

Trust Board

Report Cover Sheet

Agenda Item: 12

Date of Meeting:	Wednesday 29 July 2020			
Report Title:	Integrated Quality and Learning Report			
Purpose of Report:	To provide assurance to the Board on the Trusts quality and safety performance in the last 18 months to May 2020.			
	Decision: <input type="checkbox"/>	Discussion: <input type="checkbox"/>	Assurance: <input checked="" type="checkbox"/>	Information: <input checked="" type="checkbox"/>
Trust Goals that the report relates to: (Including reference to any specific risk)	<p>Goal 3 In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs.</p> <p>Goal 4 All our services will have a high safety culture in which openness, fairness, accountability and learning from high levels of incident reporting and mortality reviews is the norm.</p>			
Recommendations: (Action required by Board of Directors)	To receive for information on the Trust's key quality and safety indicators			
Financial Implications:	Financial sanctions may be applied by NHS England and commissioners in relation to Health Care Associated Infection (HCAI)			
Risk Management Implications:	The indicators contained relate to the quality of patient care. Risks are associated with any areas of poor performance of these indicators.			
Human Resource Implications:	None			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	<p>Objective 1 All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.</p>			
Author:	Andrew Ward – Senior Information Analyst Wendy Mcfadden – Safecare Lead – Clinical Effectiveness Andrea Tweddell - Strategic Lead for Patient Safety			
Presented by:	Dr H Lloyd, Director of Nursing, Quality and Midwifery			

Integrated Quality and Learning Report

May 2020



Gateshead Health
NHS Foundation Trust



Overall
Good

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Good ●

Integrated Quality and Learning Report

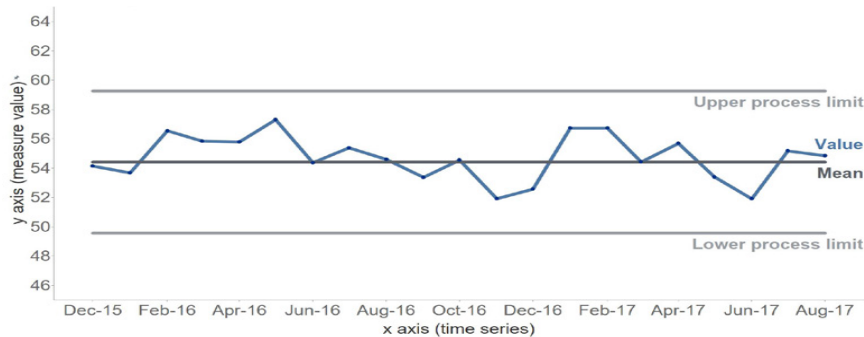
Introduction and about SPC

This report details quality indicators monitored by the Trust and also provides trust learning from these indicators. It is designed as an enhancement to replace the previous Trust Quality and Safety Dashboard and CLIP (Complaints, Litigation, Incidents, PALS).

Statistical process Control (SPC) has been used where appropriate to identify where situations may be improving or deteriorating.

Statistical process control (SPC) chart

This is an SPC chart. It's a time series line chart with three reference lines that help you appreciate variation in the data.



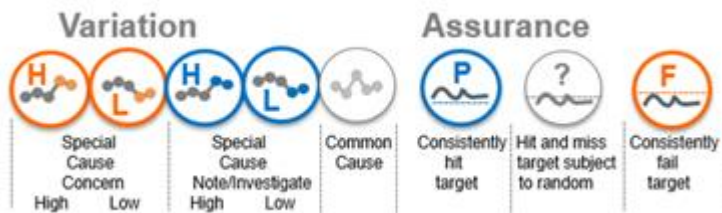
The reference lines are:

- centre reference line: the average line (often represented by the mean, sometimes the median)
- upper and lower reference lines: the process limits, also known as control limits.

You can expect approximately 99% of data points to fall within the process limits.

Key

The following symbols are used in this report to identify areas of special cause variation, or where targets are consistently achieved, failed, or may be achieved / fail as a result of normal variation.

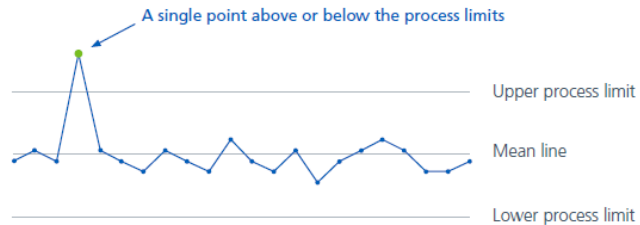


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more about SPC

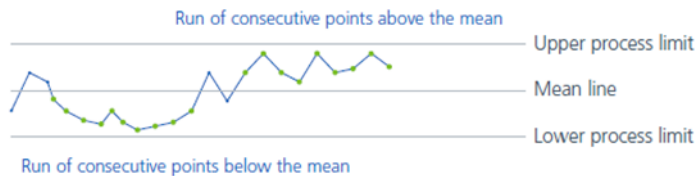
A single point outside the control limits

Whenever a data point falls outside a process limit (upper or lower) something unexpected has happened because we know that 99% of data should fall within the process limits.



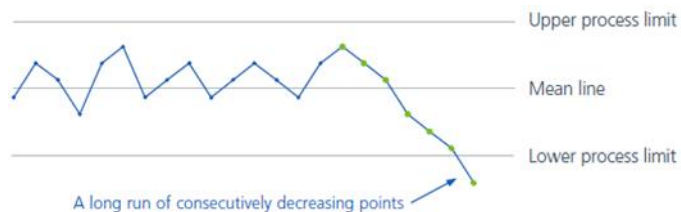
Consecutive points above or below the mean line

A run of values above or below the average (mean) line represents a trend that should not result from natural variation in the system.



Six consecutive points increasing or decreasing

A run of six or more values showing continuous increase or decrease is a sign that something unusual is happening in the system.



Integrated Quality and Learning Report

Included this month



Gateshead Health
NHS Foundation Trust

Please note that data in this report is accurate at the time of production. The severity and number of incidents may change due to additional information being available following investigation, meaning the severity may be re-categorised.

