Cover page	
Meeting	**Trust Board**
Paper No.	10
Paper Title	Quality Governance Report
Date of meeting	7th February 2019
Date paper was written	15th January 2019
Responsible Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author	Peter Jeffries, Associate Director of Quality, Governance and Risk
Previously considered by	Quality and Safety Committee 23rd January 2019

The Board is asked to:			
☐ Approve	☑ Receive	☐ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☐ Responsive	☐ Well-led

Link to strategic objective(s)	☐ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☑ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	***Risk 951:*** 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 ***Risk 1204:*** If the Maternity Service does not evidence a robust approach to learning and quality improvement there will be a lack of public confidence and reputational damage ***Risk 1134:*** If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to Patients. ***Risk 1185:*** if we do not have the Patients in the right place, by removing medical outliers, Patient experience will be affected

Equality Impact Assessment	(•) Stage 1 only (no negative impact identified) ( ) Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
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
Financial assessment	*Is there a financial impact associated with the paper?*

Main Paper

Situation

The purpose of this report is to provide the Committee with assurance relating to our compliance with quality performance measures during December 2018.

Background

The report has previously been received at Quality and Safety Committee on 23rd January 2019

Assessment

Key points to note:

In December 2018 there was no avoidable grade 3 or 4 pressure ulcers recorded.

In December 2018 we reported three serious incidents. Board are asked to note one of these incidents has been designated as a never event after seeking clarity from the central NHSI Safety Team (as discussed at Quality and Safety Committee in December 2018). The number of serious incidents reported was similar to the same period in 2017/18.

In December there were eleven adult and six children's referrals made to local authority Safeguarding Teams.

During December 1 >12 hour ED wait breach was recorded and had a serious harm review undertaken which concluded that no harm had been caused.

The overall percentage of respondents who would recommend the ward they were treated on to friends and family if they needed similar care and treatment was 97.4% which was slightly lower than Novembers figure of 97.6%

An increased number of >12 hours discharge breaches from ITU were recorded in December 2018 totalling 42 compared to a figure of 30 in November 2018

Recommendation

Trust Board are asked to:

- Receive and take assurance from the Quality Governance report

Paper 10

Quality Governance Report January 2019

INTRODUCTION

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

The report will be submitted to the Quality and Safety Committee as a standalone document and will then be presented to Trust Board as part of the integrated 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.

CONTENTS

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

Measure	Year end 17/18	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
CDI due to lapse in care (CCG panel)	13	1	1	0	1	1	2	0	1	2				7	2	25
Total CDI reported	32	6	2	2	2	2	2	0	2	2	1	1	2	14	2	25
MRSA Bacteraemia Infections *Contaminant	0	0	0	0	1	1*	0	1*	0	0	1*	1 *	0	5	0	0
MSSA Bacteraemia Infections	26	2	3	1	1	1	3	2	4	3	1	2	1	18	None	None
E. Coli Bacteraemia Infections	29	6	5	2	4	2	6	6	4	3	7	8	5	45	None	None
MRSA Screening (elective) (%)		94.0%	95.0%	95.4%	96.5%	96.5%	95.7%	95.6%	95.4%	97.6%	95.4%	95.9%	95.2%	95.9%	95%	95%
MRSA Screening (non elective) (%)		94.8%	94.0%	95.62%	96.7%	95.9%	96.6%	96.2%	96.8%	96.7%	96.5%	97.1%	97.0%	96.6	95%	95%
Grade 2 Avoidable	48	6	5	4	0	3	2	3	0	2	1	1	2	14	0	0
Grade 2 Unavoidable	157	14	18	10	15	7	9	7	11	10	4	2	1*	66*	None	None
Grade 3 Avoidable	9	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Grade 3 Unavoidable	22	6	1	2	2	1	0	2	0	3	1	2	3	14	None	None
Grade 4 Avoidable	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0
Grade 4 Unavoidable	1	0	0	0	0	1	0	0	0	0	0	0	0	1	None	None
Falls reported as serious incidents	3	0	1	0	0	0	1	0	1	0	0	0	0	2	None	None
Number of Serious Incidents	48	3	3	2	2	4	9	1	2	2	3	4	3	30	None	None

Measure	Year end 17/18	Jan 18	Feb 18	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Year to date 18/19	Monthly Target 2018/19	Annual Target 2018/19
Never Event	2	0	1	0	0	1	1	0	0	1	0	0	1	4	0	0
Catheter Associated UTI (number of patients on prevalence audit)		3	1	6	3	2	10	1	3	3	2	6	0*	30	None	None
WHO Safe Surgery Checklist (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE Assessment		95.1	95.68	95.2%	95.1%	95.9%	95.9%	95.9%	95.6%	96.0%	97.3%	95.9%		95.9%	95%	95%
ITU discharge delays>12hrs	380	17	28	35	41	27	35	36	36	46	40	30	42	333	None	None
No of MSA breaches other areas	1	0	0	0	0	0	0	1	0	0	0	0	0	1	None	None
Complaints (No)	600	49	60	56	54	55	55	60	54	58	55	82	40	513	None	None
Friends and Family Response Rate (%)	23.8%	11.1%	13.6%	16.1%	19.9%	17.7%	20.4%	20.8%	20.8%	16.5%	14.6%	16.7%	11.4%	14.8%	None	None
Friends and Family Test Score (%)	96.6%	96.6	96.2%	96.4%	97.3%	96.6%	96.6%	95.6%	93.3%	97.1%	97.2%	97.6%	97.4%	96.5%	95%	95%

***** *Grade 2 unavoidable pressure ulcers figure was subject to final validation at the point this report was compiled to Quality and Safety Committee*

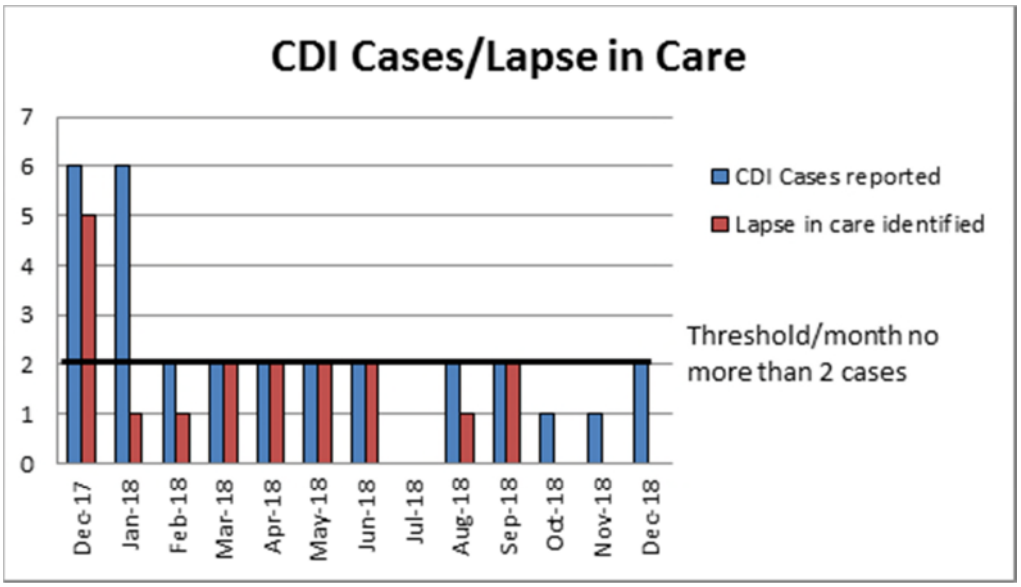
***** *Previous Catheter Associated UTI figures were based on information from the NHS Safety Thermometer. In December 2018 SaTH moved to a new point prevalence audit based around patients with an in situ urinary catheter or who have had a urinary catheter in place within the previous 72 hours*

