Worcestershire Acute Hospitals NHS Trust

Date of meeting	15 March 2018
Paper number	D1

Quality Report

For approval:		For assurance:	x	To note:	

Accountable Director	Vicky Morris, Chief Nursing Officer Suneil Kapadia, Chief Medical Officer		
Presented by	Vicky Morris CNO	**Author**	Vicky Morris CNO

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
QGC	Dec, Jan & Feb 2018	

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		
Moderate	√	
Limited		
None		
Not applicable		

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

Date of meeting	15 March 2018
Paper number	D1

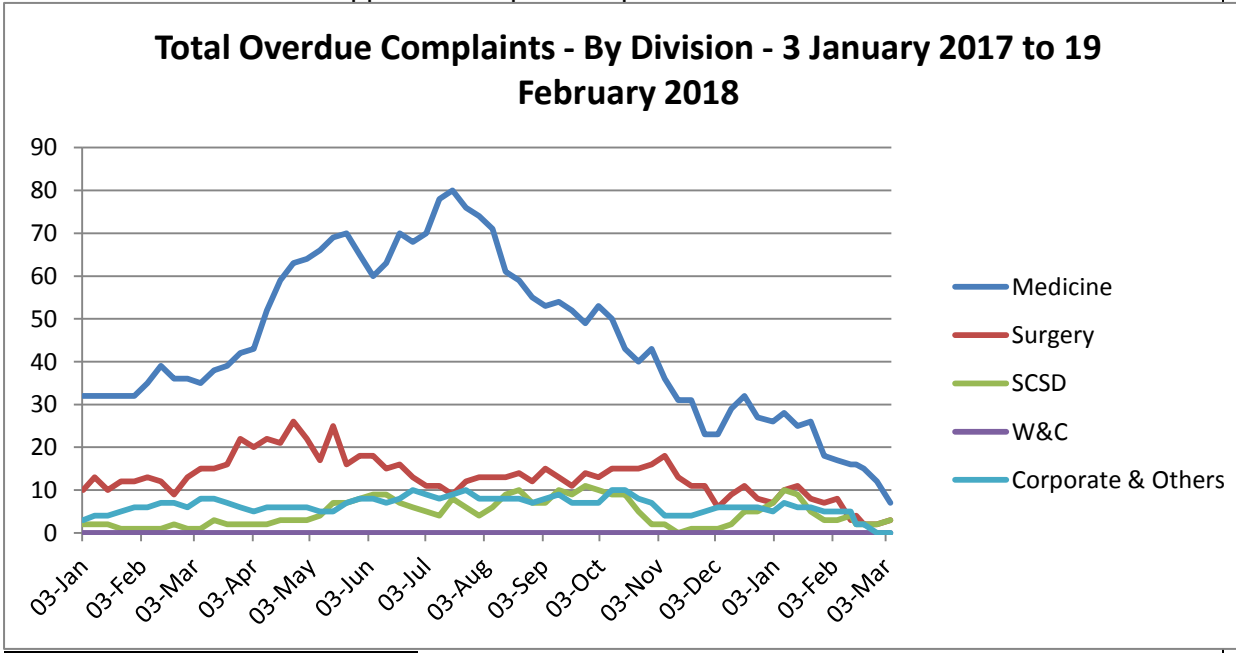
Executive Summary

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

   During the reporting period, the Trust was subject to three Care Quality Commission (CQC) visits (although included within one Inspection period).
   - 22-26th January 2018 which included core service reviews in; Out Patient services, Diagnostics and Women and Children's.
   - 13-15th February 2018 which included core service reviews in; Surgery, Outpatients and Women and Children's services.
   - 26-28th February 2018 which covered the "Well led" domain

   Following each of the core service reviews CQC fed back to the CEO, CNO and CMO and confirmed that feedback in writing within a few days of the visits. The Trust does not anticipate a published report until May 2018.