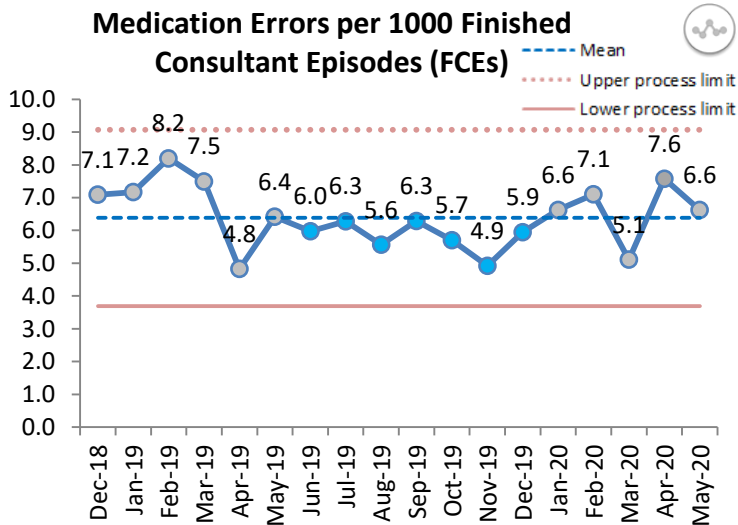
Safe	5-17	<ul style="list-style-type: none">• Medication Errors• Health-Care Associated Infections• Falls• Pressure damage	<ul style="list-style-type: none">• Never Events• Serious Incidents (SIs)• Patient Safety Incidents
Effective	18-19	<ul style="list-style-type: none">• Mortality• HSMR• SHMI	
Caring	20	<ul style="list-style-type: none">• Friends and Family Test	
Responsive	21	<ul style="list-style-type: none">• Compliments• Informal Complaints• Formal Complaints	
Well-led	22-23	<ul style="list-style-type: none">• 15 Steps Challenge• CQUIN	

Integrated Quality and Learning Report

Safe

Medication Reporting

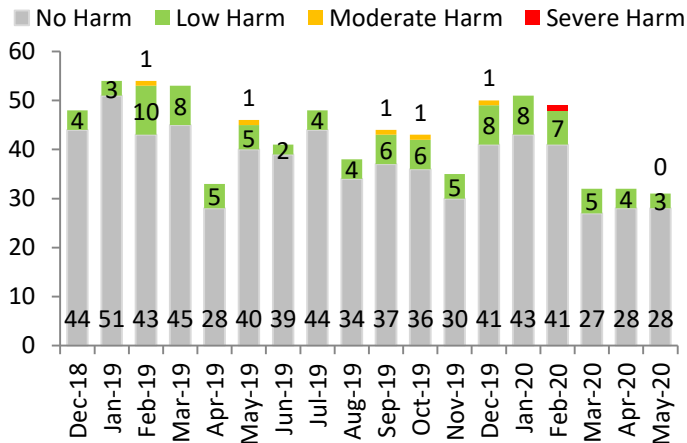
Medication Errors per 1000 Finished Consultant Episodes (FCEs)



Medication Errors

- A total of 31 medication errors were reported in May 2020.
- There were 0 moderate harm and 0 severe harm errors.
- Common cause variation is observed in the medication error rate following a recent shift over the previous 9 months.
- Lower overall reporting rates are likely to reflect recent reduced patient activity due to the current COVID-19 response and this is in line with the national picture.
- Recent medication safety improvement initiatives have focussed on mitigating risk of medication error due to the current COVID-19 response.

Severity of Medication Errors



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Healthcare Associated Infections

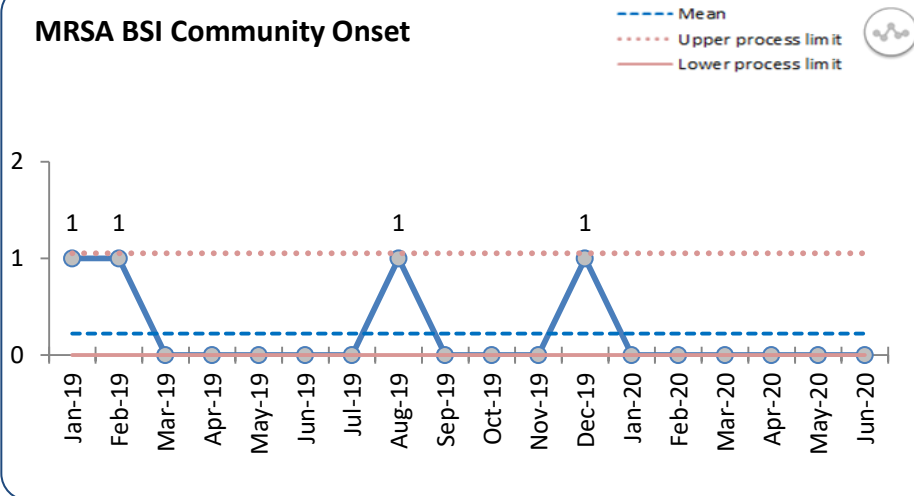
MRSA

Safe

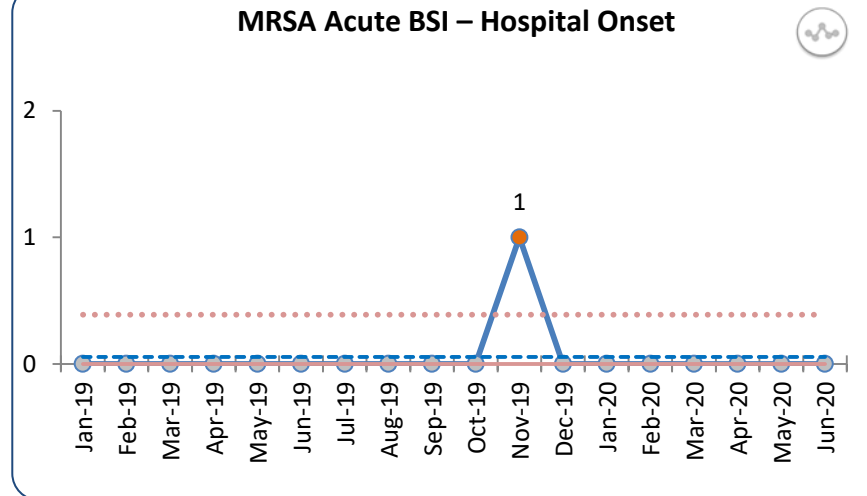
The Trust adopts the national aspiration of a zero tolerance to all avoidable infections including MRSA blood stream infections (BSI).

The trust has had zero incidence of hospital onset or Community onset MRSA BSI in 2020-21.

MRSA BSI Community Onset



MRSA Acute BSI – Hospital Onset



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Healthcare Associated Infections

Clostridium Difficile

Safe

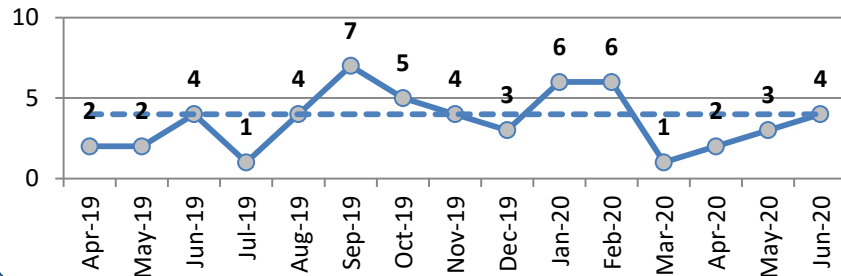
For the period 01/04/19 – 31/03/2020 the Trust reported 45 healthcare associated CDI cases.

