NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	16 January 2018
Paper number	D1

Quality Report

For approval:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing Officer (CNO) Suneil Kapadia, Chief Medical Officer (CMO)		
Presented by	Vicky Morris CNO Suneil Kapadia, CMO	**Author**	Dilly Wilkinson, Deputy Chief Nursing officer

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√	Invest and realise the full potential of our staff to provide compassionate and personalised care	√
Ensure the Trust is financially viable and makes the best use of resources for our patients		Develop and sustain our business		Not applicable	

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability	√	Operational Performance	√	Quality of Care	√
Finance and use of resources		Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Quality Governance Committee	21.12.17	

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	P1.1, 1.2, 1.3, 2.1

Level of assurance and trend indicate the level of assurance the report gives

	√	↑↓→
Significant		
Limited	√	
None		
Not applicable		

Recommendations	The Board is asked to consider the key updates provide by the CMO and CNO in relation to quality and the key actions required to improve the levels of assurance.

Date of meeting	16 January 2018
Paper number	D1

Executive Summary

This paper is provided to ensure the Board are sighted on areas of Quality Improvement and any variances to the Quality Improvement Plan.

- During the reporting period, the Trust was subject to an unannounced CQC inspection which reviewed the core services of medical care (including older person's care) and Urgent and Emergency care at both the Worcestershire Royal and the Alexandra Hospitals. The CQC also assessed progress against the s29A notice issued to the Trust in July 2017 as part of this inspection. The Trust is yet to receive a final report but a letter received by the Chief Executive following the inspection outlines some indications of improvements seen across both core services.
- VTE risk assessment compliance rate for November demonstrates on-going improvements with achievement of 94.21% against an expected trajectory for the month of 94%. This is an area where moderate assurance has been provided by the Clinical Governance group as well as the Quality Governance Committee where the divisions have demonstrated these improvements.
- The NHSI infection prevention lead has been into the Trust in December at the request of the Trust. As an outcome of that review and the increasing confidence in the leadership and management of a recent CPE (Carbapenemase-producing enterobacteriaceae) outbreak, the Trust has been de-escalated to green on the NHS Improvement infection control and prevention risk escalation matrix as the Trust has demonstrated clear improvement.
- The Quality Governance Committee received the first draft of the Quality Improvement Strategy (2018-2021) which has been drafted following engagement with staff and patients. The final draft will be considered for approval in March, which will provide the Trust Board and the organisation with a prospective and continuous programme of improvement.
- The quality indicators for improved responsiveness to complaints and serious incidents is an area of concern for the Trust Board. The report appendix outlines the improvements made to the performance but the trajectory of zero overdue complaints and serious incidents has not been achieved by the end of December deadline.
- A previous proposal considered by the Board relating to safety and leadership walkabouts has now become embedded practice. There have been six completed walkabouts and 12 are planned. It is important to note that wards and departments are now contacting the Quality Hub to request visits. QGC will receive the trends and themes arising from these visits and the Hub will follow up and track all required actions.

Background

The Trust approved a Quality Improvement Plan in July 2017 which provides a clear programme management approach to ensuring that the Trust provides clear evidence of Quality Improvements. This plan currently identifies the priority quality issues highlighted in previous CQC reports and is monitored by the Quality Improvement Board.

The Trust Board is fully sighted on the outcome of previous CQC Inspections and the Section 29a regulatory notice placed on the Trust in January 2017 and reiterated following the July 2017 CQC report. There has been an unannounced CQC inspection in November 2017 to formally review our progress against Section 29a notice but at the time of this paper, no formal final report has been received. The Trust has submitted information requests to

Date of meeting	16 January 2018
Paper number	D1

the CQC prior to a further unannounced inspection anticipated to be in early quarter 4. The Trust has also been advised that a 'well-led' review will be undertaken by the CQC on 26-28 February 2018.

Issues and options

- The Quality Governance Committee reviews all aspects of quality performance in detail and uses real time data from informatics, the quality audits undertaken and the papers presented to the Committee to triangulate the information and consider a level of assurance against the quality and safety aspects of the Board Assurance Framework.
- The divisions are working to eradicate overdue complaints and serious incidents. Capacity constraints which have delayed progress in both these areas have been partially addressed and subject to weekly performance management and support to achieve the required standards. Trajectories have been established for each division. Appendix 1 identifies progress on complaint management over this calendar year.
- This paper links to Care Quality Commission regulatory requirements and a risk of reputational concerns basis based on the quality and safety of care provided for our patients, if improvements are not made.
- The views of relevant internal stakeholders (staff and patients) and our external stakeholders (commissioners and regulatory partners) is fundamental to the Trust's improvement programme and quality improvement strategy.