Section Two: Key Messages by exception

Infection Prevention and Control

Clostridium Difficile (C Diff)

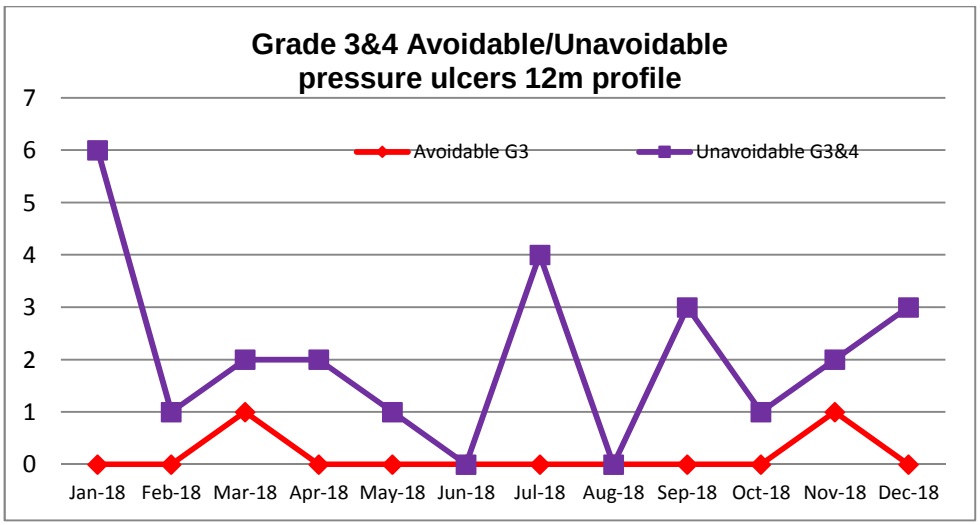
One incident of C diff during was reported during October, one in November and two in December 2018. The quarterly review panel convened by our commissioner to review the cases from quarter 3 will not meet until the end of January; therefore the final decision relating to any lapses in care will be reported during February. We are currently under the target trajectory for the financial year to date. This target is set by PHE.



Methicillin-resistant Staphylococcus Aureus (MRSA)

There were no cases of MRSA Bacteraemia in December. In November there were two 'Pre 48 hour' cases reported one of which not attributed to SaTH, the other was still under investigation at the time of the previous report. This investigation has now completed and the decision was the case is considered a contaminant, therefore will be attributable to the Trust. This brings the total cases attributed to SaTH for the financial year to date to 5 cases. This is against a target of 0. 4 of these cases were contaminants.

Learning from in service pressure ulcer incidence

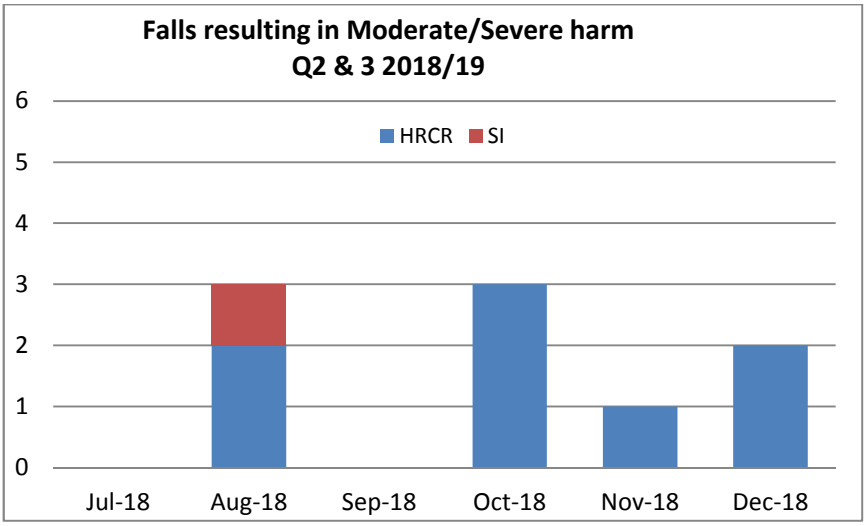


There were no avoidable grade 3 or 4 pressure ulcers reported in December 2018. During Quarter 3 there have been were 5 Category 3 pressure ulcers classified as unavoidable, 3 of which were reported in December 2018.

To date we have identified four avoidable Category 2 pressure ulcers during Qtr. 3 2018/19. RCAs have been completed and appropriate actions identified and shared with the ward staff. The learning related to inconsistencies relating to accurate assessment and monitoring of the condition of the patient's skin, in one case this was complicated by the patient's compliance, another by being end of life.

We have reported 14 avoidable Category 2 pressure ulcers in the financial year to date. (We reported a total of 33 to date for 2017/18)