2. Complaints performance continues to be of concern and the Chief Nursing Officer is working with the Divisions to resolve the challenges. There had been a significant increase of complaints received in December 2017 and January 2018 and the performance indicators have been reviewed by the Quality Governance Committee and the improvements towards the trajectories noted in the graph below (fig 1). The Divisions had given an undertaking to resolve their overdue complaints by the end of February, however 3 of the Divisions have missed this trajectory and the CNO will continue to work with the Divisions to support the required improvements.



	Dec-17	Jan-18	Feb-18
Actual	40.43%	41.67%	53.33%
Trajectory	60%	65%	70%
National Standard	80.00%	80.00%	80.00%

3. The Divisions have worked hard to improve the performance of Serious Incidents Investigations, with an improvement in the number of overdue Incidents, with only 1 Serious Incident overdue. Analysis indicates that the top 5 categories of incidents are: Tissue Viability, Patient Falls, Bed Management, Medication and Treatment.

4. Through the Clinical Governance Group the Divisions are recognising collective risks which they have discussed and recorded in their Divisional Risk registers. These have been collated into the Corporate Risk Register where applicable. Some of these issues include additional "surge areas" over and above the winter plan which have been opened to accommodate inpatients over the winter period and the associated staffing across the Divisions. All staff recognise that these are necessary and short term measures, which have reduced facilities for inpatients. The CNO has been working with the Divisional Directors of Nursing to ensure that each of these areas have a:
   - "Ward environmental risk assessment" which enables staff to identify any issues regarding supporting Inpatient care in that environment and the mitigation of those issues.
   - Individual patient have a risk assessments undertaken to ensure that patients transferred into these areas have been risk assessed against the criteria agreed.
   - Support from Divisional and corporate nursing given to substantive staff who are not used to supporting inpatient care through training and awareness sessions.
   - Daily Quality audits undertaken on each and every patient nursed in these areas to ensure that documentation evidences good quality care and provides an opportunity to discuss the care received by patients. These audits are being reviewed by the CNO on a daily basis.

   The Care Quality Commission are aware of these additional areas being utilised when required and the Commissioners have recently undertaken their own quality audits in these surge areas (week beginning 5th March) and have fed back that whilst the physical areas are not ideal, the evaluation of care and documentation was good and the patients fed back very positively about the care provided.

   The nurse staffing across all areas continues to be closely monitored given the additional pressure of opening these surge areas. The staffing App is monitored across Divisions and additional corporate monitoring has been put in place each day to ensure that potential risks are mitigated. The staffing continues to be challenging and further work being undertaken to review the Dependency and Acuity and outcomes where staffing has been under the required template.

Background

This report is the routine report to the Trust Board on quality.

Issues and options

The Trust Board have continued its programme of Safety walkabouts across a range of wards, engaging staff in the discussion about Quality Improvements they wish to share and celebrate but importantly discuss any risks and safety issues for their ward areas and any actions which can be supported.

Recommendations

The Trust Board is asked to consider the key updates provided by the CMO and CNO in relation to Quality and the key actions required to improve the levels of assurance.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March
Paper number	D2

Learning From Deaths Report

For approval:		For assurance:	√	To note:	√

Accountable Director	**Dr Suneil Kapadia, Chief Medical Officer**		
Presented by	**Dr Suneil Kapadia**	**Author**	**Dr Steve Graystone, AMD Patient Safety**

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
CGG	March 2018	Reviewed and discussed

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		
	Moderate		
	Limited	√	↑
	None		
	Not applicable		

Recommendations	Trust Board is asked to: Note the rate of review of care in patients who have died Note the learning and changes in practice Note the proposed learning pathway for dissemination through the Trust

Worcestershire Acute Hospitals NHS Trust

Date of meeting	15 March
Paper number	D2

Executive Summary

The Trust is currently reviewing over 75% of deaths for the quality of care delivered. Learning and changes in practice are beginning to emerge from the review process at specialty and corporate level. The Trust has developed a learning pathway to ensure lessons and practice changes are disseminated throughout the Trust.

Background

The purpose of this report is to provide information related to learning from mortality reviews and the pathways for dissemination of this learning.

