Whittington Health

Trust Board

3rd May 2017

Title:	**Quarterly Safety and Quality Board Report - Quarterly report April 2017**		
Agenda item:	17065	Paper	05
Action requested:	For the Board to discuss and make any additional recommendations.		
Executive Summary:	This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation. On this occasion, this report includes a review of the progress within the past financial year against all of our Sign up to Safety priorities.		
Summary of recommendations:	It is recommended that the contents are discussed		
Fit with WH strategy:	To deliver consistent high quality, safe services.		
Reference to related / other documents:	Quality Account 2015-16 Sign up to Safety Pledges Clinical Strategy 2015-20 CQC standards 7 day services clinical standards		
Date paper completed:	26th April 2017		

Author name and title:		**Richard Jennings, Executive Medical Director**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

1) Executive Summary

This is the regular paper for the Trust Board to provide an overview of safety and quality in the organisation. On this occasion, this report includes a review of the progress within the past financial year against all of our Sign up to Safety priorities.

This report provides an update on mortality, and the Trust's HSMR and SHMI figures remain assuring.

2) Contents

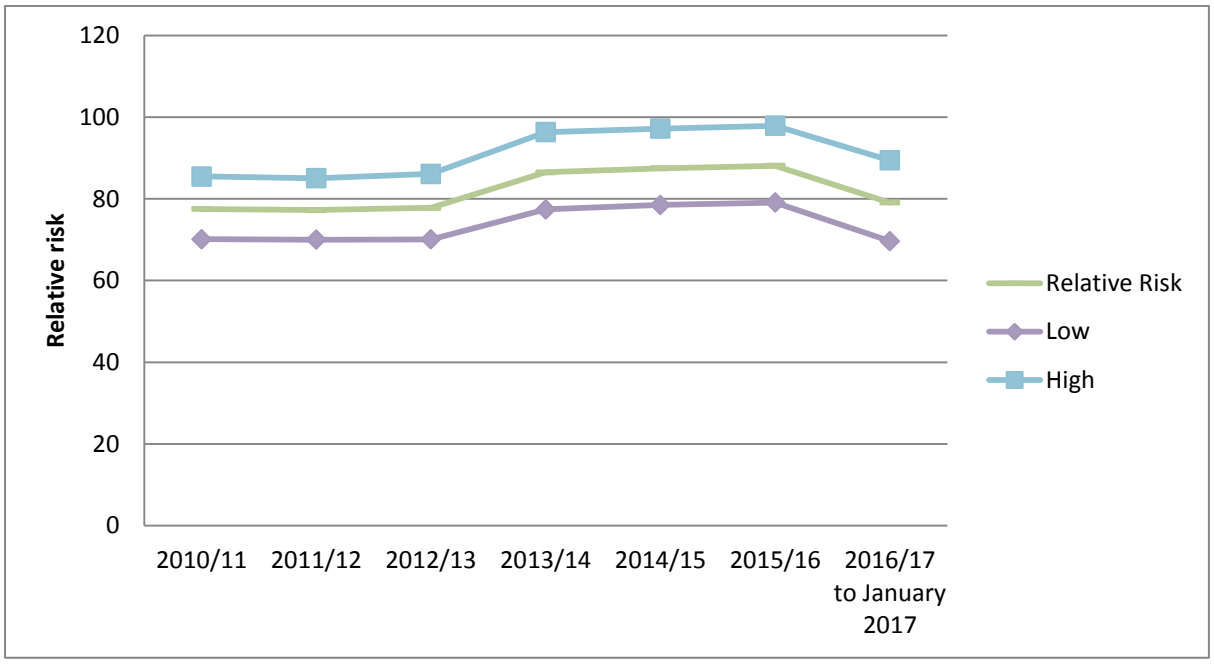
3. Mortality

This Trust's HSMR and SHMI have both been 'lower than expected' since 2005/06.