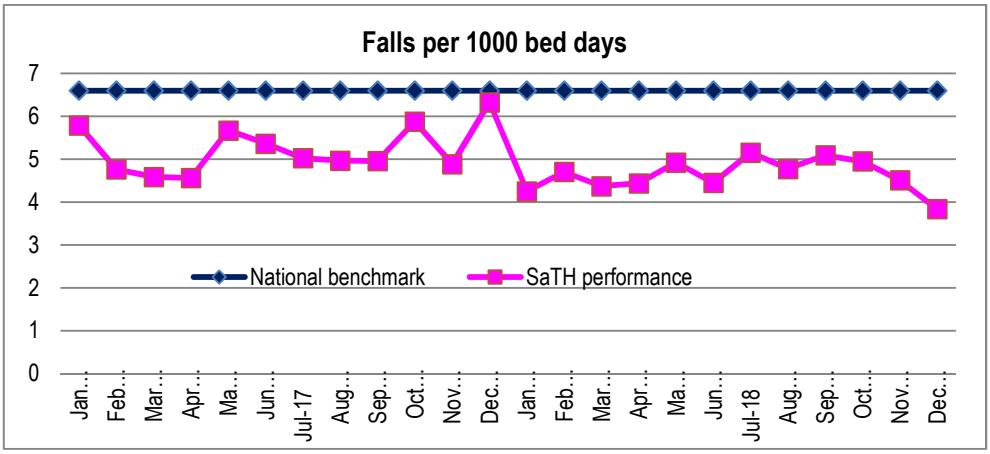
Patient Falls



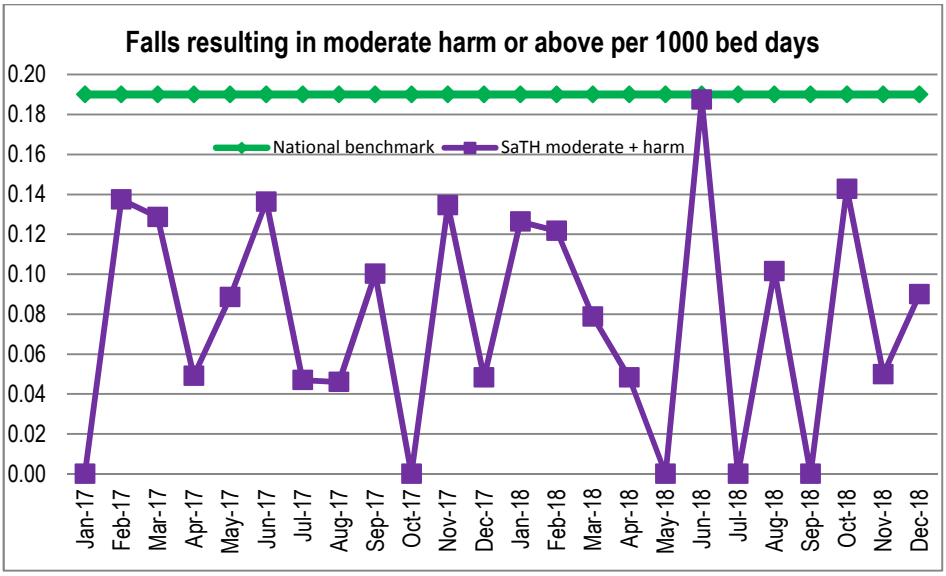
During December 2018 there were two falls resulting in moderate harm both of which were investigated as high risk case reviews.

In both instances the patients injuries were small sub-arachnoid haemhorrages, which did not require surgical intervention. In both cases appropriate assessments were in place and the falls deemed unpreventable.

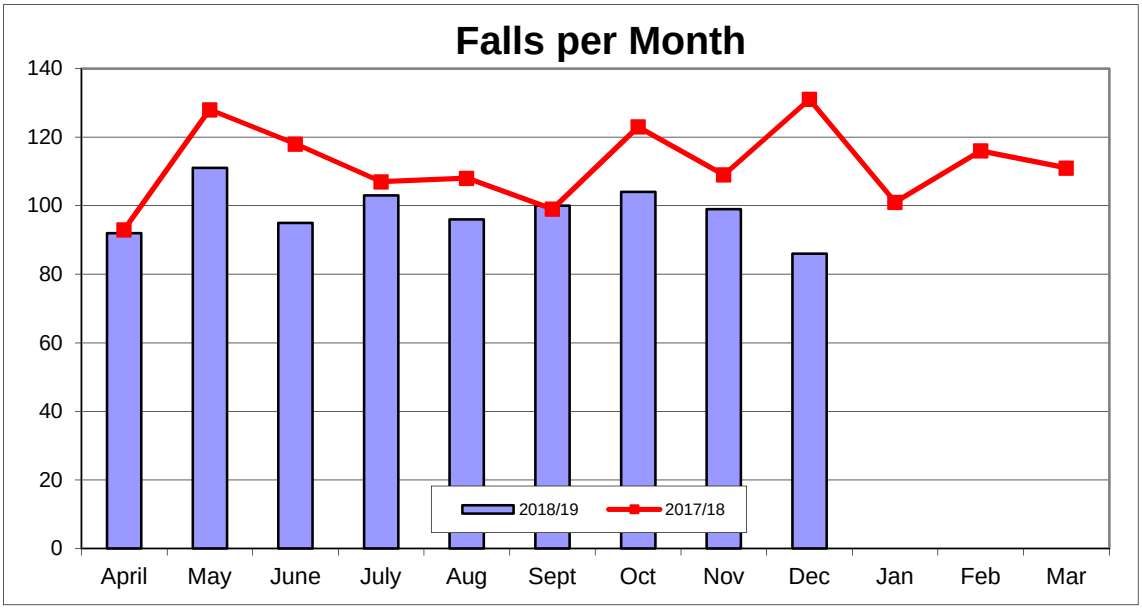
The Trust continues to perform well when benchmarked nationally as outlined in the graph below:



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



Complaints & PALS

40 formal complaints were received December 2018; this is in keeping with lower numbers over the holiday season. There are no new trends in relation to the subject of complaints, but there has been an increase in complaints related to the AMU at PRH. This has been raised with the manager and matron and appears to be linked to capacity issues and the length of time patients are waiting to be seen. 124 PALS contact were received in December 2018.

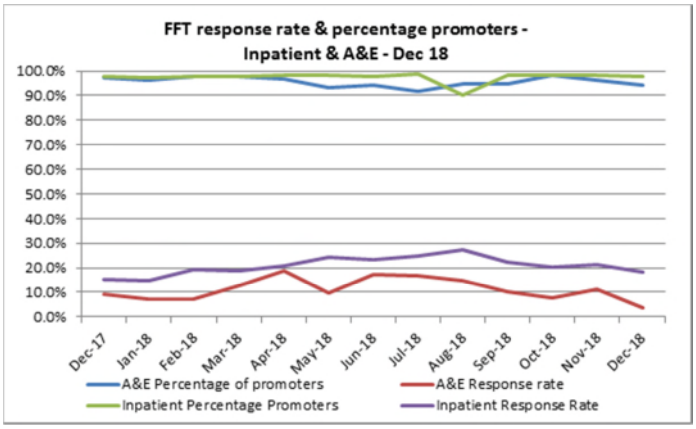
Friends and Family Test

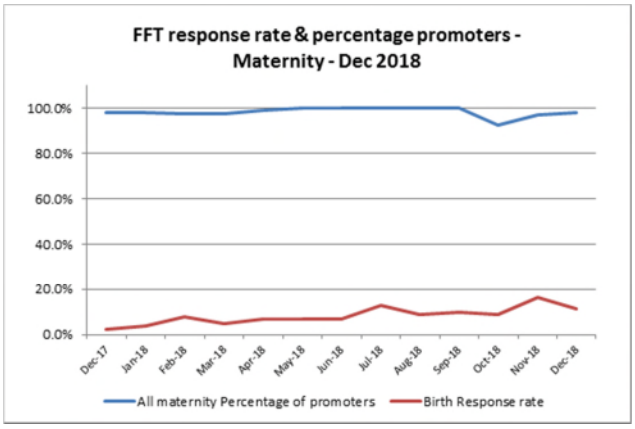
The overall response rate was 11.4% which is a decrease compared to the previous month (16.7%). Inpatients, A&E and Maternity Birth all individually saw a decline percentage of completed FFTs cards compared to November.

