The Shrewsbury and Telford Hospital NHS Trust

Paper 11

Recommendation ☑ **DECISION** ☑ **NOTE**	**The Trust Board is asked to:** **Discuss** the current performance in relation to key quality indicators as at the end of September 2018 **Consider** the actions being taken where performance requires improvement **Question** the report to ensure appropriate assurance is in place
Reporting to:	**Trust Board**
Date	25 October 2018
Paper Title	Quality Governance Report
Brief Description	The purpose of this report is to provide the Trust Board with assurance relating to our compliance with quality performance measures during September 2018 **Key points to note:** Fifty eight complaints were received in September in relation to Trust services. The Booking Centre and Outpatients have had a high number related to problems with appointments. The number of complaints closed within timescales continues to improve although there are still a number of late responses. Two complaints were reopened in September – in both cases the complainants were disputing what was recorded in the patient notes. The percentage of patients that would recommend the ward or area in which they received care was 97.1% in September – an improvement from August but the response was reduced from 21.1% to 16.5%. The reduction in responses was seen in ED and inpatient areas. In September we saw an increase in the number of patients who waited more than 12 hours for transfer to a ward from an intensive care area once their condition had improved. The total number of patients transferred also increased compared to last month. However, there were no reports of a mixed sex accommodation breach in any other areas of the hospital. In September we reported no avoidable pressure ulcers of category three or four – it is now eight months since we have done so for category three and the last avoidable grade four we reported was in September 2016. In the year to date we have reported six avoidable category two ulcers which is an improving picture compared to last year when we reported 47 in total. There were no falls resulting in moderate or severe harm in September and the total for the Qtr was three. There are still high numbers of incidents that are awaiting review by the handlers – these are the low or no harm incidents but it is important that we understand the themes and trends indicated by these incidents. This is one of the priorities within our Quality Account for 2018/19. The Executive Rapid Review meeting identifies and reports the trends noted in the moderate and above incidents and complaints to CGE. These include appointment issues, delays in radiology reporting and transport issues. Five patients received their first definitive treatment for cancer after 104 days in August 2018 (the target for referral to treatment being 62 days) which is an increase of the three that were reported for July. Two related to patients who were being treated for lung cancer, two to upper gastrointestinal and one

	urology. In accordance with the Trust's procedure, a harm proforma and an RCA is requested from the clinician / operational team responsible for each individual patient. The Lead Cancer Nurse will carry out a clinical incident review for any patient graded as 1B (potential harm) or 1C (harm caused) following completion of the harm proforma. In Qtr Two 2018-2019 there were 32 safeguarding concerns raised that involved the Trust. Of these, 25 were raised by the Trust against other agencies and seven were raised against the Trust. None of the latter met the criteria for a Section 42 enquiry. There were no safeguarding concerns raised by external agencies against Trust services in September. The Trust raised ten adult concerns, one internally. Safeguarding training is a mandatory requirement under the Children Act 2004 for staff in the public sector. This is also a mandatory requirement for Adult Safeguarding under the Care Act 2014 and now more recently with the Intercollegiate document 2018. The requirement for training set by CQC is 80%. At present we are not achieving the compliance levels for Level Two training which is at 61% for adults and 64% for children. A recovery plan is in place and additional training sessions arranged. Additionally we have low levels of compliance with MCA and DOLS training which is now mandatory for all relevant staff. The Trust has purchased training from the Local Authority to provide training for as many staff as possible in the next few months and longer term the provision of on line training is also being explored. We continue to train relevant staff in PREVENT WRAP training and are progressing towards the 85% compliance with a total of 63% compliance at the end of September. We have reported two C Diff incidents in September – total for Qtr 2 2018-2019 is four compared to seven in the same period last year. We have seen an improvement in our performance regarding mortality over the last four years, and this has been maintained over the last year. This is demonstrated consistently over the four mortality parameters that we use and we now are consistently lower than our peer comparators. The paper contains an update of progress in this area, based on the most up to date information available.
Sponsoring Director	Deirdre Fowler, Director of Nursing. Midwifery and Quality
Author(s)	Dee Radford, Quality Manager Sam Hooper, Medical Performance Manager
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 **Safest and Kindest –** delivering the safest and highest quality care causing zero harm

Link to Board Assurance Framework	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 (DTOC) lists, and streamline our internal processes we will not improve our 'simple' discharges (RR 951) If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185)
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

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

Quarterly Quality Governance Report

Quarter Two 2018-2019

July – September 2018

Introduction

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of September 2018. The report will provide assurance to the Quality and Safety Assurance Committee and the Trust Board where we are compliant with key performance measures and that where we have not met our targets that there are recovery plans in place. This report also relates, in some detail, to the metrics reported for Quarter Two 2018-2019 as a whole and the themes that may be identified.

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 reports for consideration and triangulation with performance and workforce indicators.

The report will be submitted to our commissioners provide assurance to them that we are fulfilling our contractual requirements as required in the Quality Schedule of our 2018-2019 contract.

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 – how are we doing?

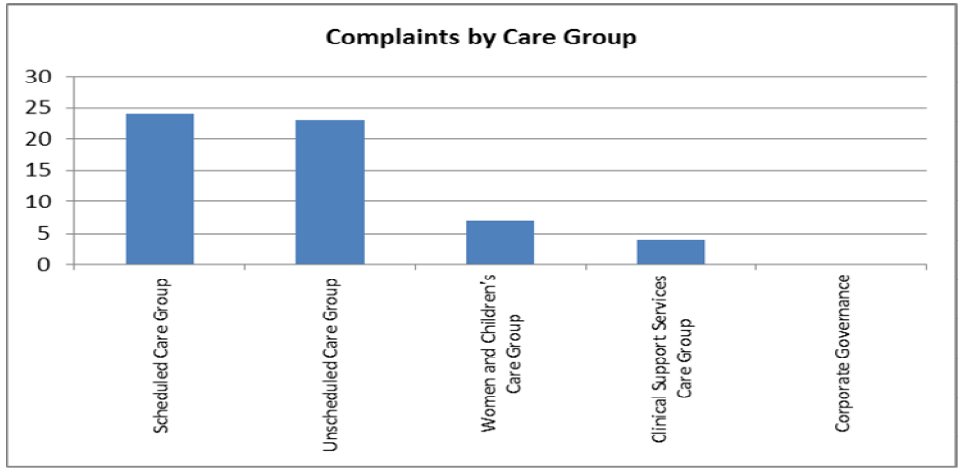
Measure	Year end 17/18	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Sept 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
CDI due to lapse in care (Qtly CCG panel)	13	1	1	3	1	1	0	1	1	2				4	0	25
Total CDI reported	32	1	3	6	6	2	2	2	2	2	0	2	2	10	None	None
MRSA Bacteraemia Infections	0	0	0	0	0	0	0	1	1	0	1	0	0	3	0	0
MSSA Bacteraemia Infections	26	3	2	4	2	3	1	1	1	3	2	4	3	14	None	None
E. Coli Bacteraemia Infections	29	1	4	2	6	5	2	4	2	6	6	4	3	25	None	None
MRSA Screening (elective) (%)		95.5	96.4	96.0	94.0	95.0	95.4	96.5	96.5	95.7	95.6	95.4	97.6	96.2	95%	95%
MRSA Screening (non elective) (%)		97.2	95.3	95.5	94.8	94.0	95.62	96.7	95.9	96.6	96.2	96.8	96.7	96.4	95%	95%
Grade 2 Avoidable	47	4	6	4	6	4	3	0	2	2	1	0	1	6	0	0
Grade 2 Unavoidable	157	12	12	12	14	17	9	15	6	9	5	5	3	43	None	None
Grade 3 Avoidable	9	2	2	1	0	0	1	0	0	0	0	0	0	0	0	0
Grade 3 Unavoidable	22	1	0	2	6	1	2	2	0	0	4	0	3	9	None	None
Grade 4 Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grade 4 Unavoidable	1	0	0	0	0	0	0	0	1	0	0	0	0	1	None	None
Falls reported as serious incidents	3	0	0	0	0	1	0	0	0	1	0	1	0	2	None	None
Number of Serious Incidents	77	9	7	3	8	15	13	2	4	9	1	2	2	20	None	None
Never Events	2	0	1	1	0	1	0	1	1	1	1	0	0	4	0	0

Catheter Associated UTI (number of patients on prevalence audit)		5	6	6	3	1	6	3	2	10	1	3	3	22	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		96.4	95.9	95.5	95.1	95.68	95.2%	95.1%	95.9%	95.9%	95.9%	95.6%		95.68	95%	95%
ITU discharge delays>12hrs	380	37	33	39	17	28	35	41	27	35	36	36	41	216	None	None
No of MSA breaches other areas	1	0	1	0	0	0	0	0	0	0	1	0	0	1	None	None
Complaints (No)	600	45	61	31	49	60	56	54	55	55	60	54	58	224	None	None
Friends and Family Response Rate (%)	23.8%	15%	14.3%	12.3%	11.1%	13.6%	16.1%	19.9%	17.7%	20.4%	20.8%	20.8%	16.5%	19.35%	None	None
Friends and Family Test Score (%)	96.6%	96.1	96.8	97.4	96.6	96.2%	96.4%	97.3%	96.6%	96.6%	95.6%	93.3%	97.1%	96.08%	95%	95%

Section Two: Key Messages by exception

Complaints and PALS

The Quality and Safety Committee receive a separate quarterly report in relation to Complaints and PALS. Therefore the summary below shows complaints received and closed in September 2018 only.

