Cover page	
Meeting	**Trust Board**
Paper Title	Quality Governance Report
Date of meeting	6th February 2020
Date paper was written	28th January 2020
Responsible Director	Barbara Beal, Director of Nursing, Midwifery and Quality
Author	Peter Jeffries, Associate Director of Quality, Governance and Risk/Kara Blackwell, Deputy Director of Nursing
Previously considered by	N/A

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)	*Select the strategic objective which this paper supports* ☐ 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)	**BAF 1134:** We need to deliver plans jointly agreed with the local health and care system so our admission and discharge processes ensure patients are receiving safe and effective care in the right place **BAF 1533:** We need to implement all of the 'integrated improvement plan' which responds to CQC concerns so that we can evidence provision of outstanding care to our patients **BAF 1204:** Our maternity services need to evidence learning and improvement to enable the public to be confident that the service is safe

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	N/A

Main Paper

Situation

The purpose of this report is to provide the Trust Board with assurance relating to our compliance with quality performance measures during December 2019.

Background

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of December 2019. The report will provide assurance to the Board where we are compliant with key performance measures and outline areas where further assurance may be required.

Assessment

Key points to note by exception:

- There were six cases of C Difficile attributed to the Trust in December 2019. The Trust has now reported 44 cases YTD against this target, therefore breaching the target of 43 for 2019/20.
- Although the performance has remained above the 95% target for 6 months since June 2019 Non-elective MRSA screening is showing special cause concern due to a run of 8 data points below the mean. It is suggested this measure is monitored closely.
- There were eight serious incidents reported in December 2019 which are detailed in the attached report.
- Although patient falls demonstrate common cause variation (and for falls per 1000 bed days/falls resulting in moderate harm measures remain below benchmark levels) Ward 9 has seen an unusual increase in reported falls during December 2019 which will require monitoring.
- From January 2020 reporting of delayed discharges from ITU will now focuses on > than 4 hours delayed discharges (previously by local agreement with commissioners reporting focussed on > than 12 hour delays). The > 4 hours measure shows special cause concern with a number of data points above the mean since December 2018 and in October 2019 above the upper control limit.

Recommendation

Trust Board are asked to:

- Receive and take assurance from the Quality Governance report

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We Value Respect
Together We Achieve

Quality Governance Report January 2020

INTRODUCTION

This report covers our performance against contractual and regulatory metrics related to quality and safety during the month of December 2019. The report will provide assurance to the Quality and Safety 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.

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

Infection Prevention and Control

This section of the report provides an update on hospital acquired infections (Clostridium Difficile, MRSA, MSSA, and E.coli bacteremia, Klebsiella BC cases and Pseudomonas Aeruginosa cases).

Clostridium Difficile

This financial year there has been changes in the CDI reporting algorithm. The changes that affect SaTH as an acute Trust are:

- A reduction in the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks are also attributed to the Trust.

Although these changes meant that the target for the Trust for 2019/20 increased the number of expected cases attributable to the Trust was also expected to increase. The Trust has now reported 44 cases YTD against this target, therefore breaching the target of 43 for 2019/20.

Measure	Apr 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Year to date 19/20	Monthly Target 2019/20	Annual Target 2019/20
CDI due to lapse in care (CCG panel)	1	2	2	3	2	4				17	3	43
Total CDI reported	2	3	7	5	6	8	3	4	6	44	3	43

There were six cases of C difficile attributed to the Trust in December 2019. Three cases were post 48 hour cases, and three were attributed to the Trust due to recent contact.

RCA's are completed on every case to ascertain whether there has been a lapse in care. Of the six cases in December. Two were noted to have been on the same ward at RSH within 28 days of each other, Ward 32SS – 2 cases of C diff linked to the ward in a 28 day period. One of the samples was unable to be typed therefore it cannot be confirmed if the cases are linked or not however, this has been declared as an outbreak. An initial meeting has been held, actions have been put in place and a follow up meeting is being arranged.

MRSA Bactereamia

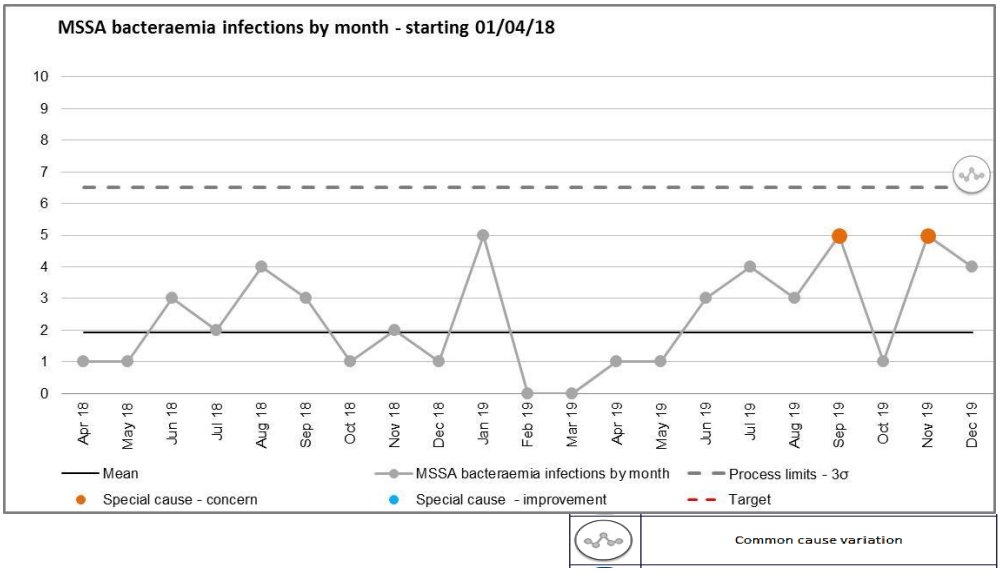
No cases of MRSA bacteraemia have been reported in December 2019

Measure	Apr 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Year to date 19/20	Monthly Target 2019/20	Annual Target 2019/20
MRSA Bacteraemia Infections *Contaminant	0	1	0	0	0	0	0	0	0	1	0	0

Although there were no MRSA bacteraemias reported in December 2019. There were 2 cases of colonization on ward 22 T&O linked to the ward in 28 days. Typing of these samples has shown them to be indistinguishable therefore would indicate cross infection. This has been declared as an outbreak. Ward hand hygiene and cleanliness were reviewed at an initial meeting, Tristell cleaning was instigated and IPC Quality Walks have been implemented to monitor standards and peer hand hygiene audits are in place.

