

<b>Report to:</b>	<b>Public Board of Directors</b>	<b>Agenda item:</b>	<b>10</b>
<b>Date of Meeting:</b>	<b>29 July 2020</b>		

<b>Title of Report:</b>	<b>Quality Report</b>
<b>Status:</b>	<b>For discussion</b>
<b>Board Sponsor:</b>	<b>Lisa Cheek, Director of Nursing and Midwifery</b>
<b>Author:</b>	<b>Sarah Merritt, Interim Deputy Director of Nursing and Midwifery, and John Kirby, Quality Assurance and Risk Business Analyst</b>
<b>Appendices</b>	<b>None</b>

<b>1.</b>	<b>Executive Summary of the Report</b>
<p>This Quality Report provides an update using the Improving Together 2020 patient safety and quality improvement priorities. The areas of focus have been organised using the True North objectives and the Care Quality Commission domains. The structure of the Quality Report this month has been refreshed and focuses on:</p> <ul style="list-style-type: none"> <li>○ Clinical risk and Incident reporting</li> <li>○ Falls</li> <li>○ Pressure Ulcers</li> <li>○ Infection Control</li> <li>○ Complaints and Patient Advice and Liaison Service</li> <li>○ Peer Audits</li> <li>○ Staffing indicators</li> <li>○ Divisional Driver Reports and Counter measure summaries</li> </ul>	

<b>2.</b>	<b>Recommendations (Note, Approve, Discuss)</b>
To note progress to improve quality, patient safety and patient experience at the RUH.	

<b>3.</b>	<b>Legal / Regulatory Implications</b>
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).	

<b>4.</b>	<b>Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)</b>
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.	

<b>5.</b>	<b>Resources Implications (Financial / staffing)</b>
Delivery of the priorities is dependent on the continuation of the agreed resources for each project.	

<b>6.</b>	<b>Equality and Diversity</b>
Ensures compliance with the Equality Delivery System (EDS)	

<b>7.</b>	<b>References to previous reports</b>
Monthly Quality Reports to Management Board and Board of Directors	

<b>8.</b>	<b>Freedom of Information</b>
Public	

Author: Sarah Merritt, Interim Deputy Director of Nursing & Midwifery & John Kirby, Quality Assurance and Risk Business Analyst Document Approved by: Lisa Cheek, Director of Nursing and Midwifery Agenda Item: 10	Date: 24 July 2020 Version: 1  Page 1 of 1
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# Quality Board Report

## July 2020



# Quality Board Report | July 2020

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**Safe**

Clinical Risk and Serious Incidents | Falls | Pressure  
Ulcers | Infection Prevention and Control



**Caring**

Patient Experience | Complaints | PALS | FFT



**Effective**

Peer Audit results



**Responsive**

Patient Moves | Mixed-Sex Accommodation



**Well led**

Appraisal Rates | Training | Use of Resources |  
Vacancies



**Appendices**

Divisional Driver Reports

# Quality Board Report | July 2020

## Executive Summary



### Falls

- 192** Inpatient falls in Quarter 1 2020/21, on track for a 5% reduction from 2019/20
- 4** Inpatient falls (moderate and above) in Quarter 1 2020/21, on track for a 5% reduction from 2019/20
- 11** Repeat falls in June 2020, a reduction from 16 in May 2020. Currently on track for trajectory (5% reduction from 2019/20)
- 4** Repeat fallers in June 2020, a reduction from 8 in May 2020. Currently on track for trajectory (5% reduction from 2019/20)

### Pressure Ulcers

- 1** Category 2 pressure ulcer reported – no lapses in care
- 0** Category 3 pressure ulcers reported (Target for 2020/21: 0)
- 0** Category 4 pressure ulcers reported (Target for 2020/21: 0)
- 0** Medical Device Related pressure ulcers reported
- 2** Suspected Deep Tissue Injuries waiting for final validation

### Serious Incidents

- 6** SIs reported to StEIS in June 2020
- 31** SIs remain open and under investigation (including those awaiting approval for closure from the CCG) as of 16/07/2020
- 0** of the SIs open are overdue according to the agreed deadline date

### Infection Control

- 6** Hospital onset *C. diff* infections (increase in 5 from May 2020)
- 1** Community onset healthcare associated *C. diff* infection in 2020/21 (31 May 2020)
- 42** *C. diff* infections in 2019/20 against a trajectory of 59. Trust objective achieved
- 0** Hospital onset MRSA Bloodstream infections since October 2019
- 8** Hospital onset MSSA Bloodstream infections year to date in 2020/21 (10% reduction local target)
- 1** Community onset healthcare associated *C. diff* infection in 2020/21 (31 May 2020)
- 11** *E. Coli* bloodstream infections in 2020/21 (Target: 10% reduction)



### Complaints and PALS

- 73%** Complaints closed within 35 day target
- 200** contacts with PALS. 16% increase from May 2020. 35% decrease from June 2019