Recommendations

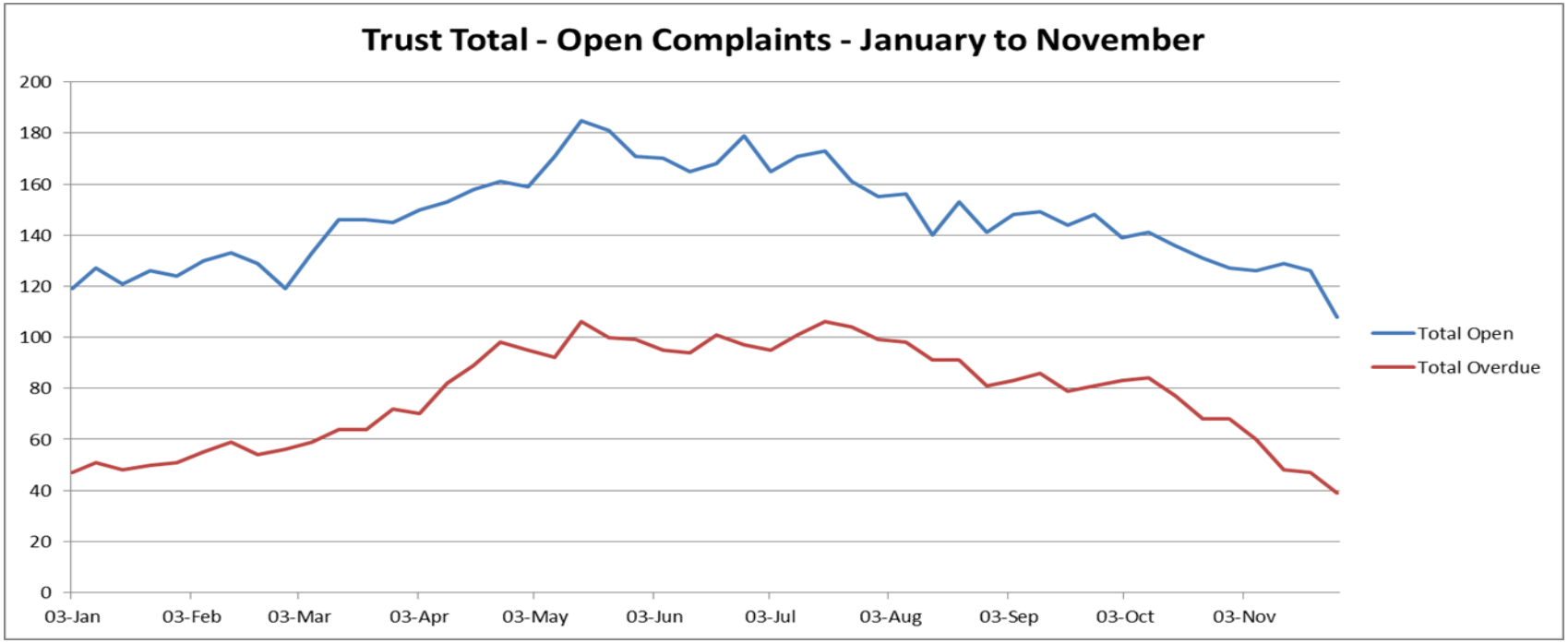
The Board is are asked to consider the key updates provide by the CMO and CNO in relation to Quality since the last Board meeting in November and the key actions required to improve the levels of Assurance.

Appendices

Appendix 1: Complaints deep dive

Appendix 1

Complaints deep dive update



NHS
Worcestershire
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NHS Trust

Date of meeting	16 January 2018
Paper number	D2

Learning from Deaths

For approval:		For assurance:	✓	To note:	

Accountable Director	**Dr Suneil Kapadia, Chief Medical Officer**		
Presented by	**Dr Suneil Kapadia, Chief Medical Officer**	**Authors**	Dr SA Kapadia CMO Dr Stephen Graystone Assoc Medical Director Mr John Reading information analyst

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	✓	Design healthcare around the needs of our patients, with our partners	✓	Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Develop and sustain our business			

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	✓
Finance and use of resources		Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
QGC	21st December 2017	Received

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R1.1 R1.3

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited	✓	→
	None		
	Not applicable		