The IPR data for December 2018 is as follows:

The FFT response rate for IPR = 11.4%
The FFT percentage promoters for IPR = 97.4%

	Percentage Promoters	Response Rate
Inpatient	98.0%	18.4%
A&E	94.5%	3.9%
Maternity overall	98.0%	11.3% (Birth only)
Outpatients	97.4%	NA





Learning from Incidents

Serious Incidents

Category	Number
Delayed action following CT results	1
Possible Never Event - Wrong eye laser	1
Treatment delay	1
	3

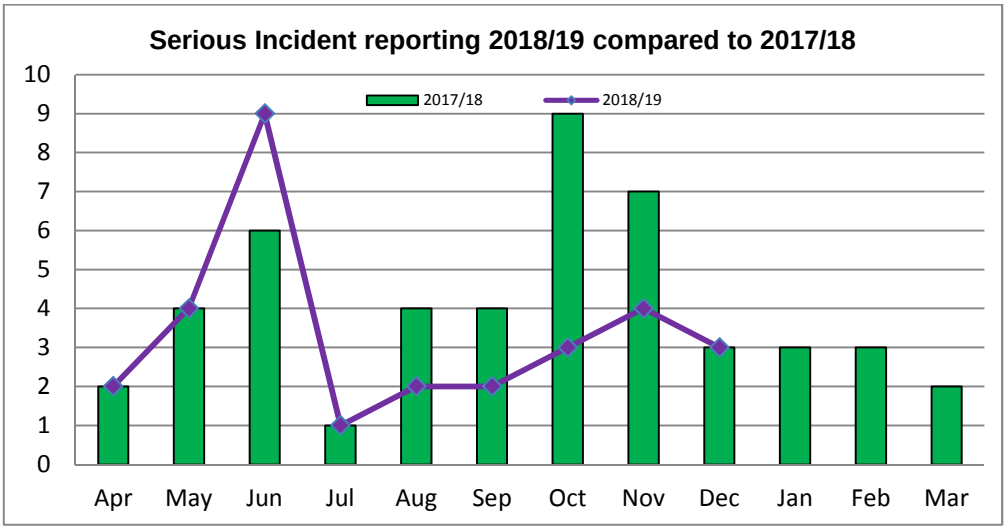
December SI's

- Incidental finding identified on diagnostic renal CT scan. Recommendation on the report for further imaging of a 3cm liver lesion. Not taken to MDT as planned. 12 months later patient re-presented and CT scan has identified the lesion is now 9.1cm which is no longer operable.

- Patient booked for outpatients left eye retinal PRP indirect laser. Patient was consented and agreed for left eye retinal laser. The left eye was prepared with anaesthetic drops in preparation for the laser specific contact lens application. The contact lens was placed on the right eye and a few laser spots applied, before the procedure was halted. While there is evidence to suggest this may not be a Never Event, at the request of the Commissioners this has been identified as such until the investigation is

completed at which time evidence one way or another may be submitted to suggest the appropriate classification.

- In August 2018 this patient underwent a total knee replacement performed on his right knee. During the post-operative period he developed a swollen, tender and warm right calf with reduced sensation. An Ultrasound of the limb was performed and a 3.2 cm popliteal aneurysm was identified. On transfer to rehabilitation, the discharge summary identified that the rehabilitation ward should monitor the limb and recommended that the GP arrange a vascular appointment. He was readmitted to SaTH in December 2018, investigations determined that the aneurysm had ruptured. No appointment with the vascular team had been arranged by the GP, and monitoring by the rehabilitation team had not recognised signs of deterioration. On review the vascular team have advised that referral to their team could have been facilitated by the MSK team. Incident being managed by SaTH and the rehabilitation hospital.



As shown in the graph above the number of serious incidents reported in December 2017/18 was at a similar level to the number reported in the same period during 2016/17.

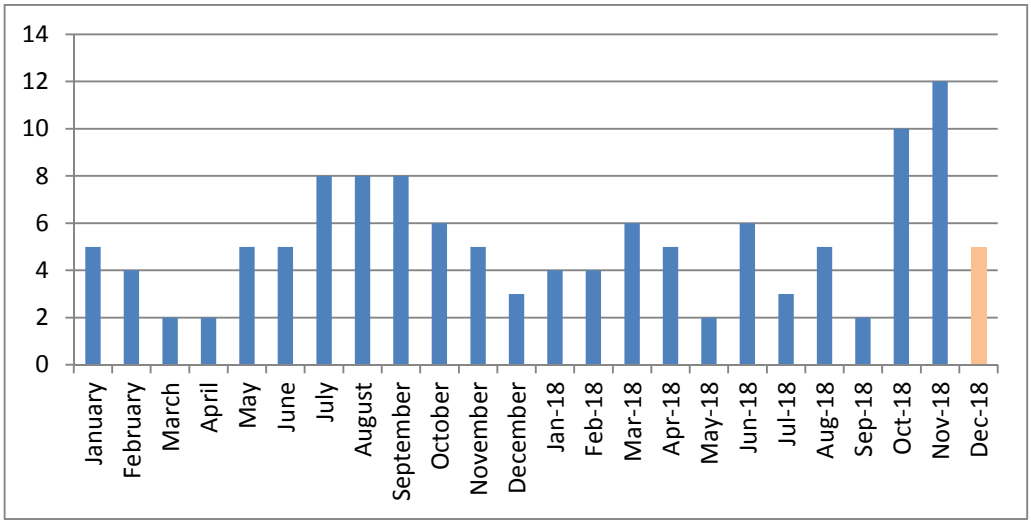
> 12 Hour ED breaches/harm reviews

During December 1 >12 hour ED wait breach was recorded. The breach was subject to a serious harm review. The review concluded that no harm had been caused

Waiting for cancer treatment for more than 104 days

104+ Day Breaches – Year to date (January 2017 onwards)