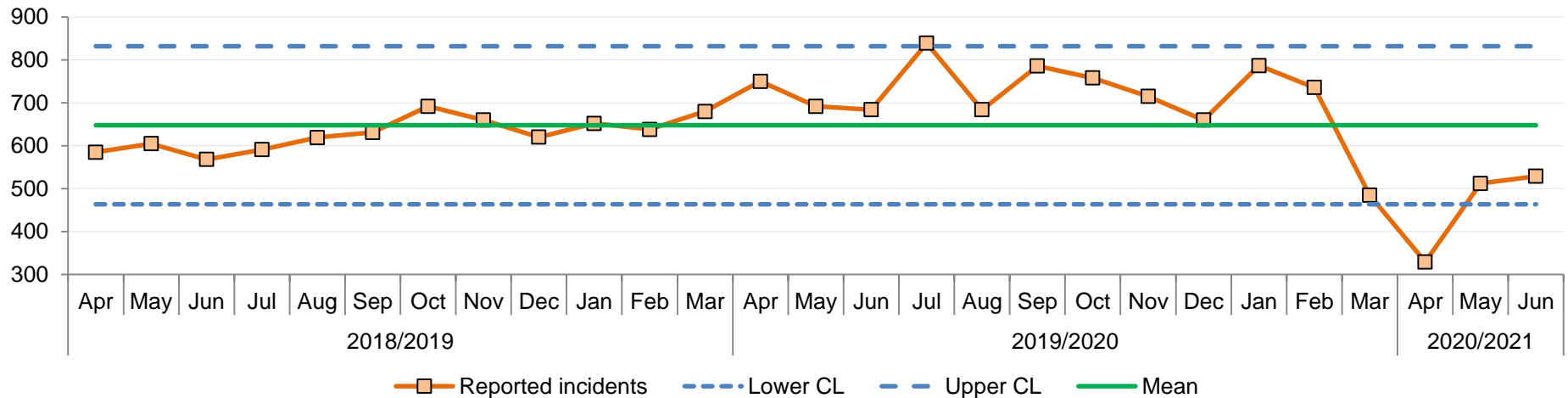


### Appraisals, Training and Turnover

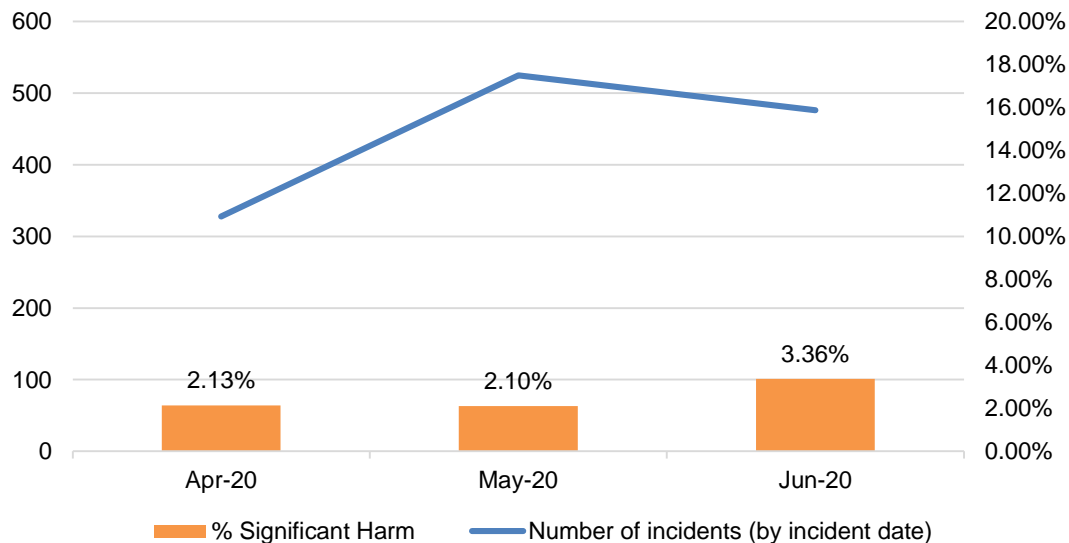
- 75.4%** Staff appraisal compliance (Target: 90%)
- 89.3%** Mandatory training compliance (Target: 90%)
- 10.7%** Staff turnover rate (Target: <11%, 12 month rolling)

# Safe | Incident Reporting

Reported Patient Safety Incidents



Patient Safety incidents - Significant harm by date of incident

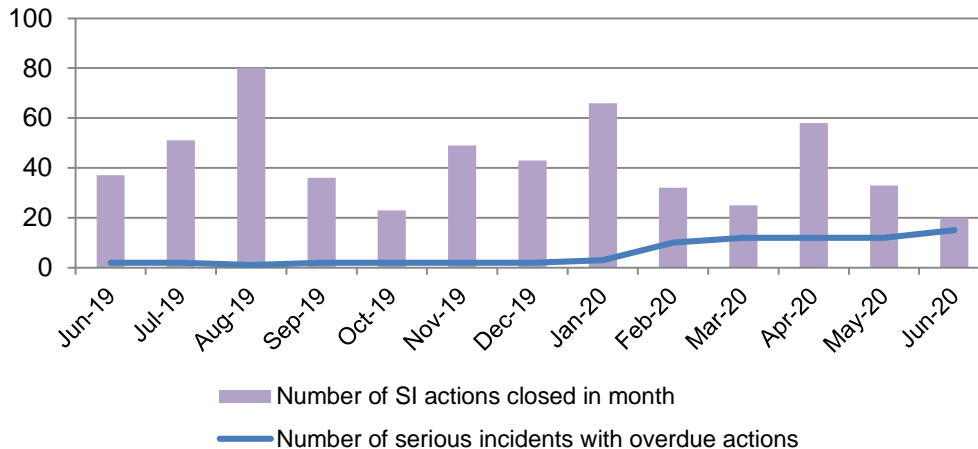


## Commentary on performance

- The number of incidents reported over the period decreased proportionally with the reduction of patient activity as a result of the Covid-19 response.
- There has been an increase in the number of incidents with significant harm reported as a result of Structured Judgement Reviews. 4 incidents relating to SJRs were reported on Datix in June 2020 which increased the proportion of significant harm incidents reported. When based on date of incident instead of date reported, there has not been a significant increase in moderate or above harm incidents in June 2020

# Safe | Serious Incidents

Completion of action plans from SI investigations



Date of incident	ID	Serious Incidents for June 2020
17/04/2019	84281	Failure to monitor deteriorating patient
01/05/2020	84346	Bilateral DVT
07/06/2020	84378	Wrong medication
04/06/2020	84386	Neonatal re-admission
28/05/2020	84431	Post operative complication
10/06/2020	84596	Pressure Ulcer - Category 3

6

SIs reported to StEIS in June 2020

31

SIs remain open and under investigation (including those awaiting approval for closure from the CCG) as of 16/07/2020

2

RCAs have been circulated for virtual sign off

0

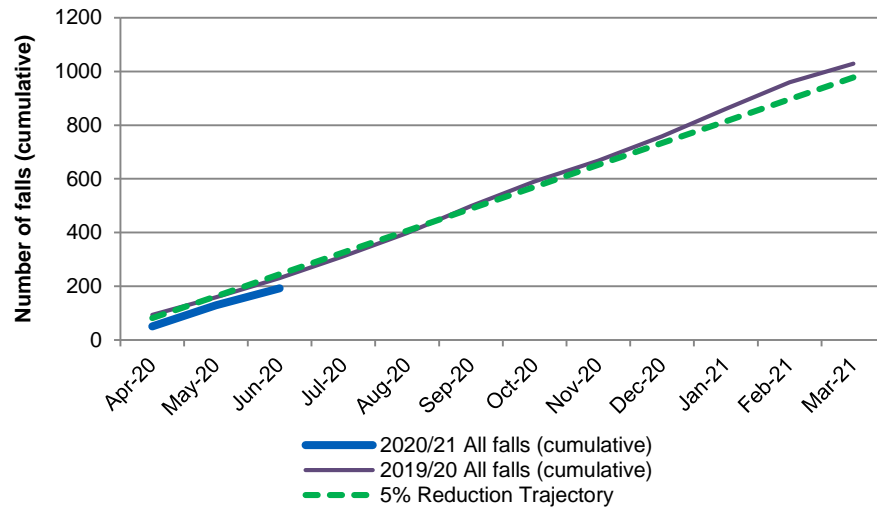
of the SIs open are overdue according to the agreed deadline date

## Commentary on performance

- There are 15 SIs with overdue actions according to the timescales identified in the action plans. Many of the outstanding actions from SIs relate to sharing of investigation findings and learning through governance meetings. It was agreed at the first meeting of the SI Review Panel that a review of how learning is disseminated across the organisation following SI investigations and how these actions are recorded on Datix would be undertaken and form part of the group's work plan. It is anticipated that this review and the monitoring of completed actions through the Panel's Key Performance Indicators (KPI) will help to reduce the number of actions that are overdue. The panel will also review actions implemented from SI investigations on a quarterly basis to provide assurance that these actions have led to demonstrable improvements in practice.
- As the Operational Clinical Governance (OCGC) meetings were put on hold due to Covid-19 pressures, a virtual sign off process was established to review completed SI Investigation reports with SI investigation reports e-mailed to members of OCGC for review and comment. There were 2 SIs that were approved by the Virtual Serious Incident Review Panel in June 2020.
- The first meeting of the new Serious Incident Review Panel was held on 7 July 2020. From July onwards the panel is responsible for the review and approval of SI investigation reports.