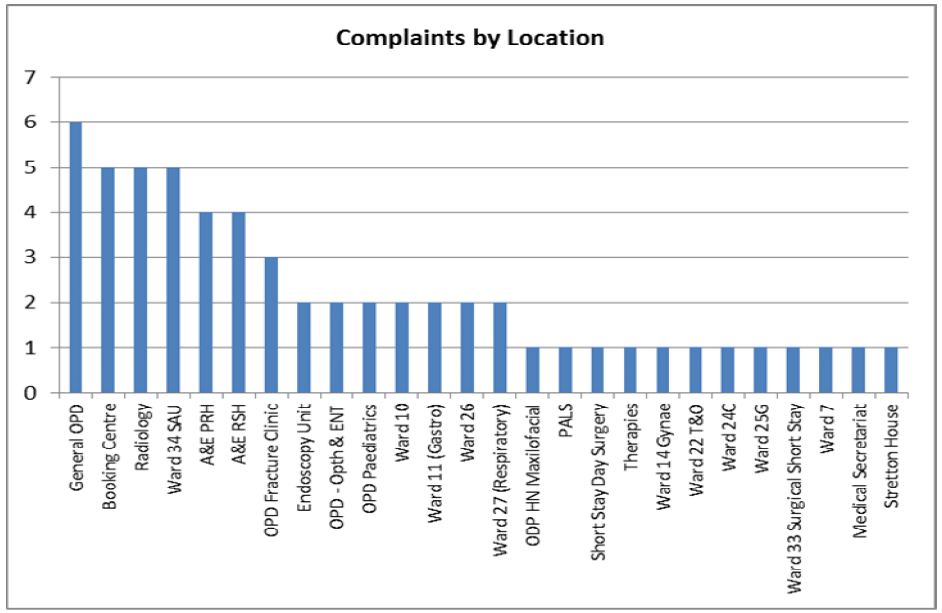


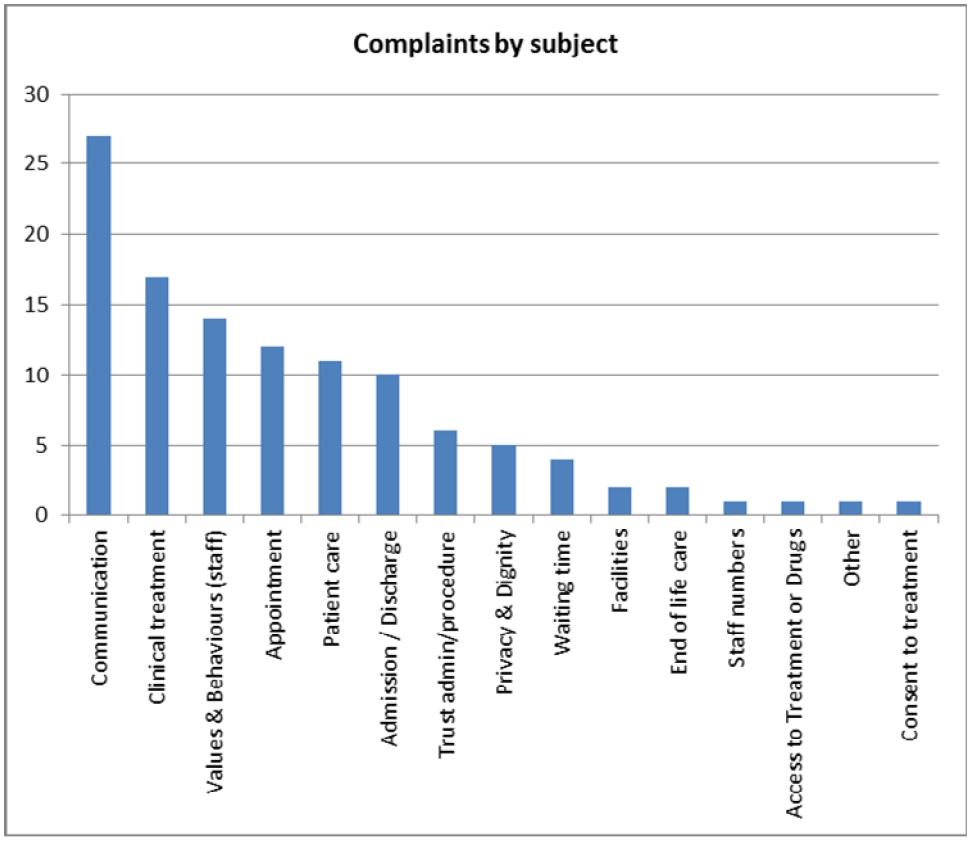
New Complaints

58 formal complaints were received in September 2018 in line with expected figures.

Top Locations of Complaints

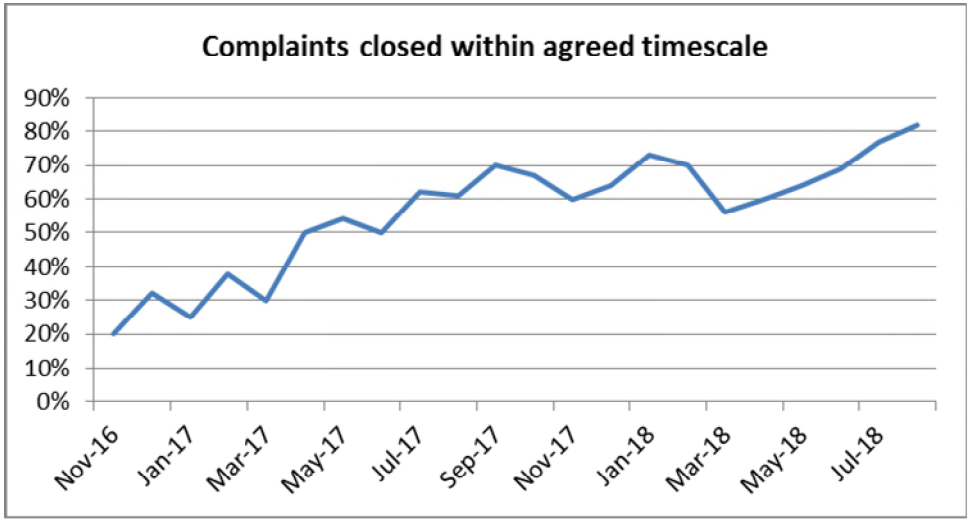
The Booking Centre and Outpatients have had a high number of complaints due to problems with appointments. There has been an increase in complaints relating to SAU which is being reviewed by the matron and ward manager.





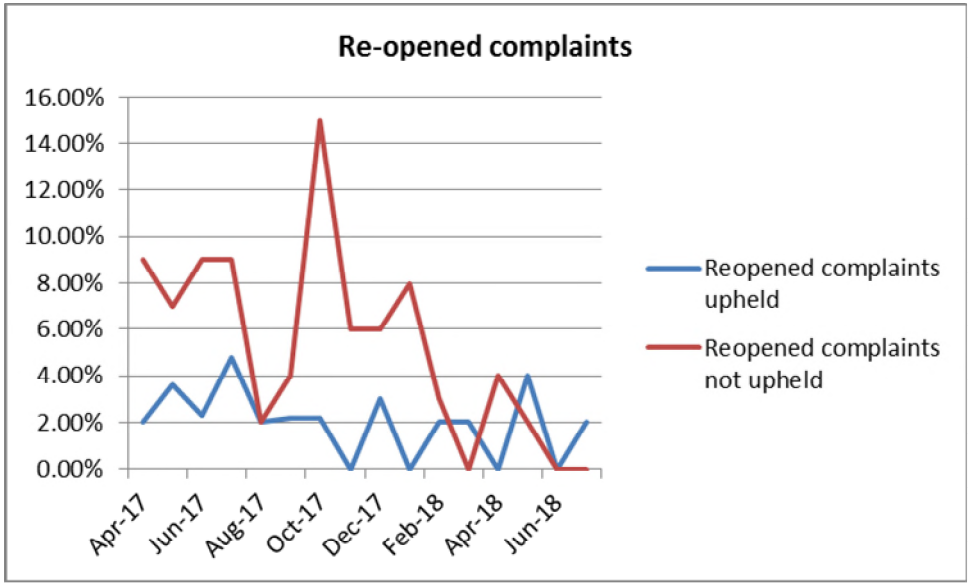
Complaints by Subject

The main issues raised in September 2018 are around communication and treatment.



Complaints closed within agreed timescale

The number of complaints closed within timescale continues to improve, however there are still a number of late responses received from the Care Groups. These delays can be due to a variety of reasons, including clinical pressures, staff being off sick, and notes being unavailable.



Reopened complaints

Two complaints were re-opened in September 2018, relating to complaints in May and July 2018. In both cases, the complainants are disputing what was recorded in the notes.

Parliamentary & Health Service Ombudsman (PHSO)

The Trust has been advised of two new referrals to the PHSO in quarter two:

- Patient's son was unhappy with discharge arrangements
- Patient's family unhappy with the management of the patient's diabetes

During quarter two the Ombudsman concluded three investigations; all three were not upheld

Patient Advice and Liaison Service (PALS)

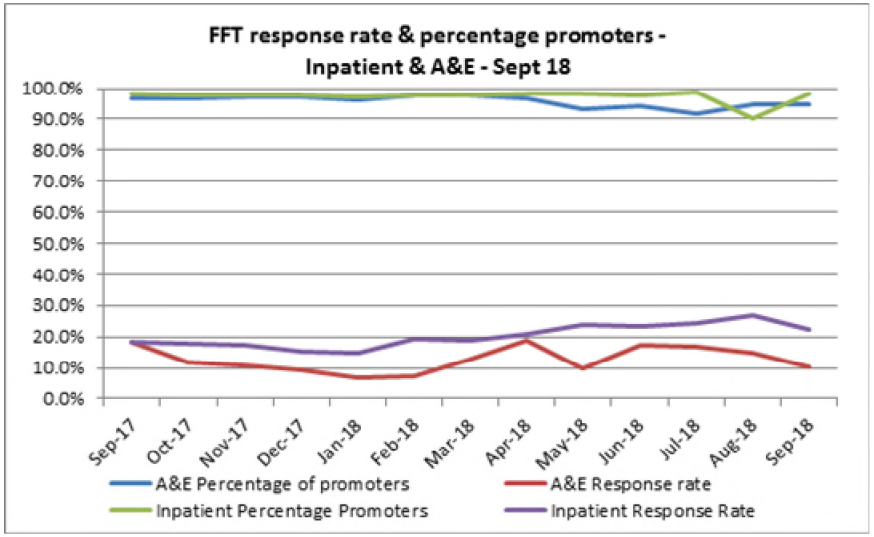
The Trust received 145 PALS contacts in September 2018.

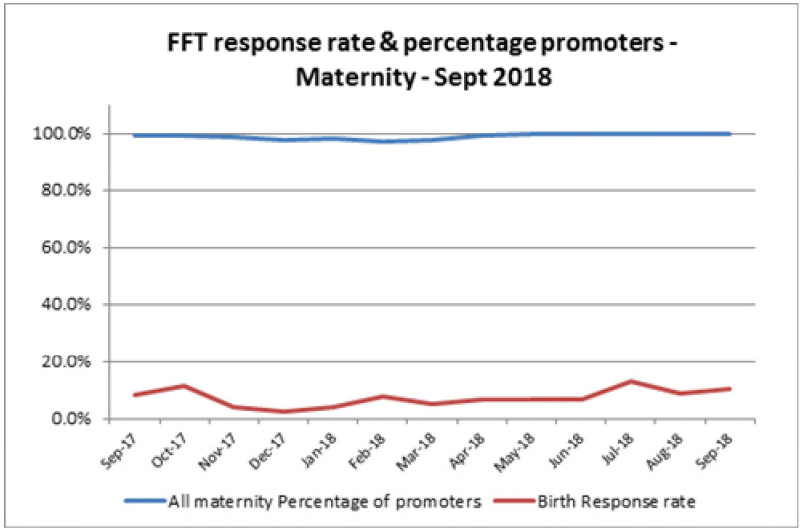
Friends and Family Test Feedback (FFT)

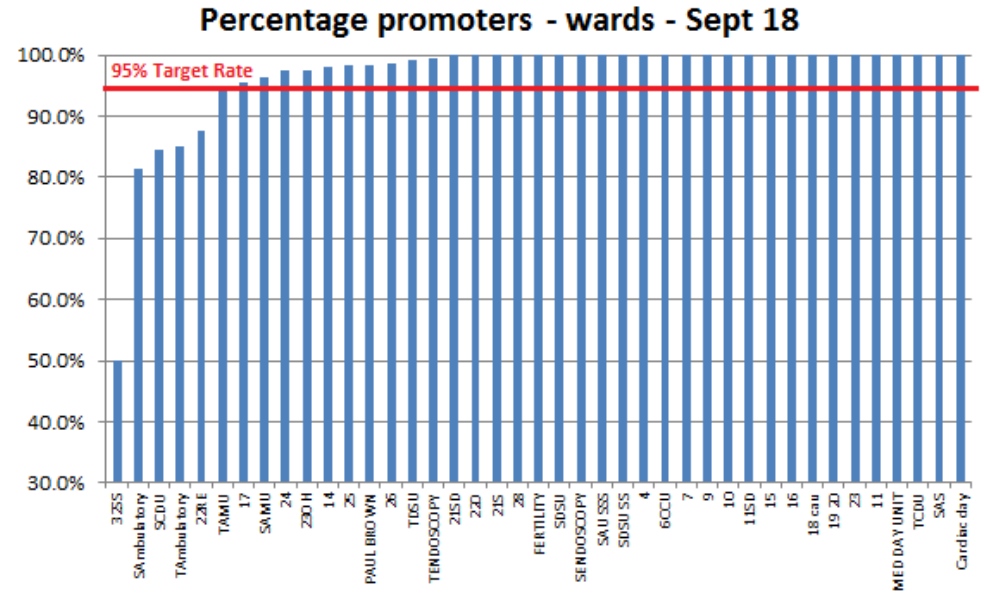
The overall percentage of patients who would recommend the ward they were treated on to friends and family if they needed similar care and treatment was 97.1% which was an improvement on August's overall figure. Individually, Inpatients and Outpatients both saw an increase in the percentage of patients who would recommend compared to August. A&E in September was 0.4% lower than August and maternity remained at 100%.

The overall response rate was 16.5% which is a decline compared to the previous month (21.1%). A&E and Inpatient both saw lower returns individually, however Maternity Birth improved compared to August.