Recommendations	The Board is asked to note that the Trust crude mortality, HSMR and SHMI figures are within the 'as expected' banding. HSMR and SHMI values are reducing (improving). The Trust Board is asked to note that mortality reviews are conducted by a group of medical examiners (currently 3 – will increase to 6 by

	the end of Jan 2018) as well as speciality consultants. The Trust board is asked to note over 50% of inpatient deaths and all ED deaths are reviewed within 30 days. The increasing number of Medical Examiners will help improve this figure. The Trust Board is asked to note that during Q1 and Q2, there were 9 avoidable deaths. These were confirmed through the serious incident investigation process. The Trust Board is asked to note our reporting of deaths is compliant with the national quality metrics.

Date of meeting	16 January 2018
Paper number	D2

Executive Summary

Mortality as measured by a 12 month rolling average for HSMR and crude mortality remains within the expected variation as does mortality measured by SHMI i.e. the Trust is not an outlier for these metrics.

The previously elevated HSMR for patients with sepsis has continued to decrease and is the Trust is no longer an outlier.

Mortality reviews being undertaken within 30 days has increased from 20% to 55%.

Overall, 70% of deaths have a mortality review.

The most recent report from the National Reporting and Learning Service published September 2017 and covering the period 1st October 2016 – 31st March 2017, demonstrated that the Trust reported 0.4% of incidents as resulting in death.

There were 9 avoidable deaths reported from April 2017 to September 2017.

Recruitment to Medical Examiner positions to move the Trust to compliance with the National Quality Board standards is progressing with 7 people identified.

Background

The purpose of this monthly report is to provide information related to the Trust's Mortality Performance. This is illustrated using several metrics; Crude Mortality Rate, Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-Level Mortality Indicator (SHMI).

Issues and options

HSMR - appendix 1

The data was extracted from HED on the 07/12/2017, and the latest data available was for September 2017.

12 Month Rolling Average	
Oct 2016 to Sep 2017	101.83
Oct 2015 to Sep 2016	109.32

The Trust is not an outlier in respect of its HSMR for the period October 2016 and September 2017.

Mortality reviews - appendix 2

On the 24th May 2017 an electronic system was introduced to facilitate the collation of Mortality Review Data. This led initially to a significant increase in the rate of review completion within 30 days of death. This has now plateaued. The input from the Medical Examiners from the beginning of December 2017 will improve this position.

Structured Judgement Review Update

A transition plan is in place to move from the current process to one compliant with the standards set out by the national quality board. This relies on a group of trained medical examiners (clinicians) undertaking reviews.

Date of meeting	16 January 2018
Paper number	D2

Progress against this plan is reported to the Quality Improvement Programme Board and Clinical Governance Group on a monthly basis

- Three medical examiners undertaking review from 1st December, two medical examiners to start undertaking reviews in January, one medical examiner to begin reviews in February, Two further consultants have expressed an interest in the role.
- Team trained to undertake mortality reviews in patients with learning disabilities using the national learning disabilities mortality review (LeDeR) methodology

National Quality Board mandated metrics Appendix 3
The trust has adopted the NHSI dashboard for reporting Peer review and will adopted a structured review methodology in line with the RCP process.

Specific Diagnostic Group information
The 3 Diagnostic Groups with the greatest number of mortalities between July 2016 to June 2017 were; Pneumonia, Septicaemia and Acute Cerebrovascular Disease.

Learning
Learning takes place from all serious incidents. This is through a variety of forums and widely disseminated through the trust. Learning from the avoidable deaths includes:

- Patient discharge from Trauma is now consultant led
- Enhanced processes for the identification of sepsis and the involvement of the oncology team
- Revised documentation in respect of venous thrombolytic assessment
- Targeted infection control training in respect of stool sampling.

Recommendations

The Board is asked to note that the Trust Crude mortality, HSMR and SHMI figures are within the 'as expected' banding. HSMR and SHMI values are reducing (improving).

The Trust Board is asked to note that mortality reviews are conducted by a group of medical examiners (currently 3 – will increase to 6 by the end of Jan 2018) as well as speciality consultants.

