Report: Quality Report

Presented by: Tracey McErlain-Burns, Chief Nurse and Dr Conrad Wareham, Medical Director

Author(s): As above

Strategic Objective: Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Partners: Securing the future together

Regulatory relevance:
Monitor: Licence Condition FT4
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B1, B2, B3, B6
Corporate Risk Register: 3870, 3936, 4080, 4174

Purpose of this paper:
To summarise a set of quality indicators and to provide assurance to the Board of Directors.

Summary of Key Points:
The key points arising from the report are:

- An increase in complaints and informal concerns in the Division of Planned Care and Surgery is being investigated.

- HSMR and SHMI are both raised. As part of the mitigation process, the Mortality and Quality Alerts Group is meeting regularly, and systematically reviewing all deaths and new alerts. The Medical Director is leading on the progression of actions to support a reduction in HSMR and SHMI.

- Nurse staffing reviews are regularly taking place and opportunities to explore new skill mix models consistent with the transformation of clinical services are being pursued.

Board action required: For noting
1. **Introduction**

1.1 The Clinical Quality Report is presented to the Board of Directors to complement the information presented in the Integrated Performance Report.

1.2 A range of quality indicators are included in this report. Over time they may change as the narrative changes to reflect the content of the Integrated Performance Report.

2. **Healthcare Associated Infections**

2.1 Year-to-date the incidence of MRSA bacteraemia is zero and the incidence of hospital acquired C-difficile is 17 cases, against a trajectory of 19 cases. Case 16 and 17 occurred within 4 days of each other on ward B4 in January 2016. An initial review has taken place. Ribotype and finger print analysis are awaited.

2.2 There have been no ward closures or serious operational impacts resulting from Norovirus so far this year.

3. **Harm Free Care**

3.1 The NHS Safety Thermometer result for December was 94.05%, a 0.8% reduction on the previous month. This compares to the national median of 93.57%. The focus remains on pressure ulcer avoidance and the prevention of falls, especially those resulting in harm. The Stop Falls campaign has been launched and a team of colleagues are visiting the Trust reporting the highest Harm Free Care rate in the TRFT peer group of medium sized, integrated Trusts.

4. **Complaints**

4.1 There was a decrease in the total number of formal complaints in Q3 compared to the previous two quarters. At the same time there was an increase in the number of informal concerns raised. Consistent with previous quarters many of the informal concerns are about the out-patient appointment processes.

4.2 Compared to Q3 of 14/15 there was a decrease in complaints across the two medical divisions and an increase in complaints within the surgical division. In Q3, 44% of complaints arose in relation to services provided by the division of planned care and surgery and, at the same time, there was in increase in the number of informal concerns specifically around ophthalmology, urology and anaesthetics. The Deputy Chief Nurse and the Patient Experience Team are reviewing this feedback with the General Manager and Governance Lead for planned care and surgery.

5. **Friends and Family Test**

5.1 At the end of December the Trust was achieving the Quality Account priorities; 97% against a target of 95% positive in-patient FFT scores; 88% against a target of 85% positive Emergency Department scores and 41% against a target of 40% in-patient response rate.
6. **Serious Incidents and Never Events**

6.1 There were three serious incidents in December, one of which the Trust will be seeking to de-log on the basis of the investigation. Of the other two, one concerns the management of the adult deteriorating patient and the second involves a patient who sustained a fracture following a fall.

6.2 In the month of December 95% of colleagues reporting a clinical incident received feedback on closure of the incident. The lowest rate was 90.6% in Family Health and the highest was 98.1% in the Diagnostics and Support services.

7. **Mortality**

7.1 HSMR remains raised at 107.3 for September 2015 (the latest reporting period) essentially unchanged from August. (Appendix 1)

7.2 SHMI is 109.42 for the April 2014 to March 2015 period which is also raised.

7.3 Crude mortality in month for December 2015 has risen slightly to 1.37% but is substantially less than the same period the preceding year.

7.4 There were two new CUSUM 99% confidence interval alerts for fever of unknown origin and malignant neoplasm without specification but absolute numbers are small and these are being monitored. There are no significantly raised HSMR diagnosis groups but the pneumonia and non-hypertensive congestive heart failure numbers remain high. Review of the deaths of these patients is underway in the division.

7.5 It is also noted that carcinoma of the colon deaths for October 2014 to September 2015 are higher than expected and these cases are being reviewed by the division.

7.6 SHMI diagnostic groups are showing high results too for non-hypertensive congestive heart failure, pneumonia and other lower respiratory disease. Figures are also significantly raised for acute renal failure (30 vs 21.88) April 2014 to March 2015. There is currently a work-stream underway in the Trust on Acute Kidney Injury under Sign Up for Safety.

7.7 Ranked performance with other Trusts is unchanged from the previous month’s report.

7.8 The pattern for weekend vs weekday mortality is similar although there are no significantly worse days. Mortality for patients with a length of stay of less than one day remains high and is the subject of an in depth review by the palliative care team.

7.9 There were several apologies for this month’s Mortality meeting but there was representation from integrated medicine and family health and a good standard of discussion.

7.10 Medicine introduced a weekly preliminary review of all deaths within a week in October. This has been consistently happening and not identifying any clear preventable deaths. This process has also been able to give timely assurance of a lack of emerging issues when there have been more deaths than usual in a particular week.
7.11 NHS England wrote to medical directors before Christmas outlining expectations for NHS Trust's future mortality reporting. The current processes at TRFT are already in line with almost of the expectations however Trusts will now be expected to formally review external audits (e.g. National Confidential Enquiries into Perioperative Deaths, etc) within their mortality processes. This was noted at the most recent mortality and quality alerts meeting.