	Percentage Promoters	**Response Rate**
Maternity overall	100%	10.1% (Birth only)
A&E	94.6%	10.2%
Inpatient	98.5%	22.4%
Outpatients	96.4%	NA

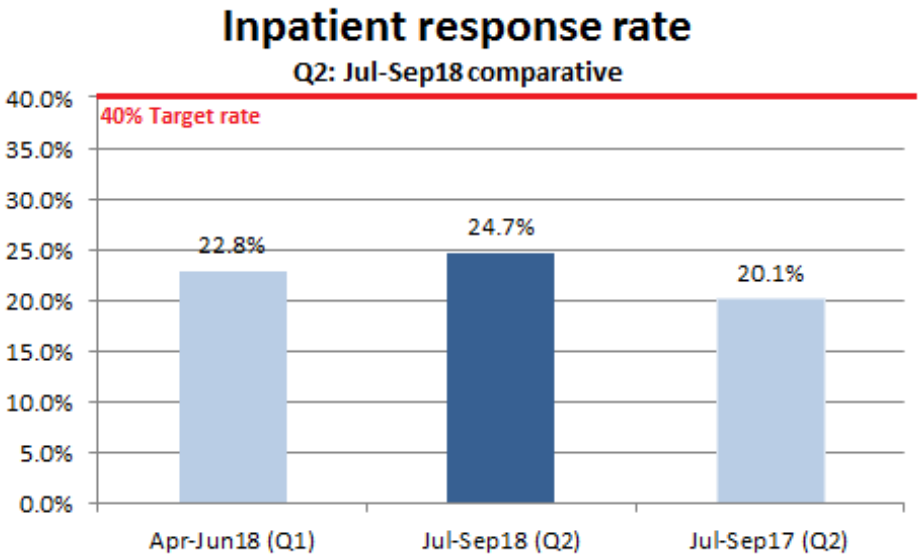






Inpatient Summary

- The most recently published National Inpatient promoter figure is for Aug 18 at 95.7%. SaTH exceeded this with a rate of 98.0% for inpatients in Aug18. SaTH has remained consistently high, with the most recent figure at 98.5% in Sep18.
- The vast majority of inpatient areas are achieving the Trust target of 95.0% for patients who would recommend the ward (percentage of promoters).
- The National response rate for inpatients in Aug18 was 25.0% which is higher than SaTH's overall response rate of 21.1%.
- This quarter (Jul-Sep18) has seen an improved response rate compared to the previous quarter (Apr-Jun18) as well as compared to this time last year (Jul-Sep17).



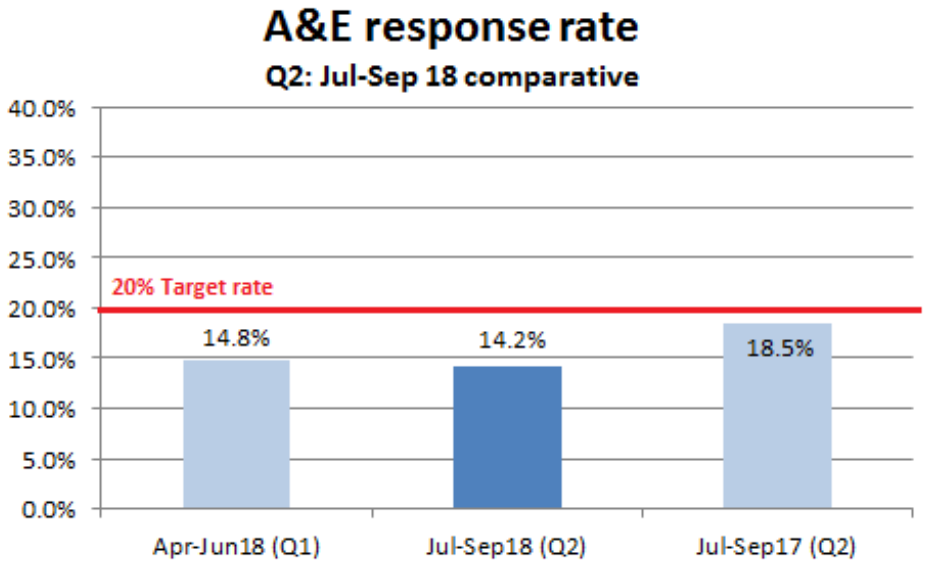
Maternity

- The most recently published National percentage of promoters for Maternity was Aug18 which was 96.1%. SaTH results were higher than the National Aug18 figures, at 100%.
- The response rate for Maternity only includes 'birth'. SaTH was 8.9% in Aug18 which is considerably lower than the National response rate of 20.3% in Aug18. The most recent Sep18 response rate for SaTH birth has improved reaching 10.1%.

AE	TARGET	Jul-18	Aug-18	Sep-18
SaTH Response Rate	>=20%	17.0%	14.9%	10.2%
SaTH % Recommenders	>=95%	91.6%	95.0%	94.6%
National Response Rate	No Target	12.8%	12.9%	
National % Recommend	No Target	86.7%	87.7%	

A&E Summary

- The most recently published National percentage of promoters figure for A&E is Aug18 at 87.7%, which SaTH exceeded with 95.0%.
- SaTH's response rate of 14.9% in Aug18 was higher than the National response rate of 12.9%. SaTH's recent Sep18 response rate has dropped slightly to 10.2%.
- Overall, this quarter (Jul-Sep18) had a lower response rate (14.2%) compared to this time last year (Jul-Sep17) at 18.5%. Figures are however similar to Quarter 1 of this year (14.8%).



Outpatients

- SaTH has seen consistently high percentage of promoter figures for Outpatients in Q2. Jul18 was 94.4%, Aug18 96.0% and Sep18 96.4%
- These figures compare favourably to the most recent National results which are Aug18 at 93.8%.

Delayed Discharges from ITU and Mixed Sex Accommodation Breaches

In September the number of patients that were waiting more than 12 hours to be transferred from our high dependency areas to a ward increased from the number recorded in August as did the total number of patients transferred from the units. The greatest numbers of patients delayed were at the Royal Shrewsbury Hospital where 31 patients waited more than 12 hours, 28 of whom were delayed more than 24 hours. At the Princess Royal Hospital, eight patients waited over 24 hours and two more than 12 hours. Nineteen patients were transferred in less than 12 hours at the Royal Shrewsbury Hospital and 11 at the Princess Royal Hospital.

Whilst waiting for transfer patients are cared for in an area that may have members of the opposite sex also receiving care. Every effort is made to ensure that patients' privacy and dignity is maintained during this time and that when a bed is available on the appropriate ward they are moved as soon as possible. The number of patients waiting for transfer is discussed at the three times a day bed meeting so that a suitable bed is identified for them in a timely way.

There were no incidents resulting in a breach of Mixed Sex Accommodation definitions outside of the critical care areas reported in September bringing the number of such incidents to one in the quarter.
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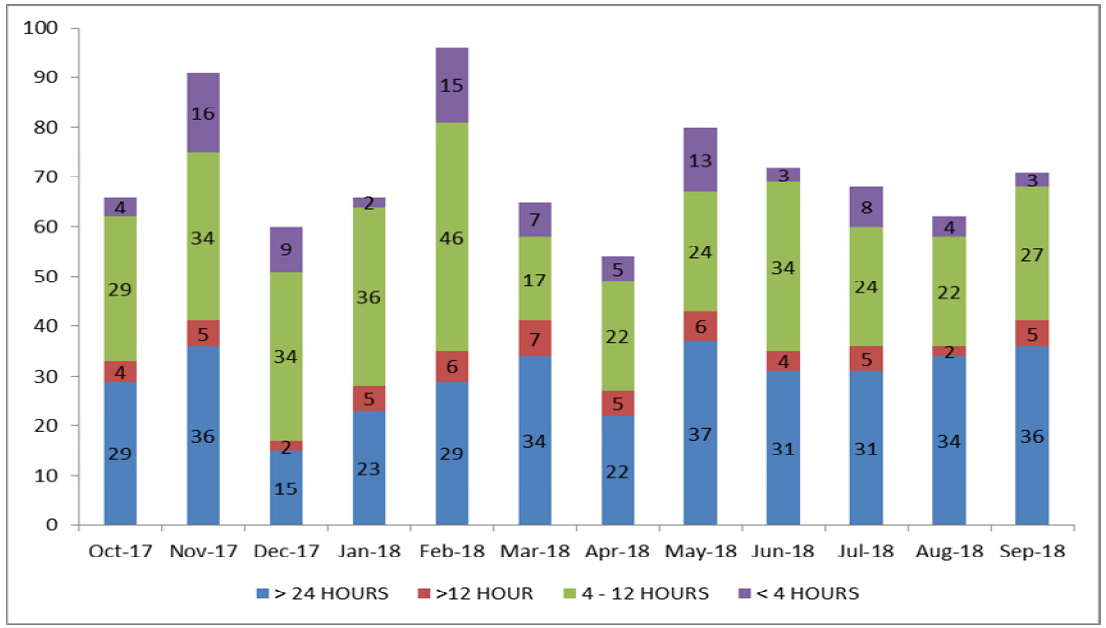
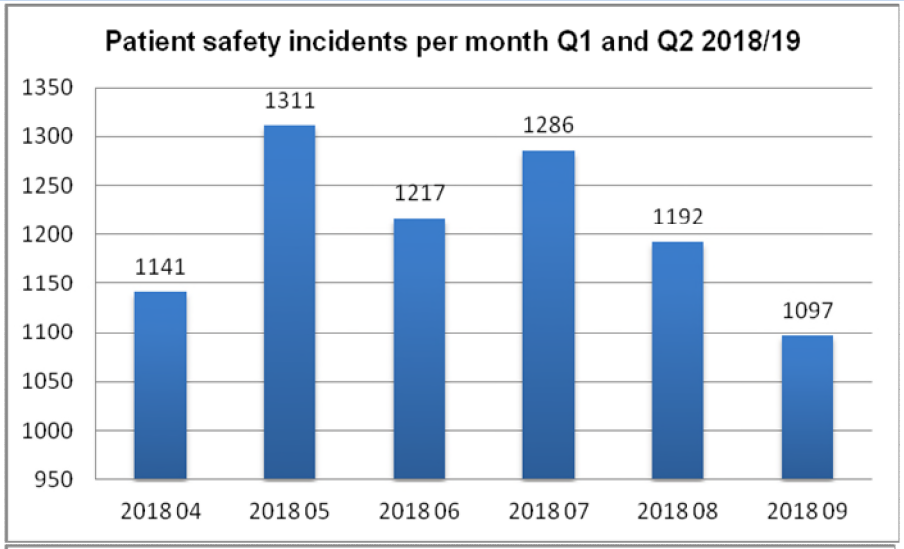
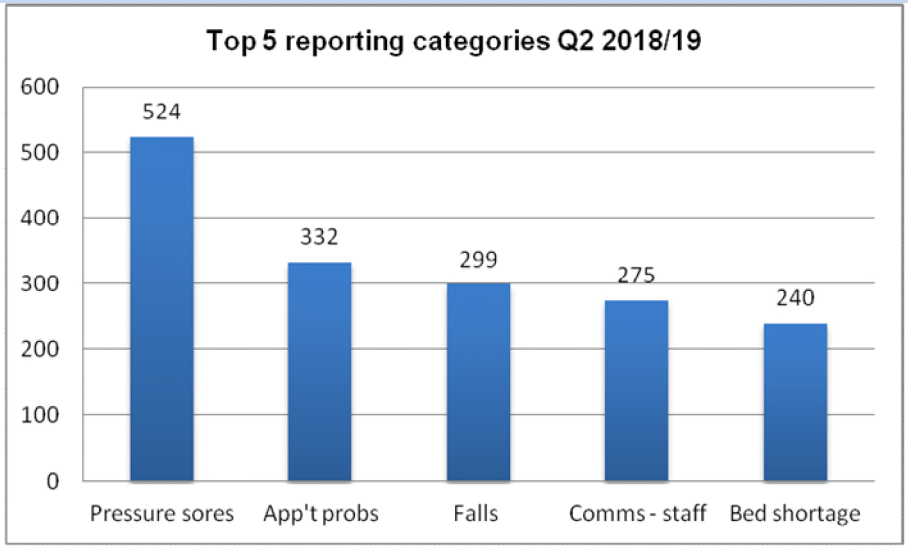
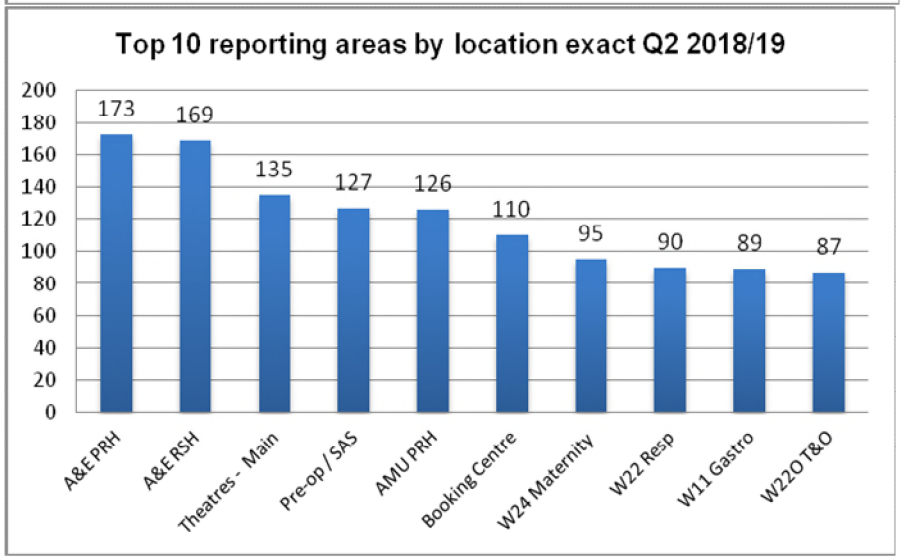


