TRUST BOARD
30TH MAY 2019

AGENDA ITEM NUMBER  15.1
TITLE OF PAPER  Quality Report
Confidential  NO
Suitable for public access  YES

PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED
Quality of Care Committee 23 May 2019.

STRATEGIC OBJECTIVES

Quality Of Care  ✓ The Quality Report provides an overview of QA and QI efforts and outcomes across the Trust and reflects the priorities set out for 2019/2020.
People  ✓
Modern Healthcare  ✓
Digital  ✓
Collaborate  ✓

EXECUTIVE SUMMARY

This is the first quality report for 2019/20 and includes our new quality improvement priorities, which are led at Executive Level by the Chief Nurse and Medical Director. These priorities are shown in blue italics within each section. There are 5 KPIs specifically set to capture outcomes and these are the Quality of Care indicators for the Trust Balanced Scorecard. Performance against these KPIs is shown within the sections as outlined below.

-Number of surgical site infections  S. 2.1
-Number of medication errors with harm reported  S. 1.1
-Maintaining NHS Safety Thermometer combined harm free care below the national average  S. 2.2
-The number of deaths considered more likely than not due to problems in care (reported quarterly in arrears in the separate Learning from Deaths papers).
-Percentage of complaints responded to within the Trust target of 25 working days  S. 6.1

Medication safety: In April 2019 there were 10 incidents with harm reported, which is in-line with the trajectory to reduce the number to fewer than 132 in 2019/2020. This report describes learning from incidents and improvements, as well as the revised aims and priorities for the year ahead.

Infection Prevention and Control: The reduction of in-hospital infections is a key quality priority for 2019/2020 and our approach includes a number of components within existing infection control plans relating to MRSA, E.Coli, establishing a baseline rate of surgical site infections and then achieving a 5% reduction. In April 2019, there were 3 hospital-apportioned cases of C.difficile and 19 cases of E.coli bacteraemia (community and hospital-onset), one of which was ‘hospital-onset’.

Becoming a learning organisation through multi-professional education: This section describes the objectives identified for this year relating to this aim, as well as the details of the most recent Trust-wide learning event.

Effectiveness: In April 2019 there were 114 inpatient deaths which remains within common cause variation. This report summarises the progress with completion of structured judgement reviews. A full review of learning from deaths will be provided in the Q4 paper to be presented to Board in June 2019. Stroke is rated as level C using the Sentinel Stroke National Audit Programme (SSNAP) rating for the December 2018 quarter. Improvement actions are in S. 4.2.

Experience: 84% of complaints due out in April were issued within the Trust’s 25 working day timescale which is a significant improvement.

Appendix A to this report includes data and other information provided for assurance.

Appendix B is a discussion paper on the December 2018 CQC publication Opening the door to change: NHS safety culture and the need for transformation.

Appendix C shows results of the National Audit of Care at the End of Life based on patient care in April 2018. Particular strengths included governance, having a specialist palliative care team which provides training, and recognising that the patient was dying and exploring the communication of this with the patient and family.
appropriately. Things we need to do better are assessing the needs of families and others who may need further support, and communicating with patients about clinical care decisions around end of life. The End of Life Care Steering Group will oversee the action plan which is currently being formulated.

<table>
<thead>
<tr>
<th>AUTHOR NAME/ROLE</th>
<th>Dr Erica Heppleston, Associate Director of Quality</th>
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<tr>
<td>PRESENTED BY</td>
<td>Sue Tranka, Chief Nurse &amp; Dr David Fluck, Medical Director</td>
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<td>BOARD ACTION</td>
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1. IMPROVING MEDICATION SAFETY:

In 2019/2020, the improvement in medication safety has been identified as an on-going priority and the strategy developed to achieve this includes the goal of improving the safety culture and reducing medication related harm in line with the WHO five-year challenge set in 2017, by improving access to medicines expertise through alternative use of resources and addressing human factors through use of e-prescribing and automation. This priority work is led by the Chief Pharmacist, Mr Olatokunbo Ogunbanjo.

1.1 REDUCING PATIENT HARM

A key KPI for improving medication safety in 2019/20 is to reduce medication incidents with any harm to less than 132 in the year. This is a 30% reduction compared with last year, which was the baseline, and forms part of a trajectory for a 50% reduction by 2021/22. In April 2019, there were 10 incidents with harm reported which is in line with the limit of fewer than 11 such incidents per month.

