EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **10 JUNE 2016**

REPORT FROM: **QUALITY COMMITTEE CHAIR**

PURPOSE: **Discussion**

PURPOSE OF THE COMMITTEE:

The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety.

EXECUTIVE SUMMARY

The following provides feedback from both the May and June Quality Committee meetings.

The report seeks to answer the following questions in relation to the quality and safety performance:

1. What went well over the period reported?
2. What concerns were highlighted?
3. Were the annual objectives for 2015/16 met?
4. Looking forward, what are the annual objectives for 2016/17 and what are the risks to achieving these?

MEETING HELD ON 8 JUNE 2016

The following went well over the reporting period:

- HSMR remains below the national average;
- Incident reporting remains high;
- Non-elective mortality has reduced for the second month and is below last year's rate;
- There was no increase in serious incidents reported;
- No MRSA bacteraemias were reported;
- There was a drop in E-coli and MSSA bacteraemias;
- Hospital acquired harm free care remains high (good);
- Decrease in the number of falls;
- No avoidable deep ulcers reported;
- Safe staffing is improved this month;
- A slight improvement in the Friends and Family test star rating.

Concerns highlighted over the reporting period:

- Elective mortality rose this month;
- There were five severe harm incidents reported;
- The Trust is on limit for the monthly C-Diff trajectory;
- Old and new harm free care remains below where we would like;
- We are above trajectory for category 2 avoidable ulcers;
- Mixed sex breaches, although reduced this month are still occurring;
- Complaints rose in number this month and the response times were the worst they have

been for over a year.

Other topics discussed where concerns or actions were taken:

- VTE assessment remains a risk: Reporting of the completed assessments is still not meeting the national standard. Corrective action is being put in place and the Committee requested that other methods of improving the recording of assessments be utilised. There was no evidence to suggest there were resulting patient safety issues.
- The Integrated Performance Report was received for the first time. The Committee recognised there were data areas which needed to be refined.
- Focussed work was in place at William Harvey Hospital to ensure the mixed sex policy was being adhered to.
- The Committee discussed the rising number of complaints for which reasons were unclear. The Committee was disappointed to hear performance against response times had deteriorated. The Deputy Chief Nurse was undertaking focussed work with the Patient Experience Team.
- The findings of the National Inpatient Survey was discussed and actions being rolled out within the Trust. Results correlated with the outcome of the Friends and Family test and would be triangulated with the Heat Maps.
- Progress against the Quality Improvement Strategy for quarter four was received. The Committee agreed the report mirrored the metrics within the Integrated Performance Report and this report would be used by the Committee for monitoring going forward.
- The Trust was reporting within the limit for *C.difficile* trajectory. The Committee heard that work continued to reinforce basic nursing, medical and therapy care aligned to infection control strategies.
- Assurances were received that clinical leads have been asked to produce a 2016/17 clinical audit plan for their areas to ensure compliance with the national clinical audit programme. The Committee asked for a written report to the next meeting.
- The Committee received a report outlining the positive outcome of the E-CasCard System roll out to improve patient tracking steps and records within Emergency Departments and A&E. There were some implementation issues but mitigating actions have been put in place. The system will improve the following: Identifier to alert when patients awaiting treatments; mandatory fields to ensure that clinicians have to complete key tracking steps before exiting the system; improve the robustness of recording, accessing and sharing information; roll out to majors will improve the time taken to discharge patients from A&E. The Committee asked for an update report in six months' time.
- Corporate Risk Register (Quality Risks): Three new risks have been added: VTE Assessment and documentation; delays in first trimester and anomaly obstetric ultrasound scans; and delays in intra hospital ambulance transfers.
- A Risk Manager was now in post who has been working effectively with divisions to standardise risk registers and processes across divisions and to transpose risks onto the new electronic system. The Committee noted further work was required by Executive Directors and Divisions: to make sure all staff receive training on the new system; ensure the risks are updated; ensure actions are meaningful to the risks; and to ensure progress notes are up to date.
- The quarterly Integrated claims/Incidents/Complaints report for quarter four mirrored themes the Committee was already aware. There was a drive to improve Duty of Candour compliance.
- The benefits of using the Global Trigger Tool to monitor harm events were discussed. This was currently inactive within the Trust and a report would be brought to a future Committee meeting to discuss a way forward.
- The recommendations from the Mazar's report commissioned by NHS England were discussed. These were RAG rated. The Committee discussed the importance of robust case note reviews.
- The Committee noted the challenges around meeting the 62 day cancer targets, in

particular demand and capacity issues within colonoscopy and endoscopy. The Cancer Board was monitoring this.

- Minutes of Governance Board meetings are received at each Quality Committee meeting and there were no things of which the Committee was not already aware. One area to note from the June meeting related to risks around aging equipment within nuclear medicine which the Committee requested be added to the risk register.