Section Three – Patient Safety

All Patient Safety Incidents







Patient Safety Incidents

A total of 3575 patient safety incidents were reported in Qtr 2 2018-2019 across the Trust. This compares to 3535 in the same quarter of 2017/18. It is a slight decrease from the 3600 reported in Qtr 1 of 2018/19. Some of the decrease may be linked to organisational approaches towards boarded patients.

Top Five Reporting Categories/Top Ten Areas

It should be noted that of the 524 pressure ulcers reported, 350 were present on admission, 100 were skin conditions other than pressure ulcers, meaning that 74 potential pressure ulcers were reported as having occurred in our care, this total may reduce during the process of validation. Bed shortages reduced in reporting by a total of 321 between Qtr 1 and Qtr 2 which supports the rationale that this is indicative of the Trust implementing changes during August/September 2018 to reduce/eliminate the number of boarded patients across the service and why reporting figures are lower. The top 10 reporting areas remain spread across the Trust, and the top 3 highest reporters remain consistent.

Patient safety incident management current status and of Q2 2018/19	In holding area, awaiting review	Being reviewed	Awaiting final approval	Final approval	Total
Scheduled Care Group	528↑	113↓	309↓	513↑	**1463**
Unscheduled Care Group	463↑	97↓	281↑	582↓	**1423**
Women and Children's Care Group	64↓	64↓	71↑	297↑	**496**
Clinical Support Services Care Group	56↑	15↓	21↑	31↓	**123**
Corporate Governance Directorate	3↓	0 =	1 ↑	2 ↑	**6**
Ambulance/ Patient first	6↓	0 ↓	3 =	1 ↑	**10**
Resources Directorate	7↓	2 =	6 ↑	11↑	**26**
Quality & Safety Directorate	11↑	1 =	9 ↑	5 ↑	**26**
Totals:	**1038**↑	**292**↓	**701**↓	**1432**	**3573**

The table above shows the detail relating to the current status of incidents and those which have been given final approval 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. Overall there is a reduction in the number of incidents staying open.

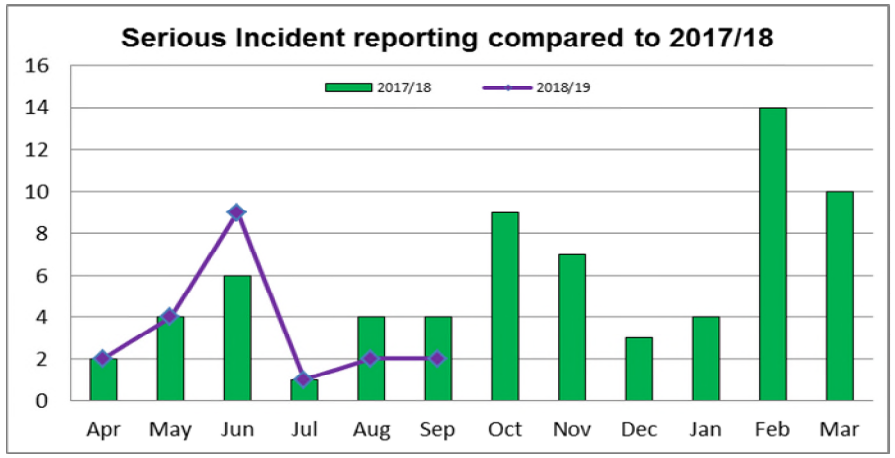
The Executive Rapid Review Meeting has met weekly since early September 2017. The aim of the meeting is to provide assurance that immediate actions are taken in relation to serious and moderate incidents (clinical and health and safety) and complaints about patient care and that themes are identified and addressed. Care Group Heads of Nursing (or a representative) 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.

The group identifies trends and concerns at each meeting. These include:

- Issues relating to appointments – particularly in the Ophthalmology service
- Staff attitude – most commonly medical staff and in Outpatient areas
- Delays in Radiology imaging reporting
- Transport delays - There were several incidents where delays in transport services led to extended stays for some of our patients.

Serious Incidents Reported in Quarter 2 2018/19

Type of Incident	Care Group	Date of incident
July:		
'Never Event' (wrong route medication)	Unscheduled Care	24/07/2018
August:		
Fall (fractured femur)	Unscheduled Care	02/08/2018
Cluster of OPD appointments	Scheduled Care	30/08/2018
September:		
Never Event – retained foreign object	Women and Children	29/08/2018
Major incident/emergency preparedness	IT/Unscheduled Care	18/04/2018
TOTAL		**5**



Serious incidents

There is a slight reduction in the number of Serious Incidents for January to March 2018.

Telford and Wrekin CCG to date have agreed to downgrade a total of six of the 12 hour trolley waits that are linked to PRH A&E.

Shropshire CCG continues to decline to downgrade Serious Incidents which do not meet the SI Framework.

Serious Incident (SI) Reporting Status

The table below shows that there are 15 incidents open to investigation. Of these; four have agreed extensions with commissioners due to factors affecting capacity to complete the investigation. In addition there are six investigations which have breached the external deadline due to a variety of internal and external factors. Progress on these is being managed to ensure resolution as soon as possible.

Incident Status at 2nd October 2018

	New Incidents for Q2	5
	Incidents being investigated	14
	Out of internal deadline (excludes external deadline & RCAs with extensions)	1
	Out of external deadline with CCG/CSU (excludes RCAs with extensions)	6
	CCG/CSU have been asked to close incident	21

Action plan completion status

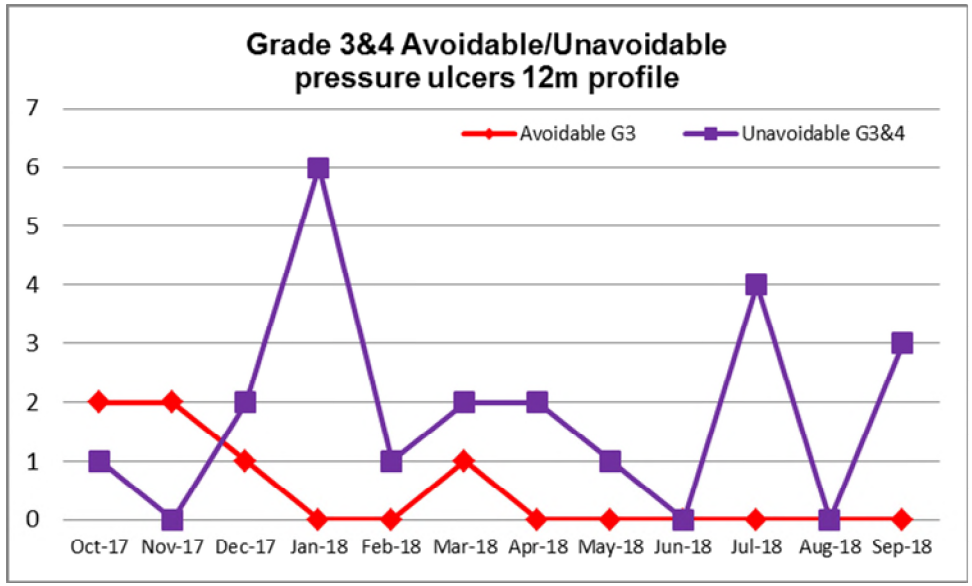
There are 12 RCA action plans out of date for 2016/17, with none closed since the last report. There are 28 RCA action plans out of date for 2017/18 with 4 closed since the last report. Overall the total number of RCA action plans going out of deadline has increased. There are 3 RCA action plans out of date for 2018/19. 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 2 2018-19 with learning identified

StEIS No	Type of Incident	Clinical Area	Learning identified
2018/11682	IG	Administration	Consideration to be given to using other/safer methods of communication, rather than using a fax machine. Acknowledged that moving forward with nhs.mail across the Trust will facilitate this
2018/11135	Delayed diagnosis	Medicine	Patients with learning difficulties may not be able to express themselves as clearly as may be expected. Therefore there is it essential to ensure a full and accurate history from the patient as possible, and use other resources available, such as family members/carers.
2018/6126	Fall	Outpatients	Estates are adopting the company's advice with regards to the door testing frequency (the automatic doors in Ophthalmology OPD closed on the patient precipitating her fall
2017/30323	Obstetric/affecting baby	Maternity	Clearer escalation strategies with regards to induction of labour and their transfer to the Labour ward. Extend the opening hours of the Triage service to allow more flexibility for the Labour ward to progress labouring women within the timescales set by the escalation strategy
2018/13168	Treatment delay	Paediatrics	Standardised approach for neurosurgical paediatric cases to involve the support from the anaesthetic team, in preparation for transfer to tertiary referral centres
2018/3582	Treatment delay	Medicine	When there is any element of doubt regarding diagnosis, a further review must be carried out in a timely way. The medical documentation was very poor. It is imperative that documentation of any reviews and decisions must be completed as near to the event as reasonably practicable.

StEIS No	Type of Incident	Clinical Area	Learning identified
2018/14788	Visitor fall	Emergency Care	Estates to conduct a review of all toilets within RSH to establish whether there is any evidence that this defect is commonly left unreported elsewhere in the Trust.
2018/15431	Appointment delay	Ophthalmology	The investigation of this incident has led to the identification of a problem within the SEMA software, this is being rectified and monitored and information shared.
2018/8027	Sub-optimal Care	Emergency Care	Observations must be recorded and monitored at the recommended intervals. Where indicated, escalation to the Nurse in Charge and Doctor must happen and be documented as such. An emergency call system is required in every ED cubicle
2018/13866	Never Event	H&N Theatres	Zero tolerance for any non-urgent interruptions within the theatre environment. Surgeons need more familiarity with safety critical policies and procedures. Highlighted the central importance of the team leader. Re-clarification, reinforcement and dissemination of the 'Stop the Line' ethos.
2018/10077	Delayed diagnosis	EC & Surgery	Investigation identified that there are two renal colic pathways in the organisation; one for urology and one for ED. This will be reduced to a single pathway.

Avoidable Hospital Acquired Pressure Ulcers



We reported no avoidable Category 3 or 4 pressure ulcers for Qtr 2. We have not identified or reported any avoidable Category 4 pressure ulcers since September 2016.