** Please note December 2018 is a predicted figure (unvalidated)*



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

Specialty	Day Treated	Breach Reason
Colorectal	134	Patient choice - patient delayed first appointment. Patient requested second opinion from other named consultant (via GP). Second 2WW referral delayed this pathway.
	126	Complex pathway / delay for diagnostics. Initial referral to Upper GI. Referred to colorectal team after day 62. 27 days for CT from request to report. 16 days for biopsy from request to report. 27 day wait for oncology OPA (capacity).
	134	Delay for diagnostics / complex diagnostic pathway. 31 days for CT from request to report. x3 subsequent investigations failed to find or rule out cancer.
Haematology	119	Complex pathway. Initial referral to H&N and treatment within target. Subsequent diagnosis meant treatment remained outstanding. Referred to Haematology day 77. 14 day wait for first appointment with Haematologist
Head & Neck	148	Delays following tertiary referral. Patient request to be transferred to New Cross. Tertiary referral day 16.
Lung	130	Complex pathway. Required referral to tertiary centre (UHNM) for investigation. Further referral to specialist Mesothelioma centre for treatment. Patient and family refused contact to arrange appointments etc. Referred back to SaTH for treatment.
	109	Complex pathway. Initial referral to Colorectal. Referred to Lung after day 62. 19-day wait for first respiratory OPA. Patient admitted to hospital delaying pathway.
Skin	112	Other reason - change to treatment plan. Plans made for surgery under vascular team at SaTH. Consultant decision to refer to UHB specialist MDT due to complexity of surgery / concerns about potential wound closure problems.
Upper GI	111	Complex pathway / delay for OPA (oncology). Patient required referral to tertiary centre for investigation. 21 day wait for oncology OPA following referral by surgical team.
	161	Complex pathway. Patient required referral to x2 tertiary centres (3 referrals). Referred to QE for surgery. Referred back to SaTH as not fit for surgery.
Urology	122	Delay for diagnostics / elective capacity inadequate. 34 days for TRUSB from request to report. Elective capacity - only one surgeon performs prostatectomy at SaTH.
	181	Delay for diagnostics. 79 day wait for TRUSB. Patient cancelled / delayed MRI.

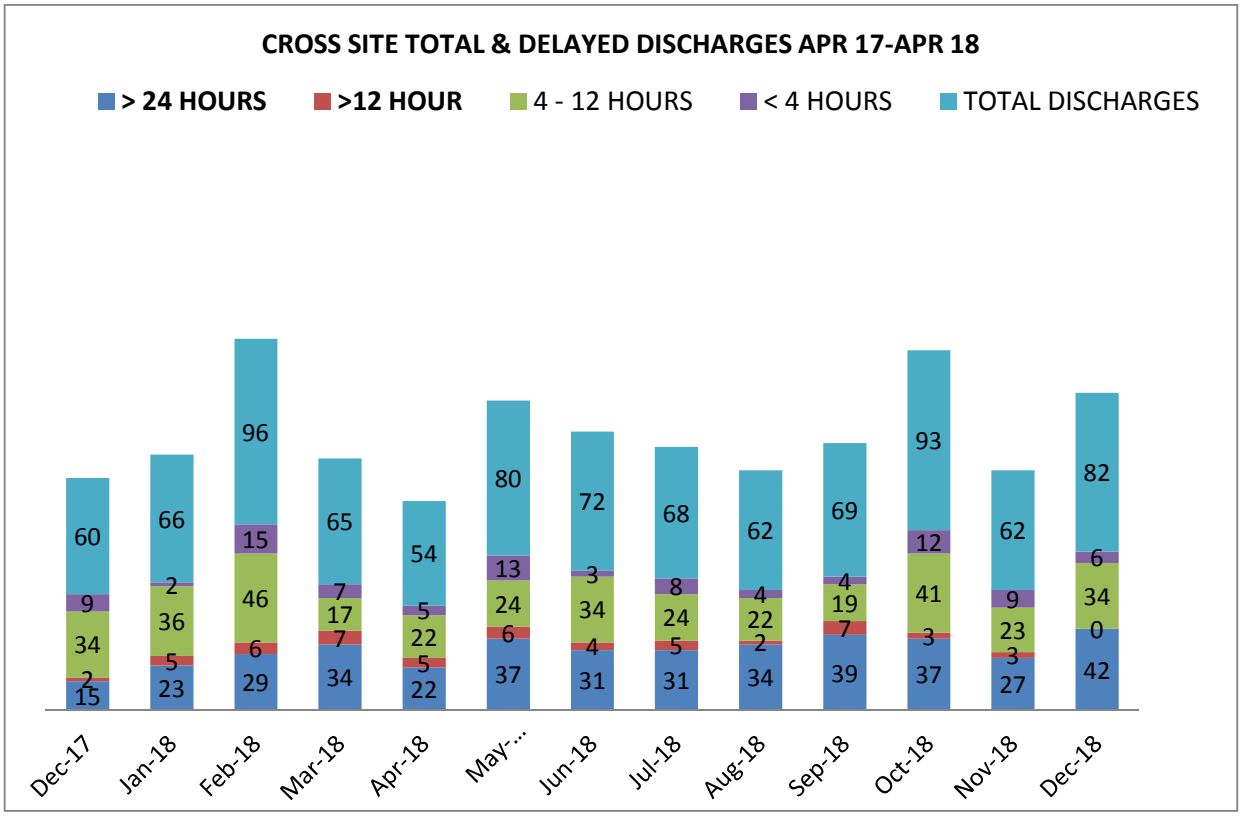
In accordance with the Trust's procedure, a harm proforma and an RCA will be requested from the clinician / operational team responsible for each individual patient. On completion, both the harm proforma and RCA will be reviewed and signed off by the Cancer Board prior to sharing with the CCG (in line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

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.

Escalation highlights for all patients reaching day 83 are flagged to Operational Managers either at weekly PTL meeting or by email from Cancer Performance Manager with request to confirm actions to be

taken to avoid day 104+ breaches. These escalations will be in addition to usual escalation procedure.

Delayed Discharges from ITU and Mixed Sex Accommodation Breaches



Of the delayed discharges from ITU in December 2018 there were 25 mixed sex accommodation breaches (22 at RSH and 3 at PRH).

Safeguarding Adults with Care and Support Needs and Children and Young People

Adult safeguarding:

In December 2018 4 adult safeguarding referrals were made against the Trust these related too:

1 x patient discharged to a Nursing Home without analgesia (controlled medication) from ward 25

1 x patient developed an acquired grade 3 pressure ulcer from his cervical collar ITU and ward PRH scored 35 on pressure ulcer protocol

1 x patient from Rapid Review formal complaint converted to safeguarding - general care and pressure ulcer ward 11 and 8 PRH

1x patient developed an acquired deep tissue injury from leg splint scored 25 on pressure ulcer protocol CCU PRH

There was one low level concern closed to safeguarding. This related to a referral made by Social services as patient discharged from ward 10 with a pressure ulcer. Closed as this was present on admission to PRH.