In April 2019 there were zero medication incidents reported with moderate or severe patient harm. The medication safety improvement programme also seeks to increase reporting of all incidents, particularly those medication incidents that result in ‘no harm’. In 2018/19 there were 741 no harm medication incidents reported. The 2019/20 KPI is that the number of medication errors resulting in no harm will increase by 15% by March 2020 to 852. In April 2019 there were 65 reported medication related incidents with no harm.
The central approach to delivering the medication safety programme will continue to be generating and implementing change ideas within multi-disciplinary teams to address root causes of the harm. Specific improvements in April included improving medication chart documentation to reduce omitted doses, revising protocols for heparin infusion management with more practical guidance, and setting up a working group for learning about anticoagulation from SIRIs and SJRs. Refresher training was given on alcohol withdrawal regimes and strengthening governance of single nurse check medicine administration.

2. INFECTION PREVENTION AND CONTROL

As part of the work to prioritise and align our quality improvement and assurance work, we are taking a strategic approach to the reduction of instances of, and harm caused by, in-hospital infections. This is a key quality priority for 2019/2020. This approach focuses on improving outcomes for patients and reducing the incidence and impact of infection in the organisation and includes a number of components of the existing infection control plans relating to MRSA, E.Coli, establishing a rate of surgical site infections and then achieving a 5% reduction.

2.1 SURGICAL SITE INFECTIONS

One of the current priorities for strengthening infection prevention and control is to reduce surgical site infections (SSIs). The outcome KPIs will be both the number of surgical site infections and SSI rates will be baselined then an in-year reduction percent will be set.

The SSI reduction programme is being led by Mr Shashi Irukulla, the TASCC Divisional Director who is also the GIRFT SSI Trust Champion. Reducing SSIs will benefit patients through faster recovery and a lower risk of a re-operation. Efficiency benefits include shorter hospital stays and fewer readmissions. SSI reduction is to initially focus on the specialities of breast, colorectal, obstetrics, orthopaedics and spinal surgery. Specialties are currently finalising leads for each surgical pathway and a project group by the SSI GIRFT Champion is meeting monthly to oversee progress.

An initial focus is on better identification and reporting of SSIs whilst identifying resources needed to make the improvements. Awareness campaigns will promote identification by surveillance by ward teams linked to using the Datix reporting system to capture cases arising. Additional resources are being identified by the SSI Clinical Leads and surveillance nurse posts are being considered.

Learning from prior projects has shown the effectiveness of a number of interventions in the pre-operative, intra-operative and post-operative phases of surgery. These include nutrition and temperature monitoring, timed antibiotic administration, and optimising wound management. Next steps are consistently adopting and spreading this best practice in theatres, whilst supporting more widespread actions across the Trust.

In order to spread the use of these best-practice interventions, the team are carrying out point-prevalence audits in both Ashford and St Peter’s theatres; as well as sharing data on compliance with the clinical teams. Findings from the audits in March and April 2019 have identified areas for improvement; including, availability and consistency of antibiotic guidelines and patient warming pre-surgery; and the team are taking action on each of these.

As part of the national GIRFT SSI audit, prospective reporting of SSIs will be in place from May 2019. From January 2019, retrospective reporting of SSIs has been in place in some specialties and nine SSIs were initially identified in the period January to March 2019. These incidents have been shared with the relevant teams and will be reviewed for learning. Further audits and validation of incidents are underway and data will be provided as part of this report from May 2019.

2.2 HOSPITAL ACQUIRED INFECTIONS

The infection prevention and control strategy will be deployed during the year, with specific improvement targets for E. coli, C. diff, and catheter associated urinary tract infection (CAUTI). This programme is being led by Mrs Ann Birler, Nurse Consultant/Deputy Director of Infection Prevention and Control.

The annual target in 2019/2020 for reduction of C.difficile cases is for no more than 28 cases to occur. The definition for Trust-apportioned cases has changed to include hospital-onset cases and those cases with a
community onset where the patient has been an inpatient in the previous 4 weeks. There were 3 Trust apportioned cases in April 2019 and root cause analyses are being undertaken with clinical teams for each of these. During 2019/2020 focus to minimise the risk of C.difficile continues around appropriate antibiotic prescribing, assessment and monitoring of patients with diarrhoea. Weekly antimicrobial stewardship ward rounds are in place by the Antibiotic Pharmacist and Microbiologist Lead, and guidelines are being reviewed and updated. An updated Patient Stool Record is about to be issued and this includes an assessment flow diagram to aid appropriate management of patients with diarrhoea. We will also focus on evidencing that Divisional ownership and learning from RCAs is in place.