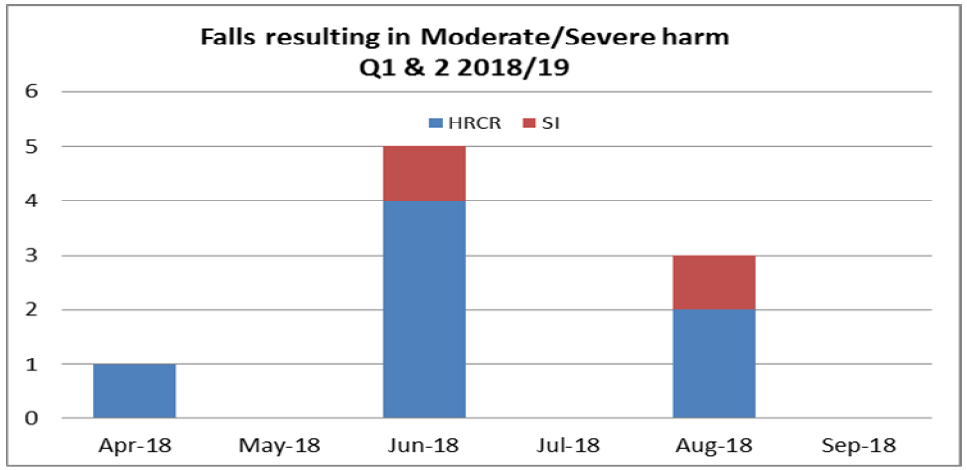
To date we have identified two avoidable Category 2 pressure ulcers during Qtr 2 2018/19. RCAs have been completed and appropriate actions identified and shared with the ward staff. The learning related to inconsistencies relating to accurate monitoring of the condition of the patient's skin, although in one case this was compounded by issues with patient concordance.

We have six avoidable Category 2 pressure ulcers in the financial year to date. (We reported a total of 47 to date for 2017/18)

During Quarter 2 there were seven Category 3 pressure ulcers classified as unavoidable, of which, 3 were reported in September 2018.

Pressure Ulcer Site	Rationale for not reporting as an SI
Sacrum	Complex overall case where due to medical condition repositioning effectively was very challenging. In addition, the patient at times declined repositioning. On balance, TVN confirms this is likely to be unavoidable
Sacrum	Evidence of poor compliance with advice, skin damage quite small, does not meet the criteria for reporting as an SI. TVN confirms this is likely to be unavoidable
Sacrum	Deterioration from Grade 2 identified on admission. Undergoing HRCR but there is evidence that this may have been misgraded on admission – this may be removed from the list retrospectively if the investigation is able to demonstrate that the initial grading was incorrect. Care was appropriate for the patient's condition

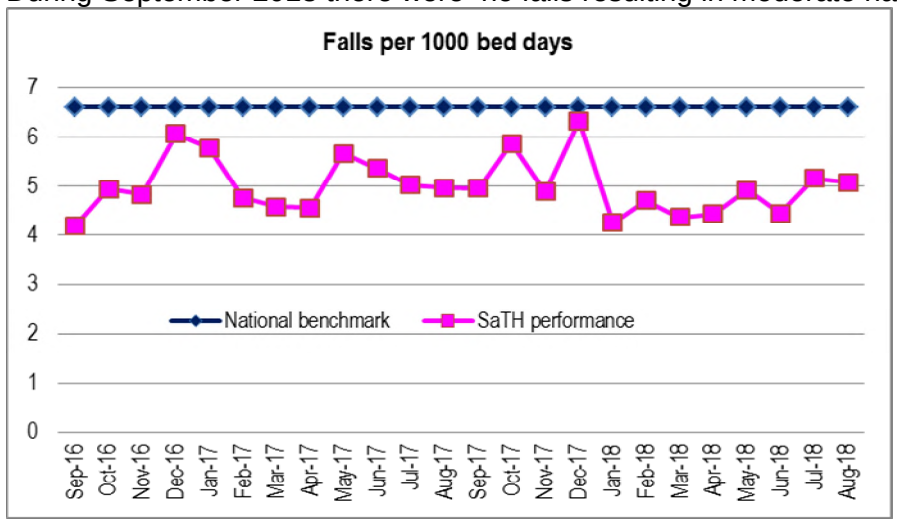
Patient Falls

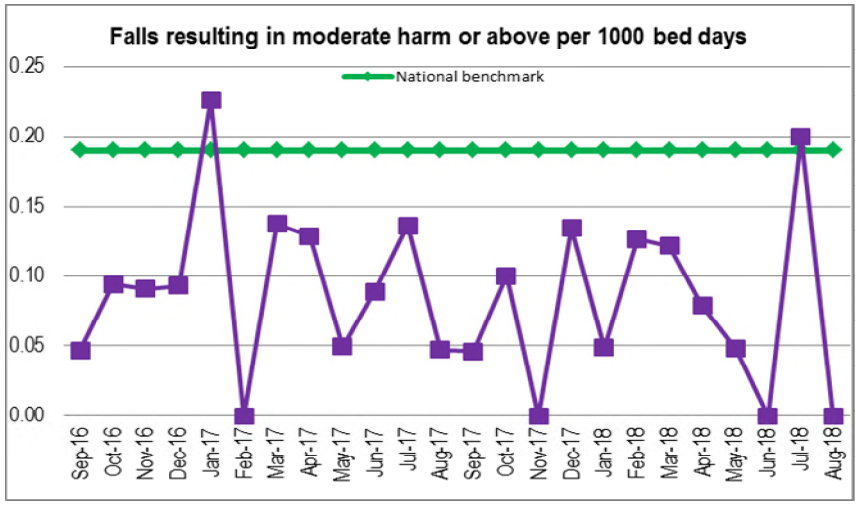


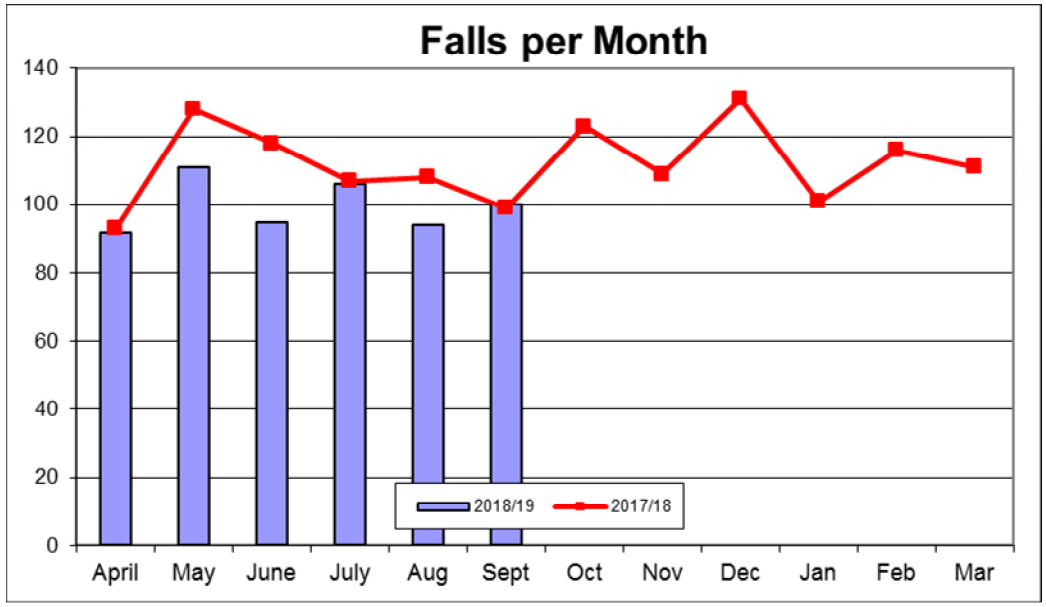
Patient falls resulting in severe harm

In Qtr 2, a total of three patients sustained a fall resulting in moderate or severe harm. One incident is being managed as a Serious Incident; the remainder are being managed as HRCRs.

During September 2018 there were no falls resulting in moderate harm or above:







Patient Falls

The chart to the side indicates the number of patient falls reported per month compared to 2017/18. At present we have reported fewer falls than the same period last year.

The charts above show the falls per 1000 bed days compared to the national benchmark for all reportable falls in total and those resulting in moderate harm and above. The Trust continues to perform well when benchmarked nationally.

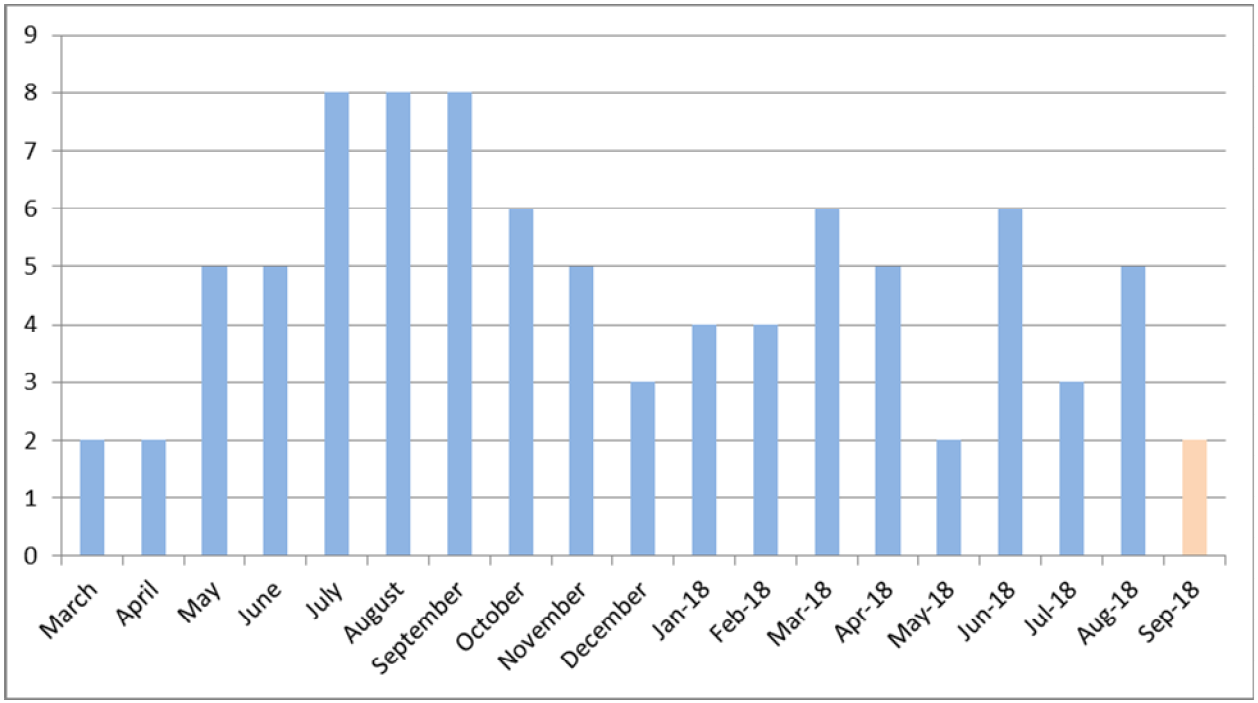
Patients waiting more than 104 days for Cancer Treatment

Five patients received their first definitive treatment for cancer after 104 days in August 2018 (the target for referral to treatment being 62 days):

Two related to patients who were being treated for lung cancer, two to upper gastrointestinal and one urology. In accordance with the Trust's procedure, a harm proforma and an investigation will be requested from the clinician / operational team responsible for each individual patient. On completion, both the harm proforma and investigation report will be reviewed and signed off by the Cancer Board prior to sharing with the CCG (in line with NHS England Guidelines). From December 2017, under the leadership of the Lead Cancer Nurse, a clinical incident review will also be undertaken for any patient graded as 1B (potential harm) or 1C (harm caused) following completion of the harm proforma.

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.