Issues and options

Learning from Deaths

A. Mortality Reviews

The quality of care delivered to patients who die whilst an inpatient is reviewed by either speciality Consultants not involved in the patents care or, increasingly, by trained Medical Examiners.

Since May 2017 970 reviews have been completed of 1276 deaths occurring (76%).

The reviews reach one of three broad conclusions which result in three pathways for learning:

1. Care was good – this outcome is shared at the speciality morbidity and mortality meetings
2. There were gaps or errors in care, but these did not have a significant impact on the individual patient outcome – the themes identified are reviewed at the speciality morbidity and mortality meetings and actions identified to reduce the risk of recurrence
3. There were gaps or errors in care identified that had an adverse impact on the patients outcome – these cases are reviewed by divisional governance teams and an Initial Case Review presented to the Serious Incident Review and Learning Group where a decision is made as to whether the incident should be reported as a Serious Incident. The outcome of the more detailed investigation is presented to the group. Based on this final report as decision is made as to whether the death was, on the balance of probability, using a 50:50 judgement avoidable or not.

B. Learning from reviews & changes in practice

1. Examples of speciality level reviews by Division

Surgical Division	
Case/Issue	Change in practice
Death following complex urology surgery	Formal Multidisciplinary review process established to manage post-operative care of complex urology cases were complications occur.
Emergency Medicine Division	
Case/Issue	Change in practice
Delay in assessing patients in ED	Medical staffing rota altered to increase staffing at night

Key triggers in acute onset cerebral symptoms missed in handover from WMAS to ED	Modification in standard information shared (using a checklist) for patients presenting with headache and altered conscious level
Delay in diagnosis of leaking Aortic aneurysm	ED Dr Training programme modified to include variations to standard presentation for a leaking Aortic Aneurysm
Death following discharge after Road Traffic Collision	New guidelines for management of trauma in the over 75s. All in this group have a minimum observation period prior to discharge by a senior clinician.
Ineffective escalation of a medical patient in ED due to lack of clarity of ownership	Regular frequent board rounds established to ensure clarity of responsibility and timely escalation of concerns.
Speciality Medicine Division	
Case/Issue	Change in practice
Error in delivery of long term oxygen therapy (LTOT)	Policy and practice updated to ensure no loss of information during transfer between hospital wards
Error in the management of a chest drain	Training modified in light of the incident. Policy and routine documentation also modified.
Death from Pulmonary Embolism	Ward pharmacists check VTE form completion when checking VTE prophylaxis prescription and raise any gaps with senior clinician covering the ward
Haemorrhage following liver biopsy	Programme of training in human factors and clinical team working established
SCSD	
Case/Issue	Change in practice
Inter hospital transfer of a patient on an antibiotic regime not used in the Trust – dosing error	Antibiotic management guidelines modified to include monitoring whilst transitioning between regimes.
Blood science report conducted in a specialist centre not flagged as abnormal on ICE – no treatment commenced	ICE modified such that investigations done at a reference laboratory that show abnormal results are flagged on in the same way as abnormal values resulting from in-house tests.

2. Deaths managed as Serious incidents

Eight serious incident reports have been closed in January were the patients eventual outcome was death. The table below

Case description	**Probability of incident causing death**	**Key action/change in practice**
Falls leading to harm (2 cases)	Case 1: < 50% Case 2: >50%	New falls documentation implemented to ensure clearer risk assessment and management plan Targeted action in ED to ensure safe care at

		times of high demand/pressure
Pressure damage to skin (3 cases)	Case 1: <50% Case 2: < 50% Case 3: 0%	Improvements in nutritional management Improved local induction for agency staff No practice change, lesion present on admission
Delayed management of sepsis	Case 1: >50%	Ward to receive focussed sepsis training from specialist sepsis nurse
Failure to follow safe transfusion practice during major haemorrhage	Case 1: 0%	Major haemorrhage drills implemented in transfusion laboratory
Failure to monitor and respond to clinical deterioration	Case 1: >50%	Improved handover process from ambulance service to ED staff and from ED to ward staff

