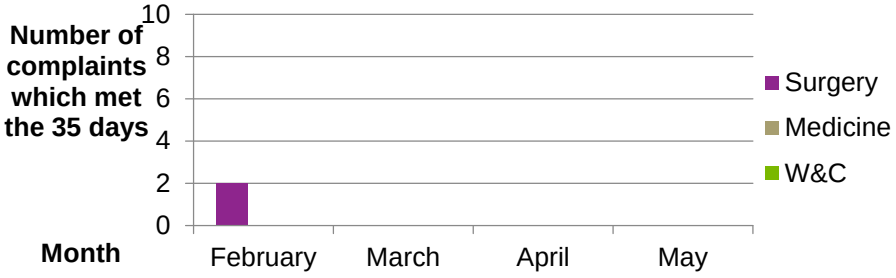
QUALITY REPORT

PART A – Patient Experience

Complaints and Patient Advice and Liaison Report

Total number of complaints which did not breach 35 days



12 complaints were closed in February:

- 2 of the 12 met the 35 day target (17%).
- 3 were Surgery closed, 2 met the 35 day target (67 %)
- 8 were Medicine closed, all breached the target (0%)
- 1 was Women's & Children's closed, breached the target(0%)

24 formal complaints in February:

- 11 complaints were for Medical Division
- 10 complaints were for Surgical Division
- 3 complaints were for Women's & Children's Division

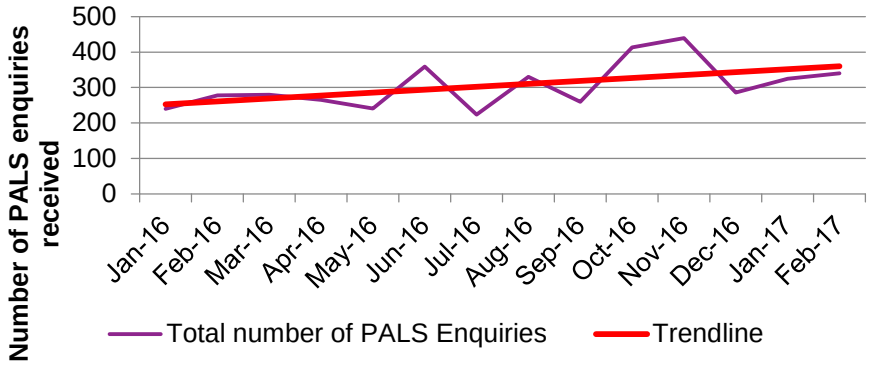
Clinical Care and Concerns – 15 complaints raised ; 8 were for the Medical Divison, 5 for the Surgical Division, and 2 for the Women and Children's Division.

Communication and Information – 6 complaints received, 3 were for Medical Division, 2 were for Surgical Division and 1 for Women & Children's Division.

Staff Attitude and Behaviour – 2 complaints received, 1 related to Medical Division and the other to Surgical Division.

Appointments – 1 complaint where the patient was concerned with the booking of an appointment.

Total number of PALS enquiries



There were **340 contacts with the PALS** service in February:

- 205 required resolution (60%)
- 99 requested information or advice (29%)
- 9 were compliments (3%)
- 18 provided feedback (8%)

Top three subjects requiring resolution:

Parking – 74 (36%) contacts related to issues regarding parking at the RUH site - mainly client's receiving car parking notices and enquiries/difficulties from disabled blue badge holders in registering their badges.