104+ day breaches - year to date (January 2017 onwards) September 2018 is a predicted figure (unvalidated)

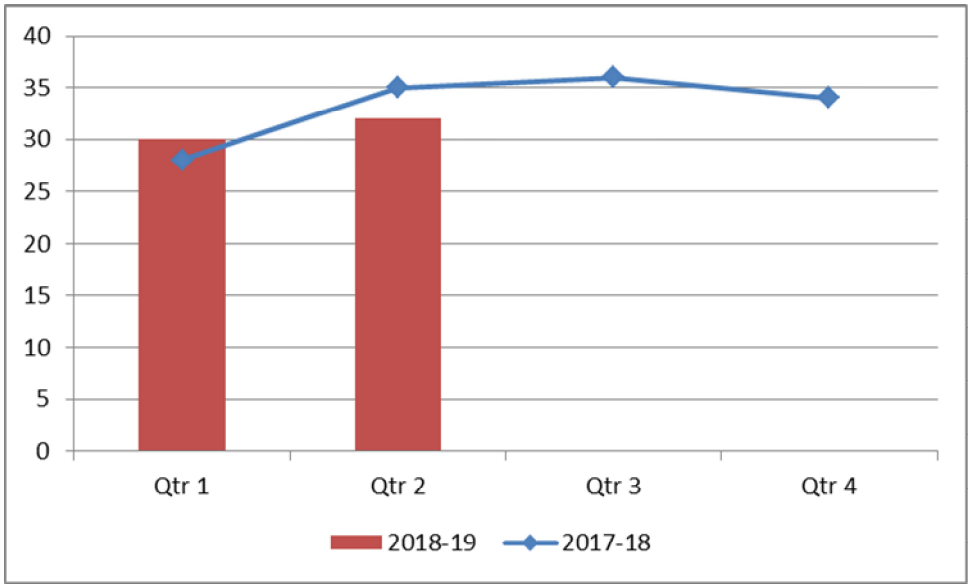


Safeguarding

Safeguarding Vulnerable Adults

In Qtr Two 2018-2019 there were 32 safeguarding concerns raised that involved the Trust. Of these, 25 were raised by the Trust against other agencies and seven were raised against the Trust. None of the latter met the criteria for a Section 42 enquiry. (Section 42 of the Care Act places a duty on local authorities to make enquiries, or cause enquiries to be made, where certain adults are considered to be experiencing or at risk of abuse or neglect. The purpose of the enquiries is to decide if any safeguarding action is necessary and if so, who is to take it).

Safeguarding concerns involving the Trust Qtr Two 2018-2019



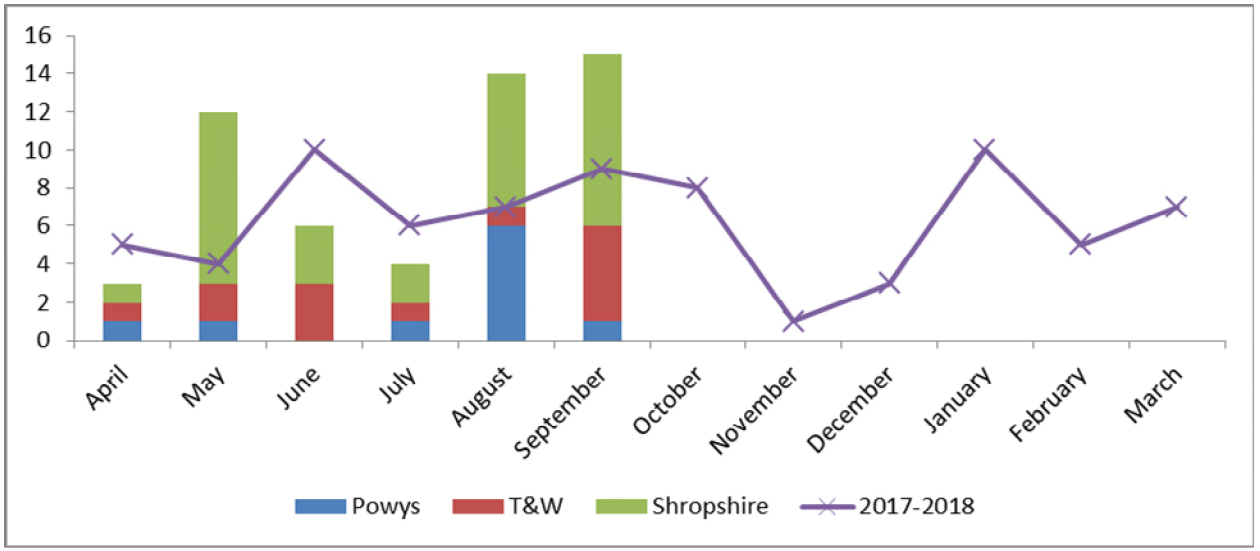
The seven concerns raised about the Trust related to:

Area concerned	Detail	Actions and Outcome
Ward 7 and Ward 8 PRH	A relative raised concerns regarding the care on ward seven and also discharge arrangements from ward eight, both at PRH. The patient was readmitted within 24 hours of discharge.	Investigation complete Statements submitted to the Safeguarding Team and the CCG The Ward Manager is discussing this referral with her members of staff. She will highlight the importance of keeping relatives informed regarding discharge arrangements Outcome: Does not meet the criteria for a section 42 enquiry. Closed to safeguarding.
Ward 10 PRH	A referral was made by a Nursing Home as a patient was discharged with excoriated sacrum and feet. Barrier cream being used in the hospital was not sent out with the patient on discharge. The patient was readmitted within 48 hours of discharge.	Investigation complete Statements submitted to the relevant safeguarding team and relevant CCG. Outcome: Does not meet the criteria for a section 42 enquiry. Closed to safeguarding.
Ward 28 RSH	Referral made by Safeguarding SaTH as patient was discharged without requesting District Nurse to administer their daily insulin. Readmitted the following day with hyperglycaemia.	Investigation complete Statements submitted to the safeguarding team and relevant CCG. Discharging nurse did not follow the correct pathway in her discharge arrangements. Ward Manager has reinforced that there are different processes for DN referrals depending on where the patient resides. Outcome: Closed to safeguarding as substantiated
Ward 28 RSH	Referral made by Safeguarding SaTH as patient developed two Grade 3 sacral pressure ulcers. Assessed by TVN and scored 17 against the Pressure Ulcer Protocol for Adult Safeguarding.	Closed to safeguarding. For internal investigation.

Area concerned	Detail	Actions and Outcome
Ward 27 RSH	Referral made by family member who raised concerns that a patient was discharged from ward 27 SD without care and catheter equipment.	Investigation completed Statement submitted to the safeguarding Team and relevant CCG. Documentation supports that patient was discharged with a catheter pack and education provided in regards to catheter care before discharge. A referral was also made to the District Nurses. Patient was also assessed as fully independent of her personal care. Does not meet the criteria for a section 42 enquiry. Closed to safeguarding.
Ward 10 PRH	Referral made by patient as he was discharged without care being arranged. Patient had requested the care himself and contacted Social Services when he arrived home	Closed to safeguarding. For internal investigation
Ward 8 PRH	Referral made by warden as patient had been discharged without requesting District Nurse to administer insulin.	Closed to safeguarding. For internal investigation

Deprivation of Liberty Safeguards (DOLS)

The chart below shows the number of DOLS referrals made to our Local Authorities during Qtrs One and Two 2018-2019. There were 33 referrals in Qtr two compared to 21 referrals in Qtr One. At the time of reporting none of the referrals had been approved by the Local authorities.



Safeguarding Training

Safeguarding training is a mandatory requirement under the Children Act 2004 for staff in the public sector. This is also a mandatory requirement for Adult Safeguarding under the Care Act 2014 and now more recently with the Intercollegiate document 2018. The requirement for training set by CQC is 80%. At present we are not achieving the compliance levels for Level Two training which is at 61% for adults and 64% for Children. A recovery plan is in place and additional training sessions arranged. Additionally the training is now mandatory.

Safeguarding Children

During the first two quarters of 2018-2019 there were no Safeguarding Children referrals made to social care in relation to the Trust. During Qtr 2 the Trust made referrals to social care in relation to 21 children and young people. None were children in the care of the local authorities or on a Child Protection plan.

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.

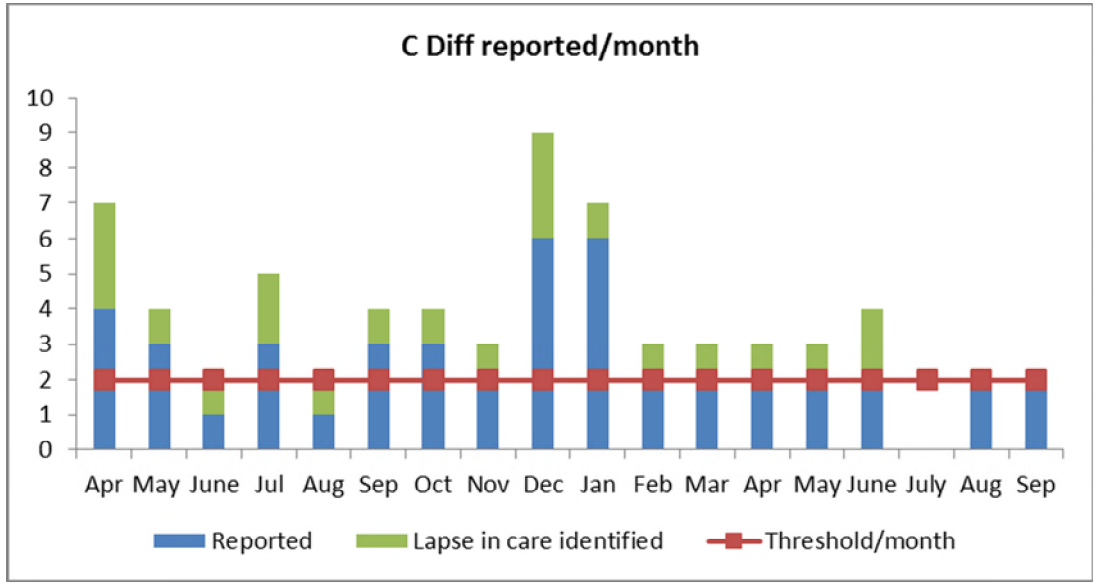
During Qtr one 2018-2019 the Trust continued to train members of staff through WRAP as part of the Statutory training programme but since July 2018 this has ceased and the training is either via online training through a national programme or face to face sessions arranged in different areas of the Trust. We are now 62.9% compliant with training for WRAP.

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)

In September two C Diff incidents were reported, bringing the total in the quarter to four compared to seven in the same quarter last year. The chart below shows the number of C Diff incidents reported since April 2017 to date.



MRSA Bacteraemia

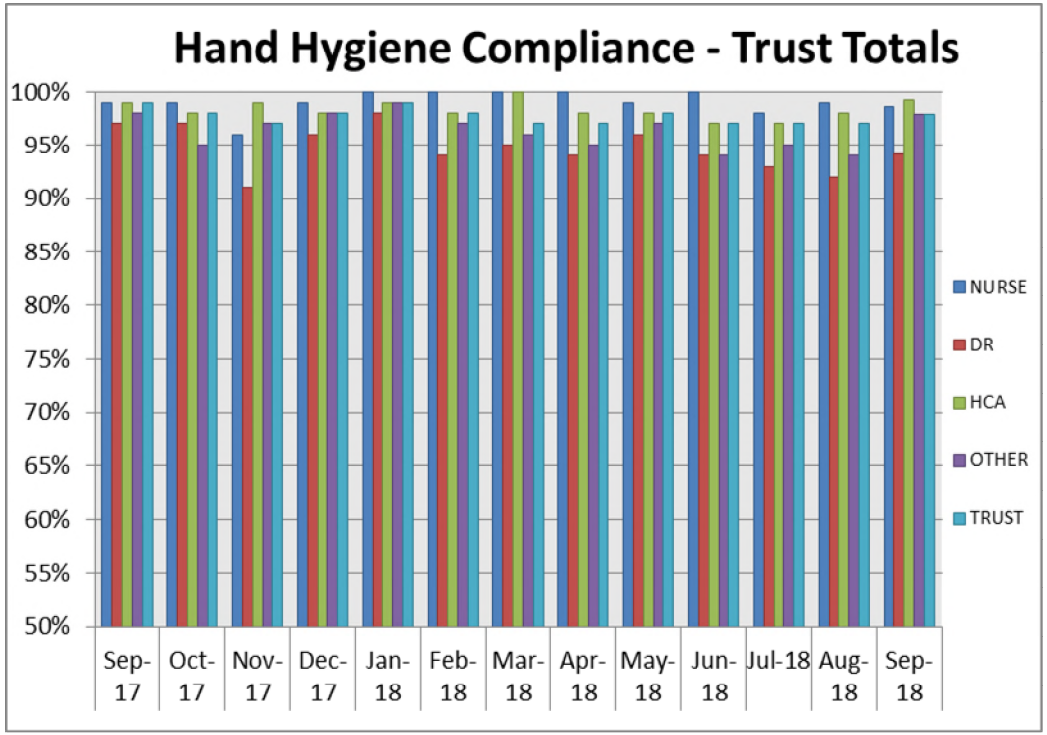
No MRSA bacteraemia were reported in September, bringing the total in the quarter to one (reported in July).