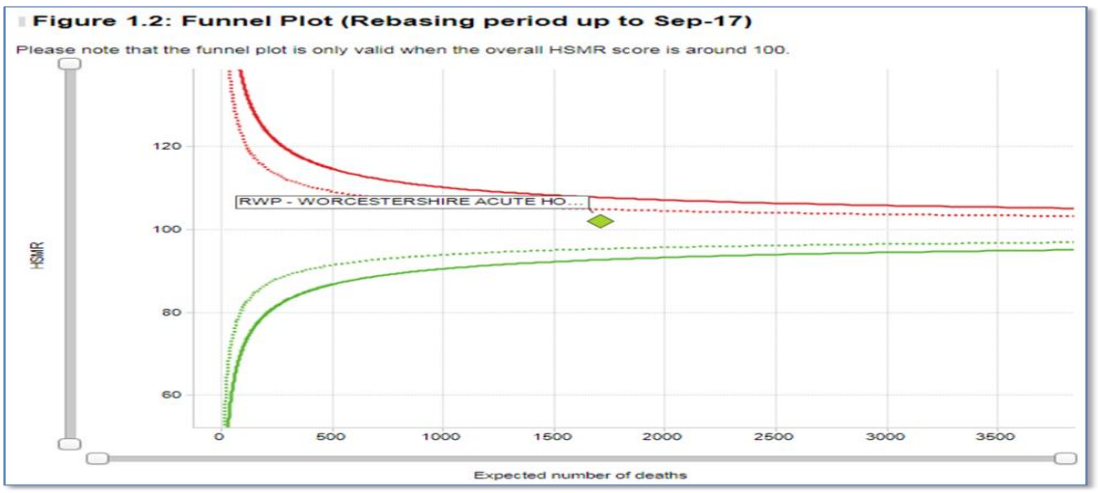
The Trust board is asked to note over 50% of inpatient deaths and all ED deaths are reviewed within 30 days. The increasing number of Medical Examiners will help improve this figure.

The Trust Board is asked to note that during Q1 and Q2, there were 9 avoidable deaths. These were confirmed through the serious incident investigation process.

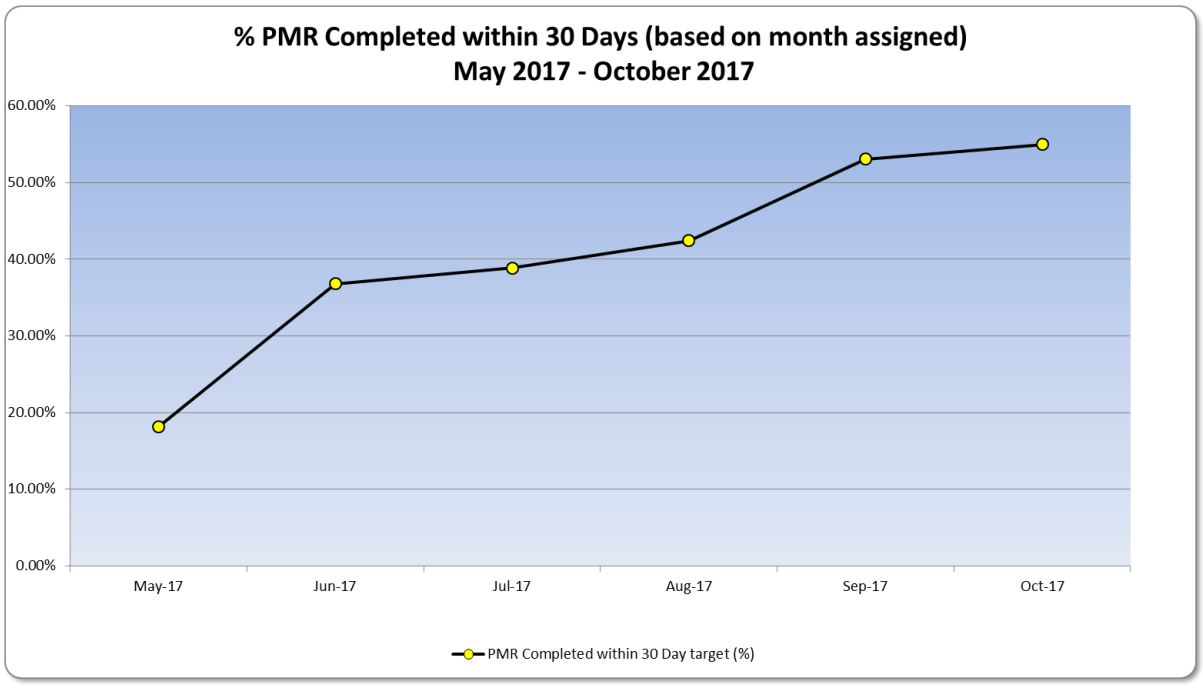
The Trust Board is asked to note our reporting of deaths is compliant with the national quality metrics.