3.1 Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (HSMR) is a measure of the number of deaths in a hospital expressed as a number which is a ratio of the national average, which is set at 100. HSMR is an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for. It has been used by many hospitals worldwide to assess and analyse mortality rates and to identify areas for improvement. HSMR is calculated as the ratio of the actual number of deaths to the expected number of deaths, multiplied by 100. A ratio less than 100 indicates that a hospital's mortality rate is lower than the average national rate of the baseline year.

Chart 1: Whittington Health Hospital Standardised Mortality Ratio (HSMR) by financial year (April 2010 – January 2017)



The green line on the above Chart 1 represents this Trust's HSMR.

3.2 Summary Hospital-level Mortality Indicator (SHMI)

SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust. It is used along with other information to inform the decision making of Trusts, regulators and commissioning organisations.

National guidance emphasises that SHMI is not a measure of quality of care, but is meant as an indicator for further investigation.

SHMI is calculated in a way that is similar to the HSMR calculation, but unlike HSMR, the SHMI calculation takes into account deaths within 30 days of discharge of hospital as well as inpatient deaths.

Whittington Health continues to have the lowest SHMI score in England. We consider this data is as described because the data is obtained from Hospital Episodes Statistics data and sourced via the HSCIC Indicator portal.

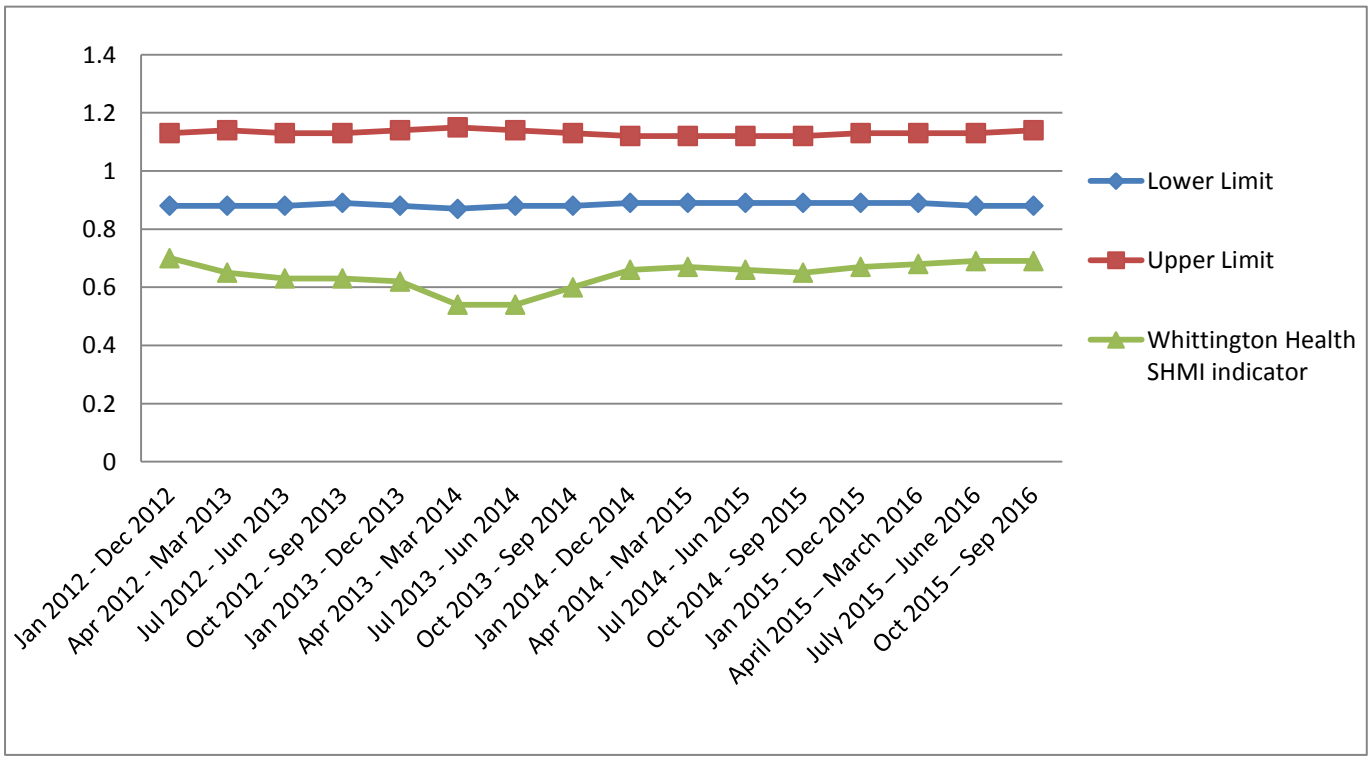
The most recent data available (released in March 2017) covers the period October 2015 – September 2016:

Whittington Health SHMI score	**0.6897**
National standard	**1.00**
Lowest national score	**0.6897 (Whittington Health)**
Highest national score	**1.1638**

Table 1: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (April 2010 – September 2016)

Data Period	Lower Limit	Upper Limit	Whittington Health SHMI indicator
Jan 2012 - Dec 2012	0.88	1.13	0.7
Apr 2012 - Mar 2013	0.88	1.14	0.65
Jul 2012 - Jun 2013	0.88	1.13	0.63
Oct 2012 - Sep 2013	0.89	1.13	0.63
Jan 2013 - Dec 2013	0.88	1.14	0.62
Apr 2013 - Mar 2014	0.87	1.15	0.54
Jul 2013 - Jun 2014	0.88	1.14	0.54
Oct 2013 - Sep 2014	0.88	1.13	0.6
Jan 2014 - Dec 2014	0.89	1.12	0.66
Apr 2014 - Mar 2015	0.89	1.12	0.67
Jul 2014 - Jun 2015	0.89	1.12	0.66
Oct 2014 - Sep 2015	0.89	1.12	0.65
Jan 2015 - Dec 2015	0.89	1.13	0.67
April 2015 – March 2016	0.89	1.13	0.68
July 2015 – June 2016	0.88	1.13	0.69
Oct 2015 – Sep 2016	0.88	1.14	0.69

Chart 2: Whittington Health Summary Hospital-level Mortality Indicator (SHMI) (January 2012 – September 2016)



In the above Chart 2 the lower limit (blue diamonds) represents the lower 95% confidence limit from the national expected value; the upper limit (red squares) represents the upper 95% confidence limit from the national expected value.

4. Infection control report

4.1 MRSA Bacteraemia

From 1st April 2016 to 31st March 2017 there were two Trust attributable MRSA bacteraemia in the same patient in October 2016 on Mary Seacole South Ward and then in March 2017 on Cloudesley Ward. There was a full post infection review and there were no identified issues with hand hygiene, peripheral line care, MRSA suppression therapy or any other recognised contributory factor. On analysis the investigating team felt that the patient may have been slightly undertreated with antimicrobials for the first episode (19 days of treatment compared to recommended duration of 28 days) and that has been fed back to the Microbiology team involved.