All cases have been jointly reviewed with 35 cases successfully presented for appeal, therefore the Trust had 10 cases held against the identified ambition of 40 cases.

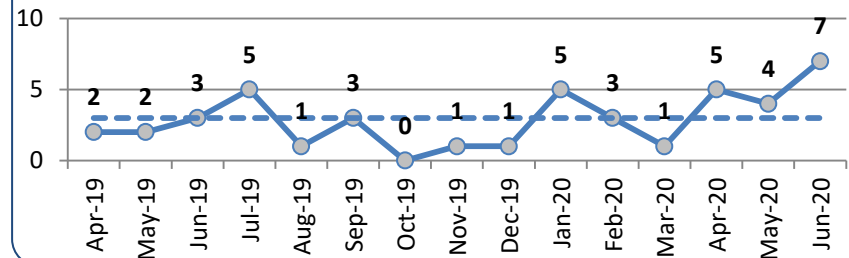
For 2020/21 the appeals process has been removed and due to the current COVID-19 pandemic, NHS E/NHS I has not yet identified the required target.

For the period 01/04/2020 to 30/06/2020 the Trust has reported 9 healthcare associated CDI. Two of the cases have been jointly reviewed where best practice has been followed relating to sample submission, antimicrobial prescribing and documentation.

Healthcare Associated Clostridium difficile Infection (CDI) — Median



Indeterminate / Community Associated Clostridium difficile Infection (CDI) — Median

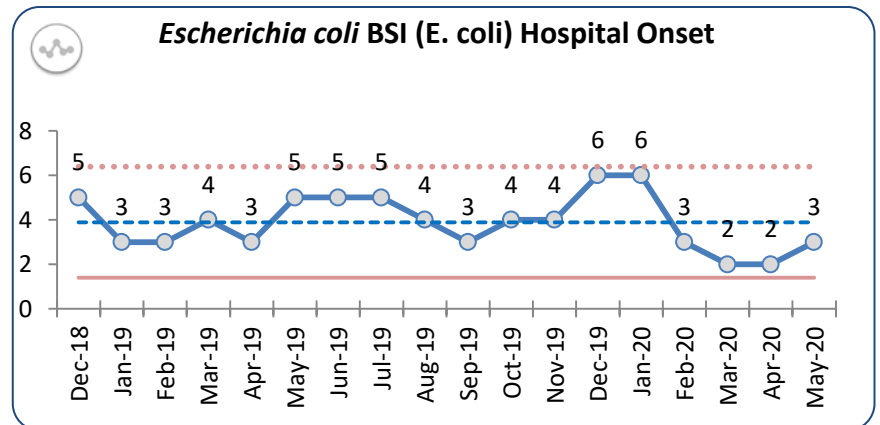
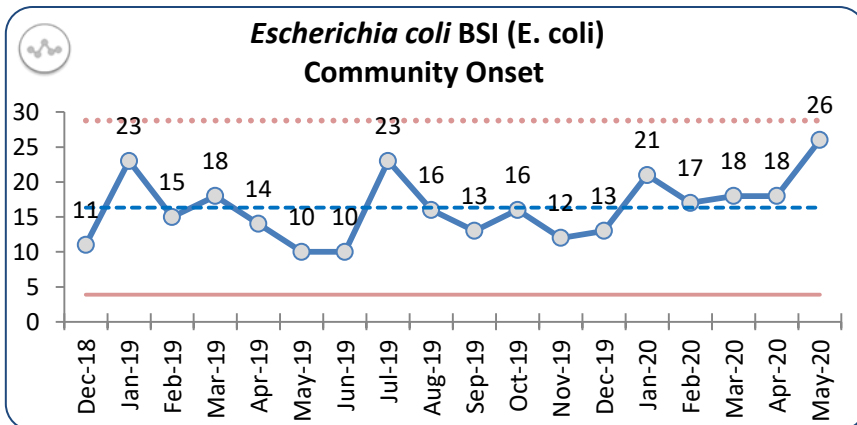
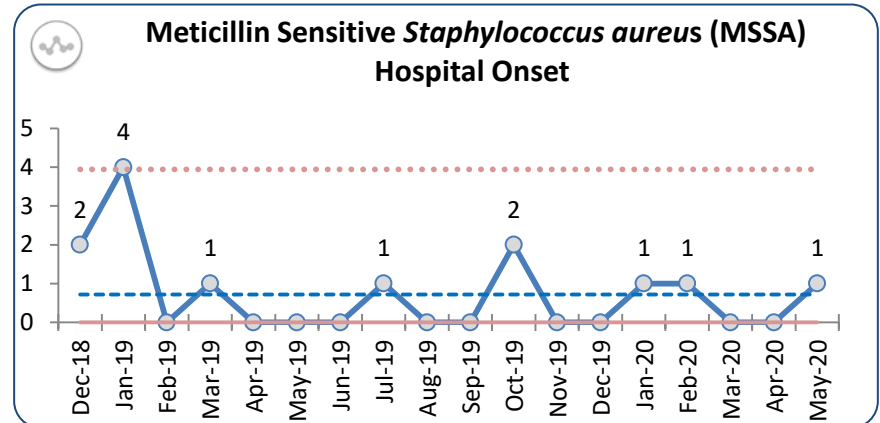
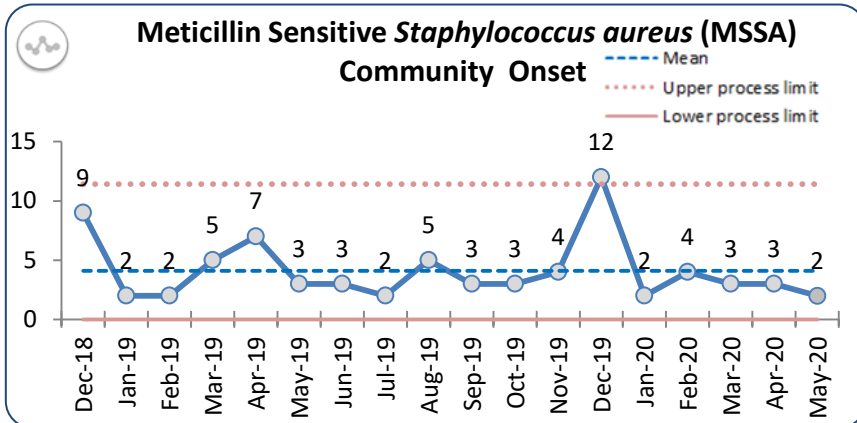


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Healthcare Associated Infections