Prior to the implementation of the assessment of the level avoidability in January 2018 eleven incidents were closed at the Serious Incident Group were the patients outcome was death These cases are being reviewed by the AMD for Patient Safety and the DMD for Surgery to arrive at consensus on degree of avoidability. This process has not yet completed. The cases and key learning are listed below:

Case Description	**Probability of incident causing death**	**Key action/change in practice**
C Diff 1a on death certificate (2 cases)	Yet to be determined	Education in clinical areas regarding stool specimen policy Add empirical Metronidazole to the risk assessment document
Death following discharge from ED	Yet to be determined	New guidelines for identification and management of high risk patients including minimum observation period prior to discharge by a senior clinician
Pulmonary embolism death (2)	Yet to be determined	Enhanced monitoring of VTE risk assessments at point of admission and at 24 hours for all adult patients admitted.
Death from unrecognised sepsis (2)	Yet to be determined	Appointment of sepsis nurse to: • Continue sepsis recognition & management audit. • Continue training re sepsis and NEWS to all wards. • Roll out 'NEWS Boards' facilitating deteriorating patent identification. Ensure all

		consultants and other senior medical staff receive training on sepsis and NEWS.
Delayed recognition of intra-abdominal pathology (2 Cases)	Yet to be determined	• Consultant on duty to be informed of any deteriorating patient under their care who has been escalated. • Senior clinicians need to attend to, assess and manage the critically ill patient irrespective of the assumed ability of the junior doctor or possible diagnosis
Fall leading to harm	Yet to be determined	New falls documentation implemented to ensure clearer risk assessment and management plan Revision of post falls proforma to ensure timely investigations.
Death following biopsy	Yet to be determined	Improved senior medical cover and handover process at weekends

3. Sharing of learning

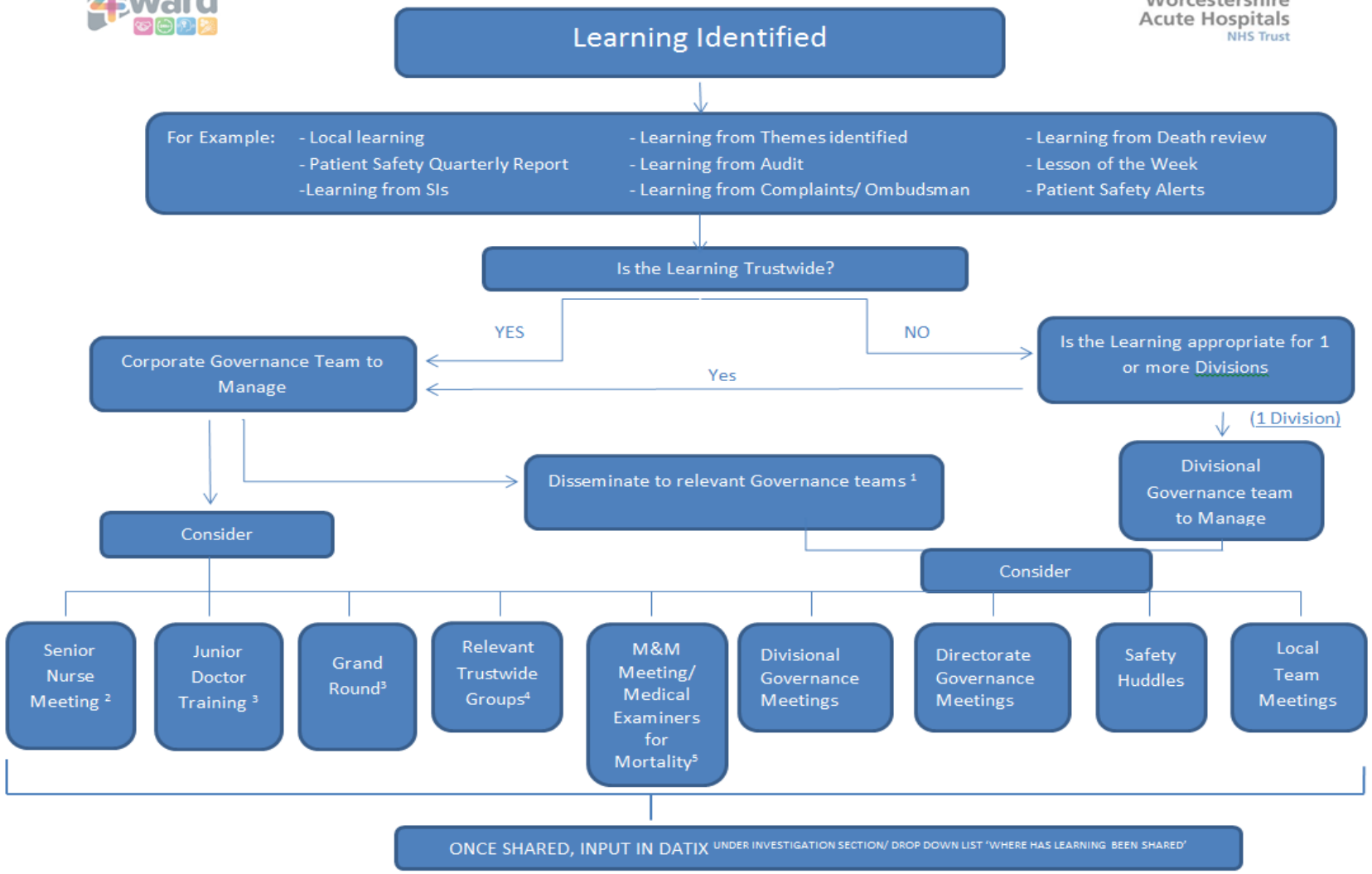
Appendix 1 outlines the route through which learning will be disseminated through the Trust.