Visit by NHSi Senior Infection Prevention and Control Advisor

The visit by the NHSi Senior Infection Prevention and Control Advisor took place on 19 June 2018 at PRH in response to a period of increased incidences. As a result, the Trust has been required to complete an Improvement Action Plan which has been developed and is in progress. The action plan is being monitored by the Trust Infection Prevention and Control Committee for assurance against completion.

Hand Hygiene Audits

The hand hygiene observational audit results have been analysed against staff groups and show the following level of compliance:



NURSE	DR	HCA	OTHER	TRUST
98.6%	94.2%	99.3%	97.9%	97.9%

Section four: Mortality

Introduction

SaTH aspires to be an organisation delivering high quality care which is clinically effective and safe and this partly is achieved by continually monitoring and learning from mortality. These can provide SaTH with valuable insights into areas for improvement. To support that the governance around mortality is well developed, in order to provide continued learning and improvements to the clinical pathways and to reduce unnecessary harm to patients.

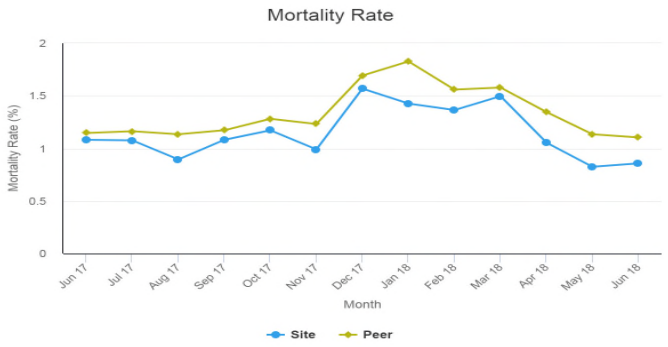
We have seen an improvement in our performance regarding mortality over the last four years, and this has been maintained over the last year. This is demonstrated consistently over the four mortality parameters that we use and we now are consistently lower than our peer comparators[1]. The following is an update of progress in this area, based on the most up to date information available.

1. Mortality Rate

This indicator provides a basic view of mortality: the number of deaths divided by the total spells.

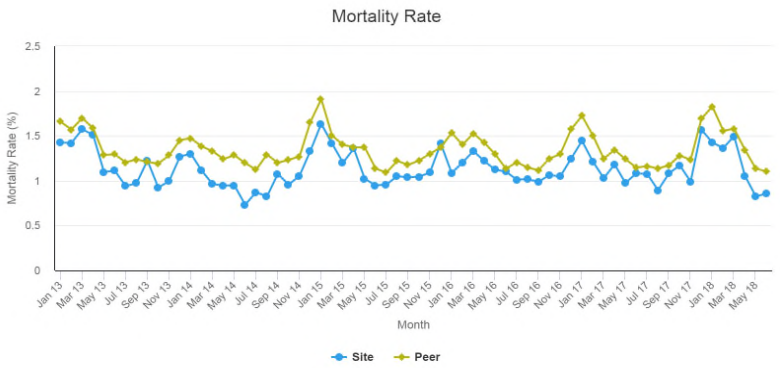
SaTH Mortality Rate (June 2017 – June 2018)
SaTH 0.86% v Peer 1.10%

Figure 1 – Short term view



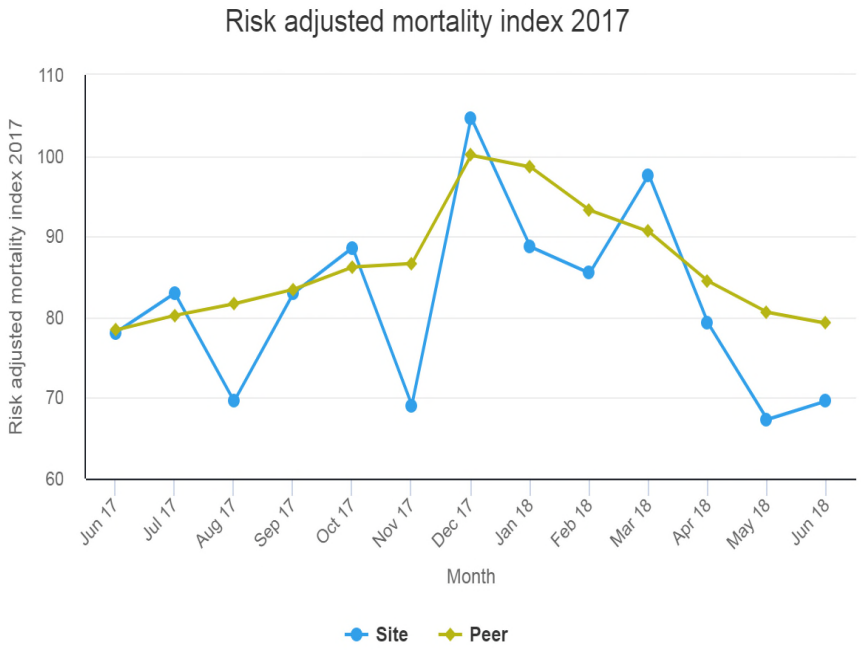
SaTH Mortality Rate (January 2013 – June 2018)

Figure 2 – Long term view

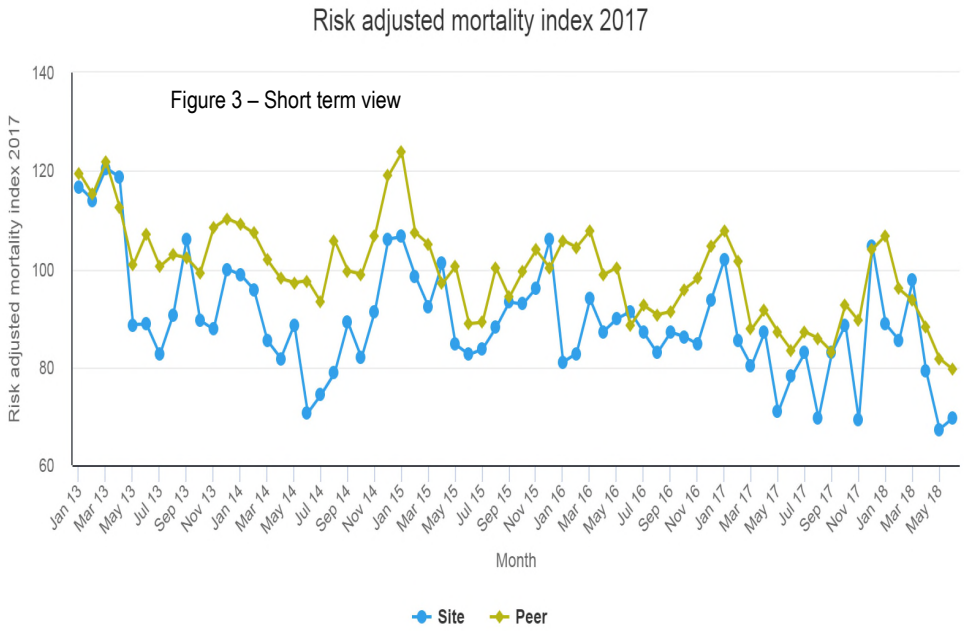


2. RAMI – Risk Adjusted Mortality Index *

RAMI (June 2017 – June 2018)
SaTH 69.62 v Peer 79.50



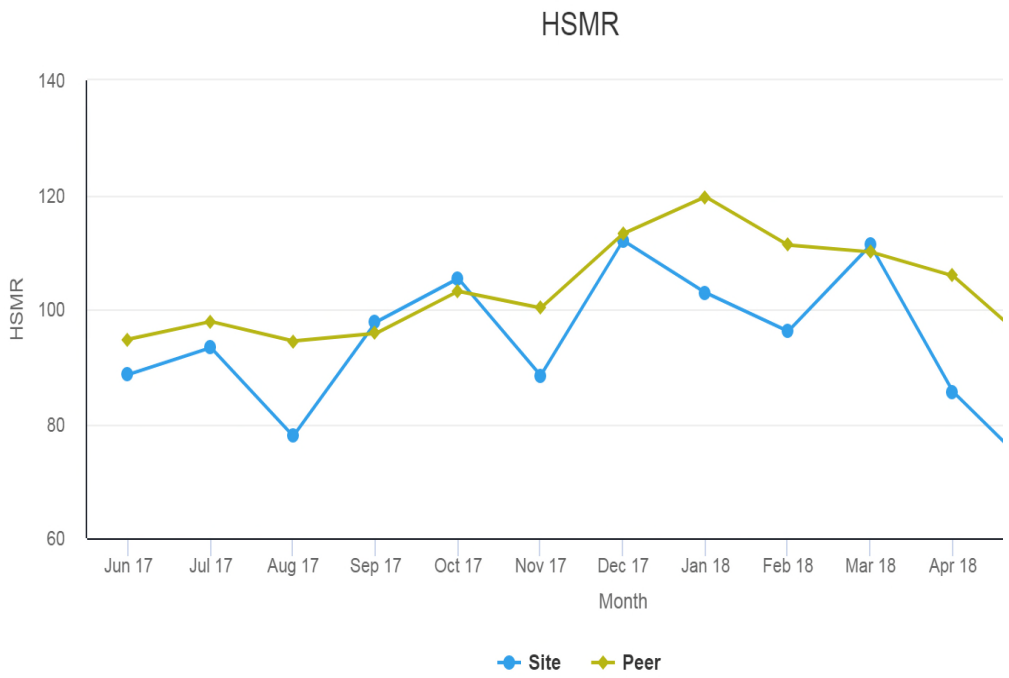
RAMI – SaTH v Trust Peer (January 2013 – June 2018)



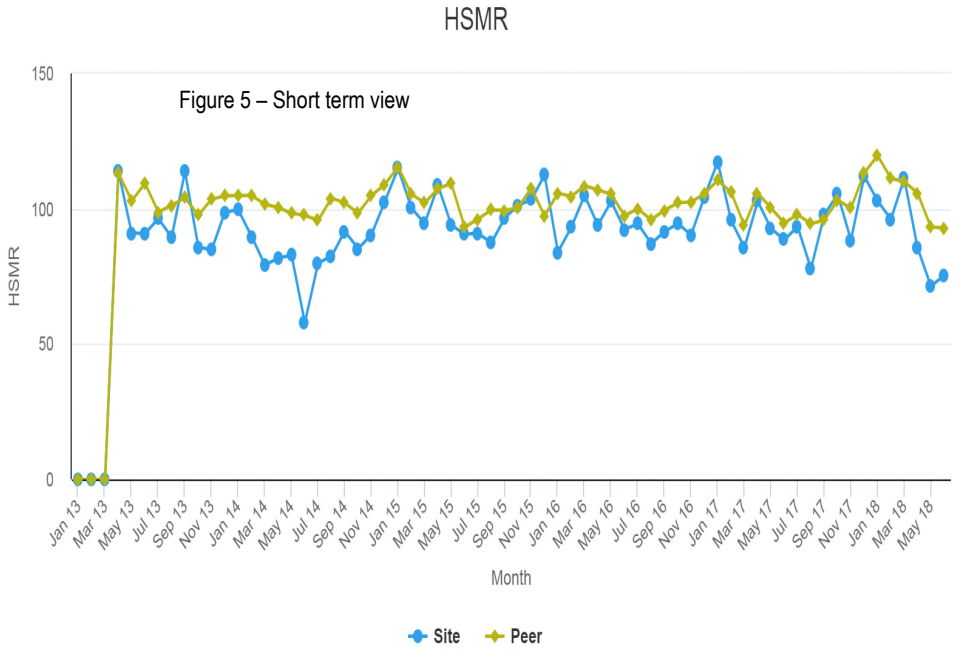
* This mortality ratio is described as the number of observed deaths divided by the number of predicted deaths. RAMI was developed by CHKS (Caspe Healthcare Knowledge System). It includes palliative care but excludes certain specialties, such as Mental Handicap, Mental Illness, Child & Adolescent Psychiatry, Forensic Psychiatry, Psychotherapy, Old Age Psychiatry.