MSSA & E Coli

Safe



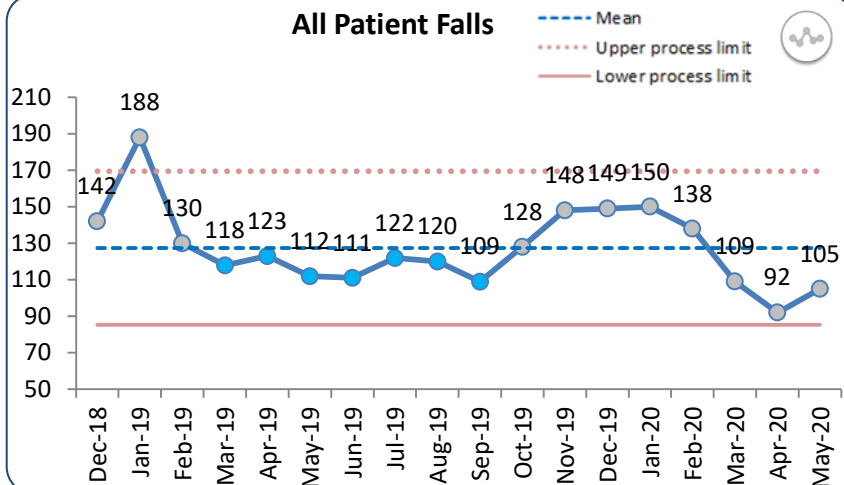
Normal variation observed for MSSA and E.coli

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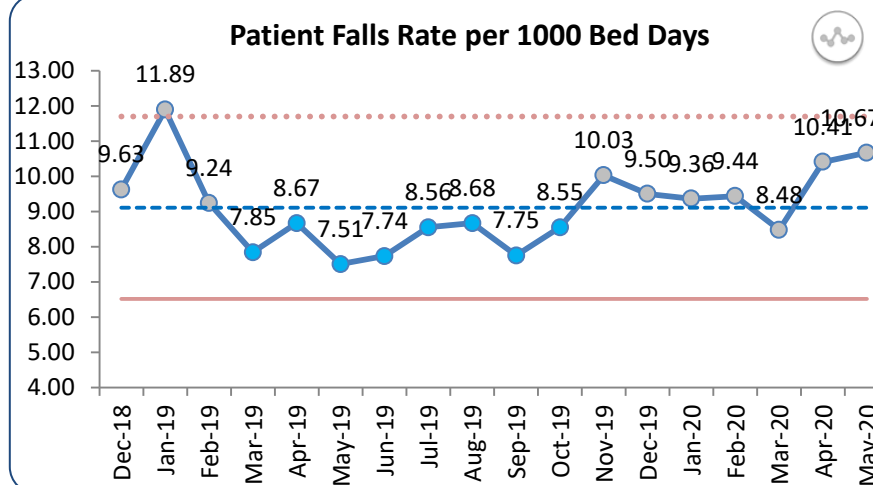
Safe

Falls

All Patient Falls



Patient Falls Rate per 1000 Bed Days



Patient Falls – statistics and learning

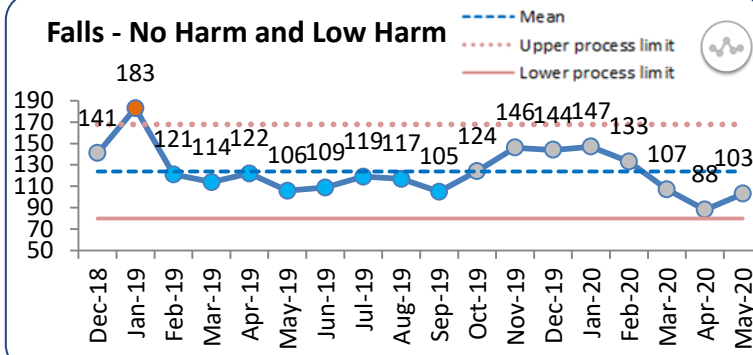
- March 2020 – 109 falls reported; 90 no harm; 17 low harm; 1 moderate harm (injuries to facial bones and shoulder) and 1 severe harm (fractured neck of femur - NOF). The moderate harm incident remains under review and the severe harm investigation is awaiting final presentation at the Trust Falls Panel.
- April 2020 – 92 falls reported; 72 no harm; 16 low harm; 2 moderate harm (cerebral haemorrhage + fractured pubic rami) and 2 severe harm (both fractured NOF). These incidents are all under review at present and learning from these incidents will be included in future reports.
- May 2020 – 105 falls reported; 79 no harm; 24 low harm; 2 moderate harm (cerebral haemorrhage and unwitnessed collapse following sudden deterioration – patient was on end of life pathway and found to be deceased following the collapse. No injuries were evident) Both of these incidents remain under review within the Business Units.

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Safe

Falls

Falls - No Harm and Low Harm



Further learning from Inpatient Patient Falls

Due to the suspension of a number of elective activities and also the reduced bed occupancy, the total number of inpatient falls reported has decreased.

The actual inpatient falls rate remains within normal variation.

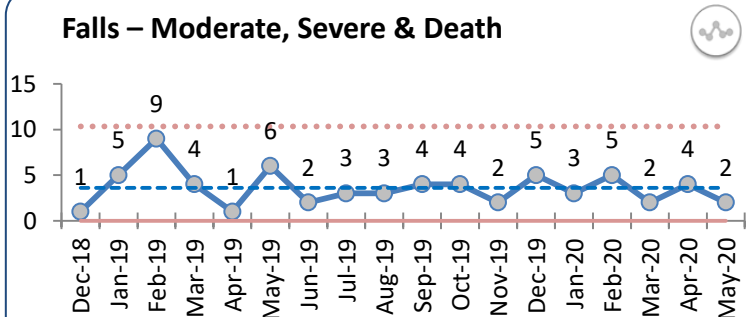
The majority of falls incidents from May 2020 remain under review and therefore lessons learned will be identified and shared in future reports.

All Serious Incident Panels were suspended as part of the Trust's response to the Covid-19 pandemic; the Falls Serious Incident Panel was reinstated in June and 6 cases were presented.

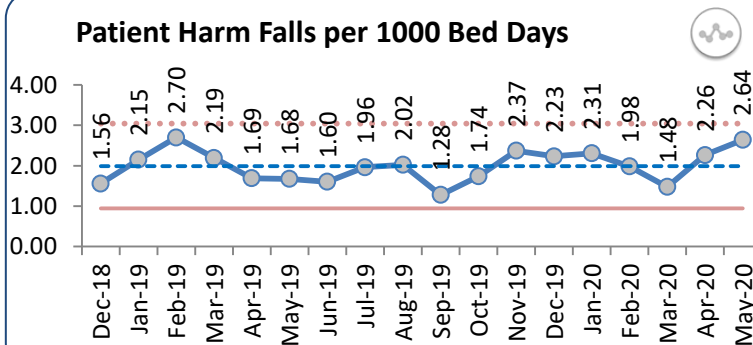
A number of investigations have been delayed during the pandemic and support will be offered to the individual teams by the Patient Safety Team to assist with the completion of investigation reports.