The Trust target for reduction of all cases of E.coli bacteraemia (community and hospital-onset) for 2019/2020 is no more than 186 cases, and 29 for hospital-onset cases. There were a total of 19 cases in April 2019 and of these, 1 was hospital-onset. The RCA is still underway, however, the preliminary indication is that this case appears to be a community infection. The approach to improvement is tailored learning by clinical teams based on root cause analyses of hospital-acquired cases if device related.

The Trust delivers a national catheter training programme. The Catheter Pathway was reviewed in 2018 and the plan was to implement this to improve care and communication between clinical teams. However, the Trust is currently in the process of agreeing with community colleagues whether this pathway or the new national pathway should be implemented.

To date the Trust has not collected regular data on the level of new hospital-acquired catheter associated UTIs (CAUTIs), so incidence of this harm cannot currently be reported at present. The national Safety Thermometer for 2018/19 showed 7 CAUTIs, however, this is only cases for patients sampled on the monthly audit spot dates. The Safety Thermometer CAUTI figure for the percentage of patients with CAUTIs on the spot day for 2018/19 was 0.12 which was below the national average of 0.27. The next step is to implement systems and processes to identify and record all new CAUTI. Once this initial data collection has been done, there will be a baseline level for this measure and then the limit for the year for new CAUTIs can be set.

As above, new harms are measured each month using spot day audits per the national Safety Thermometer programme. The ‘Classic’ Safety Thermometer is a measurement tool for improvement which focuses on 4 common harms in healthcare: pressure ulcers, falls, CAUTIs and venous thromboembolism (VTE). In this tool a low score represents good performance. The Trust has been a sound performer in this programme. Combined new harms were 1.49 in 2017/18, and 1.56 for 2018/19 which was favourably below the national average for last year of 2.12. The spot day new harms Safety Thermometer KPI for 2019/20 is to remain below the national average. Data is reported in arrears and will be shown next month.

Avoidable cases of both MRSA and MSSA bacteraemias will reduce to zero by the end of 2019/20. In April there were 0 cases of Trust MRSA and 0 MSSA bacteraemias.

2.3 SEPSIS

Sepsis has been a particular priority of the Trust for the past 4 years and in 2015/16 the national Sepsis Six bundle was rolled out in Adult and Paediatric EDs followed by inpatient screening tools. ED has a dedicated Sepsis Team and in 2018/19 a Deteriorating Patient Group was formed.

Our current year’s QI KPI for sepsis is that by Q4 all patients with sepsis will be identified and treated with antibiotics within 1 hour of identification. For 2018/19 combined performance was 84.4% with ED at 87.4% and 82.2% for inpatients. The plan is for sepsis performance to be reported quarterly in arrears for ED and inpatients which should be available for Q1 2018/19 from July 2019.

An effective way of measuring this KPI for inpatients is under consideration. Previously inpatient data for the above indicator has been captured using spot audits at a point in time. A long-term solution is anticipated to be electronic capture of data using the Cerner electronic patient record system. A way to collect the data using the VitalPAC screening module is also currently being considered. The challenge is that Sepsis 6 data is not always completed in
VitalPAC so drug charts also require review which is manually intensive. Continuation of spot point-prevalence data audits is likely to be the most feasible option.

### 3.0 BECOMING A LEARNING ORGANISATION THROUGH MULTI-PROFESSIONAL LEARNING

In line with the Strategy, the next phase in becoming a learning organisation is to develop a Trustwide platform where learning can be shared across professional groups. This will be achieved through developing a truly multi-professional education programme. The Director of Clinical Education, Professor Pankaj Sharma, is leading on changes to the approach to education in the organisation, which includes the aim of enabling more MDT learning to take place at a local level. This will support ensuring that learning from deaths, serious incidents, safety themes and service user feedback is channelled through the education programme. The aim is to widen the attendance, reach and hence learning from these events.

A new QI priority is for **multi-professional hours spent at QI related learning events to increase by 10% during 2019/20.** Next steps are to establish a baseline for this measure so that quarterly reporting can be in place by July for the end of Q1.