MSSA Bactereamia infections

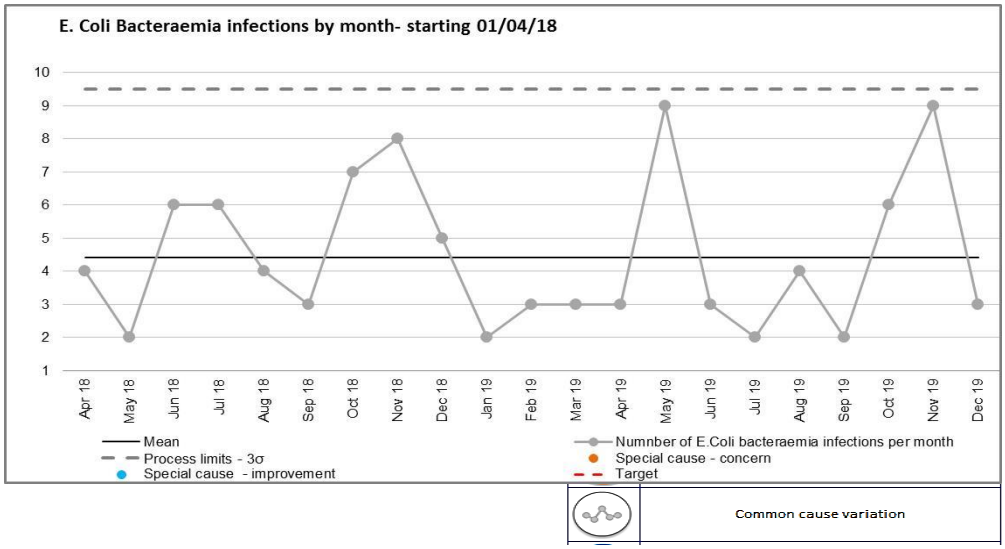
Reporting MSSA bacteraemia has been a mandatory requirement since January 2011. All hospital attributed (> 2 days from admission) are reviewed by the consultant microbiologist.



MSSA bacteraemia infections demonstrate common cause variation. Two out of three data points in the last three months had been approaching the upper process limit but the data point for December 2019 has moved away from the upper control limit.

There were four post 48 hour MSSA Bacteraemia in December 2019. None of these were considered to be device/intervention related. In three cases microbiology considered the source to be septic arthritis, and in the fourth case the source was considered to be a diabetic foot.

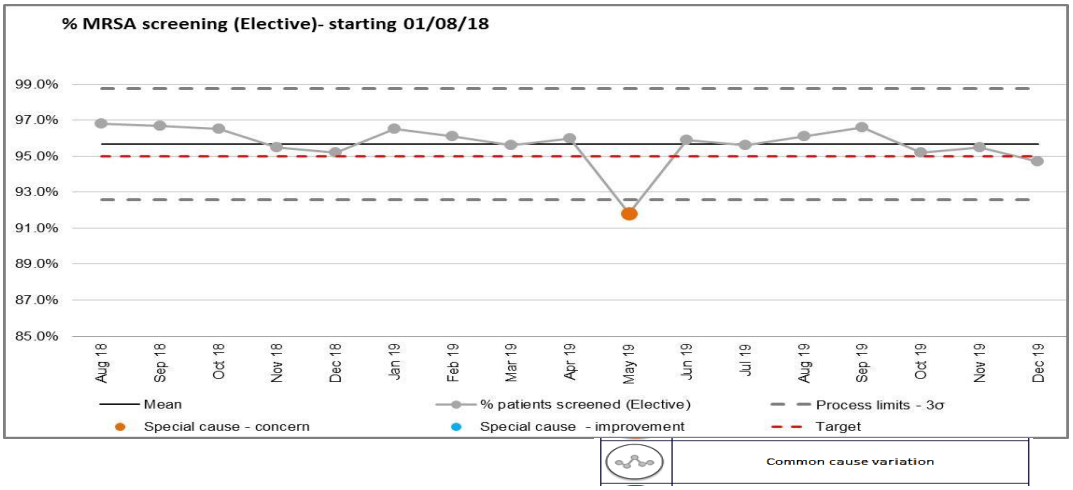
E-Coli Bacteraemia infections



E.Coli bacteraemia infections demonstrate common cause variation.

There were three Post 48 hour Ecoli Bacteraemia in December, two cases were lower UTI's, one was an upper UTI, and none of them were considered to be device or intervention related.

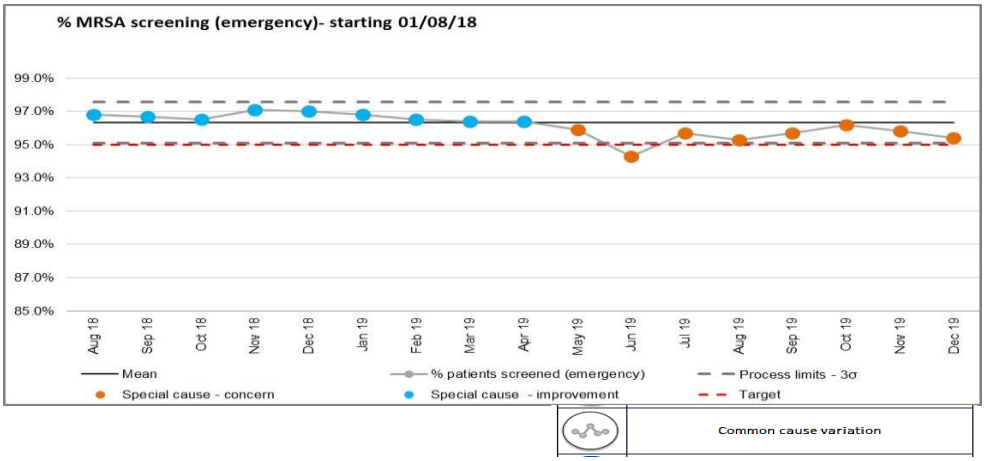
% MRSA screening – Elective



Elective MRSA screening is showing common cause variation.

However for the first time since May 2019 the Trust has not achieved the 95% target for MRSA Elective Screening at 94.7%. The largest numbers of missed elective MRSA screens come from Clinical Haematology and ENT Departments. The matrons for these areas are currently investigating the missed screens.