Key learning that has been identified involves the use and accessibility of the 'hover jack' equipment to transfer patients with suspected bony injury from the floor to their beds. In order to understand the issues encountered by staff who need to use the hover jack equipment the Patient Safety Team will meet with the Facilities Manager to review the current process in place and try to identify where improvements can be made to support staff with the requesting of this equipment.

Falls – Moderate, Severe & Death



Patient Harm Falls per 1000 Bed Days

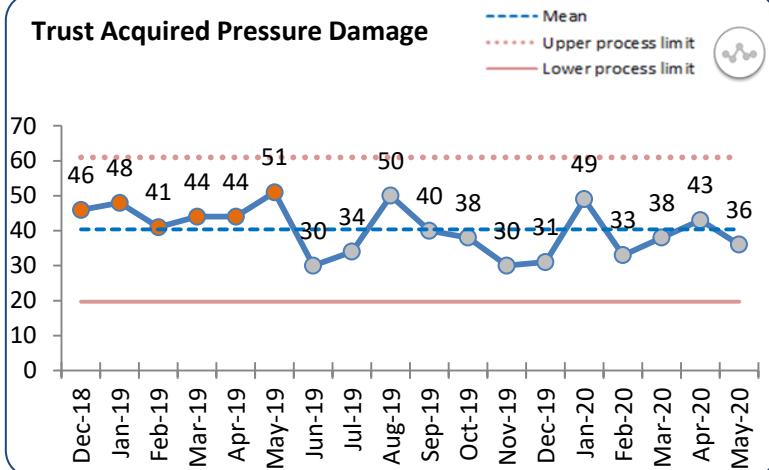


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Safe

Trust & Hospital Acquired Pressure Damage

Trust Acquired Pressure Damage



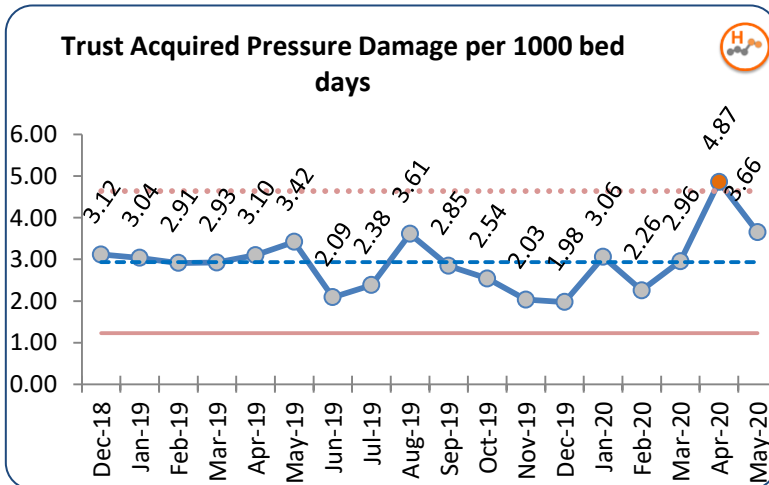
Trust Acquired Pressure Damage

(Category 2 and above including deterioration, unstageable and deep tissue injuries)

Please note that these figures include pressure damage acquired in both acute and community settings whilst under the care of the Trust.

- Special Cause Variation deterioration identified in the rate of Trust Acquired Pressure damage per 1000 bed days in April 2020.
- 43 incidents of Trust acquired pressure damage were reported in April 2020.
- 8 incidents observed in an acute setting
 - 6 x category 2
 - 1 x device related category 2 pressure ulcer
 - 1 x unstageable
- 28 incidents observed in a community setting during Trust care
 - 20 x category 2
 - 6 x unstageable
 - 1 x category 4
 - 1 x Deep tissue Injury

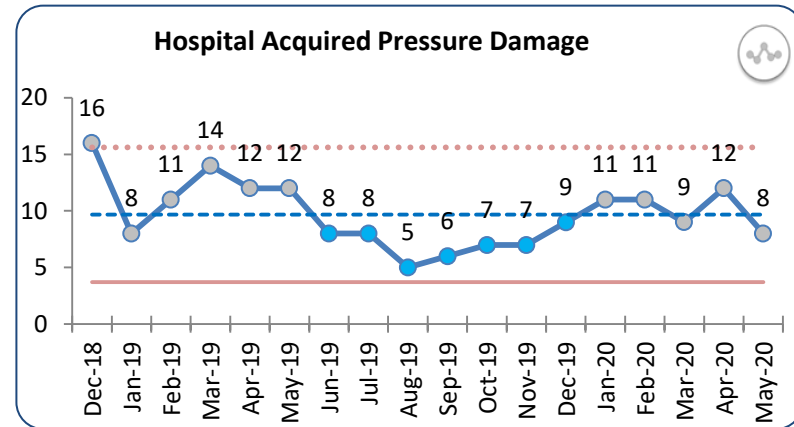
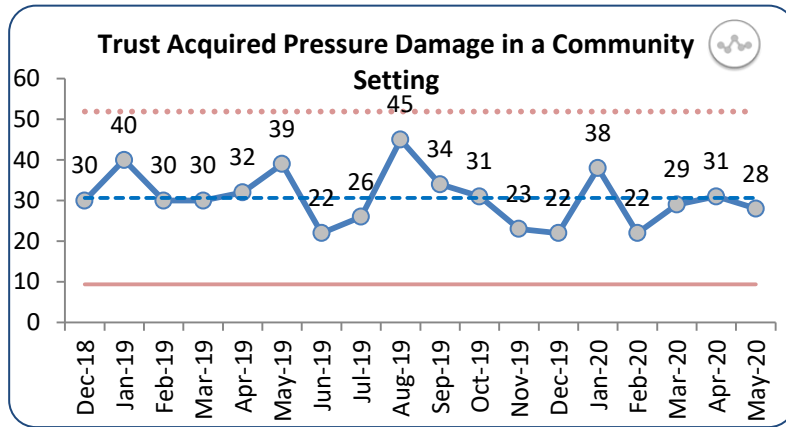
Trust Acquired Pressure Damage per 1000 bed days



Integrated Quality and Learning Report

Safe

Trust & Hospital Acquired Pressure Damage



The monthly reporting of pressure damage has not changed significantly yet the overall rate of Trust acquired pressure damage has increased, demonstrating special cause variation (Apr-20). Whilst the findings of Investigations are awaited, it is important to consider the case mix of patients admitted since the Trust suspended routine clinical activity in order to prepare for the management of COVID-19, leading to a higher number of critically ill patients more pre-disposed to pressure damage.

