporate Induction and then through Safeguarding Updates.
- Workshop to Raise Awareness of Prevent (WRAP) – required by specific staff and provided through face to face training by facilitators who have been provided with a Home Office reference number (currently four in the Trust). NHS England have stated that all Trusts must have achieved a compliance rate of 85% of applicable staff trained through WRAP by March 2018.

During Qtr three 2017-2018 the Trust continued to train members of staff through WRAP sessions and our total of trained staff is now 32% against the target of 85%. Whilst this is an improvement against our baseline, we are not projected to achieve the required compliance rate of 85% by the end of March at present. We have identified further opportunities when we can train staff to achieve as high a compliance rate as possible and are working with commissioners to provide assurance to them that we are doing all we can to train staff.

Infection Prevention and Control



Clostridium Difficile (C Diff)

We are above our internal target for C Diff for the year so far – we have reported twenty six cases as shown which exceeds the maximum of no more than 25 cases in the year required by the commissioners.

Post Incident Reviews (PIR) are carried out on all cases and submitted to the CCG for review and consideration of whether the infection is attributable to the care provided by the Trust. As at the end of September, four cases had been considered not attributable to the Trust and nine were considered to have elements that contributed to the infection.

Section four: Recommendations for the Board

The Board is asked to:

- **Seek Assurance** in relation to key quality indicators as at the end of December 2017 and approve the assurance and improvement processes in place
- **Consider** the actions being taken where performance requires improvement
- **Question** the report to ensure appropriate assurance is in place