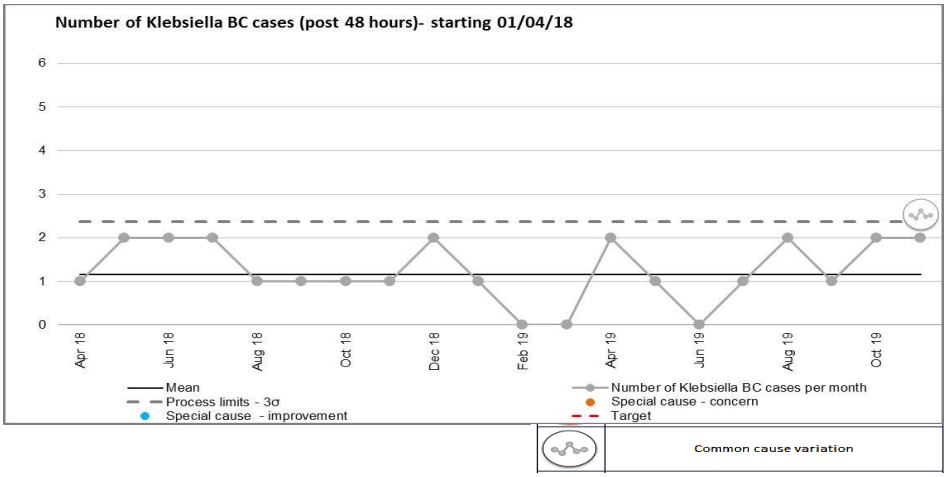
% MRSA screening – Non Elective



Although the performance has remained above the 95% target for 6 months since June 2019 Non-elective MRSA screening is showing special cause concern due to a run of 8 data points below the mean. It is suggested this measure is monitored closely.

Klebsiella BC cases (post 48 hours)

The reporting of Klebsiella BC is mandated as part of the national contract from April 2020

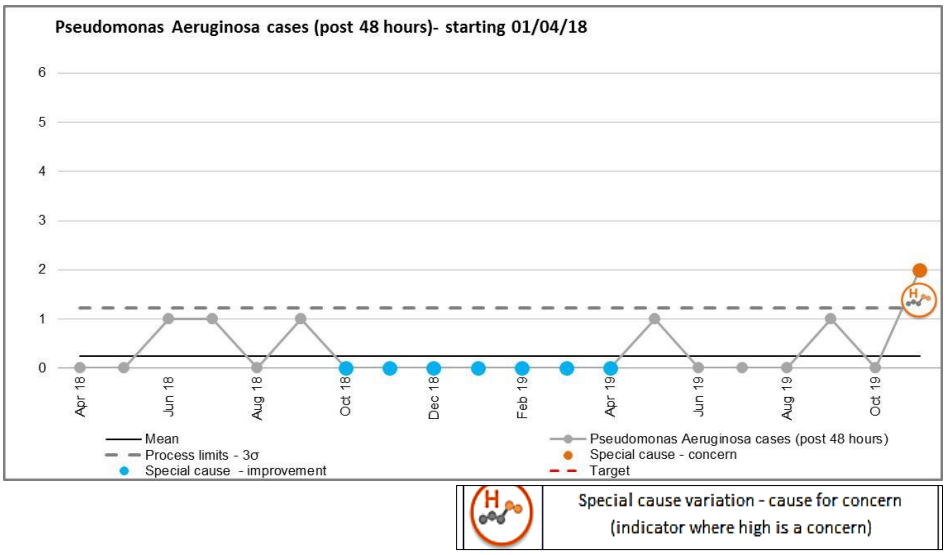


Klebsiella BC cases (post 48 hours) demonstrates common cause variation.

There was one post 48 Klebsiella Bacteraemia in December. The source was thought to be a Lower UTI, and the case was not considered to be device/intervention related.

Pseudomonas Aeruginosa cases (post 48 hours)

The reporting of Pseudomonas Aeruginosa is mandated as part of the national contract from April 2020.

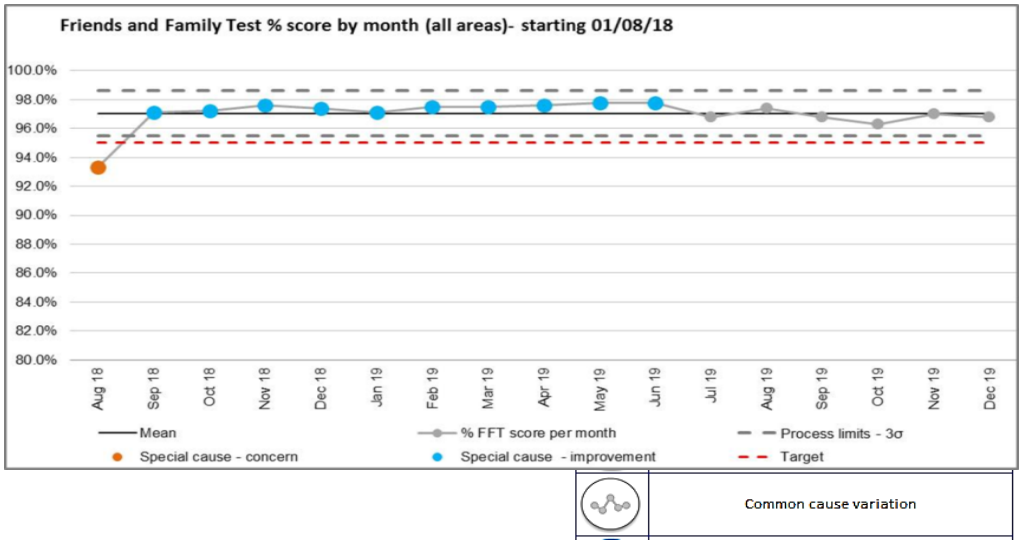


Pseudomonas Aeruginocases (post 48 hours) show special cause variation as one data point (relating to December 2019) is above the upper control limit.

There were two Post 48 cases of Pseudomonas aeruginosa Bacteraemia in December 2019. One of these cases was thought to be device related; the source was an Upper UTI and was a CAUTI. The second case was not considered to be device related and the source was a lower respiratory tract infection.

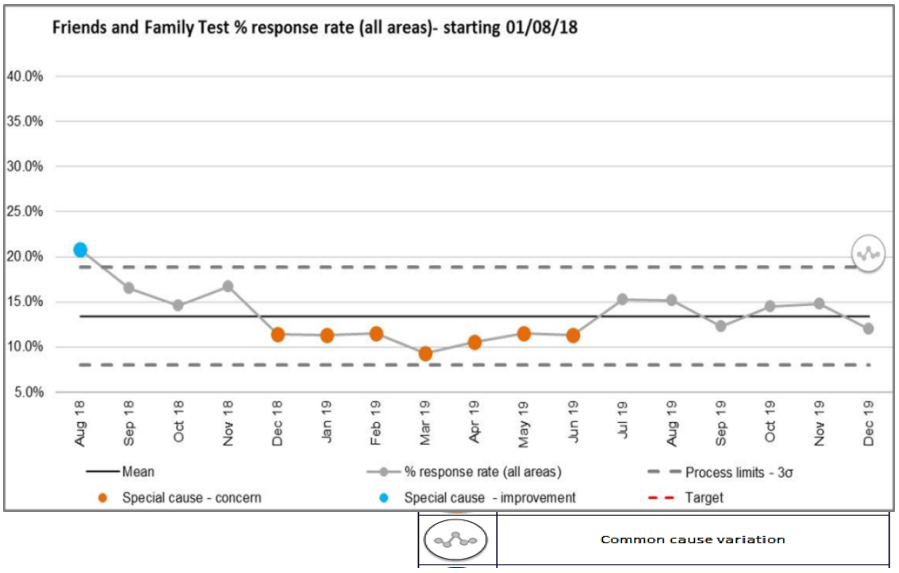
Friends and Family Test

Friends and Family Test % Overall Score (all areas) by month



Friends and family test % score for all areas (inpatients, outpatients, ED and Maternity) demonstrates common cause variation and since August 2019 has continuously been above the 95% target.