Alongside the higher number of critically ill patients admitted to the Trust, the TVN team were also required to make adjustments to their routine working practices in order to reduce the possibility of transferring Covid-19 from one area to another. Visiting wards and care homes was suspended and advice / recommendations were made remotely which may have had an impact on the wound management.

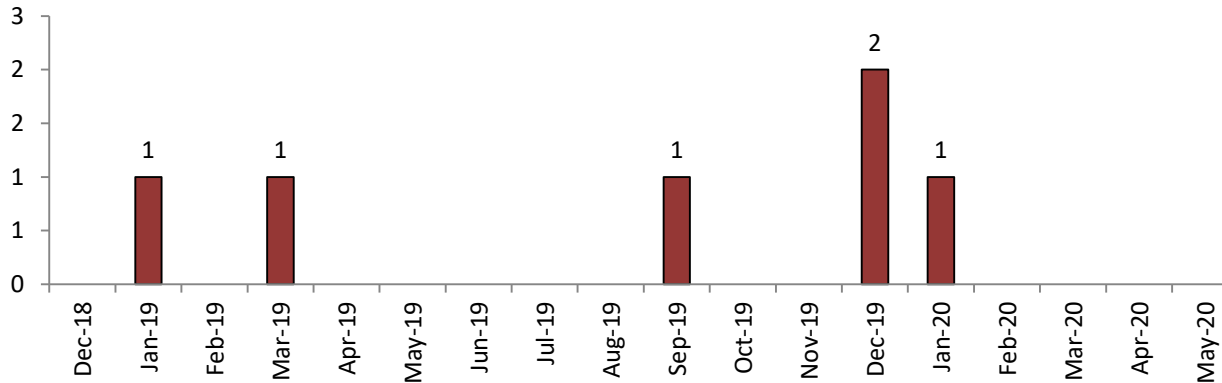
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Safe

Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The Trust operates a zero tolerance approach to Never Events. When Never Events occur a comprehensive investigation is undertaken to identify learning and implement appropriate actions.

Never Events



Never Events

- January 2020 – Wrong site surgery carried out.
- December 2019 – 2 x Wrong implant/prosthesis identified from procedures undertaken in August and October 2015
- September 2019 – Overdose of methotrexate for non-cancer treatment (moderate harm)
- March 2019 - Wrong Patient for treatment/procedure (Low Harm)
- January 2019 - Incorrect Site for Surgery (Low Harm)

Integrated Quality and Learning Report

Safe

Never Events

Learning from Never Event Investigations

The majority of incidents which have been identified as Never Events within this timeframe (January 2019 to date) have occurred within the theatre environment and following Human Factors investigations of each case, similar recommendations have been made:

Fatigue, stress, pressure

- Campaigns which have been developed nationally to support staff in raising awareness of common contributory factors such as fatigue, stress and pressure are to be re-launched. These include HALT and Stop Before You Block.

Process / Systems

- LocSSIPs have been developed to address the gap in process/systems, however audit of compliance with the requirements is necessary to confirm that staff are following them every time.

Distraction / Norms

- Distraction also features in a number of Never Events within theatre and therefore it is important that theatre etiquette was addressed; there should be clear guidance for entering and leaving the operating room when an operation is underway and also how communication is undertaken with staff both inside and outside of the theatre.

Knowledge

- Recommending training / education of an individual will not stop an incident from reoccurring however identifying a gap in the knowledge of a team / department or wider may support more meaningful learning. Following the overdose of methotrexate for non cancer treatment, education regarding the safe use of chemotoxins was recommended.

Communication

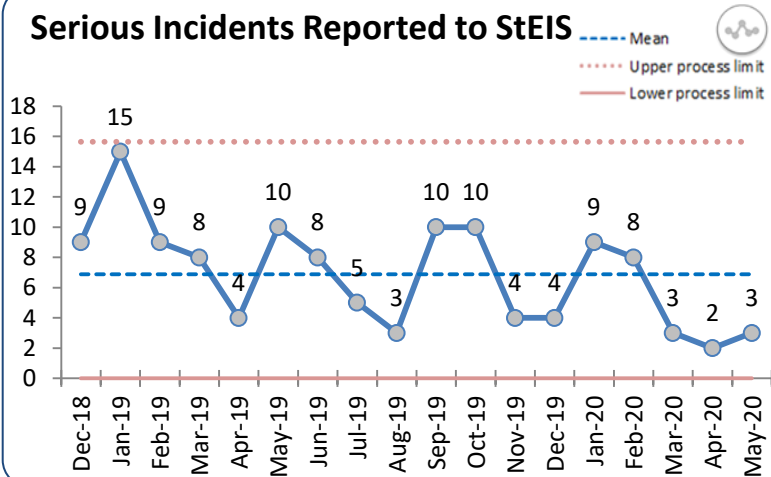
- The most common human factor recognised in a patient safety investigation is communication and this includes both verbal and written forms. Additional white boards have been identified as a way of supporting communication between team members within theatre and outside of the theatre environment, referral processes have been developed to ensure accurate patient information is shared between teams. Sharing the lessons learned following an investigation; not just within departments but also within and between Business Units is essential to raise awareness of how and why Never Events happen and also provide teams with the opportunity to 'sense-check' their own areas for similar human factors occurring.

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Serious Incidents

Safe

Serious Incidents Reported to StEIS



Serious Incidents Reported to StEIS

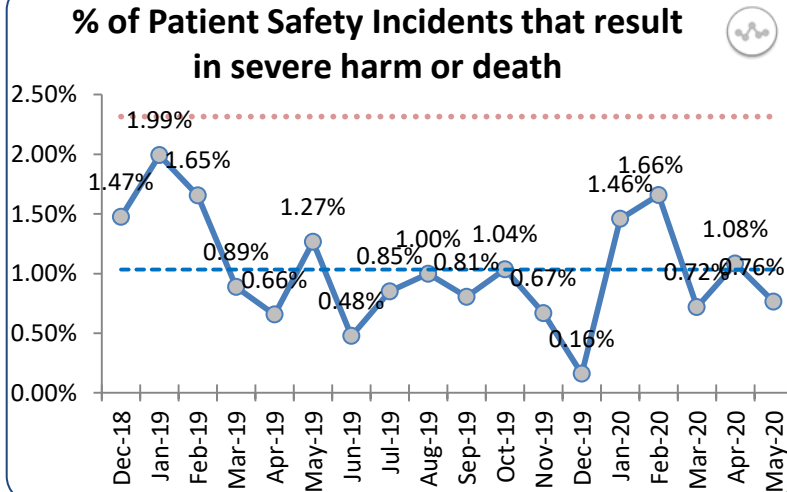
3 serious incidents were reported in May 2020

- 1 x Diagnosis - delay / failure
- 1 x Deterioration to Category 4 during trust care (Severe harm)
- 1x Sexual assault incident - patient on patient

2 serious incidents was reported in April 2020:

- 1 x category 4 pressure damage
- 1x fall from height (chair) – Severe harm

% of Patient Safety Incidents that result in severe harm or death



Learning from Serious Incidents Review

The Serious Incident Review Panel was reinstated in June; seven incidents have been presented, either for discussion around the severity of the incident or for final presentation.