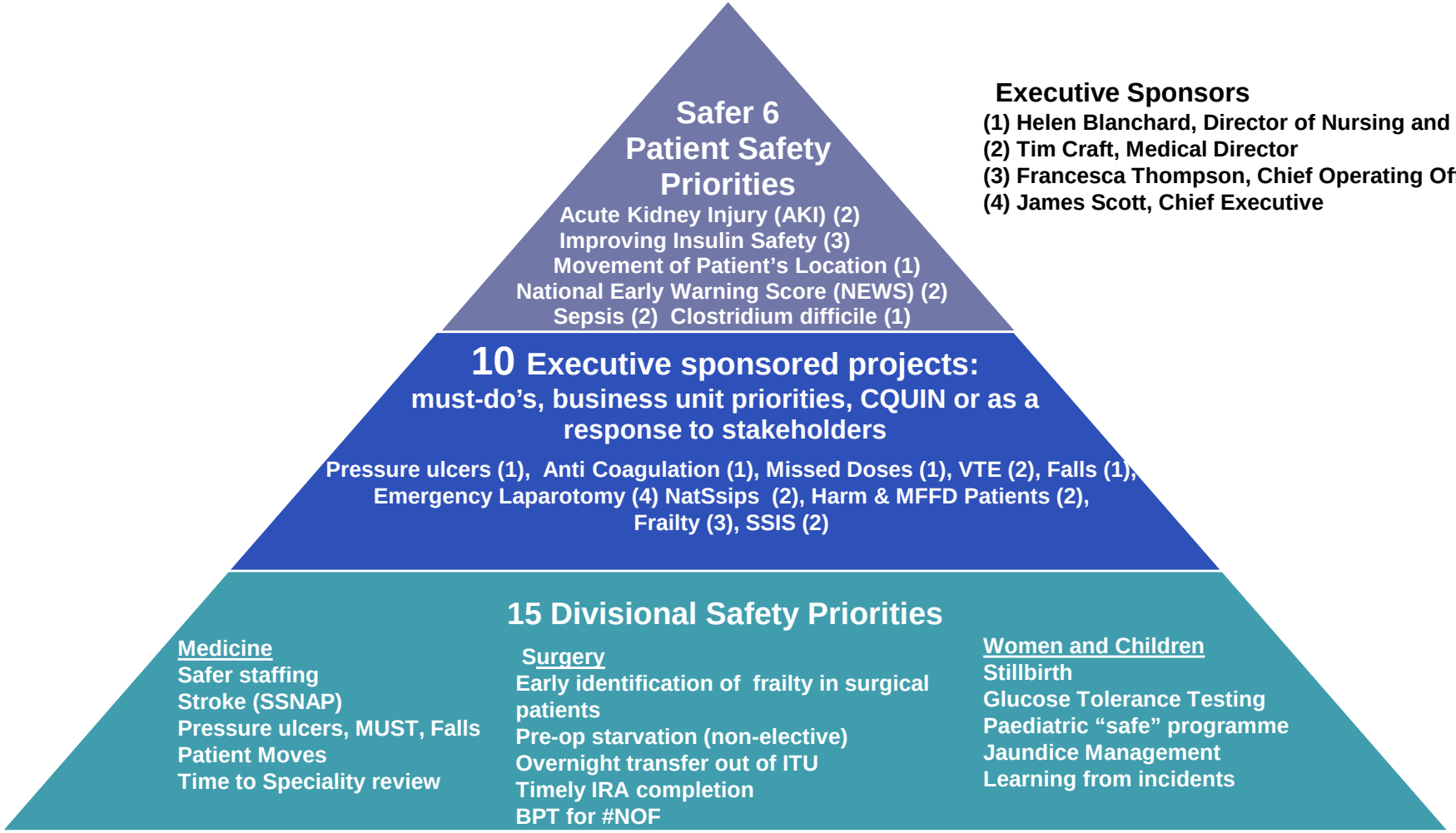
Clinical care and concerns – 33 contacts were in relation to clinical care and treatment. There were no themes to these contacts, however many of the contacts requested further clinical information.

Appointments and cancelled admissions – there were **26 contacts (13%)** regarding appointments (waiting for new/follow up appointment).

13 (6%) enquiries were from patients who had their surgery cancelled or had not yet had a date for surgery.

QUALITY REPORT

PART B – Patient Safety and Quality Improvement



Executive Sponsors
(1) Helen Blanchard, Director of Nursing and Midwifery
(2) Tim Craft, Medical Director
(3) Francesca Thompson, Chief Operating Officer
(4) James Scott, Chief Executive

Patient Safety – Surgical Site Infection Surveillance (SSIS) Tim Craft

The Orthopaedic Directorate continues to submit data of all surgical site infections following Total Knee Replacement (TKR), Total Hip Replacement (THR) and Repair of Femur Surgery. The Trust submits data on a quarterly basis rather than the mandated 1 quarter per annum as set out by Public Health England (PHE) in order to provide more robust collection of surgical site infections