Friends and Family Test overall % response rate (all areas) by month



Friends and family test % response rate having previously indicated special cause concern in December 2018 to June 2019 is continues to demonstrate common cause variation but is not showing signs of returning to the previous higher level of 21% recorded in August 2018.

It is suggested this measure continues to be monitored closely.

The split between areas for percentage of recommenders and response rate for December 2019 is outlined below:

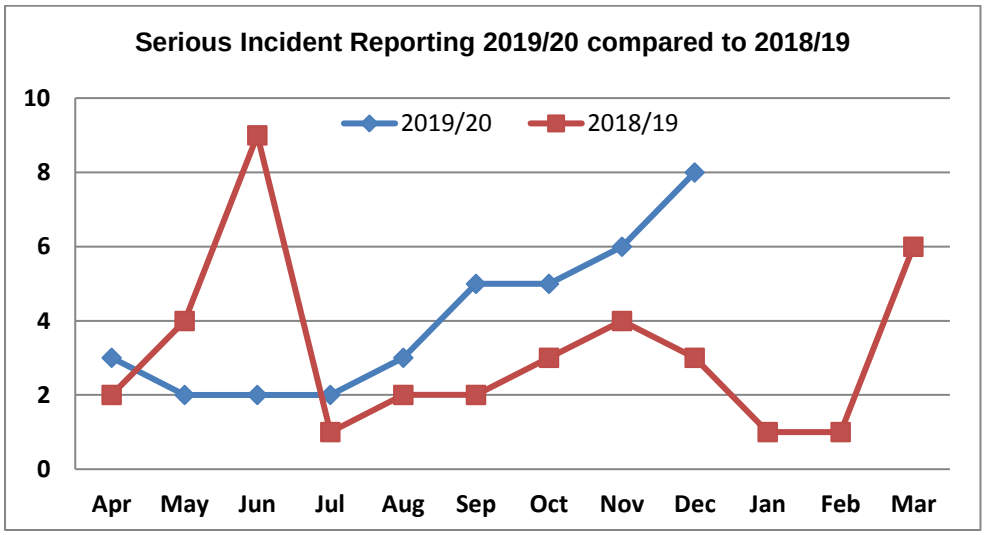
	Percentage of Recommenders	Response Rate
Inpatient	98%	20.9%
A&E	88.9%	3.1%
Maternity overall	99.5%	32.1% (Birth only)
Outpatients	96.4%	NA

Serious incidents

December 2019 Serious Incidents

In December 2019 we reported eight serious incidents as shown in below. Overall reporting numbers are higher in December 2019/20 when compared to the same reporting period for 2018/19.

Serious incident reporting 2019/20 compared to 2018/19



Categories of incidents reported in December 2019

December:		
Delayed treatment	USCG	23/11/2019
Fall - #NOF, #Wrist & head injury	USCG	03/12/2019
Maternity Obstetric affecting baby	W&CCG	01/12/2019
Maternity Obstetric affecting mother	W&CCG	12/12/2019
Delayed diagnosis	SCG	12/07/2018
Delayed diagnosis	SCG	20/12/2018
Delayed diagnosis	SCG	10/05/2018
Unexpected death	USCG	14/12/2019

December 2019 Serious Incidents:

- *Treatment delay* – Delay of 2 hours until the medication was given for a high potassium.

  Immediate actions: awareness raised with staff regarding handover of patients to AMU and clarity of information.

- *Fall* – An inpatient fall resulting in fractures and a contunison to the patients head.

  Immediate actions: no immeadiate actions identified. On admission to the ward fall risk assessment, bedrails assessment and moving and handling strategy were updated. Actions to be identified pending full investigation.

- *Maternity affecting baby* – a mother not referred to triage in line with guidelines after an ultrasound scan

  Immediate actions: Message sent to all staff regarding protocol for abnormal ultrasound scan and referal to triage.

- *Maternity affecting mother* – concerns relating monitoring of a mother after casearian section

  Immediate actions: Postnatal ward manager advised regarding the lack of documentation of urine output, fluid balance chart not completed. The Matron will conduct spot checks to monitor compliance.The incident has been included in staff huddles for wider learning

- *Delayed diagnosis* – delay in treatment of a bowel cancer

  Immediate actions: Following local review and governance discussion no immeadiate actions identified pending full investigaiton

- *Delayed diagnosis* – bowel cancer not identified via bowel screening

  Immediate actions: As this incident relates to a screening service , it will has also been reported to Quality Assurance Service via the via the Bowel Screening Service Manager

- *Delayed diagnosis* – delay in treatment for a liver cancer

  Immediate actions: Following local review and governance discussion no immeadiate actions identified pending full investigaiton

- *Unexpected death* – concerns relating to appropriate observations in ED

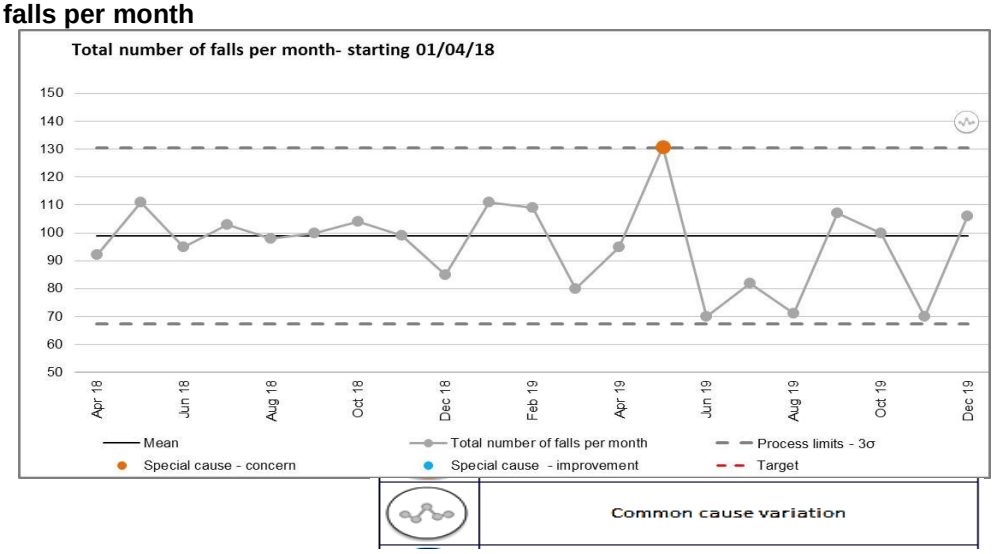
- Immediate actions: An agency nurse involved is this incident has been suspended from working at the Trust pending completion of the investigation.