### 3.1 TRUSTWIDE LEARNING EVENTS

A Trustwide learning event held in April 2019 attended by 40 staff and patient advocates shared learning from 2 mortality case reviews. A small panel comprising the reviewer and those involved with the patients’ care discussed themes from the cases.

The first case showcased the excellent end of life care provided to the patient. The group also explored the difficulties around sensitive and timely identification of someone who is dying, particularly when this is early on in a hospital admission.

In the next case the discussion centred upon how the initial assessment from the first stage review can be modified from more experienced second stage review. The initial assessment of perceived poor care changed on second review to be adequate care with some good elements around ward round decision making and continuity of care. The discussion centred upon ways of communicating changes in review findings, and clinical factors surrounding expectations of standard of care which should be provided to inpatients.

Wider learning as part of the SJR programme was a greater appreciation of the time and expertise devoted to performing the reviews, debate on how cases are selected for in-depth reviews, and an understanding of the truly multi-disciplinary nature of the learning from deaths programme. It is hoped that more reviewers will be recruited given the interest the learning event generated.

### 3.2 TEAM CULTURE

An integral aspect of an established learning culture is building a safe and just team culture in order to support patient safety. This involves a combination of human-resource based approaches including safety culture assessments. We will provide an update on this work at quarter-end.
4.0 EFFECTIVENESS

4.1 LEARNING FROM DEATHS
The Learning from Deaths Programme is led by the Chief of Patient Safety/Deputy Medical Director, Dr Paul Murray. In April 2019 there were 114 inpatient deaths which remains within common cause variation.

![Crude Mortality - In-Hospital Deaths](image)

The Risk Adjusted Mortality Index (RAMI) is shown below. This excludes deaths related to 30 days post discharge, zero length of stay, palliative care code Z51.5 and maternity. The RAMI remains within common-cause variation and is reported one month in arrears.

![Mortality - RAMI](image)

**Note:** The RAMI measure is based on a new calculation from CHKS and this has been re-calculated back to April 2015.

As outlined above, the Trust has been participating in the National Learning from Deaths programme and performing structured judgement reviews (SJRs) to learn from this. For 2018/19 the SJR completion rate has increased from 66% to 72% as further cases pertaining to that period have been completed after year-end.

The **aim for 2019/20 is that by Q4 100% of applicable deaths will receive a timely structured judgement review (SJR) per the Mortality Committee approved selection criteria.** Data is reported quarterly in arrears in the ‘Learning from Deaths’ reports. These reports outline any cases which receive poor care along with learning and improvement actions. The next Learning from Deaths quarterly report is due in June 2019 for Q4 2018/2019.
A related priority this year, as part of learning from deaths and addressing episodes of poor care, is to establish the Medical Examiner role with an associated team by March 2020. Rollout of the new national medical examiner led system is to occur nationally across 2019. This is a non-statutory system which brings further scrutiny as all deaths will be reviewed by either a medical examiner or the Coroner.

4.2 STROKE

The Trust aim by the end of Q4 2018/19 is for the Sentinel Stroke National Audit Programme (SSNAP) overall rating to be A or B. During the past 18 months Sentinel Stroke National Audit Programme (SSNAP) quarter-end ratings were: B (March 18), C (June 18), D (September 2018) and C (December 2018). The ratings dip largely reflects ability to access to a designated stroke bed. Stroke unit access was 47% for 2018/19 and has fluctuated in the past 5 months with 41% (December 2018), 65% (January 2019), 67% (February), 47% (March) and 42% (April). The Clinical Lead for Stroke, Consultant Dr Giosue Gulle, oversees this programme of improvement. Bed access has dropped since February due to stroke direct access beds being occupied despite ring fencing, and the Stroke Service does not have Consultant presence 7 days per week. Two new Consultants were appointed in May, with a 3 month lead time, to support 7 day service (7DS) working going forward. Imaging access within timeframe also continues to be challenging with 68% patient scanned within 1 hour which is to be addressed with a plan for a Computed Tomography (CT) scanner within ED and supported by improving layout of the ED in the new build to promote more timely review to identify potential stroke patients. All patients were scanned within 12 hours.