An extraordinary panel was convened to receive the final reports for two maternity cases reported to and reviewed by HSIB; a third report currently in draft was discussed however a number of amendments were requested by the Maternity team before agreeing the report as complete.

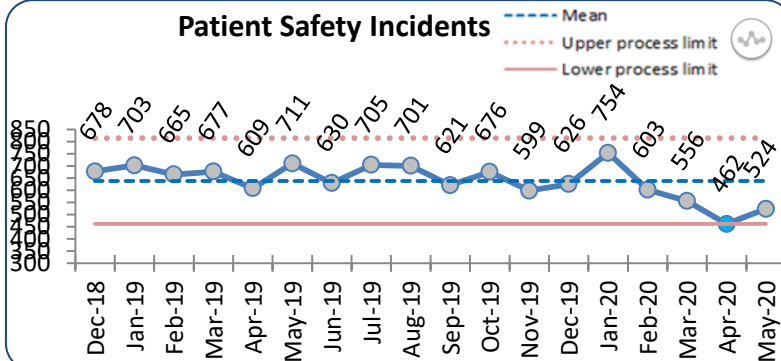
Four incidents have been reported to StEIS since the panel was reinstated: one investigation is almost completed; one is under review by HSIB; one is a historic Never Event and the remaining incident has been reviewed and investigation is underway; it has also been reported to the NHSE Screening and Immunisation Team.

Integrated Quality and Learning Report

Safe

Patient Safety Incidents

Patient Safety Incidents



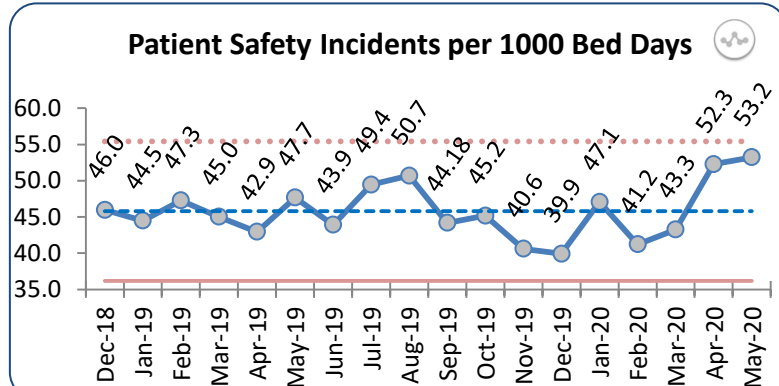
Patient Safety Culture

The NRLS (National Reporting & Learning System) incident reported rate was 37.29 incidents per 1000 bed days in May 2020.

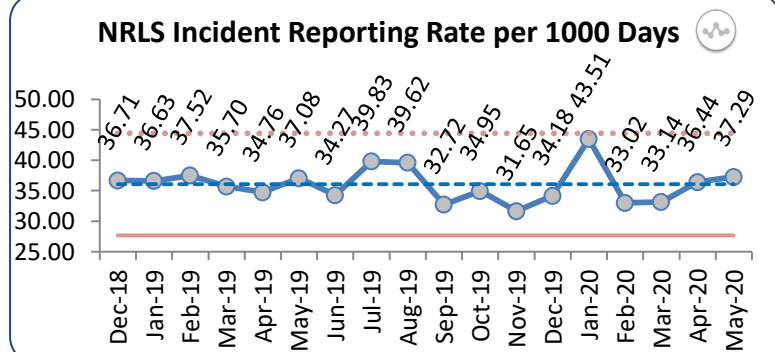
Patient Safety Incidents

- 462 patient safety incidents were reported in April 2020
- 524 patient safety incidents were reported in May 2020
- The top 5 incident types for May 2020 are listed below:
 - Pressure damage
 - Patient falls
 - Delay / failure to treat / monitor
 - Medication
 - Pathology sample issues

Patient Safety Incidents per 1000 Bed Days



NRLS Incident Reporting Rate per 1000 Days



Learning from Patient Safety Incidents

All staff should be assured that reporting incidents is a positive process. The purpose of reporting is to ensure processes and practices are being adhered to, embed a just culture and to ensure best possible outcomes for patients.

The reporting figures during April and May (2020) are significantly reduced when compared to the same period last year however a review of incident reporting for June 2020 demonstrates similar figures to last June.

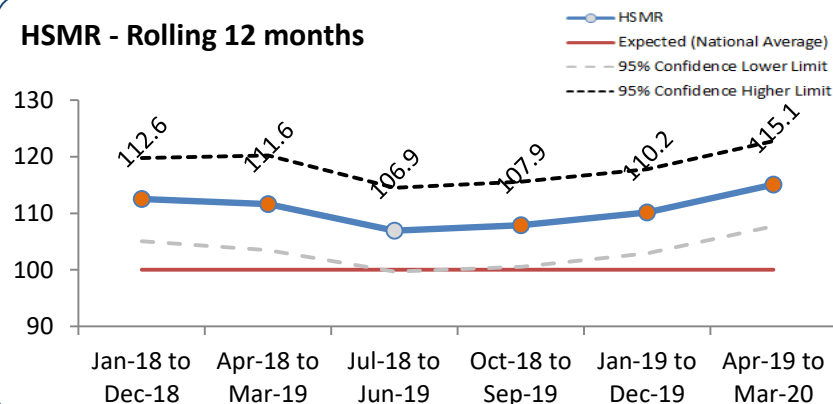
This reduction may be explained by the suspension of elective work and overall reduction in patients attending the hospital during this time period. There is minimal variation in the most commonly reported patient safety incidents i.e. patient falls; pressure damage; medication; pathology sample issues and discharge / transfer failure. The requirement for the Trust to investigate incidents generated by Primary Care has also been reduced during April and May with the majority being sent for thematic analysis and information rather than individual investigation.