Patient Falls

During December 2019 there was one fall reported which required reporting as Serious Incidents and a further which is being managed as a High Risk Case Review which is detailed detailed on the following page.

Site of injury	Rationale for not reporting as an SI
Small sub-dural haematoma	Appropriate risk reduction strategies in place, no remedial surgical intervention was required, no lowering of GCS; classed as a moderate harm incident and is being managed as a HRCR.

Total number of falls per month

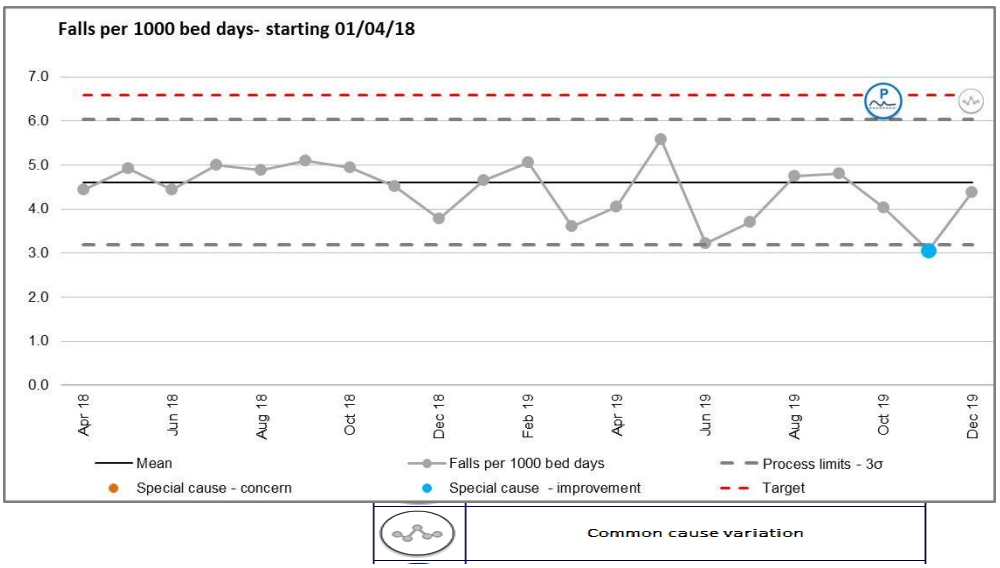


Total number of falls demonstrates common cause variation.

Ward 9 has seen an unusual increase in reporting falls during December 2019 which will require monitoring. The Falls Prevention Practitioner will review and complete targeted work to support the ward team.

In addition a new falls risk assessment and falls prevention care plan for inpatients at risk of falls is being implemented as part of the new nursing documentation

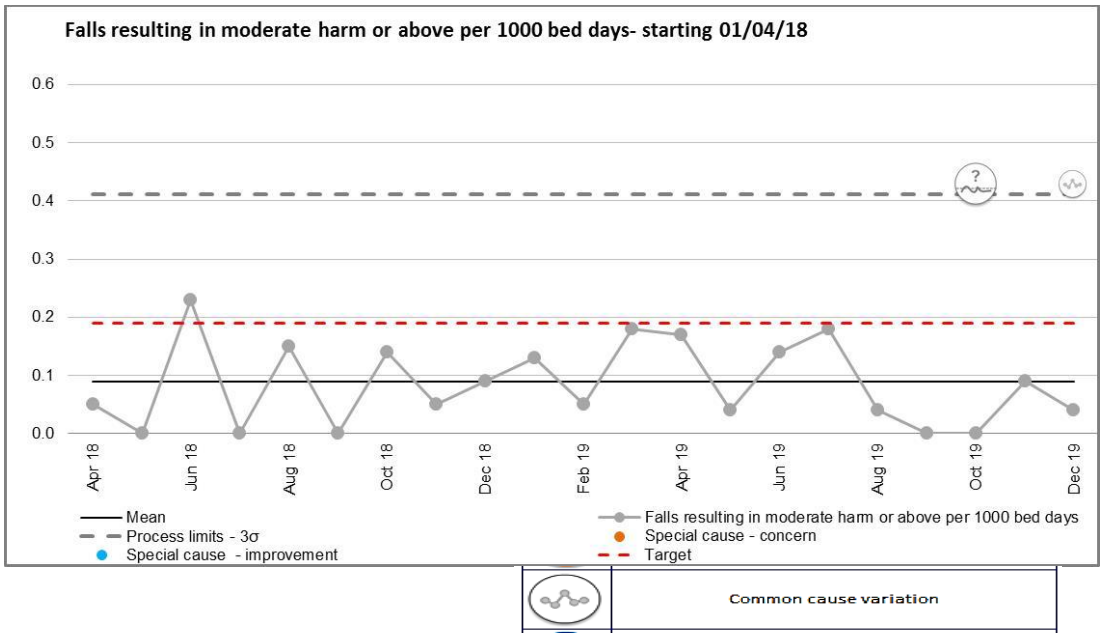
Falls per 1000 bed days



Falls per 1000 bed days demonstrates common cause variation (with a single point of special cause improvement falling below the lower control limit in November 2019).

SaTH is expected to consistently meet the benchmark target of 6.6 falls per 1000 bed days within common cause variation.

Falls per 1000 bed days resulting in moderate harm or above



Falls per 1000 bed days resulting in moderate harm or above demonstrates common cause variation.

It is possible within common cause variation the system may occasionally exceed the benchmark target of 0.19 per 1000 bed days as demonstrated in June 2018.

Hospital Acquired Pressure Ulcers

During December 2019 there was one category 3 pressure ulcer identified requiring investigation.