The patients spending 90% of their inpatient stay in a designated stroke bed was 85% in April. This month 5/10 (50%) of eligible patients were thrombolysed within 1 hour. In 3 of these cases insufficiently controlled hypertension was the reason for the clinical need to delay the start time for thrombolysis. The need to treat patients with medication to lower their blood pressure before performing thrombolysis is the commonest cause of the 1 hour requirement not being met.

Two significant issues within the stroke pathway are swallowing screens being performed within 4 hours and the review by a Stroke Specialist Consultant.

Swallowing screens are not being done within the required 4 hours, and that includes the associated review of the patient’s level of consciousness. The Speech and Language Therapists have been rolling out refresher training for nurses in the HASU about these screens as per the standard bedside protocol for swallowing assessments. This training includes emphasising the importance that a screen is performed for all patients upon arrival in the unit, and also in the ED if the patient is still awaiting transfer to the ward within that first 4 hour window.

72% of patients were reviewed by a Stroke Specialist Consultant within 14 hours and this reflects that Consultant Cover is not currently in place over the weekend. As above, 2 new Consultants are being hired to resolve this.

The Service does not have a prediction at present to guide when a B rating is likely to be achievable, however, solving direct access within 4 hours in particular is considered to be a key requirement needing resolution before that rating is likely to rise.

4.3 IMPROVING THE END OF LIFE EXPERIENCE

As part of learning from deaths and addressing episodes of poor care, a further aim is to develop a ‘bereavement pathway’ and improve the end of life experience. The End of Life Care Service is led by Dr Clare Smith, Consultant in Palliative Care.

The Trust’s 2018-2023 End of Life Care Strategy aims to ensure patients receive individualised shared care at the right time and place, which meets national guidance standards, that is compassionately given by our staff. This is the second year of implementing this strategy and key workstreams are care in people’s last 1000 days of life, communication including care in last days of life, quality and safety with the end of life nursing care bundle,
continuous learning so all staff receive EOLC training. The programme includes linking-in with system partners including hospices and community teams.

An ongoing audit against NICE\textsuperscript{1} Guideline NG 31, Care of Dying Adults in the last days of life, takes place with results collated quarterly. The aim is for more than 80% of patients recognised as dying to have an individualised care plan. Latest information is 62% for Q3 2018/19 which is an improvement from 52% in Q1 last year.

The National Audit of Care at the End of Life focusses on quality and outcomes of care experienced by people during their last hospital admission. Data was collected on patients in April 2018\textsuperscript{2} and a summary of findings is shown in Appendix 3. The End of Life Care Steering Group will oversee the action plan which is currently being formulated.

5 SAFETY

5.1 LEARNING FROM ERRORS
There were 3 Serious Incidents (SI) reported in April 2019. Details of the new incidents reported this month along with initial actions taken and learning are detailed in the Serious Incidents Requiring Investigation Report presented to Board. Five SI investigations were submitted to the CCG in April 2019 which require minor amendments before closure.

A lesson learned from the SIs submitted to the CCG in April is the procurement and availability at both Trust sites of tissue glue for use during ear, nose and throat surgery. During sinus surgery a breach was accidentally made in the skull base of the patient. This was identified during surgery and the injury was rectified with a mucosal skin flap. The glue used to secure the mucosal flap was not available at Ashford Hospital Day Surgery Unit. The patient did not experience any problems post procedure.

5.2 SAFETY ALERTS
There are currently 8 open safety alerts of which 2 are overdue for closure. 2018/005 is about Resources to Support Safer Care for Patients at Risk of Autonomic Dysreflexia and 2018/008 is on Supporting the Introduction of the National Safety Standards for Invasive Procedures. Autonomic dysreflexia is a neurological condition and the alert requires a policy with guidance on practical management of patients with this risk to ensure safer bowel care provision in particular. The second alert relates to safety standards for invasive procedures. This alert compliance is complete in practice, but still needs a guideline so staff have a resource should they need to develop safety checklists for future invasive procedures.

5.3 PRESSURE ULCERS
The improvement aim for reduction of hospital acquired category 2 and above pressure ulcers this year is a 5% decline, which equates to no more than 13 per month. An 18% reduction was achieved in 2018/2019.