# Safe | Falls

## Inpatient Falls



Currently on track for trajectory

11

Repeat falls in June 2020, a reduction from 16 in May 2020. Currently on track for trajectory (5% reduction from 2019/20)

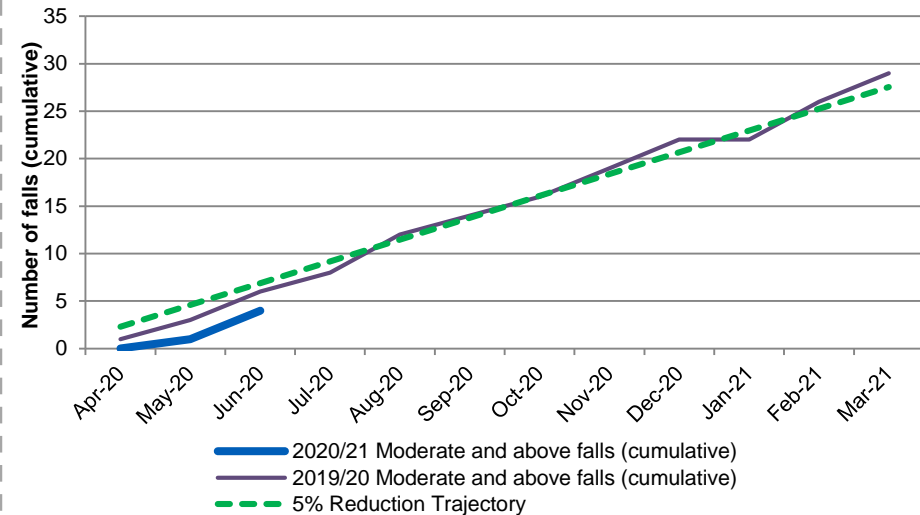
4

Repeat fallers in June 2020, a reduction from 8 in May 2020. Currently on track for trajectory (5% reduction from 2019/20)

The number of falls has reduced from 78 in May to 63 in June however the number of moderate and above harms has increased from 1 in May to 3 in June.

The number of repeat falls is 11 in June compared to 16 in May and the number of patients who fell more than once is 4 in June compared to 8 in May

## Inpatient Falls (Moderate and above)



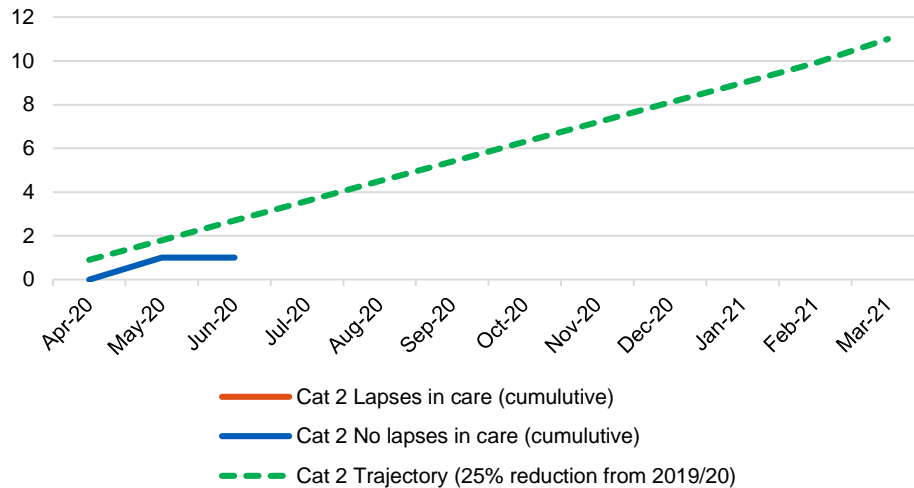
Currently on track for trajectory

### Actions

- One of the Quality Improvement nurses and the matron lead for falls are supporting the teams with a focus on Enhanced observation; short training sessions, auditing the quality and accuracy of Enhanced observations scoring, working with each area to observe how they cohort and identify Enhanced observers., e.g. Midford Ward are piloting a lanyard and badge, working on the MDT supporting Enhanced observations and are developing an information board on falls
- The Falls Steering Group are developing an A3 using the Improving Together methodology. The top contributing areas have been identified and work will be undertaken with these wards to achieve a 5% reduction by next year.

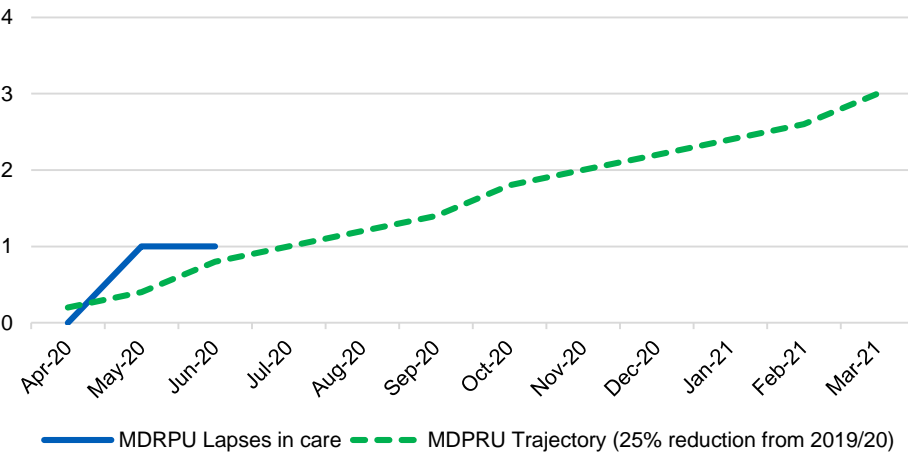
# Safe | Pressure Ulcers

Category 2 Pressure Ulcer Trajectory 2020/21



Currently on track for trajectory

Medical Device Related Pressure Ulcer Trajectory 2020/21



Above trajectory for June 2020

1

Category 2 pressure ulcer reported – no lapses in care

0

Category 3 pressure ulcers (Target for 2020/21: 0)

0

Category 4 pressure ulcers reported (Target for 2020/21: 0)