Recommendations

Trust Board is asked to:
Note the rate of review of care in patients who have died
Note the learning and changes in practice
Note the proposed learning pathway for dissemination through the Trust

Appendices

Appendix 1: Shared learning pathway


Learning Identified
For Example:
- Local learning
- Patient Safety Quarterly Report
-Learning from SIs
- Learning from Themes identified
- Learning from Audit
- Learning from Complaints/ Ombudsman
- Learning from Death review
- Lesson of the Week
- Patient Safety Alerts
Is the Learning Trustwide?
YES
NO
Corporate Governance Team to Manage
Is the Learning appropriate for 1 or more Divisions
Yes
(1 Division)
Divisional Governance team to Manage
Disseminate to relevant Governance teams 1
Consider
Consider
Senior Nurse Meeting 2
Junior Doctor Training 3
Grand Round3
Relevant Trustwide Groups4
M&M Meeting/ Medical Examiners for Mortality5
Divisional Governance Meetings
Directorate Governance Meetings
Safety Huddles
Local Team Meetings
ONCE SHARED, INPUT IN DATIX UNDER INVESTIGATION SECTION/ DROP DOWN LIST 'WHERE HAS LEARNING BEEN SHARED'

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March 2018
Paper number	D3

Quality Governance Committee Assurance Report

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			*Please see the individual summaries in the report*
Moderate			
Limited			
None			
Not applicable			

Recommendations	The board is requested • To note the Committee received the final reports for the two never events, wrong site surgery and misplaced nasogastric tube • To receive this report for assurance.

Date of meeting	15 March 2018
Paper number	D3

Executive Summary

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

February meeting

Discharge planning: I remain concerned about the discharge planning process as this impacts greatly on the patient experience. I have attended a bed meeting and I will follow this through with the Interim COO to see how we can improve patient flow issue. We were informed that further work was being undertaken by the CMO to audit the process. QGC will continue to have a watching brief on this issue with further discussion at the March meeting.

Divisional presentations: I am keen to ensure that this is a supportive process for divisions. I will be meeting with divisional directors to pursue this issue. Presentations will recommence in April.