SaTH made 11 adult safeguarding referrals in December 2018 relating to:

2x Neglect by paid carers
1 x Neglect by family member
3 x Significant self-neglect
1 x Financial abuse by a relative

3 x Domestic abuse
1 x Physical assault on patient by another patient

Children and young people:

SaTH made 6 safeguarding referrals for Children and Young People in December 2018:

1 x referral to Brighton Local Authority as a parent was in hospital at RSH and children were alone at home

4 x non-accidental injuries (1 of which has since been disproved)

1 x stabbing relating to a young person who did not wait in ED

A monthly process has been put in place with Human Resources to ensure the safeguarding team are aware of staff disciplinary investigations and if nay member of staff should be referred to the Local Authority Designated Officer (LADO).

Section Three: Mortality Review

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 (October 2017 – October 2018)
SaTH 0.79% v Peer 1.12%

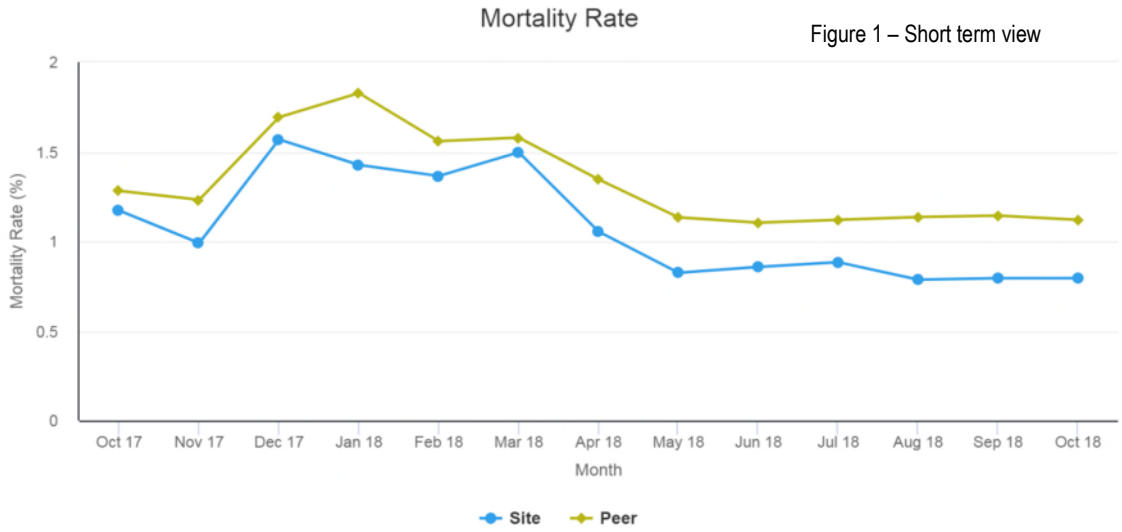


Figure 1 – Short term view

SaTH Mortality Rate (January 2014 – October 2018)

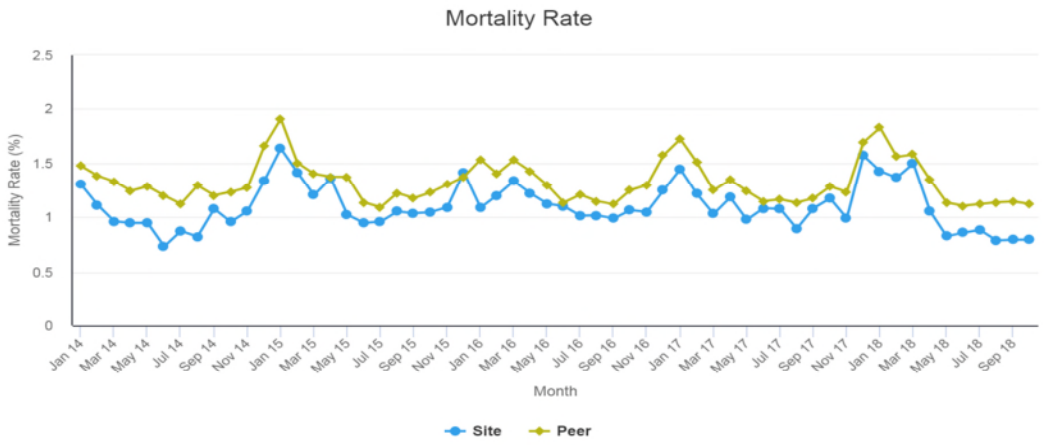


Figure 2 – Long term view

2. RAMI – Risk Adjusted Mortality Index *

RAMI (October 2017 – October 2018)
SaTH 74.01 v Peer 82.78

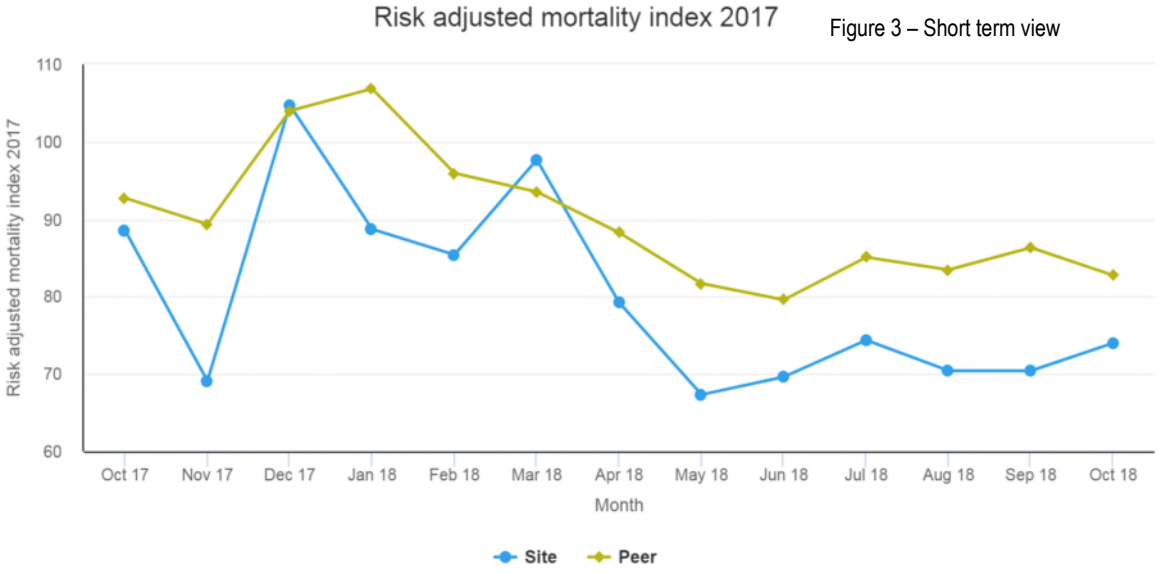


Figure 3 – Short term view

RAMI – SaTH v Trust Peer (January 2014 – October 2018)