0

Medical Device Related pressure ulcers reported

2

Suspected Deep Tissue Injuries waiting for final validation

## Commentary on performance

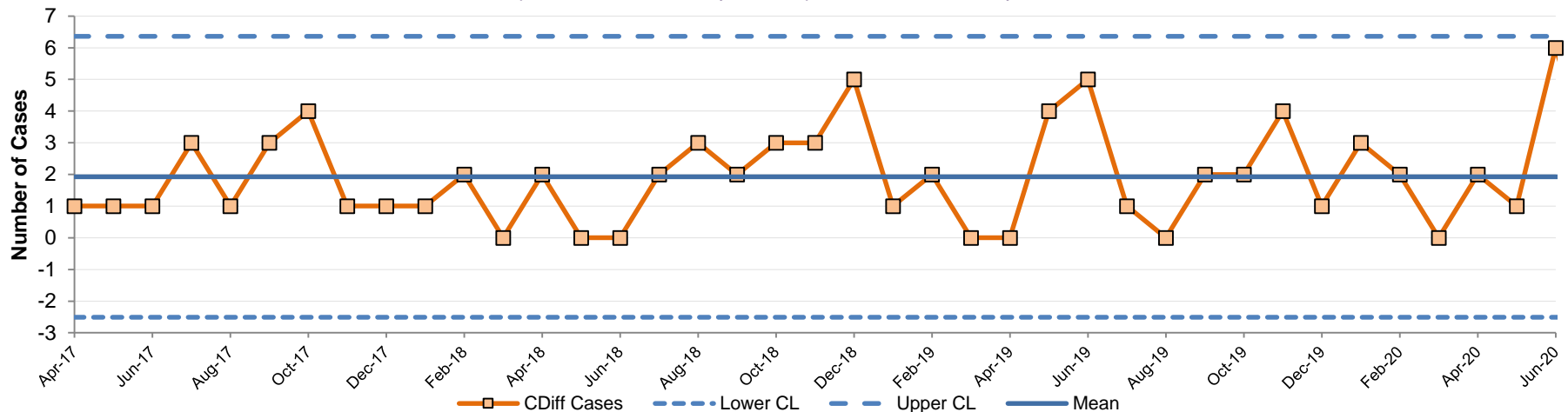
- Wards and departments have been rated red, amber and green. Red are those wards that have had an acquired pressure ulcer within the last 3 months, amber the last 6 months and green are those wards that are over a year pressure ulcer free
- The TVNs are meeting individually with the Tissue Viability Ambassadors and Senior sisters of red and amber wards to draw up action plans for prevention of further pressure ulcer incidents; as part of this work, Haygarth ward moved from red to green with no acquired pressure ulcers for a year.



# Safe | *Clostridium difficile* Infections

## Clostridium Difficile Hospital Onset Healthcare Associated Cases

Apr 17 - Mar 19 Post 3 day cases, Apr 19 onwards Post 2 day cases



6

Hospital onset infections (increase in 5 from May 2020)

1

Community onset healthcare associated infection in 2020/21 (31 May 2020)

42

Infections in 2019/20 against a trajectory of 59. Trust objective achieved

- Reporting criteria changed in April 2019: prior to this hospital onset cases were defined as those where the positive sample was taken 3 or more days after admission. From April 2019 this changed to 2 or more days after admission. There have been 9 hospital onset cases reported year to date (30 June 2020).
- Community onset healthcare associated cases are also apportioned to the Trust. These cases are defined as those where the sample is taken in the community or less than 2 days after admission. These cases are not shown in the chart above.
- There is no *Clostridium difficile* objective set for 2020/21 as NHS England/Improvement are reviewing financial sanctions and assessment for lapses of care in relation to *Clostridium difficile* to enable trusts to focus on learning from these incidents to prevent further infections.

### Actions

Meetings have been held to review the root cause analysis investigations of all hospital onset and community onset healthcare associated infections. Common themes have been identified and as a result actions have been put in place. Actions include:

- Sharing of learning at the senior sisters IPC meetings which are now taking place weekly.
- Renewed focus on documenting the patient's normal bowel habit on admission.
- Front door areas to commence stool charts from admission and document at least daily.
- Senior Sisters undertaking audits of stool chart completion.
- Primary Care antimicrobial prescribing concerns are being feedback through the CCGs.
- RCAs are being reviewed and actions monitored via the divisional governance meetings.
- Matrons and senior sisters to be involved with the *Clostridium difficile* revised swarms to identify learning.

0

Hospital onset MRSA Bloodstream infections since October 2019

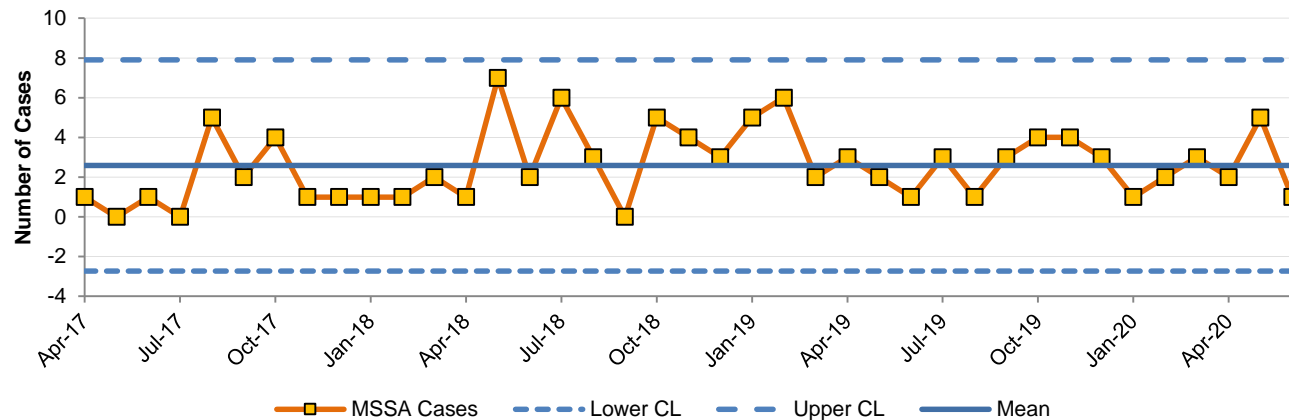
8

Hospital onset MSSA Bloodstream infections year to date in 2020/21 (10% reduction local target)