High Risk Case Review (HRCR) Pressure Ulcers December 2019

Category 3 –	The patient was admitted with a category 2 pressure ulcer, which deteriorated to a category 3 within 48 hours. It has been reviewed by the Tissue Viability Team who have confirmed there are no safeguarding concerns and it is suitable for local management as a HRCR

Measure	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Year to date 19/20	Monthly Target 2019/20	Annual Target 2019/20
Cat 2 Confirmed	10	11	14	15	14	15	8	14	11	11	8	3	100	None	None
Cat 2 Reported	10	11	14	18	14	17	11	17	13	15	22	14	141	None	None
Cat 3 HRCR	3	6	9	3	2	1	0	1	2	0	2	1	12	None	None
Cat 3 Serious Incident	0	0	0	0	0	0	0	0	0	0	0	0	0	None	None
Cat 4 HRCR	0	0	0	0	1	0	0	0	0	0	0	0	1	None	None
Cat 4 Serious Incident	0	0	0	1	0	0	0	0	0	0	0	0	1	None	None

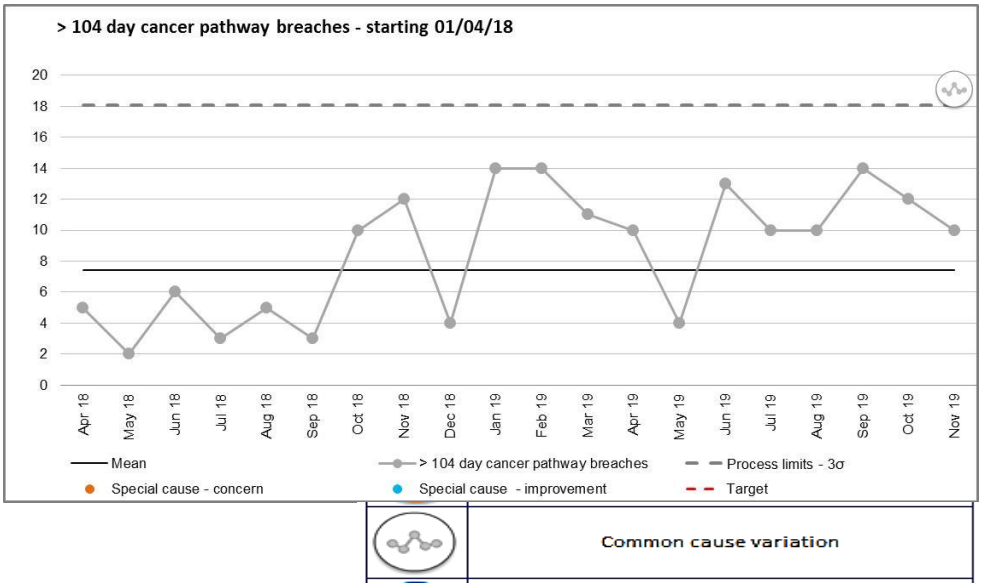
The process for the undertaking of RCAs on all acquired category 3 and above pressure ulcers is changing moving forward. From January 2020 the RCAs will be undertaken and completed within 20 working days and then presented for discussion and agreement around actions at an Tissue Viability RCA meeting chaired by the Deputy DON and Lead Nurse Tissue Viability rather than the previous arrangements where these were signed off by the Head of Nursing in the Care Group.

Waiting for cancer treatment for more than 104 days

104+ Day cancer breaches (validated position relating to November 2019:latest available validated figures)

10 patients received their first definitive treatment for cancer after 104 days in November 2019 (the target for referral to treatment being 62 days). Details of the pathway and reason for breach are outlined below:

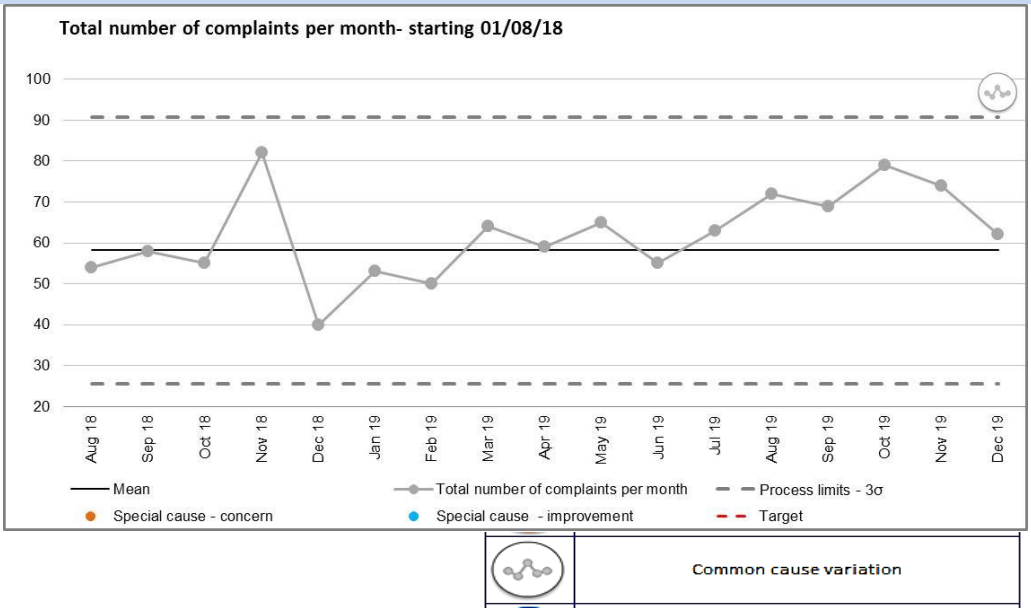
Pathway	Number of Days	Reason for Breach
Colorectal	110	Patient choice
Gynaecology	104	Delays following tertiary referral
Lung	135	Complex diagnostic pathway
Upper GI	106	Complex diagnostic pathway/delay for diagnostics
Upper GI	264	Complex diagnostic pathway/delay for diagnostics
Urology	120	Elective capacity/delay for diagnostics
Urology	121	Delay for diagnostics
Urology	104	Delay for diagnostics/late tertiary referral
Urology	150	Diagnostic delay/patient choice/outpatient capacity
Urology	113	Patient choice/late tertiary referral



Total number of > 104 day cancer pathway breaches demonstrates common cause variation.