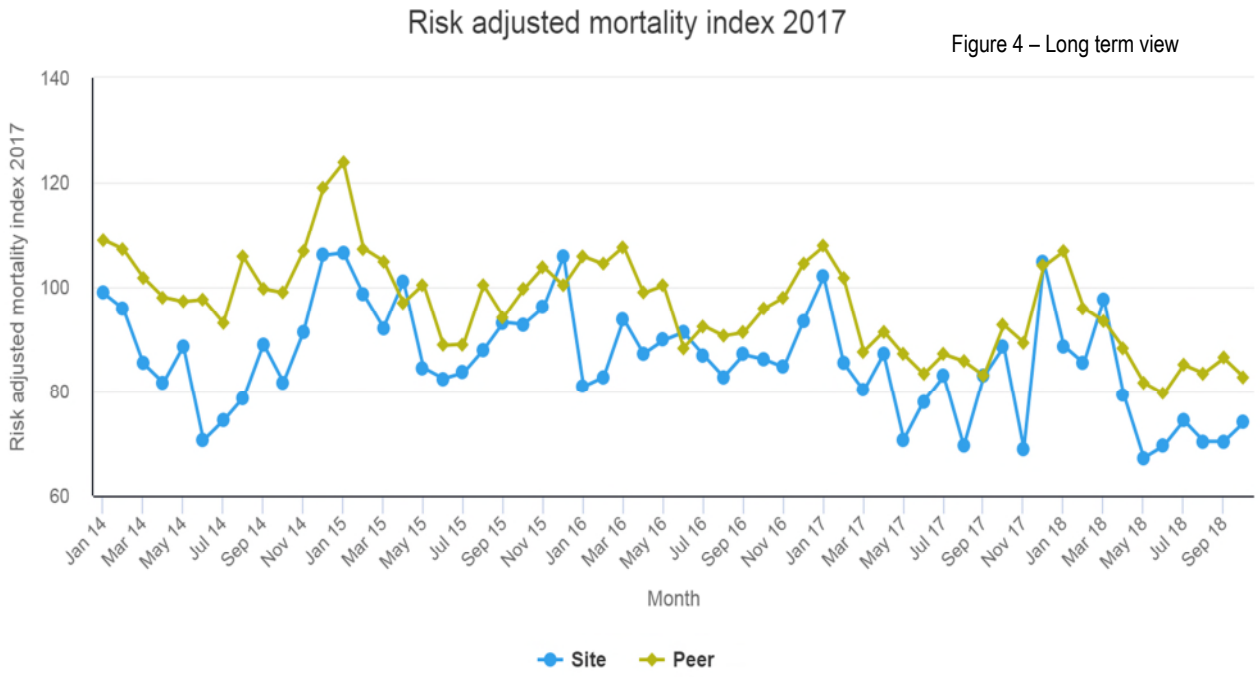


Figure 4 – Long term view

* 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 (October 2017 – October 2018)
SaTH 84.83 v Peer 90.92

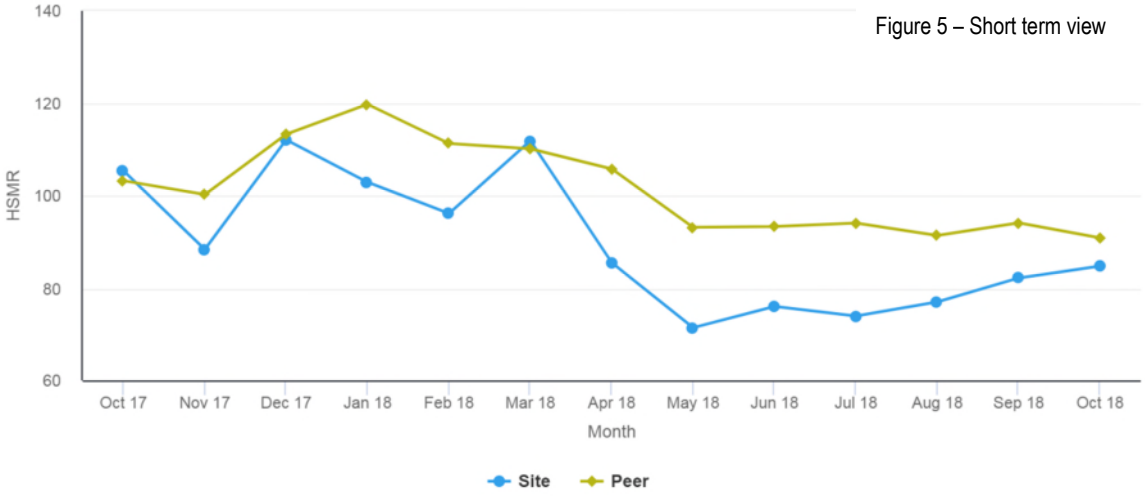


Figure 5 – Short term view

HSMR - SaTH v Trust Peer (January 2014 – October 2018)