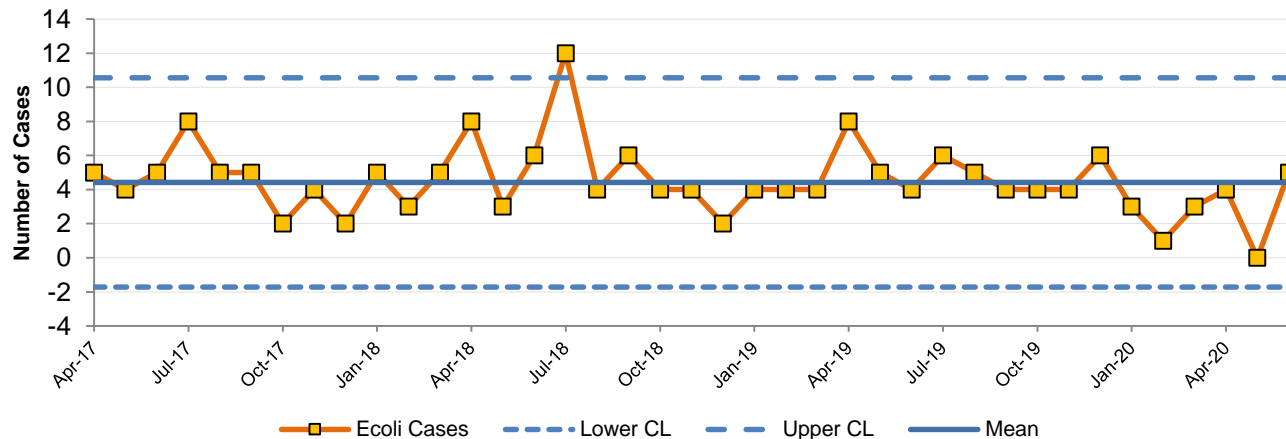
11

E. Coli bloodstream infections in 2020/21 (Target: 10% reduction)

MSSA Post 48 hour Cases



Escherichia coli Hospital Onset Healthcare Associated Cases

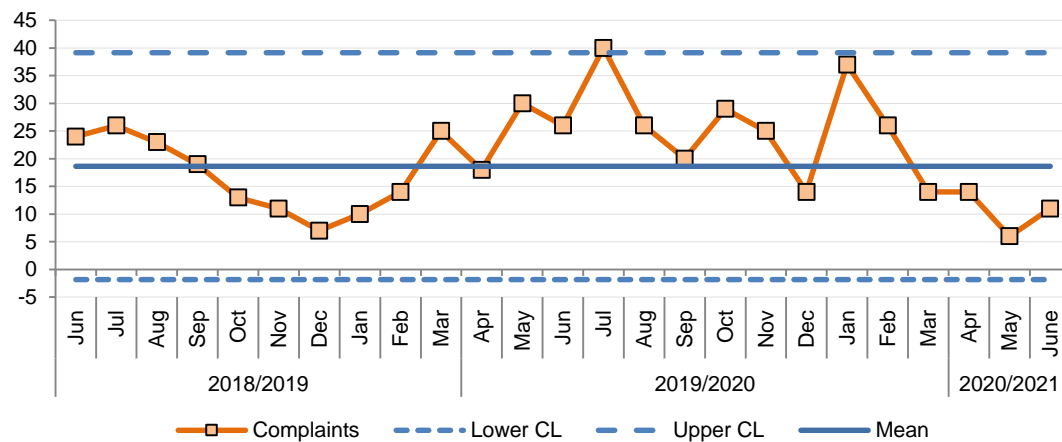


## Actions

- An overarching plan is in place to identify actions to reduce these infections:
- All hospital onset MSSA cases will be investigated using root cause analysis.
- The senior sisters are discussing incidents and sharing good practice at their weekly meetings
- Staff are regularly inspecting sites when cannulae have been removed and documenting any changes, e.g. signs of inflammation.
- Increased opportunities for offering patients drinks have been implemented to reduce dehydration.
- Work underway to include documentation of pre-hospital insertion to improve cannula insertion documentation in ED

# Caring | Complaints

Complaints – June 2020



The timeliness of complaint response rates improved from 29% in May to 64% in June. Surgery responded to all open complaints this month. In the Medicine Division one complaint breached by a couple of days due to its complexity, requiring input from a number of staff and external providers. Medicine also has one complaint due for response in June that remains open that was received in February 2020 which is being carefully monitored. W&C Division had one complaint breach by a few days due to further amendments being required prior to sign off.

## Next steps

- On 10th August, Women and Children's Division will be meeting with their Matrons and Senior Sisters to review how they are sharing their learning in line with the report by Healthwatch 'Shifting the Mindset'. The Surgery Division are also reviewing their processes for dealing with formal complaints, particularly around the identifying and sharing of learning from complaints.
- Guidance has been circulated to the Divisions around the use of Microsoft Teams when holding complaint meetings with complainants.

Response rate	Medicine	Surgery	W&C
Closed within 35 day target	3/5 (60%)	5/5 (100%)	0/1 (0%)

Subject	Medicine	Surgery	W&C
Clinical care	3	2	1
Communication		1	
Staff attitude	2	1	
Discharge	1		

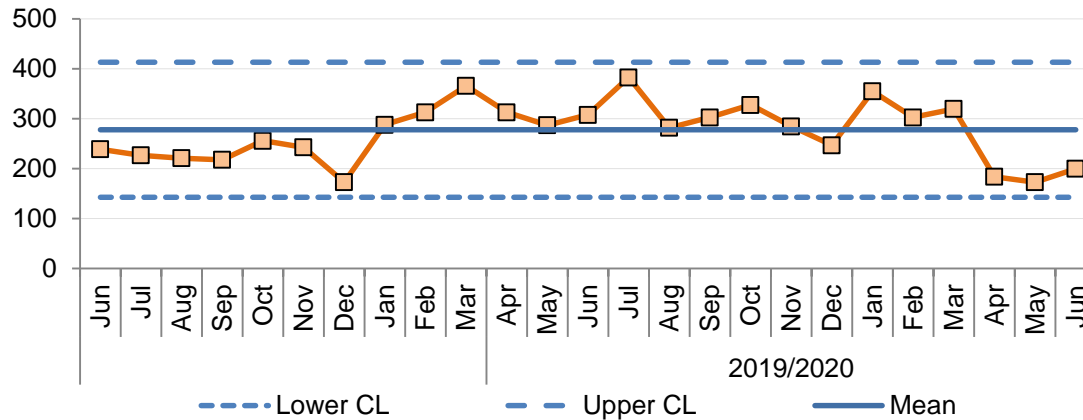
Medicine Division	Complaints Received
Acute Medicine	3
Emergency Department	2
Older Persons Unit	1

Surgery Division	Complaints Received
Orthopaedics	3
Urology	1

W&C Division	Complaints Received
Gynaecology	1

# Caring | Patient Advice and Liaison Service

PALS – June 2020



200

contacts with PALS. 16% increase from May 2020. 35% decrease from June 2019

99

Required resolution (50%)

76

requested advice or information (38%)

14

Were compliments (7%)

11

Provided feedback (5%)

## Next steps

- The PALS service is open Monday to Friday 9-5pm and patients can contact the service by telephone or e-mail. There is currently no 'walk-in' service however in line with other hospitals the PALS team are exploring options to have a walk-in service 'by appointment only' taking into account social distancing. A PALS questionnaire has been developed and went live on 1st July. The questionnaire will be used to collect feedback on patient/family/carers experience of PALS and to identify any service improvements.