MEETING HELD ON 4 MAY 2016

1. The following went well over the reporting period:
    a. Non-elective crude mortality has fallen: Non elective deaths per 1,000 non elective admissions decreased from 36.18 in Feb-16 to 33.43 in Mar-16;
    b. Less Serious incidents: 4 serious incidents were reported in March 2016 against 7 in February 2016;
    c. 40% reduction in C.difficile infections in 2015/16 with no cases in March 2016
    d. Post 48 hour E. coli bacteraemia decreased from 11 in February to 3 in March 2016, the average being 7 per month; see appended report on infection control from Dr Nash;
    e. No avoidable deep pressure ulcers and the end of year Trust performance was 8 against a maximum of 9;
    f. Lower rate of falls in March 2016 with the Trust seeing an overall improvement on the previous year of 5.47 falls per 1000 which is below the national average;
    g. Incident reporting rate has increased and in terms of the quality of the root cause analysis reports, the CCGs have complimented the Trust;
    h. Less deaths/serious harm reported, there were 5 reported in March but these may be downgraded once the investigation starts;
    i. Reduction in 7-day readmission rates improved both on a month by month basis and compared to the same period last year but they are still above the target of 2% at 3.7%;
    j. Reduction in bed occupancy from 100.9% in February to 94.44% in March 2016, although it is higher than March 2015 (95.25%);
    k. Reduction of extra beds (following high number during the winter); and
    l. In general the number of outliers remains high although there was a reduction in March 2016 on February 2016 figures from 8.38% to 7.27%.

2. The following concerns were highlighted:
    a. Harm free care is reduced from 91.8% in February to 91.5% in March 2016 against a national standard of 95%. This figure represents the harms a patient is admitted with as well as those occurring while the patient is with us. New harms only (those we can influence) are better than the national average at around 98% harm free care;
    b. Elective crude mortality has risen: Elective deaths per 1,000 elective admissions saw an increase from 0.22 in February to 0.66 in March 2016. All elective deaths are reported on Datix and discussed at the Surgical Morbidity and Mortality meetings;
    c. Staffing / Recruitment continue to be an issue which saw an increase in incidents relating to staffing. This remains on the risk register;
    d. Mixed sex accommodation occurrences increased in March 2016 which was mainly as a result of 11 breaches at the William Harvey Hospital which is mainly due to an acknowledgement of better reporting. The site team are addressing this issue;
    e. Increase in delayed transfers of care: The Committee was not assured in relation to the provision of continuing health care pending assessment by Social Services and community services;
    f. Duty of Candour is poorly recorded and the Medical Director was charged with addressing this through the Serious Incident Meeting and Root Cause Analysis Panel;
    g. The Trust continues to perform badly in terms of documenting VTE assessments on

VitalPac. The Committee has tasked the Medical Director with discussing the concerns at the Local Medical Committee in terms of sanctions for doctors;

h. Whilst the Trust met the compliance rate of 85% in March 2016 concerns remained about the systems capability to record all training attempts;
i. Consultant job planning was not completed but assurance was given that a timeline was in place to achieve this;
j. Consultant engagement is of concern in certain divisions, especially in relation to clinical audit. However, the Clinical Audit Manager is working with the Divisional Medical Directors to ensure the 2016/17 audit plan is achievable.

Other topics discussed where concerns or actions were taken:

3. Patient Experience Team (PET): The Chief Nurse highlighted a concern about the capacity of this team due to a high level of sickness and maternity leave; this had resulted in a backlog of complaints. In addition March 2016 was the first time that the 85% standard of sending responses to clients within the agreed timescale had not been met in a year. The Committee were pleased to hear that a recent appointment was seeing an improving position;
4. Intra-site transfers continued to be challenging and a new risk was being discussed at Management Board. The Committee supported the suggestion that the Trust Chief Executive should write to South East Coast Ambulance to discuss the criteria;
5. Maternity Services: overall the Committee was assured about the progress being made and congratulated the Head of Midwifery and Divisional Medical Director. Evidence showed that they were under established but recruitment was underway. The aim was to have 1 midwife for every mother in labour; and
6. External Visits: the Committee called for immediate escalation of one outstanding action relating the requirement for Ashford Borough Council to undertake an intrusive survey.

7. Progress was made against each of the objectives under review by the Quality Committee, below is the high level achievement, more details is provided in Appendix 2:
    a. Person-Centred Care – good progress
    b. Safe Care – partial progress
    c. Effective Care – good progress
    d. Implementation of the Improvement Plans – good progress

8. The following annual objectives were discussed, following approval at Board, in terms of the risks and will form a key part of the Committees work programme for 2016/17:
    a. Deliver the CQC and emergency care improvement plans to ensure Trust is removed from Special Measures at its next CQC re-inspection in 2016.
    b. Deliver the agreed improvement trajectories (as submitted to and agreed with NHS Improvement) for the emergency care, RTT, cancer and diagnostic wait standards, by end of March 2017.
    c. Transform care for people with learning disabilities with local providers as measured by self-assessment against metrics by December 2016.
    d. Deliver the following service quality improvements by March 2017:
        i. 20% reduction in sepsis associated mortality;
        ii. 20% reduction in harm from poor handover of care/transfer of care;
        iii. 30% reduction in preventable venous thromboembolism events;
        iv. 30% reduction in medication errors;
        v. 30% reduction in catheter associated urinary tract infection;
        vi. 30% reduction in falls with harm; and
        vii. 30% hospital acquired pressure ulcers.
    e. Agree new pathways with commissioners for patients ‘medically fit’ and not requiring an acute bed to reduce delays by 5% by December 2016.

BOARD ACTION:

To note and discuss the report from the Quality Committee**.**