Appendices

Appendix 1



Appendix 2



PMR – primary mortality reviews

Date of meeting	16 January 2018
Paper number	D2

Appendix 3 National Quality Board Mandatory Metrics

Month	Adult Deaths (Non LeDeR)	Number reviewed (Non-LeDeR)	Avoidable deaths (Non-LeDeR)	LeDeR	LeDeR deaths reviewed	Avoidable LeDeR deaths
April 2017	71	32	1	0	0	0
May 2017	117	70	1	0	0	0
June 2017	125	98	3	0	0	0
July 2017	144	113	2	1	1	1
Aug 2017	172	128	1	0	0	0
Sept 2017	113	81	0	0	0	0
Totals	742	522	8	1	1	1

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Date of meeting	16 January 2018
Paper number	D3

Quality Governance Committee

For approval:		For assurance:	x	To note:	

Accountable Director	Bill Tunnicliffe Non-Executive Director		
Presented by	Bill Tunnicliffe Non-Executive Director	**Author**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners	x	Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Develop and sustain our business			

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	x
Finance and use of resources		Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Not applicable		

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	P1.1 P1.2 P1.3

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited	√	
	None		
	Not applicable		

Recommendations	The board is requested to receive this report for assurance.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	16 January 2018
Paper number	D3

Executive Summary

I am pleased to report that the meeting had good attendance, including a representative from HealthWatch for most of the meeting. We considered a variety of reports and the quality of the reports is noticeably improving.

December meeting

Infection control: We were informed that NHS I visited the trust and has now rated the Trust as green. This is a significant achievement and we were pleased to thank the Chief Nurse and her staff for the considerable hard work.

Specialised Clinical Services (SCSD): The deputy Divisional Medical Director attended the meeting to update the board on quality within the SCSD. There are challenges relating to the ophthalmology backlog and the WHO checklist. I was disappointed in relation to the WHO checklist as this is standard practice for all Trusts. Whilst there is a policy in place, embedding has not taken place. It was evident that the deputy DMD had spent considerable time reviewing and enhancing the clinical governance structures and she was thanked for her work. **Limited assurance**

Clinical Governance Group (CGG): The routine report from the CGG was presented. This showed that the Group is maturing in its approach to risk and assurance levels. There remains a significant number of complaints overdue (28%) and the target of zero serious incidents outstanding by the end of December was not met. I was disappointed with both of these metrics. We were pleased with the moderate assurance given for VTE assessment. We also received the cervical cytology annual report. **Limited assurance, but increasing**

Quality Improvement Strategy/Patient carer and community strategy: Both these were received and approved as a direction of travel. They will be ready for the board to consider at its March meeting.

Patient experience following a fractured neck of femur: I asked the divisional medical director (surgery) to attend to explain the dip in performance in August in relation to the time patients took to get to theatre following fracturing their neck of femur. The DMD described an intensive regime of performance management at both hospitals including weekly harm reviews. The dip in August was caused by a surge over the bank holiday (twice as many patients as in 2016) and the theatre capacity was not available. Assurance was given in respect of theatre availability over the December bank holidays. **Limited assurance**

Learning from deaths: I am pleased to report that there has been an improvement in the number of primary mortality reviews since the implementation of the electronic system. HSMR and SHMI continue to fall and are not an outlier. Non-elective care HSMR at the Alexandra Hospital is significantly higher than the SHMI value due largely to palliative care coding. The cause of this is being investigated. Recruitment to Medical Examiner positions to move the Trust to compliance with the National Quality Board standards is progressing with 7 people identified. **Limited assurance**

Other items considered:

- Non-Executive director visits: this was received
- Clinical audit annual report
- Quality improvement board

Date of meeting	16 January 2018
Paper number	D3

- Cancer 62 day wait trajectory – this was approved on behalf of the board.

I have requested consideration of a review into the timing of discharges as I believe that the patient experience could be enhanced by more discharges taking place in the mornings.

November meeting
Due to considerable pressures on both sites and planned annual leave, this meeting had a number of executive directors missing. Items presented included:

- CGG report
- Quality improvement board
- CQUIN routine report
- Learning from Deaths
- Infection control Q2 report
- Patient experience report
- Progress on the quality account

Background

This report is the regular report to Trust Board from the QGC. It covers the meetings held in November and December 2017.

Recommendations

The board is requested to receive this report for assurance.