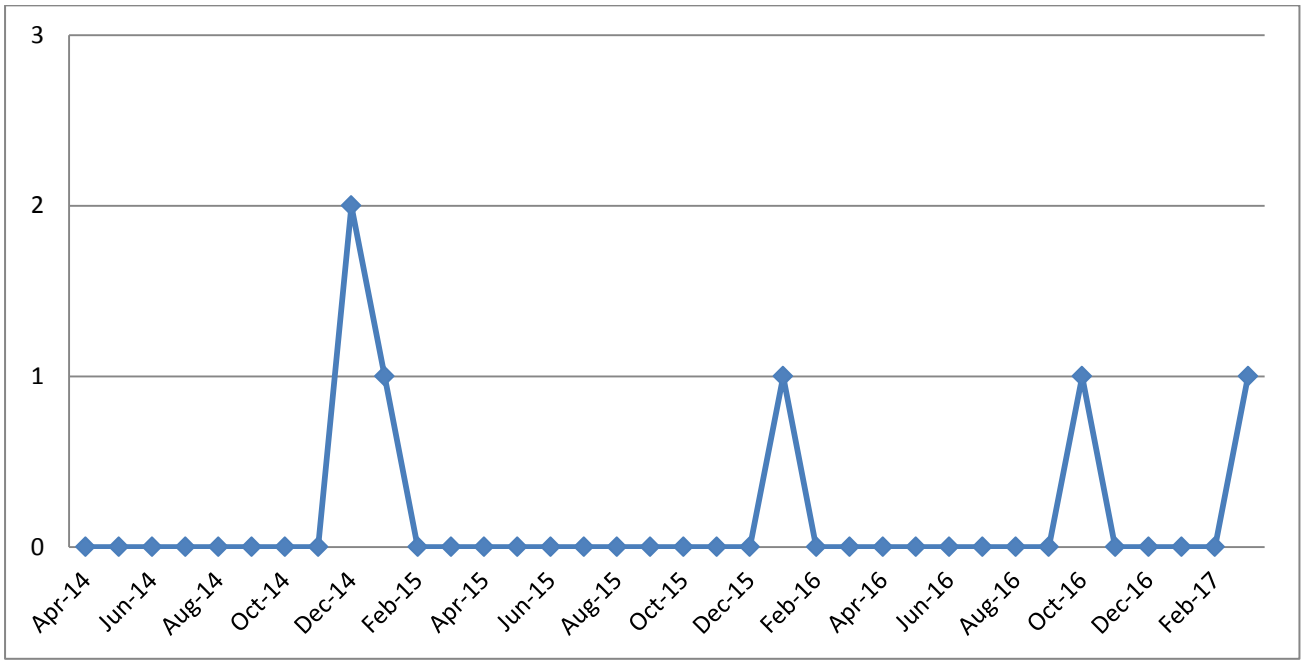
From 1st April 2017 to 26th April 2017 there have been no MRSA bacteraemia identified in the Trust.

The IPCT continue to monitor, investigate and feedback on MRSA colonisation transmission events on our care of older people (COOP) wards, Orthopaedic ward and Augmented Care Areas (Critical Care and Neonatal Unit). Table 2 below documents MRSA colonisation acquisition events:

Table 2: Whittington Health MRSA colonisation acquisition events April 2016-March 2017 (two Trust-attributable cases)

MRSA colonisation acquisition events April 2016 - March 2017													
	Apr	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Running total**
ITU	0	1	0	0	0	0	0	0	0	0	0	0	1
NICU	0	0	0	1	0	0	0	0	2	0	0	0	3
SCBU	0	0	0	0	0	0	0	0	0	0	0	0	0
Meyrick	0	0	1	0	0	1	0	0	0	0	0	1	3
Cloudesley	1	2	0	0	1	0	0	0	0	2	1	0	7
Bridges - Cavell rehab	0	0	0	0	0	0	1	0	0	0	1	0	2
Coyle #NOF	0	0	0	0	0	0	0	0	0	0	2	0	2

Chart 3: Whittington Health attributable cases of MRSA bacteraemia by month (April 2014 – March 2017)



In February/March 2017 we identified 5 cases of MRSA acquisition in orthopaedic patients, which testing revealed to be identical MRSA strains, and this was therefore reported to Public Health England as an outbreak. Four patients acquired MRSA colonisation only, but one patient had a significant surgical site infection. It is likely that this outbreak arose through some failure to comply with infection control standards, but it has not been possible to identify the cause with certainty. The post infection actions and learning arising out of this incident were further MRSA screening of all patients within the orthopaedic wards for two weeks where no new cases were identified. As there were possible failures in compliance with protocols, there has been ongoing training performed of staff in infection prevention & control within orthopaedics to reduce the risk of further cross infection. Any further acquired MRSA specimens within the hospital have also been sent for typing and there have been no more connected cases.

4.2 *Clostridium difficile*–associated diarrhoea

From 1st April 2016 to the 31st March 2017 there were seven Trust-attributable *Clostridium difficile*-associated diarrhoea cases. Consultant-led post infection reviews were held for all of these cases and the reports disseminated to relevant parties, both internally and externally. No lapses in care were identified, but these have identified delays in isolating patients to individual rooms; where individual rooms have not been available immediately staff have been encouraged to use an isolation trollies. Our agreed objective for 2016/2017 was not to exceed a threshold of 17 cases of *Clostridium difficile*-associated diarrhoea and we finished the year well under trajectory.