8. Nurse Staffing

8.1 A detailed report was presented to the Quality Assurance Committee on 07 January. The headlines for December were that Registered Nurse shift fill rates (day time) reduced in December by 1.7% to 93.9% and by a similar percentage for the night shift to 96.4%. At the same time there was a reduction in fill rates on both day shift and night shift of Healthcare Support Workers to 99% and 95.8% respectively. In regard to the Healthcare Support Workers, the new intake commenced in post on 04 January 2016.

8.2 Bank fill rates for Registered Nurses remains low at 38%, and 62% for Healthcare Support Workers (HCSW), whilst agency fill rates for both groups are around 85%.

8.3 Nursing establishments have been reviewed in the Divisions of Emergency Care, Integrated Medicine and Planned Care and Surgery. The meeting with the Head of Midwifery has not yet taken place to confirm the details of the review in the Division of Family Health. In addition a review of establishments in out-patients is yet to be undertaken.

8.4 Establishments in Emergency Care have been reviewed using the RCN ‘Best tool’ and data has been benchmarked with other Trusts. Patient activity levels on the ED have been reviewed and shift start times have been mapped to the periods of high attendance / activity levels. Meetings with the finance team are taking place on 19 January and therefore, the final proposed establishment will be appended to this report in February 2016.

8.5 A similar analysis of activity levels and benchmarking of the Acute Medical Unit has been undertaken and final meetings are taking place on 21 January. The proposed establishment will be appended to this report in February 2016.

8.6 The in-patient nursing establishments in the Division of Integrated Medicine have been reviewed using the Safer Nursing Care Tool (SNCT). The majority of in-patient medical wards have a nurse to patient ratio of 1:6.5 and skill mix of 65:35. The only significant change arises as a result of a reduced bed base of ward A2 and therefore the opportunity to reduce the funded establishment by 4 band 5 Registered Nurses. This will be achieved through removal of vacancies. The proposal is to convert those posts into HCSWs to provide a 10am to 6pm shift on Ward A5 and Ward A1 which is experiencing an increase in both acuity and dependency since the integration of cardiology and respiratory medicine, and to increase the number of HCSW on Ward A4 at night. The requirement to increase the HCSW to 3 per night on Ward A4 arises because of the decrease in the number of specialist gastroenterology beds on the ward and an increase in care of the elderly beds. This would give rise to a Ward A4 50:50 skill mix on nights and 60:40 skill mix on Ward A1 and A5. The Head of Nursing is to meet with finance to cost the changes.

8.7 As a result of the review the Chief Nurse has asked the Division of Integrated Medicine to explore the scope for recruiting therapy assistants in the Oakwood Community
Unit. This would create a 55:45 skill mix but create an opportunity to enhance rehabilitation outcomes. In addition the rehabilitation review needs to be brought to a conclusion and as such the Chief Nurse will refer this into the Clinical Service Transformation Group, together with a request for review of Breathing Space.

8.8 The Chief Nurse has also asked for a further review of the Coronary Care Unit staffing establishment which currently has a 90:10 skill mix. Benchmarking data has been requested with a view to exploring an 80:20 establishment.

8.9 The in-patient nursing establishments in the Division of Planned Care and Surgery have been reviewed using the Safer Nursing Care Tool (SNCT), with the exception of a review of Critical Care which still needs to be completed. The results of the review in Planned Care and Surgery are that the Head of Nursing will work with the Deputy Chief Nurse to explore the opportunity to convert some vacant band 5 hours to band 3/4 enhanced HCSW roles and/or therapy assistants in wards B4, B5 and SAU. These roles would support the enhanced recovery model and release Registered Nurse contact time.

8.10 Despite the reduction in bed base, the SNCT analysis of Fitzwilliam Ward suggests limited opportunity to reduce the establishment. It is proposed to reduce the establishment by 1.0wte, and convert that post into HCSW hours to increase the HCSW establishment on Sitwell Ward by 1.0 wte. A further review of Fitzwilliam Ward is underway since the regular use of the Purple Butterfly room. For a short period of time, coinciding with the use of the SNCT following the move of Ward B3 to Fitzwilliam the Purple Butterfly room was not in use whilst nursing colleagues were receiving additional end of life care training.

8.11 A further review of nursing vacancies (as per a road map to one version of the truth – appendix 2) is taking place. In the meantime a recruitment and retention plan for the next 12 months is being finalised.

8.12 Data from NHS benchmarking has been received as anticipated. However, the report lacks analysis and, therefore, the Trust is going back to NHS Benchmarking with a view to being able to report in February 2016.

8.13 A review of paediatric nurse staffing using PANDA is being completed alongside the extended Children’s Assessment Unit pilot which is due to report in February 2016.

9. Conclusion

9.1 An increase in complaints and informal concerns in the Division of Planned Care and Surgery is being investigated.

9.2 HSMR and SHMI are both raised. As part of the mitigation process, the Mortality and Quality Alerts Group is meeting regularly, and systematically reviewing all deaths and new alerts. The Medical Director is leading on the progression of actions to support a reduction in HSMR and SHMI.

9.3 Nurse staffing reviews are regularly taking place and opportunities to explore new skill mix models consistent with the transformation of clinical services are being pursued.

Tracey McErlain-Burns
Chief Nurse
January 2016

Dr Conrad Wareham
Medical Director