3. HSMR – Hospital Standardised Mortality Ratio **

HSMR (June 2017 – June 2018)
SaTH 75.35 v Peer 92.91



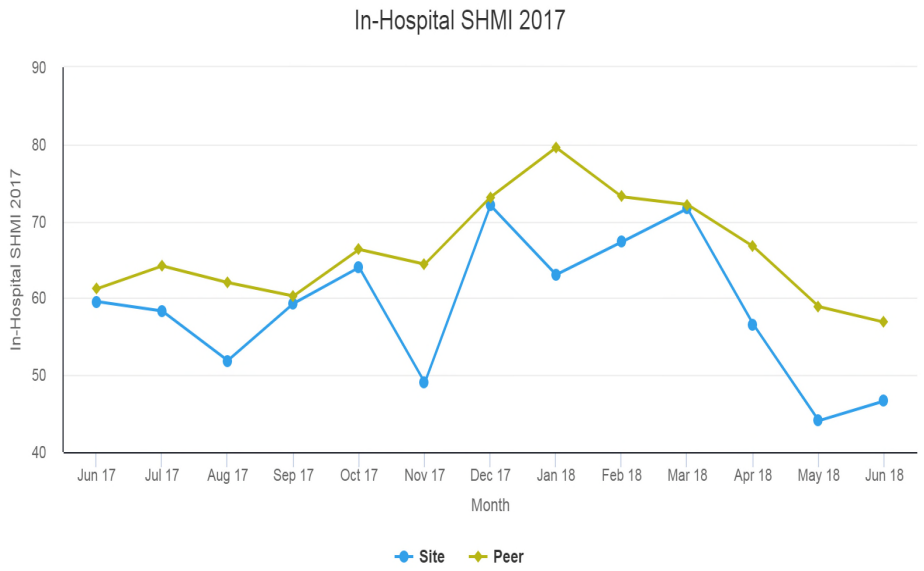
HSMR - SaTH v Trust Peer (January 2013 – June 2018)



** The HSMR is the ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups. These groups contribute to over 80% of in-hospital deaths in England.
NB A value greater than 100 means that the patient group being studied has a higher mortality level than NHS average performance.

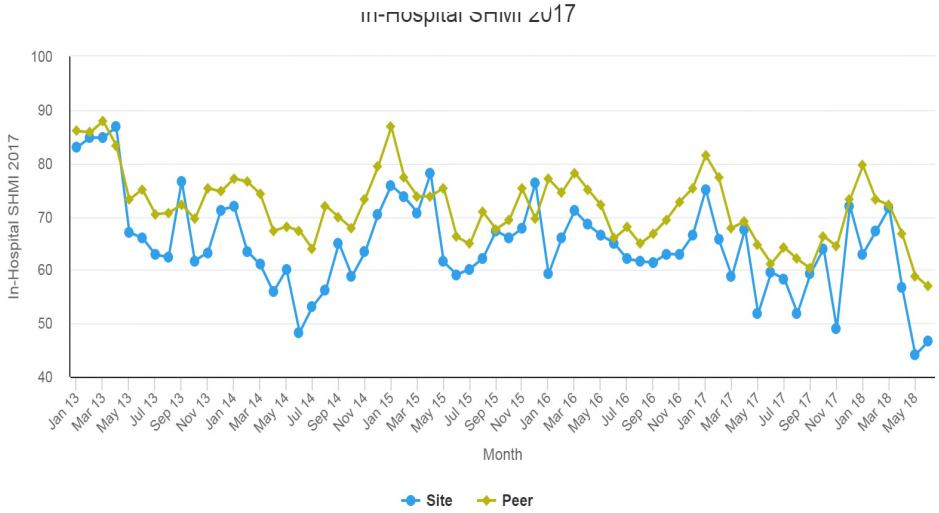
4. SHMI – Summary Hospital-level Mortality Indicator (In-hospital)
***

In-Hospital SHMI (June 2017 – June 2018)
SaTH 46.65 v Peer 56.87



In-Hospital SHMI - SaTH v Trust Peer (January 2013 – June 2018)

Figure 7 – Short term view



*** The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die, on the basis of average England figures, given the characteristics of the patients treated there. SHMI gives a complete picture of measuring hospital mortality by including deaths up to 30 days after discharge from hospital and is counted once against the discharging hospital. This does not exclude palliative care but does exclude day cases. It is based on 259 clinical classification system diagnostic groups.

SHMI-type indicators **cannot** be used to quantify hospital care quality directly due to the limitations of datasets in SUS and HES

Action Schedule Summaries

Quarter 1 (2017/2018) – Fractured Neck of Femur – RSH
An in-depth review of mortality was undertaken. The formal report noted two patients whose deaths have had avoidable factors identified. In the first patient, following an inquest, a narrative verdict found that the patient died from the effects of natural disease shortly after undergoing surgery. The second patient died following an in-patient fall but did not proceed to inquest and cause of death was noted as myocardial ischaemia, coronary artery atheroma, osteoporotic fracture left hip (treated). All patients had characteristics of frailty and significant co-morbidities. All but four patients had acute illness leading up to fracture neck of femur and need for surgery. Recommendations following the review were:

- To introduce a single page guideline for the management of hypotension based on NICE guidelines for junior doctors called to see patients with a fractured neck of femur - completed.
- Extend recovery resource for monitoring post-operatively – completed.
- Additional physiotherapy support during the winter period (November - April) – completed.

Quarter 2 (2017/2018) – Fluids and Electrolytes
An in-depth review was undertaken that demonstrated that 15% of the sample were incorrectly included due to administrative errors on source of admission. This was due to incorrect coding as this not the first consultant episode, or it was readmission from Community Hospitals when end of life care would have been more appropriate. Concern was raised about an increase in December 2015, March and April 2016 which may reflect patients being readmitted with fluid and electrolyte disorders at times of high activity. Most patients were admitted with dehydration secondary to sepsis, UTI or pneumonia. Readmission rate within 28 days overall was below peer average. The figures in November 2016 showed variation between observed and expected mortality as stable and within expected control limits. Recommendations following the review were:

- Continue to monitor this group for a further 6 months to assess any changes
- Identify administrative personnel to address the administrative errors.
- SaTH Medical Director to speak with Shropshire Community Medical Director to share conclusions and consider how to reduce number of unnecessary transfers – completed.

Further joint review of Fluid and Electrolytes completed with the Community Trust July 2017

This demonstrated a group of frail and complex patients with underlying co-morbidities which had been recognised in the previous review. It was noted that there were a number of differences in the clinical management between Acute Tr
ust and Community Trust which include:

- Intravenous fluid administration protocols
- Use of subcutaneous fluid administration
- Administration of the Sepsis bundle
- The need for greater co-ordination of decision making by and for patients regarding end of life care

This will be part of an ongoing review of continued co-operation between the Trusts.

Quarter 3 (2017/2018) - Work on Learning from Deaths Report

The standards set out within *the National Quality Board Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, investigating and Learning from Deaths in Care* were met within the specified timescales. In November 2017, the Medical Director presented the first Trust Mortality casenote review Dashboard at Trust Board. Findings from the mortality casenote review process and LeDeR review will continue to be published quarterly.

Quarter 4 (2017/2018) - Pneumonia – pleurisy, pneumothorax and pulmonary collapse
This classification group contains small numbers. 19 observed deaths over the year, compared to a sum of 12 expected deaths. Small cumulative variations therefore made a large difference, and in September 2017, 4 consecutive months of 0-2 more observed than expected deaths caused the plot line to cross the 2 SD limit, potentially triggering an alert. The 2 patients in July died at the Community hospitals and are included as superspells. Like the Fluid and Electrolyte group, these patients were elderly, with multiple co-morbidities, and whilst the majority were treated for a pleural effusion in the first consultant episode (FCE), the underlying cause of the effusion was the cause of their death.

Investigation complete and findings presented at Mortality Group. No further action to be taken.

Quarter 1 (2018/2019) – PE 90 day post-discharge
Audit is in progress using the NICE guidelines from March 2018. Reports will be completed to be presented at the Mortality Meeting in November.

Quarter 2 (2018/2019) – Emergency Department Mortality
A report identifying the patients under the new codes was put in place and the number of deaths has been checked back to April 2016. For 2017-18 there were 144 deaths recorded at PRH ED and 124 at RSH ED. There was a change in coding of deaths in the ED at the end of last year, which caused difficulties with identifying the patients for review. This information has been shared as part of a regularly updated Review of Safety Metrics in our ED. A detailed paper, that will consolidate all work on Mortality in our ED, is being prepared, in order to provide a baseline assessment prior to the changes in service provision overnight at PRH.

The preliminary findings of a detailed analysis of Emergency Department deaths at SaTH during 2017-18 suggests that the higher number of total deaths at PRH ED is partly attributable to a higher number of patients who suffered out of hospital cardiac arrests being brought to the PRH Emergency department (20-25% more). There is concern on both sites regarding the early recognition and treatment of sepsis and this featured in a small number of Serious Incidents reported by PRH. This is being addressed though the roll-out of the Trust's Sepsis Improvement Plan.

Casenote reviews confirm there is not a large variation in care between the 2 sites for patients who died in the ED. The reporting of these incidents at PRH can be seen as a measure of robust Governance for which the work of the ED and Medical Clinical Governance Leads should be acknowledged. However, a higher number of attendances and higher number of patients requiring admission via the ED in 2017-18 suggests more acutely unwell patients are currently attending PRH than in previous years, leading to a concurrent rise in death rates. With less permanent medical and nursing staff based in this department, this is of concern.

Action Schedule
Mortality review meetings identify areas which need further investigation which are noted on the table below.

2015/2016	Theme
Quarter 2	Understand and implement actions to reduce avoidable deaths in nephrological conditions and Acute Kidney Injury
Quarter 3	National Indicator - PE 90 day post discharge mortality per 1,000 spells. 28 cases
Quarter 4	Deaths with bowel pathology - 'Acute abdomens' at PRH

2016/2017	Theme
Quarter 1	Infectious Conditions – understand and implement actions to reduce avoidable deaths from infectious conditions and Sepsis
Quarter 2	Acute Myeloid Leukaemia
Quarter 3	Acute Myocardial Infarction
Quarter 4	Other Perinatal Conditions
2017/2018	Theme
Quarter 1	Fractured Neck of Femur - RSH
Quarter 2	Fluid and Electrolyte Disorders
Quarter 3	Working on Learning from Deaths Report
Quarter 4	Pneumonia – pleurisy, pneumothorax and pulmonary collapse
2018/2019	Theme
Quarter 1	PE 90 day post-discharge
Quarter 2	ED Mortality
Quarter 3	Fracture Neck of Femur - PRH

The Peer group used for this mortality report comprises of the following Trusts:

- Gloucestershire Hospitals NHS Trust
- Sandwell and West Birmingham NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- The Royal Wolverhampton Hospital NHS Trust
- The Dudley Group NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Maidstone and Tunbridge Wells NHS Trust
- East and North Hertfordshire NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- Western Sussex Hospitals NHS Foundation Trust

Section five: 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 September 2018
- **Consider** the actions being taken where performance requires improvement
- **Question** the report to ensure appropriate assurance is in place