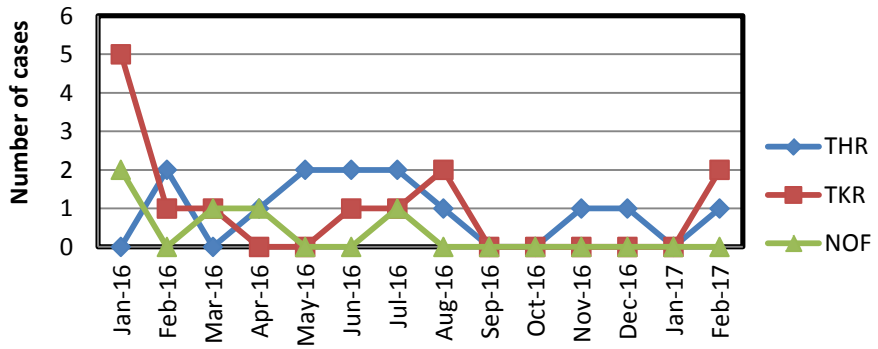
Table 1 shows a variable number of reported infections and at present no common theme has been identified. The information shows all infections including those that are patient reported and have not necessarily been seen or confirmed as an infection by a doctor. The Trust has received high outlier letters for THR/TKR surgery from PHE for the period July-September 2016 based on the previous 5 periods.

A surgical site infection TKR rate for readmitted/Inpatients infections of 2.2% ,a reduction of 0.2% compared to the previous quarter (April-June). THR readmission/inpatients 1.7% , a 3.3% reduction compared to the previous quarter.

3 surgical site infections were reported to PHE in February 2017 – 2 TKR and 1 THR- the original procedure dates for these patients were from June/September/November 2016.

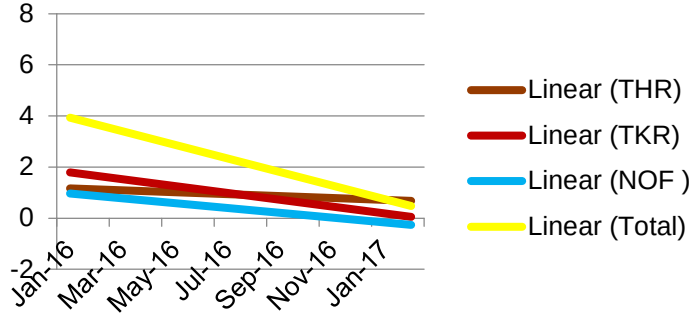
Graph 1 shows trend lines of infection rates by month by procedure which are showing a downward trend in overall infection rates over the past 12 months (previously there was an upward trend). During the previous quarter the reduction in surgical site infections for all procedures has seen the NOF infection rates remain at 0.

Table 1



- All SSIS included in this % including patient reported by month infection reported.

Graph 1



Next Steps

- SBAR investigation and analysis of cases reported in February underway
- Pre operative skin preparation wash to continue permanently as introduction in July 2016 has seen a reduction in infection rates.

Patient Safety – Executive 10 – Frailty

Francesca Thompson

Background
The CQUIN for Frailty 2016/17 is based on the National recommendation to develop a local CQUIN to *"promote a system of timely identification and proactive management of frailty*"
The indicator has been divided into three parts to achieve the following:

Part 1: 85% of patients aged 75 and over who are frail admitted under Medicine are screened for frailty
Part 2: A summary of the outcome of the Comprehensive Geriatric Assessment should be included in the discharge summary to the patient's GP for 85% of patients discharged aged 75 and over. This includes patients who are referred to the Discharge Assessment Team (DAT) and/or admitted to the ACE short stay frailty ward where a Comprehensive Geriatric Assessment has been completed and, for those with a Clinical Frailty Score (CFS) of 5 or above
Part 3: Roll out the discharge passport to patients discharged from ACE Ward, building on the work completed in 2015/16 to improve the information provided to patients on discharge

Progress
Achieved all Q1, Q2 and Q3 milestones, confirmed by both CCGs which included:

- Development of a Medical Assessment Proforma for Adult patients over the age of 75 to include the Rockwood Clinical Frailty Score and Comprehensive Geriatric Assessment (CGA) tool
- Launch of an education programme to underpin implementation of the Medical Assessment Proforma
- Initiate implementation of the discharge passport on ACE
- Inclusion of the CGA in discharge summary from ACE and Combe wards.