## Top 3 Subjects Requiring Resolution



25

Communication and Information



19

Appointments



7

Clinical Care and Concerns

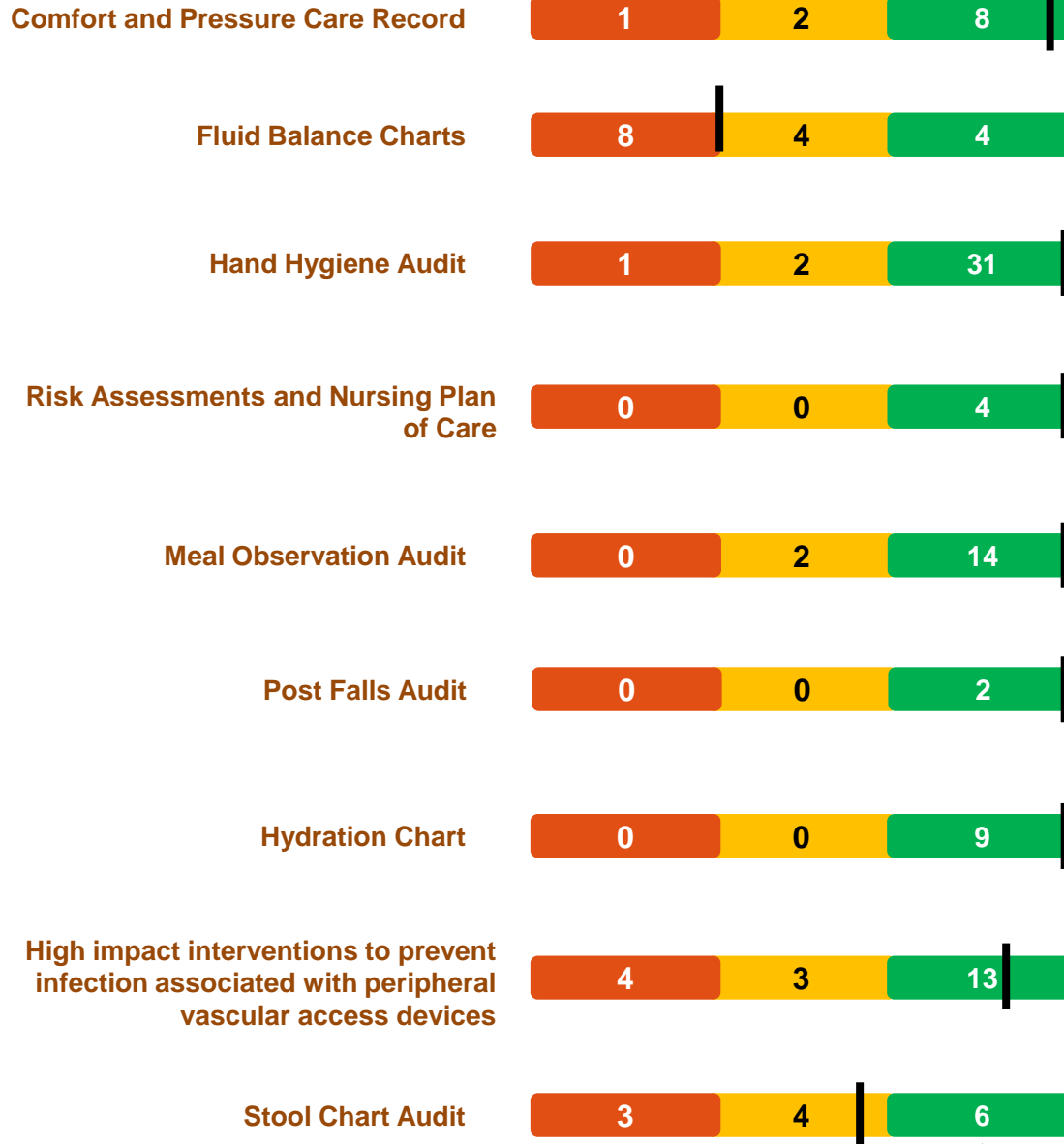
The majority of the contacts in relation to Communication and Information and Clinical Care and Concerns were general enquiries, there were no trends across these subjects. The contacts relating to appointments were mostly requests for information such as date/ time/ location in addition to queries relating to the length of time for a new appointment, these were spread across different departments.

## Advice and Information

There were 76 contacts requesting advice and information. This includes patients requesting information on how to access their medical records and family members contacting PALS to find out which ward their relatives had been admitted to.

# Effective | Peer Audit results

June 2020



Number of areas that scored green on the audit compliance

## Actions

- The peer audits were put on hold in March to relieve pressure on clinical staff at the start of the COVID-19 pandemic. These audits are now being re-established. Monthly summaries of audit performance will be disseminated to the senior sisters, matrons and Heads of Nursing.
- It is proposed that a poster / display highlighting key quality and patient safety performance information will be introduced at ward level. This will replace the existing audit posters but will include audit performance in addition to other performance information.
- Key Trust committees review the findings from these audits. For example the post falls audit results and falls care plan section of the Nursing Plan of Care are discussed at the Falls Steering Group, the comfort and pressure care record audits are discussed at the Tissue Viability Steering Group and Medicines Storage Audits reviewed at the Medicines Advisory Group (MAG).

# Well led | Appraisals, Training & Vacancies

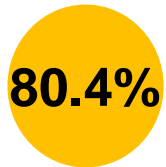
## Appraisal Rates – Trust target 90%



Medicine  
Target 90%



Surgery  
Target 90%



Women and Children's  
Target 90%

## Mandatory Training Compliance - Trust target 90%



Medicine  
(May 2020)

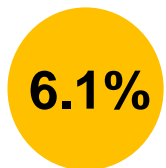


Surgery  
(May 2020)

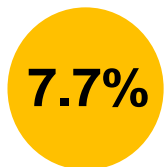


Women and Children's  
(May 2020)

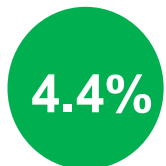
## Vacancy Rates



Medicine  
(Target 4%)



Surgery  
(Target 5%)



Women and Children's  
(Target 4%)