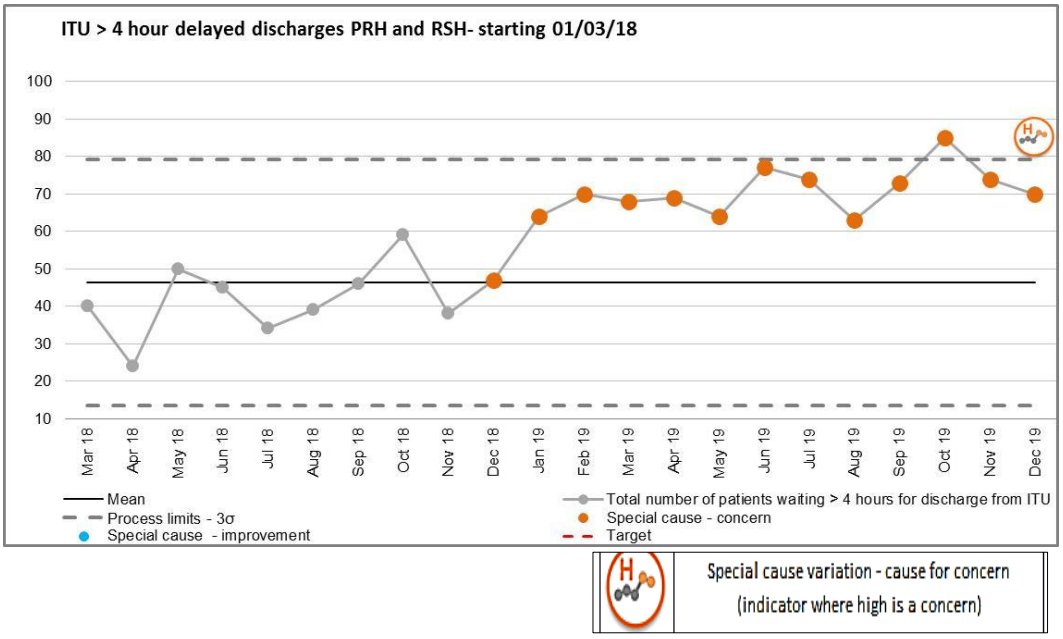
With the exception of Urology there are no clear trends. The vast majority of breaches are clinically justified due to the complexity of the patients and/or pathway. During recent months Urology breaches are accounting for half of the overall monthly totals and are due to known capacity issues regarding diagnostics and treatment include waits for MRI, TRUS and biopsy, outpatient and surgical capacity.

Complaints & PALS



The total number of complaints received on a monthly basis demonstrates common cause variation.
62 complaints were received in December 2019, 35 of which related to RSH and 27 of which related to PRH. The main subjects remain the same relating to problems with appointments and communications Slight increases have been noted for Ward 4 and Ward 9; this has been highlighted to the manager and matron for these areas for them to review.
131 PALS contacts were received. There have been a number of complaints and PALS contacts about cancelled surgeries and appointment, linked with winter pressures.

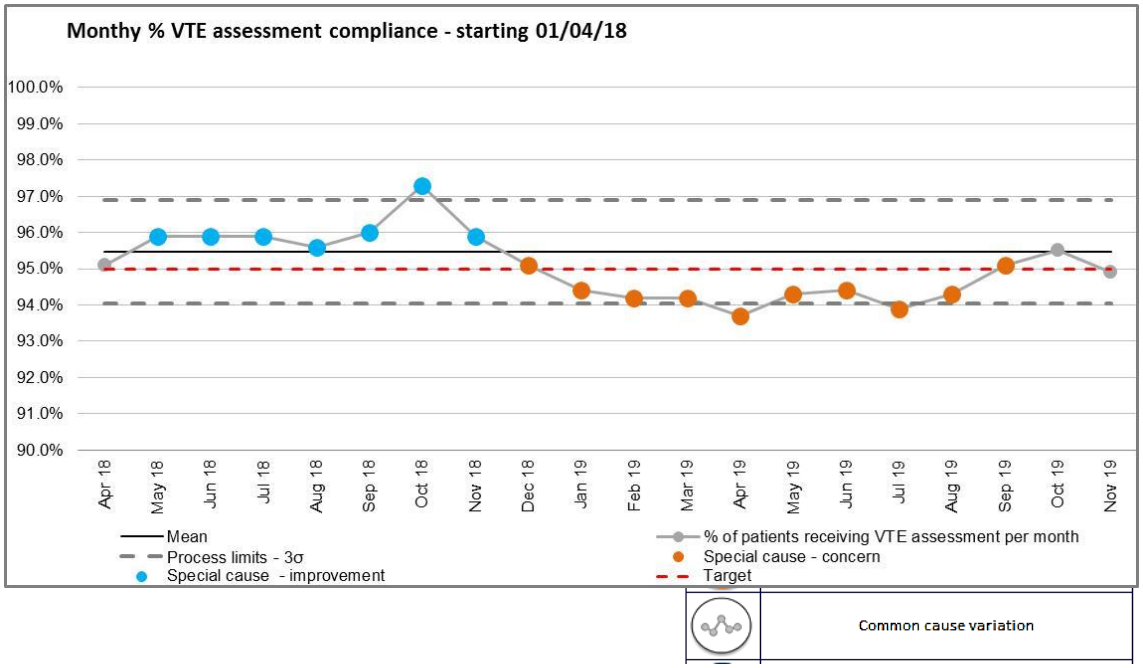
> 4 hours discharges from ITU



ITU delayed discharges (> than 4 hours) shows special cause concern. Previously by local agreement with Commissioners > 12 hour breaches were reported. From January 2020 reporting now focuses on (> than 4 hours delayed discharges).

This measure highlights challenges related to wider issues of demand, capacity and patient flow and requires close monitoring.

VTE assessment compliance



Monthly % VTE assessment is moved into common cause variation.

In November however (latest validated data) % assessment compliance was just below the 95% target at 94.9%.

A VTE assessment action plan is being led by the Medical Director and this metric will be continue to be monitored closely to assess if the action plan improves compliance.