In April 2019 there were 19 hospital-acquired category 2 and above pressure ulcers reported. Of the 10 hospital-acquired category 2 pressure ulcers, 2 were device related. There was one category 3 pressure ulcer, 7 deep-tissue injuries, and one unstageable pressure ulcer. The existing Trust-wide action plan for pressure ulcers will continue this year. In response to the rise in heel pressure ulcers in April the ‘Heel SOS’ campaign is to be refreshed and single patient use heel protectors for patients with contractures are to be sourced. Localised targets for improvement are to be set for clinical areas who are consistently reporting pressure damage each month and an update on progress will be provided in future months.

\textsuperscript{1} National Institute of Health and Care Excellence (NICE)

\textsuperscript{2} Published February 2019.
6 EXPERIENCE

6.1 COMPLAINTS
There were 43 new complaints received in April 2019. There has been special-cause variation in the number of new complaints received since November 2017, with an increase in the average number of complaints received increasing from 37 to 47 per month. The reasons for this are multifactorial and could reflect service changes, increased demand, waiting time issues, capacity issues for inpatient beds, cancelled procedures due to winter pressures, and prolonged operational pressures longer than usually occurs during winter months.

98% of these received a response within 3 working days. One complainant did not receive an acknowledgement on time due because the complaint was not forward to the Patient Experience Team as soon as it was received into the Trust due to delays in administrative processes.

There were 6 follow-up complaints reported in April 2019. The trend was that most of these cases were locally issued informal response letters which need greater quality assurance before sending to ensure that all matters raised in the original complaint are fully responded to. As part of our improvement programme all local letters will be quality assured by the Complaint Response Writer before being finally issued locally.

56 complaints were due to be closed in April 2019. 95% complaints should be responded to within Trust target of 25 working days with performance of 84% for April. 47 cases were closed within the 25 working day timescales (84%). This is a significant improvement from the previous month at 47% and a low of 25% in January 2019. The complaints handling process is currently under significant review with the aim to meet 95% within the next 2 months. 5 complaints were closed outside the 25 working days’ timescale (9%) and 4 complaints due to be closed in April still remain open past the 25 working days timescale (7%).

The Patient Experience Improvement Programme is led by the Deputy Chief Nurse, Mrs Andrea Lewis. The programme has been updated in March 2019, and in order to deliver this plan a 4 month pilot was commenced in April 2019 to centralise the Complaint Officers from each clinical division into one team. Early indications have demonstrated a significant improvement in responding to complaints within 25 days and the team is working to clear the backlog of older complaints with weekly meeting with the Chief Nurse to assist with prioritising actions and developing resolution timeframes. Work is underway to ensure complaints and concerns are dealt with at the level closest to the area where the family has experienced an issue. This involves staff engaging effectively with patients and relatives, in order to provide a timely resolution to issues and therefore preventing escalation.

Workforce capacity issues have significantly impacted the team’s ability to respond to complaints within 25 days hence the above backlog of 11 cases at the end of April. This is being addressed with the appointment of a Head of Patient Experience and Engagement, a Complaints Manager, and a Complaint Response Writer.
Complaints responded to in April have resulted in learning with changes to practice. Patients with certain mobility difficulties can sometimes find it uncomfortable to have an MRI scan using the mobile scanner, which is not as large as some fixed scanners. Two new MRI scanners are being installed in upcoming months. Signposting patients to the most appropriate scanner type for their needs was key learning.

At Ashford the Orthopaedics Ward has implemented tightened controls over discharging medications to patients after a patient was given another patient’s medication list when going home. The ward nurse now stamps the discharge letter, and it is counter-signed by the patient, to evidence that information necessary for discharge has been provided covering a range of categories including medication understanding, follow-up appointments, and information for the community care nursing service.

6.2 PALS

PALS received 166 new cases in April and closed 156 cases. 159 PALS cases were due to be closed in April 2019. 123 (77%) were closed on time within 5 working days, 32 (20%) cases were closed late and 4 (3%) remain open that were due to be closed in April.

PALS themes are consistent with previous months’ trends regarding enquiries about Outpatient services and the need to provide better information using clearer communication. There has also been a rise in appointments being cancelled and no notification received by the patient of this cancellation. There has been a slight increase in lost property concerns, along with concerns regarding care and treatment, medical records requests and delay with referrals.

6.3 BECOMING A LEARNING ORGANISATION USING PATIENT FEEDBACK

Outlined below are our key programmes within patient experience which support our Strategy aim of becoming a learning organisation.