## Staff Turnover Rates- Trust target <11% rolling 12 month



Medicine



Surgery



Women and Children's

# Appendices | Medicine Driver Report

## Driver Measures



C. Diff Infections

**5**

Target: 0



Vacancy Rate

**6.1%**

Target:  $\leq 4\%$



Diagnostics  
within 6 weeks

**61.88%**

Target:  $\leq 1\%$



Discharges by  
Midday

**331**

Target: 30% of  
all discharges

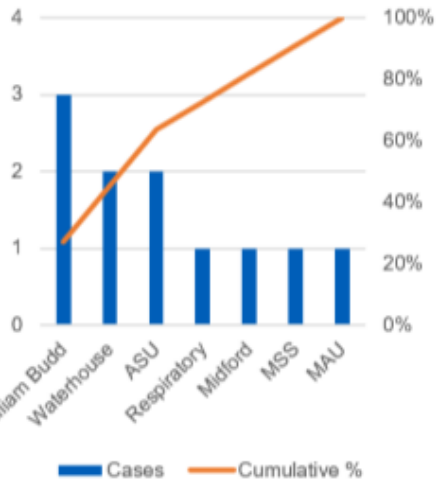


ED Time to Initial  
Assessment

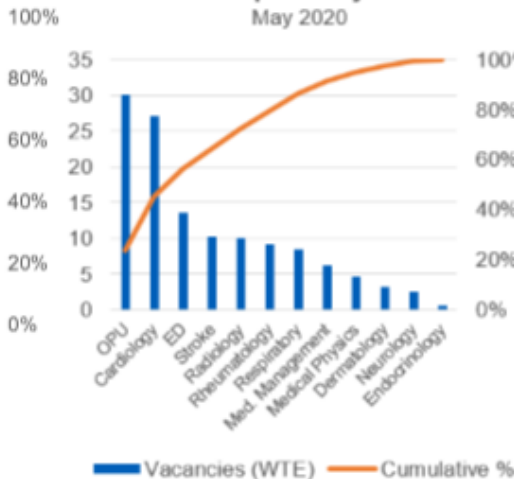
**75.0%**

Target: 95%

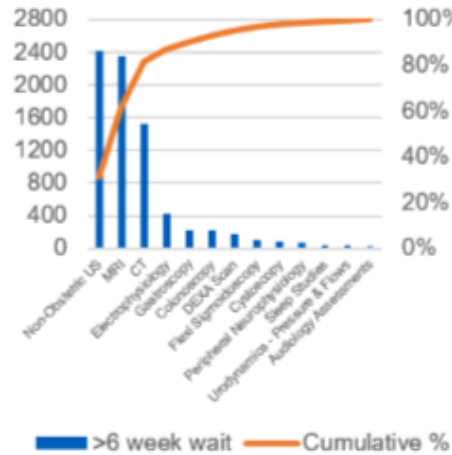
C.Diff Infections  
1 November 2019 - 30 April 2020



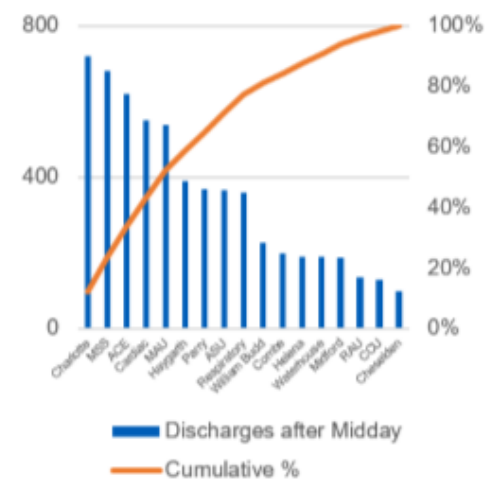
Vacancy Rate by  
Specialty  
May 2020



DM01 Breaches  
May 2020



Discharges After Midday  
December 2019 - May 2020



# Appendices | Medicine Driver Report

## Countermeasures



**C. Diff Infections** | Local induction developed for new starters around documentation of cannulation and C. Diff workbook compliance | PVC care plan documentation simplified | Standard Work is being developed for documentation of VIP scores and commencing of Stool Chart on admission | Weekly Matron walk-around and Senior Sisters meetings have been introduced



**Vacancy Rate** | A second overseas business case was approved by Management Board in Summer 2019 to appoint Registered Nurses over the course of the next three years. The recruitment plan post Covid-19 will be established with the first applicants due to arrive over the next few months | Future staff development fund (£1k every 3 years) provided by Health Education England confirmed and will be deployed across the Division |



**Diagnostics within 6 weeks** | Additional capacity is in place at Bath Clinic and Circle Bath until at least August 2020 due to reduction in CT and MRI capacity as a result of the Covid-19 response | Communications are going out to referrers via internal processes and external comms to GPs detailing the reduction in capacity | A Radiology sub-group has been put in place as part of the Phase 2 Diagnostics workstream. This monitors activity/back logs, waiting times and planned increases in capacity (following agreed actions) | BIU are currently supporting Radiology capacity modelling. The data will support forecasting, resources management, optimisation and decision-making.



**Discharges by Midday** | The Division is identifying key drivers for work streams in order to increase discharges by midday | Staff communication and Standard Work being developed regarding the use of the Discharge Hub on the day of discharge to facilitate morning discharges | Medical team will review the ward round process to: incorporate earlier TTA prescribing on ward rounds, review patients potentially for discharge to confirm morning discharges for the following day and on day of discharge | Medical team will review process for writing discharge summaries to facilitate earlier completion | Pharmacist on ward will work with senior sister to devise solutions for late TTA delivery on wards | Discharge facilitator and nurse in charge will identify patients at morning bullet round for Discharge Hub



**ED Time to Initial Assessment** | Communications team will be supporting the department in displaying live waiting times in the Minors waiting room | A Flow Coordinator role will be introduced in July 2020 in order to free up triage nurse | A plan is being developed in order for huddles and status exchanges to be recommenced | An ED receptionist will be identified to become part of the core Improving Together team



# Appendices | Surgery Driver Report

## Driver Measures



Hospital Acquired Infections

**4**

Target: 0



Recruitment of  
Band 5 Nurses—  
Theatres

**14.7 WTE**

Vacancies



RTT Incomplete  
Performance

**55.8%**

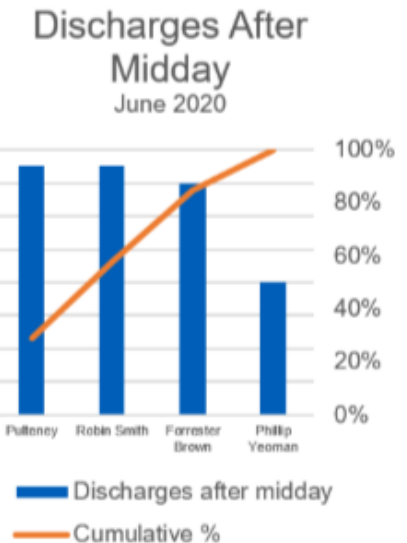
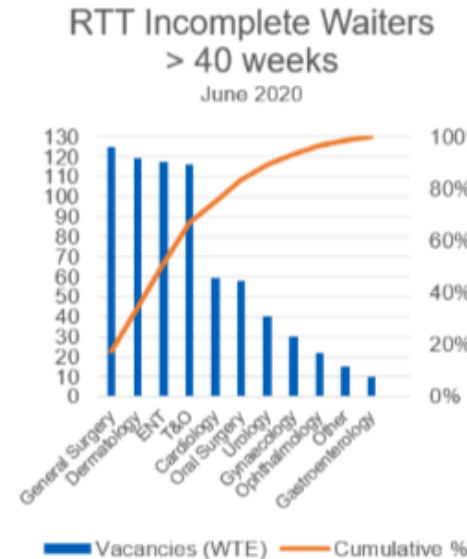
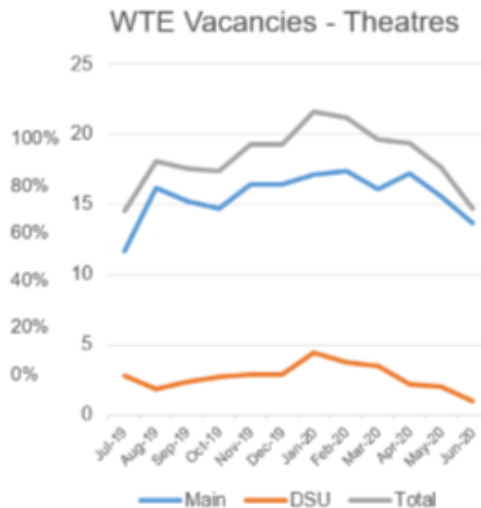
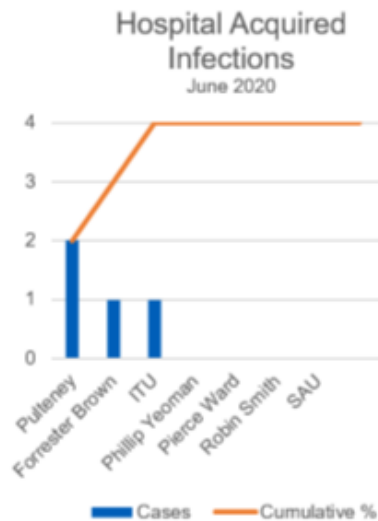
Target: 92%