Section Three: Mortality Report

Mortality metrics CHKS September 2018 – August 2019

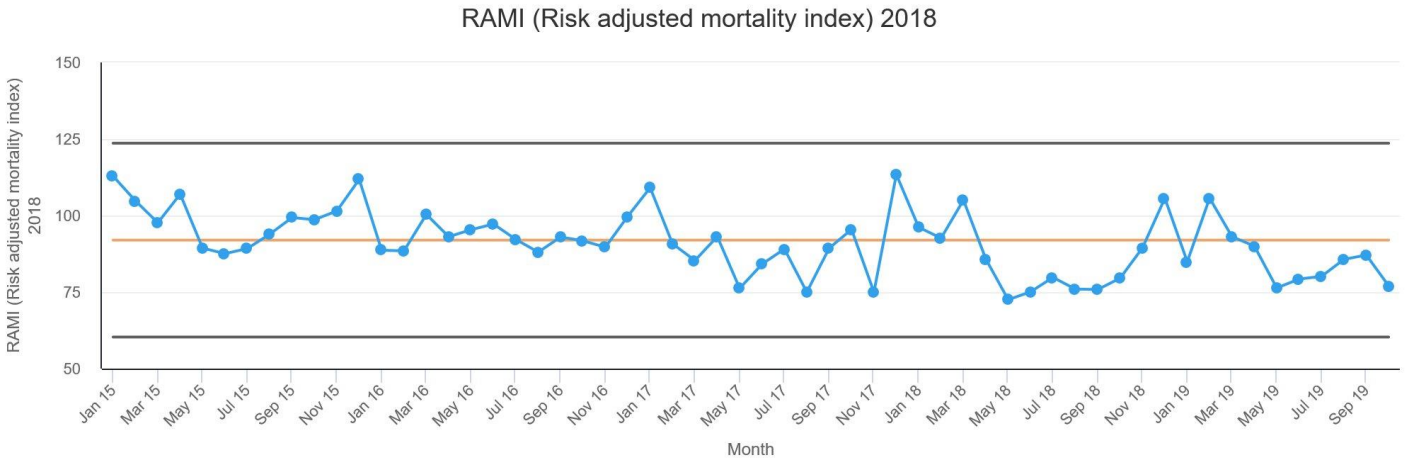
Description	Local Numerator	Local Denominator	Nov 18 - Oct 19	Nov 17 - Oct 18	Change	Peer Value	Performance
HSMR (Hospital Standardised Mortality Ratio)	1561	1760	88.69	89.40		89.84	
SHMI (Summary Hospital-Level Mortality Index) +	2092	2069	101.13	99.07		99.88	
In-Hospital SHMI (Summary Hospital-Level Mortality Index) 2018	1694	2875	58.93	60.39		65.38	
Mortality Rate	1694	172331	0.9830%	1.0590%		1.1400%	
RAMI (Risk adjusted mortality index) 2018	1694	1929	87.81	86.45		88.63	
Rate of Mortality in hospital within 30 days of elective surgery	2	3299	0.06062%	0%		0.12625%	
Rate of Mortality in hospital within 30 days of Non elective surgery	84	7915	1.0613%	1.0464%		1.3409%	
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	8	243	3.292%	4%		4.734%	
Rates of mortality in hospital within 30 days of emergency admission with a stroke	99	938	10.554%	11.218%		11.897%	
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	4	339	1.1799%	0.30303%		3.1067%	
Deaths in Low Mortality CCS Groups	15	12562	0.11941%	0.15883%		0.10665%	
Post operative pulmonary embolism or deep vein thrombosis	4	26155	0.015293%	0.03549%		0.03782%	
% Still Births	15	4190	0.3580%	0.4793%		0.3824%	
Mortality Rate - Admitted via A&E	1296	34807	3.723%	4.199%		3.408%	

Overall the Mortality metrics for the Trust, including HSMR, are within the expected range. (Performance) It has been noted that there has been an increase in baseline in the HSMR CCS Group Acute Bronchitis in 2019 which is currently being investigated

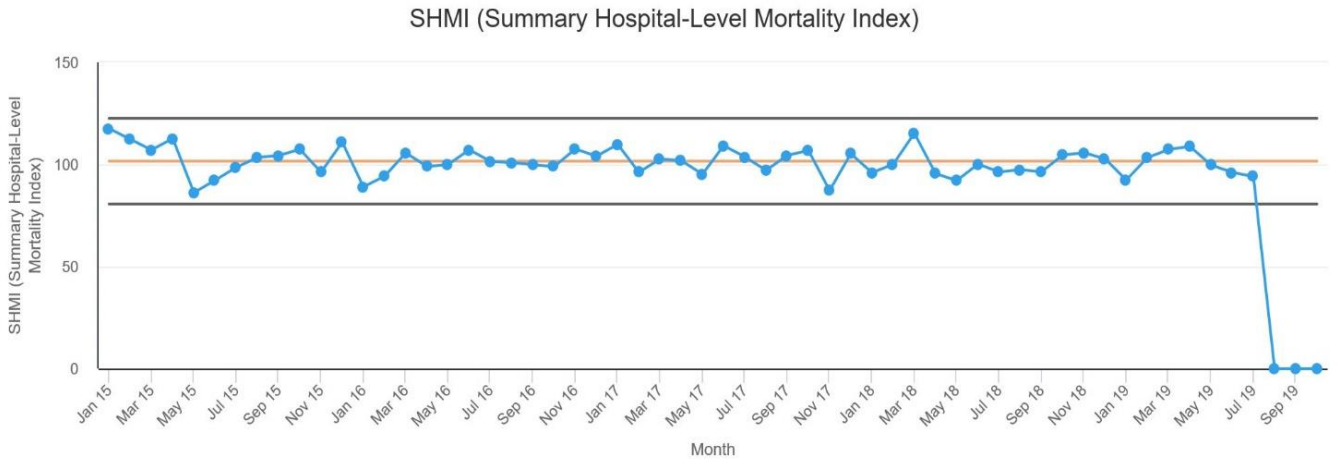
There were 3 patient deaths reported as Serious Incidents in December (details of these SI's are outline on page 8 above)

Mortality 5 year trend January 2015 to September 2019

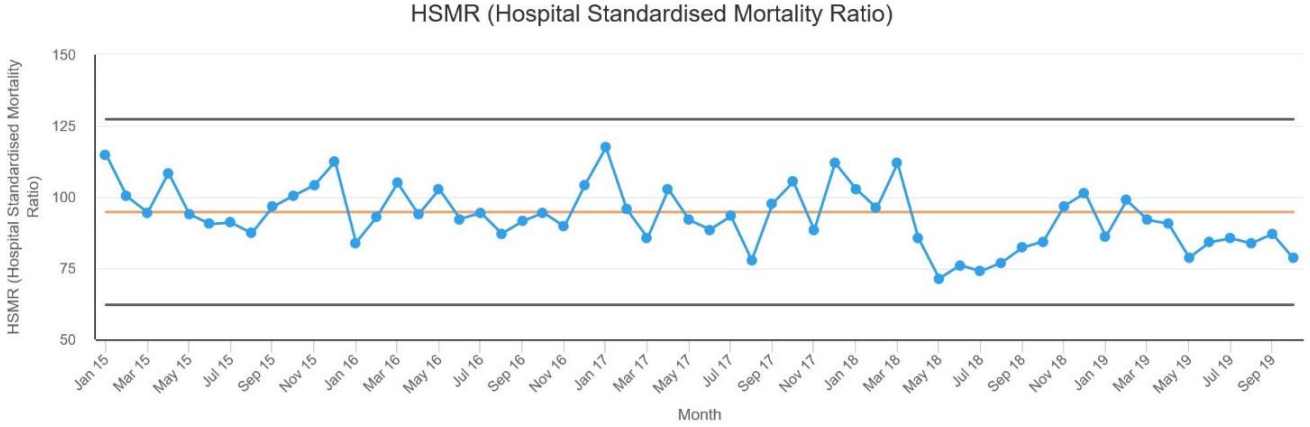
RAMI



SHMI – (note data not updated on CHKS from June 19)



HSMR



Section Four: Recommendations for the Committee

Trust Board is asked to:

- Discuss the current performance in relation to key quality indicators as at the end of December 2019
- Consider the actions being taken where performance requires improvement
- Question the report to ensure appropriate assurance is in place