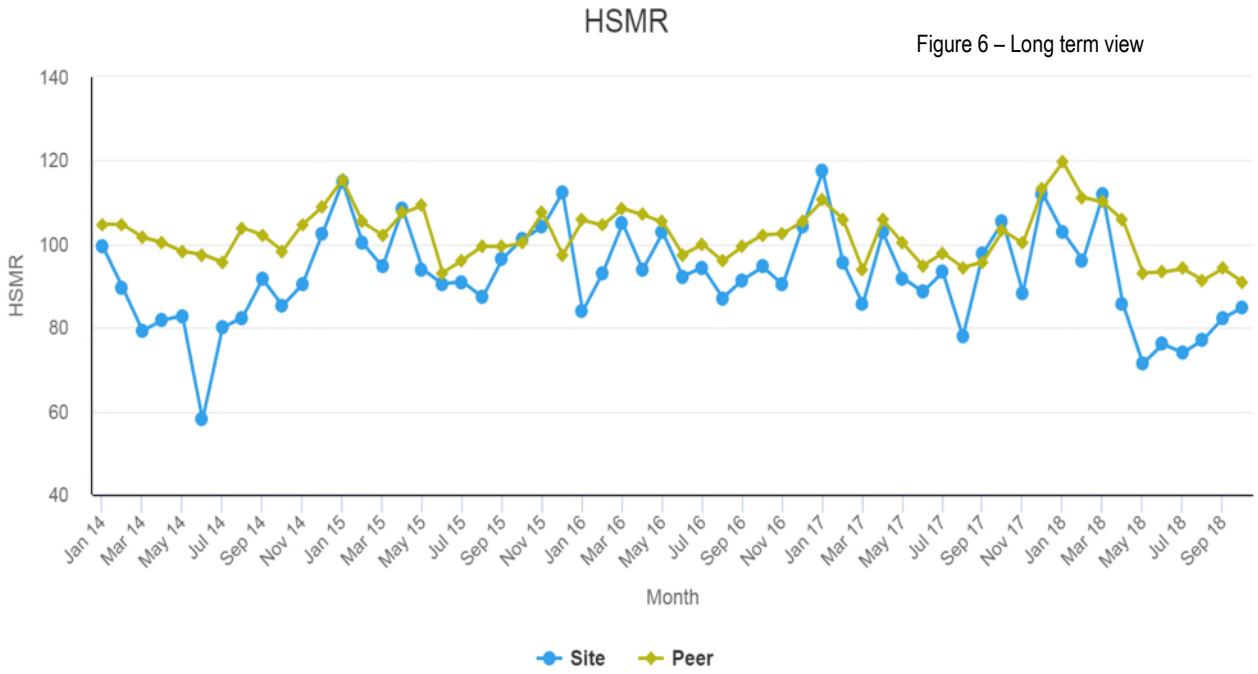


Figure 6 – Long term view

** 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 (October 2017 – October 2018)
SaTH 48.43 v Peer 58.72

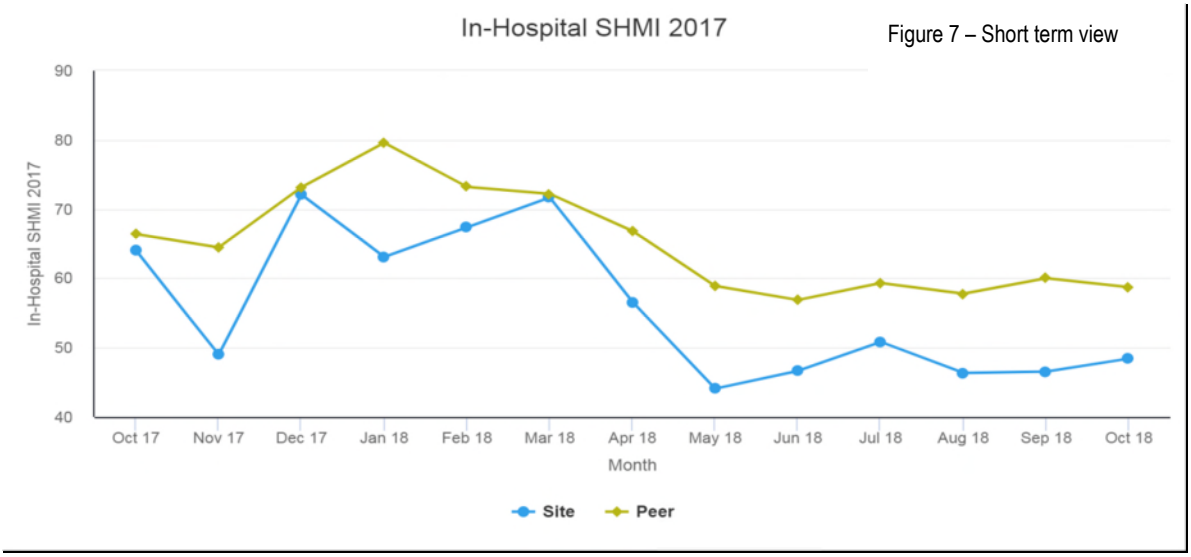


Figure 7 – Short term view

In-Hospital SHMI - SaTH v Trust Peer (January 2014 – October 2018)

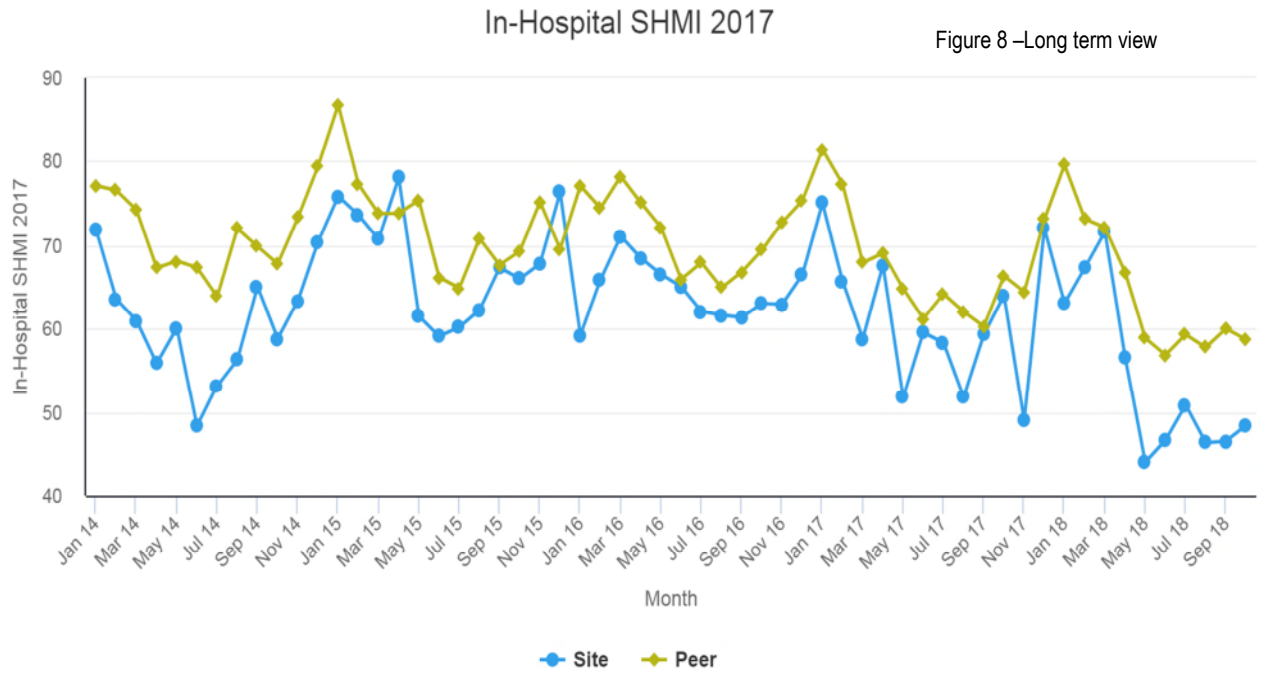


Figure 8 –Long term view

*** 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

Appendix 1 – Peer Group

The Peer group used for this 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 Four: Recommendations for the Committee

The Quality and Safety Committee is asked to:

- Discuss the current performance in relation to key quality indicators as at the end of December 2018
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place