Discharges by  
Middy

**21.7%**

Target: 92%



# Appendices | Surgery Driver Report

## ----- Countermeasures -----



**Hospital Acquired Infections** | The Multidisciplinary team are leading on the IPC agenda cross-divisional collaborative working | Introduction of Matron checklist and infection control/ environment audits | Cross-divisional thematic review of *C. diff*



**Recruitment of Band 5 Nurses** | The Division are focusing recruitment within theatres across a range of roles. To support recruitment all scheduled theatre session hours are planned in line with the Association for Perioperative Practice guidelines and confirmed at weekly theatre allocation meeting | Staff manually rota'd into sessions based on skill mix | All leave factored in | Uncovered hours put out for cover (bank/overtime). In addition the ICU matron has joined the NHSI retention programme to support further improvement.



**RTT Incomplete Performance** | To support improvement increased activity is being undertaken both in Outpatients and within Theatres. Space and IPC precautions are followed which has slowed recovery., including patient compliance with self isolation pre-operatively. Non face to face outpatients are being undertaken across a range of specialties and more support is being put in place for the specialties of ENT and OMFS due to the AGP nature of treatment. Additional MR and CT scanning is coming online Aug 20 to support both cancer and elective pathways. Reconfigure theatres to green and blue | Reconfigure wards to provide more green capacity/airport | Limited Paediatric operating capacity re-starting | Referral Assessment service on ERS to be provided | Outsourcing of echo | Angios provided to mitigate CT/MR delays



**Discharges by Midday** | Matrons are reviewing the cross-divisional A3 to inform actions | Discharge data to be analysed | Cross-divisional countermeasure summary will be developed following analysis | Data collection will be extended to Trauma & Orthopaedic wards. Transport as a limiting factor early in the day is under review.

# Appendices | W&C Driver Report

## Driver Measures



Band 5  
Recruitment  
Paediatrics/NICU

**8.5**

Target: 1



Gynaecology  
RTT Admitted

**236**

Target: <40



Paediatric OPD  
Waiting Times

**84.2%**

Target: 92%



4 Hour  
Performance  
Paediatrics

**95.4%**

Target: 95%

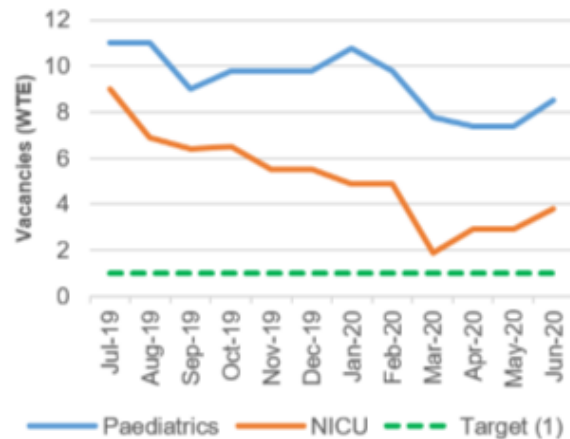


Cancer 62 day  
(Total Trust)

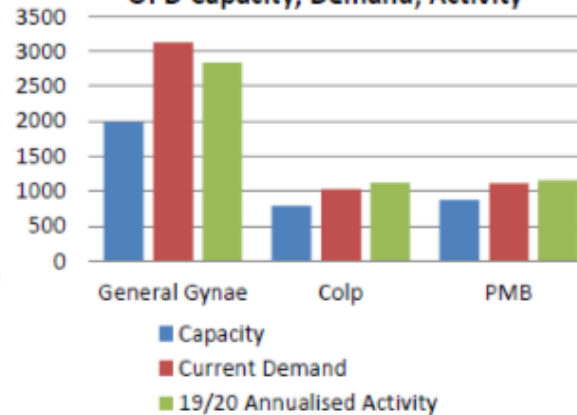
**85.6%**

Target: >85%

### B5 Nurse Vacancies



### OPD Capacity, Demand, Activity



### Paediatric open pathways performance



# Appendices | W&C Driver Report

## Countermeasures



**Band 5 Recruitment Paediatrics/NICU** | Band 5 adverts to fully promote the service and development opportunities | All Band 5 RNs to have robust personal development plans jointly agreed at the yearly appraisal in which the Band 5 development programme is reviewed | Options for ED rotation to be considered/ANP'S in PAU | Invest and develop the band 6's and 7's as most influential member of staff for Band 5s by working with the senior team to further develop management and leadership skills | Continue to support and enhance flexible shift-based working to support staff health and wellbeing as well as service needs



**Gynaecology RTT Admitted** | Waiting List Initiatives additional extra activity on hold while routine activity is slowly resumed. Consultant rota is being adapted on a weekly basis and does not yet match full job planned levels. Plans to develop and review the nursing rota to align with planned activity



**4 Hour Performance Paediatrics** | Analyse weekend 4 hour breach reasons in minors | Developing paediatric rotational post with children's ward, alongside HDU and in time, day surgery and PAU. 1 nurse in post currently | Review paediatric medical mental health, orthopaedic and surgical pathways as part of front door group identifying top contributors | Early discussion with ward to enable prompt transfer following assessment | Orthopaedic and ED teams to review pathway to improve efficiency



**Paediatric OPD Waiting Times** | Implement a Paediatric Outpatient Working Group | Await text reminder implementation planned for end of calendar year | Create and agree a standard template for general paediatric RUH clinics which will increase capacity | Explore telephone clinic models which may increase capacity in both registrar and consultant clinics | Implement new ways of working – virtual as default for 1st appointments, GP clusters, one stop clinics | Work with BIU to introduce Local Service ID | Process for consultants to implement telephone consultations in the event of DNAs



**Cancer 62 day** | Restart process of ring-fencing MRI capacity which ceased due to Covid-19 | Implement LA biopsy pathway | Review capacity and demand of clinic and job plans