Delivery and Governance
The CQUIN is delivered through the Frailty FLOW programme which reports to the Trust's Front Door Group and Urgent Care Collaborative Board

Next Steps

- Version 5 of the Medical Assessment Proforma following PDSA assessment to be launched; replacing the existing Medical Assessment Proforma i.e. only one proforma for all of the adult medical take incorporating frailty score and Comprehensive Geriatric Assessment (CGA)
- Weekly review of progress of the Medical Assessment Proforma implementation following an agreed PDSA methodology, including structured interviews with users of the proforma during Q3 in line with the CQUIN requirements
- Complete required audits to demonstrate compliance with the CQUIN requirements for Q4 including baseline measurements and delivery
- The roll out of the discharge passport on ACE is under close evaluation by the Senior Sister to ensure patients and carers/relatives benefit from this approach
- Roll out of CGA to Combe ward with a planned review of how CGA can be completed across all OPU ward areas
- RUH staff completed cohort 1 of the Health Foundation 'Sheffield FLOW programme' and are now teaching Cohort 2 in Bath (22 people, 11 coaching pairs) including three frailty pathways which provide further scope for learning and widening of networks within the area (Gloucester, Bristol and Hampshire)

Serious Incident (SI) Summary

Helen Blanchard

Current Performance

During February 2017, four Serious Incidents were reported and these remain under investigation.

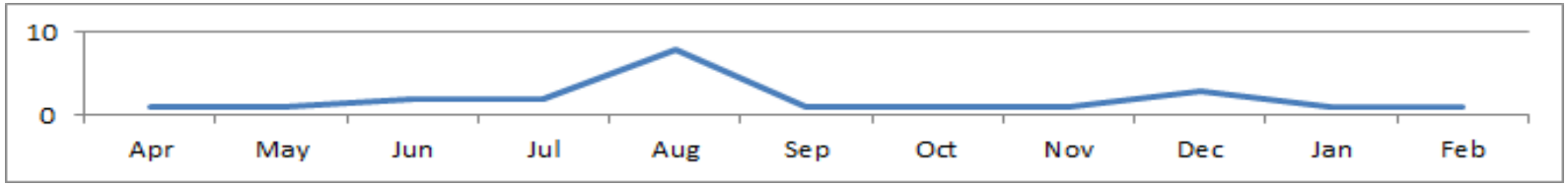
Each incident was discussed with the patient and their family and they are aware of the investigation, in line with the Duty of Candour framework.

Date of incident	Datix ID	Summary
02.02.17	**50487**	Patient fall resulting in a fracture
06.02.17	**50621**	Fall resulting in a subdural haematoma & a subarachnoid haemorrhage
13.02.17	**50875**	Patient fall resulting in a fracture
19.02.17	**50953**	Fall resulting in a fracture

Overdue Serious Incident reports summary

Helen Blanchard

Current performance



The drive to reduce the number of overdue SI reports will continue this year, working to a target of zero overdue reports.

As of 07 March 2017, there are 16 Serious Incidents that remain open. Of these, one incident report is overdue for submission to the Clinical Commissioning Group by the agreed extension date. The investigation has been completed for a further five of the 16 incidents and these investigation reports are in draft. Any delay in providing a final report is escalated to the relevant Divisional Management team, for them to identify what further support can be provided to the investigator to enable them to completing the investigation and draft the report.

The Operational Governance Committee monitors the progress against the action plans developed following the investigation and at the February OGC meeting, the status was:

	April	May	June	July	August	September	October	November	December	January	February
Outstanding action plans	11	8	5	9	10	11	15	10	14	14	14
Outstanding actions	20	10	18	23	14	14	18	18	26	23	32

The Heads of Nursing and Divisional governance leads are notified of the responsible managers who need to complete their actions. There is recently more concerted effort to reduce the number of overdue actions buy the risk team and the divisions and the number is expected to reduce through Q1 17/18.