A continuing patient experience priority aim this year is to **work with patients and families to co-design care improvements**. This is central to ensuring we learn from what both service users and staff say is important to them when making changes to our services. An experience-based co-design project for improving the complaints service started in Q3 2018 and will continue across the next 6 months. The second collaborative event is to be in June 2019 and will include feeding back on our 2 agreed improvement bundles which people at the inaugural event said mattered to them most. The bundles are promoting resolution of concerns when they first arise on the frontline, and agreeing the approach to handling a concern or complaint by working with the complainant at the outset to ensure a clear handling plan.

6.4 ELECTRONIC PATIENT FEEDBACK SOLUTION

It is vital that the Trust Strategy achievement, FFT information, and other forms of patient feedback to drive local service improvement is available in a timely manner so that services can see what they are doing well, and what needs fixing. This requires sufficient feedback volume as well as realtime access to the information.

*Trust Strategy achievement will be measured with core patient experience KPIs*, when formulated, using outputs from the newly piloted electronic feedback system, once the pilot finishes and procurement can be finalised.

In February 2019 the Trust commenced a pilot of a new real-time electronic patient feedback solution called R-outcomes [https://r-outcomes.com/](https://r-outcomes.com/) in maternity services. The pilot questions measure the three Trust strategy aims, FFT and other priority areas including accessibility of information. The first pilot was in Maternity Services.

A tabletop exercise has been conducted with R-outcomes, the Communications Team, the Maternity Team, and the Patient Experience Team. A proposed rollout and improvement plan was then developed. Initial learning from patients and staff suggested that people are willing to complete surveys if they are asked by staff and the process is in real time. Patients also informed the pilot that terminals used to gain feedback need to be suitably private so that people can be assured that feedback is non-identifiable.
A new patient experience feedback system is to be trialled in ED in June 2019. The Viewpoint system can collect information in various ways to aid data capture from users. It is proposed the trial will use standalone devices situated in the waiting room and main department, as well as IPADs and hard copies for those patients who are less mobile. Next steps are to expand the pilot to the whole of Maternity and Women’s Health Services, Medicine and the ED. The improvement and rollout strategy is currently in the process of being drawn up including setting a timeframe for the whole hospital.
EFFECTIVENESS

Percentage of Initial Mortality Screening Reviews Completed

Mortality - SHMI
### EFFECTIVENESS

**Summary total deaths and total number of cases reviewed under the Structured Judgement Review Methodology**

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<td>80%</td>
<td></td>
</tr>
<tr>
<td>Number of cases requiring an SJR</td>
<td>16</td>
<td>12</td>
<td>14</td>
<td>21</td>
<td>10</td>
<td>24</td>
<td>19</td>
<td>9</td>
<td>5</td>
<td>10</td>
<td>10</td>
<td>7</td>
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<td>159</td>
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<tr>
<td>Total deaths receiving structured judgement review</td>
<td>15</td>
<td>9</td>
<td>9</td>
<td>17</td>
<td>10</td>
<td>23</td>
<td>12</td>
<td>6</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>3</td>
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<tr>
<td>Percentage of SJRs completed</td>
<td>94%</td>
<td>75%</td>
<td>64%</td>
<td>81%</td>
<td>100%</td>
<td>96%</td>
<td>63%</td>
<td>67%</td>
<td>0%</td>
<td>40%</td>
<td>50%</td>
<td>43%</td>
<td>0%</td>
<td></td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Percentage of SJRs completed (by quarter)</td>
<td>79%</td>
<td>91%</td>
<td>55%</td>
<td>44%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total Number of reviewed deaths considered more likely than not due to problems in care</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Number of deaths of people with learning disabilities</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
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<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
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<td>7</td>
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<tr>
<td>Number of deaths of people with learning disabilities that have been reviewed</td>
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<td>1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>6</td>
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<tr>
<td>Number of deaths of people with learning disabilities considered more likely than not to be due to problems in care</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
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<td>N/A</td>
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<td>N/A</td>
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</table>

**Note:** The data in previous months will be updated each month as new cases are identified and structured judgement reviews are completed. Data is correct at the time of writing (10/05/2019).
Note: The measure of 'complaints closed within agreed response times' changed to a new method of calculation and is available from October 2017 only.
APPENDIX B

Discussion paper on the December 2018 CQC publication *Opening the door to change: NHS safety culture and the need for transformation*

Introduction
The publication outlines the findings of CQC and NHSI from looking into the reasons for the recurrence of Never Events[^3] in the NHS. The review considered 4 questions:

- How do trusts regard existing guidance to prevent Never Events
- How effectively do trusts use safety guidance
- How do other system partners support the implementation of safety guidance
- What can be learned from other industries such as aviation, nuclear, and fire and rescue.