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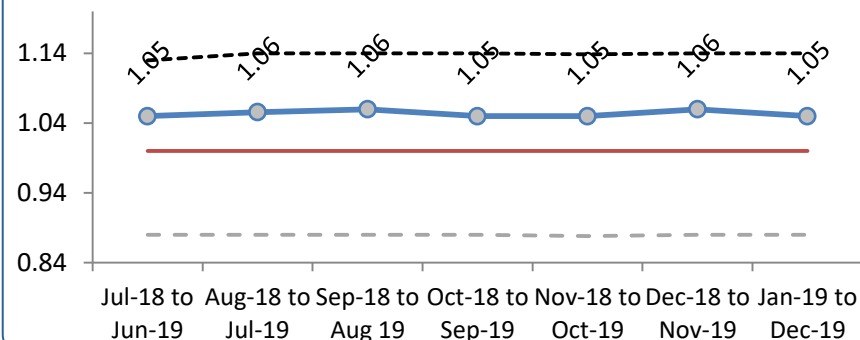
Effective

Mortality

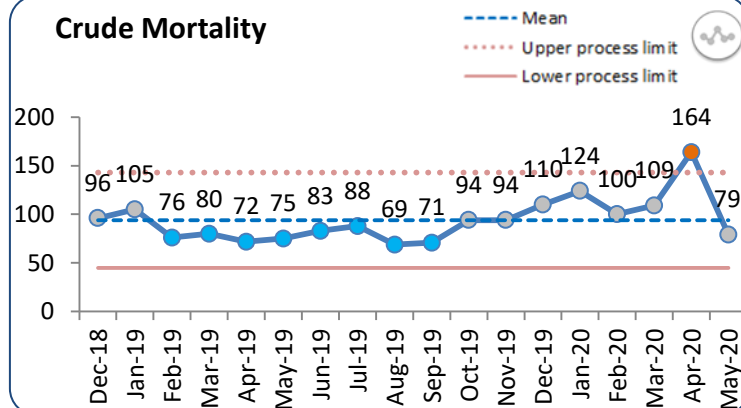
HSMR - Rolling 12 months



SHMI



Crude Mortality



Mortality Review

Period: June 2019 to May 2020

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1275	801	62.8%	97.5%	1.9%	0.5%	0.1%	0.0%	0.0%	0.1% (1)
Learning Disability Deaths	5	3	60.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

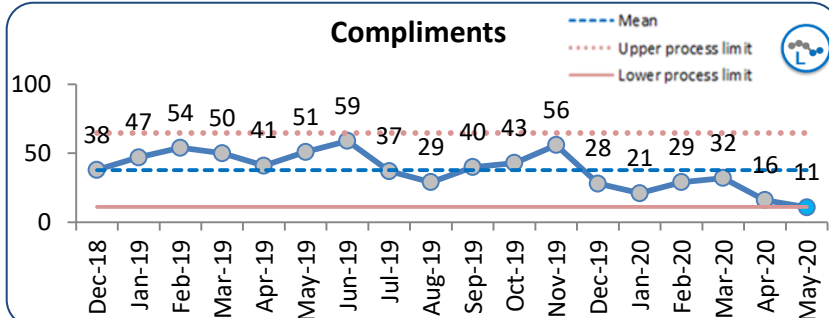
- HSMR – For the most recent 12 months the Trust is demonstrating more deaths than expected.
- SHMI – The Trust has consecutive scores of over the England Average (1) and has a banding of 'As Expected'.
- The number of inpatient deaths is showing special cause variation (high) in April. This figure includes 100 COVID-19 Deaths.
- Mortality review compliance is 62.8% of deaths reviewed; of which 97.% assessed in 'Definitely not preventable' category.
- 3 of 5 Learning Disability deaths reviewed; 60.0%. Two cases to be reviewed by mortality council.
- Learning Disability Deaths - 100% Definitely not preventable.

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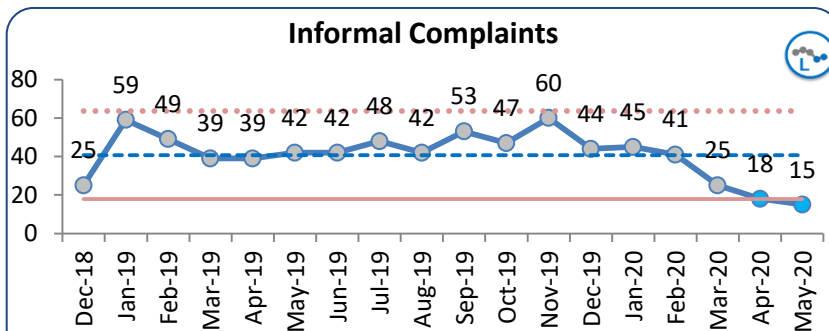
Responsive

Learning From Compliments and Complaints

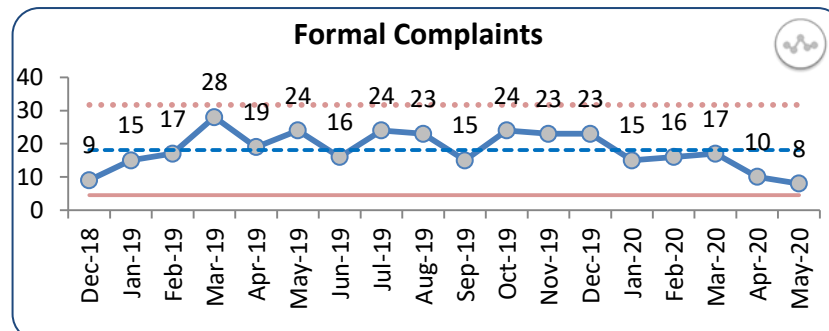
Compliments



Informal Complaints



Formal Complaints



The Top 5 themes identified in complaints were:

- Clinical Treatment - patient/family perceptions of poor medical care (6)
- Communication (1)
- Appointment including delays & cancellations (1)

Breakdown of Formal Complaints by clinical area:

- Wraparound Services (1)
- Rheumatology (1)
- Mental Health (1)
- Endocrinology & Clinical Haematology (1)
- Trauma & Orthopaedics (1)
- Gastroenterology (1)
- Acute Medicine (1)
- General Surgery (1)

Learning from Complaints

A paediatric patient did not receive abnormal test results in a timely manner.

The issue of ICE results remaining unfiled, and therefore not acted upon in a timely manner, is one which the Trust is aware of and is highlighted to medical staff across all departments and this has been discussed again within the Paediatric Department's governance meetings. It has also been reinforced to medical staff in Paediatrics that if a test result on a child is outstanding, and this is likely to make a significant difference to patient care, this should be communicated directly to the responsible Consultant. The department is further investigating the way in which genetic results are recorded on ICE to ensure that any abnormal results are shown as such.

The Trust uses risk assessments and risk registers to maintain and continuously improve patient and staff safety. This enables staff to identify, assess and record any potential risks to individuals' health, safety and experiences of care, throughout all levels of the hospital. The delay that the patient encountered with the tests results from ICE being reported is on our central Risk Register with action plans in place to ensure that instances such as this do not happen again for other families.

Integrated Quality and Learning Report

Well-led

National Acute & Community CQUIN 2020/21

Following advice from the CCG stating that a CQUIN “holiday” had been implemented for Q3,Q4 of 2019/20 and Q1 2020/2, further guidance has been published to confirm that the CQUIN scheme will remain suspended for all providers for the remainder of the year.