Nursing Quality Indicators - Exception Report

Helen Blanchard

Areas of focus

The Nursing Quality Indicators chart is attached as Appendix A.
Five wards flagged this month as having nursing quality indicators of note (below). Two of these wards, Haygarth and Respiratory, flagged for the last four months.

Haygarth Ward

Haygarth ward has flagged for the last 4 consecutive months.
The RN staffing levels (day and night) are < 90% fill rate due to sickness and vacancies.

Quality matrices to note are:

- FFT response rate <35%
- 8 falls (6 negligible harm, 2 minor harm)
- HCA sickness 5.9%
- RN appraisal 57.1%
- RN % day fill rate <90%
- RN % night fill rate <90%

Due to concerns over a number of harm events and the ward flagging on the nursing quality indicators chart a review of the ward by a Nursing Intensive Support Team has been undertaken in December and the report was finalised in February 2017. The improvement plan has been developed with the Senior Sister and Matron and will be proactively monitored by the Divisional Head of Nursing.

Sickness and vacancies are being managed proactively. RN and HCA posts are currently out to advert. Rosters are signed off by the matron and a skill mix review is undertaken daily and weekly to ensure safe staffing levels. Any shift shortages are escalated to the matron.

Haygarth Ward continued:

There has been a focus on awareness sessions for all staff due to a number of falls this month. Patients at risk are identified in daily safety briefing. Head of Nursing (Medicine) is leading an improvement work stream through the falls committee.

FFT – there is a continued focus on increasing numbers of responses focus (100% recommendation) from the senior sister.

Respiratory Ward

Quality matrices to note are:

- RN sickness 13.3%
- HCA sickness 17.1.6%
- RN appraisals 55.0%
- HCA appraisals 57.1%
- RN day staffing <90%
- RN night staffing < 90%

This ward has flagged for the last 5 consecutive months and the Head of Nursing and matron are supporting the improvement and management programme.
Management plan commenced week beginning 9.1.17. Performance objectives set with specific reference to quality indicator(i.e. appraisal rate. FFT compliance).
Staffing and sickness continue to be a issue on the ward. A midpoint review of the management plan has taken place and an improvement has been seen in the appraisal rates.
Recruitment strategies are in place including a focused approach at the next open day to promote the reputation and opportunities on Respiratory, and the commencement of a band 5 AHP role in April.

Nursing Quality Indicators - Exception Report

Helen Blanchard

Area of focus continued:

Pulteney Ward

This is the first time the ward has flagged in the past six months.

Quality matrices to note are:

- 2 complaints
- 4 falls (2 negligible harm, 1 minor harm, 1 major harm)
- RN sickness 9.5%
- RN appraisals 71.4%
- HCA appraisals 76.2%
- RN day staffing <90%
- Care staff day staffing < 90%

The Senior Sister is managing staff sickness which is both short and long term according to Trust policy and is being supported by HR and her Matron.
The high sickness has contributed to the staffing on day shifts being low with temporary staff filling night shifts as required.
The Senior Sister has developed an action plan to address the low appraisals.

Combe Ward

Quality matrices to note are:

- RN sickness 9.0%
- RN appraisals 77.8%
- HCA appraisals 80.0%
- 5 x Nurse staffing datix
- RN day staffing < 90%
- RN night staffing < 90%

Combe Ward Continued

Combe ward has triggered on RN sickness through unrelated work issues being appropriately managed through the HR process in line with our sickness policy.

The appraisal rate for both RN and HCA is below trust standard. This has been due to long term sickness, maternity leave and staff leavers in January. A marked improvement is expected in February.

The safer staffing percentage on registered nurses is due to vacancy level and high sickness the is being managed by the supervisory ward manager. Active recruitment in place through an OPU advert and trust wide recruitment initiatives.

MAU

Quality matrices to note are:

- 11 falls (9 negligible harm, 2 minor harm)
- RN sickness 7.2%
- HCA sickness 10.4%
- RN appraisals 79.5%
- HCA appraisals 78.3%
- RN staffing <90%

Recruitment to RN band 5 vacancies has been difficult. The matron and Senior Sister have reviewed the skill mix and as a result band 6 posts are being advertised, along with Band 3 HCAs. Proactive sickness management is in place by Senior Sister.

Appraisal rate – Senior sister and appraisal team leads aware of outstanding appraisals and plans in place to address through March.