Findings
Drawing on a series of examples from across the system, the study reports on challenges for trusts, challenges for the whole system, challenges for the workforce and safety culture.

**NHS Trusts:** Although patient safety alerts are generally seen as an effective way to share safety guidance, competing pressures, including high workloads, and different approaches to governance are creating challenges for trusts.

**Whole System:** Arm’s-length bodies, including CQC, Royal Colleges and professional regulators, have a substantial role to play within patient safety, but the current system is confused and complex, with no clear understanding of how it is organised and who is responsible for what. This makes it difficult for NHS trusts to prioritise what needs to be done and when.

**Educating and training staff:** Various bodies are responsible for different aspects of clinical and wider professional education in England. This includes universities, Royal Colleges, deaneries, professional regulators, Health Education England (HEE) and employers like NHS trusts. It is not easy to establish who is responsible for which elements of education or who has the authority to decide which elements of training are mandatory, for example around patient safety, and place them consistently within training programmes.

**NHS safety culture:** Never Events continue to happen and 7 key recommendations critical to improving patient safety culture across the whole system are given:

1. NHS Improvement (NHSI) should work more closely with HEE to ensure the NHS workforce has a common understanding of patient safety. HEE should develop specialised training for staff to undertake as part of their clinical education or through separate training.
2. The upcoming National Patient Safety Strategy should set out a clear vision for patient safety with clarification on the roles and responsibilities of all national and local stakeholders with clear milestones and deliverables. It should ensure that an effective safety culture is embedded at every level, from senior leadership to the frontline.
3. Leaders on patient safety must be given adequate training to drive safety in their trusts and should actively feedback into NHSI to enable learning across the system.
4. NHSI should work with professional regulators, Royal Colleges, frontline staff and patient groups to develop a framework for identifying where processes and practices in trusts could be standardised to improve safety.

[^3]: Never Events are incidents with the potential to cause serious patient harm or death that are wholly preventable if national guidance or safety recommendations are followed.
5. The (recently formed) National Patient Safety Alert Committee should work to align patient safety alerts and outputs of all bodies with a stake in safety to better enable trusts to take appropriate action in response to alerts.

6. NHSI should work with Royal Colleges and professional regulators to review the Never Events framework with a particular focus on leadership, culture and barriers to preventing errors such as human behaviours.

**Opportunities at this Trust**

Outlined below are some of the opportunities at this organisation regarding taking forward proposed changes.

**Governance around alerts** - There is an overarching system for co-ordinating the implementation of safety alerts which could be strengthened through a mechanism that tests the ongoing effectiveness of that implementation for key patient safety alerts.

**Leadership and Culture** - As part of the Strategy aim to become a learning organisation there is also scope for the Project Management Office (PMO) resource to be mobilised to support frontline staff with the implementation of alerts as well as serious incident actions that require significant process or pathway change. Consideration could be given to developing tailored patient safety specialist roles in safety critical frontline services. Staff would be prepared to master’s level in patient safety to drive safety standards, solutions and initiatives. Safety Culture should be regularly monitored throughout the Trust.

**Leadership** - The Trust may need to consider development of a local patient safety strategy document which compliments the upcoming National Patient Safety Strategy.

**Training** - As part of the Trust Education and Training Strategy there should be mandatory core safety training for all staff. This should include human factors, risk management, root cause analysis and improvement theory.

**Process standardisation** - Where possible this should be adopted as this can make it easier for staff to speak up with confidence if processes are not being followed. This also would benefit from NHSI driving standardisation across the NHS.
Summary findings from National Audit of Care and the End of Life

Data collected in April 2018, reported in February 2019. The figure below shows the national benchmark on the left and Trust submitted results on the right.

Particular strengths included governance, having a specialist palliative care team which provides training, and recognising that the patient was dying and exploring the communication of this with the patient and family appropriately. Things we need to do better are assessing the needs of families and others who may need further support, and communicating with patients about clinical care decisions around end of life. The End of Life Care Steering Group will oversee the action plan which is currently being formulated.