Care in the Corridor: We received a letter outlining work being undertaken by HealthWatch. We will receive the report in due course.

Metrics: We viewed SQuID and reflected on the rise in open incidents which have increased and the dip in VTE (venous thrombolytic embolism) assessment performance over the Christmas period. We will be reviewing the number of patients who have 'unknown' as a classification of VTE. The VTE performance increased to over 90% in January. We were pleased to see that the positive Friends and Family test. We were also pleased that over 90% of patients who have had a fractured neck of femur go to theatre within 36 hours. Associated mortality has decreased.

Never events: We received the final reports relating to the two never events, wrong site surgery in relation to a tooth extraction and a misplaced nasogastric tube.

- Wrong site surgery: actions being taken to minimise the risk of another event have been undertaken including treating each tooth extraction as a separate procedure and the WHO checklist will be used for dental surgery.
- Misplaced nasogastric tube: The NHS I tool was used in relation to the investigation which ensured all staff were involved in a discussion about the incident. The policy is currently being updated to reflect best practice and the NHS I tool.

There will be a round table discussion in relation to both never events. Learning has taken place in relation to the dental procedure and the CMO is considering how the wider learning can be disseminated, particularly in relation to new junior staff. I have asked for an update on the action plans to be presented to the Committee in three months.

Clinical Governance Group: A detailed report was presented which outlined the discussions at the CGG held earlier in the month. There were a number of good new stories for example there was significant assurance given in relation to emergency trolley audits. **Limited assurance**, recognising the progress being made. We also received an update on the complaints performance which is improving. We are increasing the number of complaints we resolve by phone and this is being taken forward by the divisional directors of nursing. We also received the recent internal audit report on complaints which showed poor processes in place in relation to Datix. We noted that the medicine division has dramatically improved their performance. **No assurance level**.

CQC update: We received a verbal update on the CQC three day visit earlier in the month. We are awaiting the written report. The visit reviewed surgery, outpatients and aspects of the paediatric and maternity services.

Quality Improvement Report: we received the current update to the quality improvement plan. We readily endorse the Quality Improvement Strategy and the underpinning strategies

which are separately on this Board agenda. We were pleased to understand that at the launch of the strategies, summaries will be available for staff.

Quarter 3 reports: We received summaries of the quarter 3 reports in relation to Safeguarding, infection prevention and control, patient experience, medicines optimisation and patient safety. We were pleased with the content and asked for the summaries to correctly reflect the current challenges.

Clinical correspondence: We received a report in relation to the reported delays with clinical correspondence. One person suffered harm and this has been dealt with appropriately. We heard that the issues were due to the lack of training on Bluespier and this training has now been rolled out. We felt the format of the report was very useful and very comprehensive. The Trust now has a standard that all aspects of clinical correspondence should be cleared within 3 months. This will be monitored through divisional reports to CGG. We were pleased to see the collaborative working within the investigation. **Significant assurance**

Mortality performance report: There is a small improvement in mortality and we are not outliers. We are improving the number of mortality reviews in 30 days. Over 70% of all deaths have been reviewed. The paper is on the board agenda and I commend it to the Committee. **Limited assurance**

Board Assurance Framework: We did not endorse the proposed risk reduction in risk 1.2 from 20 to 16 but suggested that there should be a risk reduction in 1.1. We will bring back our recommendation to the next Board meeting. We also discussed the underpinning risks from the corporate risk register and requested these to be updated.

Fractured neck of femur: We were pleased to see the improvement in time to theatre.

January meeting

We discussed the following items at our January meeting:

- Surgery division – key areas of risk and mitigations
- CQC report
- Quality Improvement Strategy
- Quality Account 2017/18 – progress
- Quality improvement board report
- Monthly mortality

Background

This report is the regular report to Trust Board from the QGC. It covers the meetings held in January and February 2018.

Recommendations

The board is requested

- To note the Committee received the final reports for the two never events, wrong site surgery and misplaced nasogastric tube
- To receive this report for assurance.