Table 3: Whittington Health *Clostridium difficile*–associated diarrhoea cases by ward

Date	No. of Cases	Ward
April 2016	2	Montoushi & Victoria
May 2016	1	Coyle
June 2016	1	Cloudesley
July 2016	1	Victoria
March 2017	1	Montuschi
March 2017	1	Coyle

From 1st April 2017 to 26th April 2017 we have identified two Trust-attributable *Clostridium difficile*-associated diarrhoea cases on Coyle and Cloudesley wards. A Consultant-led post infection review has been held on the first case and the other is scheduled for 4th May 2017. Our agreed objective for 2017/2018 is again not to exceed a threshold of 17 cases of *Clostridium difficile*-associated diarrhoea.

4.3 Improvement work in Infection Prevention and Control

Infection Prevention and Control (IPC) mandatory clinical and non-clinical training is now provided predominately via e-learning. As at 30th March 2017, 84% of Whittington Health staff has received recent (within the last 2 years) IPC training. E-learning modules have been revised to ensure they are shorter and divisional leads have been contacted to promote the e-learning packages. Face to face IPC training has now been reintroduced to the Trust induction training schedule.

Bespoke clinical and non-clinical face to face IPC training is delivered at least weekly at various sites throughout the ICO by our IPC nursing staff. We have 20 trained link staff in IPC who attend IPC Link Practitioner study days twice a year and get updated information on practical IPC topics, and also they carry out IPC audits and quality improvement projects. These practitioners then take this learning back to their clinical area. In between study days the link staff are responsible for auditing IPC practice on their wards.

4.4 Meticillin Sensitive Staphylococcus Aureus (MSSA)/ *E.coli* Bacteraemia Episodes

From 1st April 2016 to 31 March 2017 there were 6 Trust attributable MSSA bacteraemia episodes and 14 Trust attributable *E.coli* bacteraemia episodes. Each episode has had an initial investigation to see if any interventions that might pre-dispose the patient to these bacteraemia (such as urinary catheterisation or peripheral line cannulation) and whether all correct procedures were followed.

There are no set objectives for MSSA bacteraemia; however The Secretary of State for Health has instructed that from 1st April 2017, all Trusts must aim to reduce their E.*coli* bacteraemia infections by 50% over a three year period.

From 1st April 2017 there have been no Trust attributable MSSA bacteraemia episodes and zero Trust attributable *E.coli* bacteraemia episodes reported.

The post infection actions arising out of this incident were further MRSA screening of all patients within the orthopaedic wards for two weeks where no new cases were identified. As there were possible failures in compliance with protocols, there has been ongoing training performed of staff in infection prevention & control within orthopaedics to reduce the risk of further cross infection. Any further acquired MRSA specimens within the hospital have also been sent for typing and there have been no more connected cases.

4.5 Other Relevant Healthcare Associated Infection (HCAI) Issues - Carbapenamase producing Enterobacteriaceae (CPE)

Public Health England (PHE) issued guidance on the identification and control of CPE (highly resistant Gram negative bacteria). As a result of this the Trust devised an action plan, which is monitored by the Infection Prevention &Control Committee. All actions have been completed.

The Trust has processes in place to deal with a single case of CPE and a completed policy, which is available on the Trust's intranet.

IPC training talks have been updated to include information on CPE.

From 1st April 2016 to 31st March 2017 there were nine cases of CPE identified but there is no indication of cross infection within Whittington Health and none have had an infection with CPE. None of the cases identified are attributable to Whittington Health.

The on-going review of the CPE screening status of patients for fractured neck of femur repair or hip or knee replacement continues.

5 Sign up to Safety

'Sign up to Safety' is a national patient safety initiative, partly in response to the Francis and Berwick Reports. Its aim is to reduce avoidable harm across the country by half in three years**.** In March 2015 the Trust devised our own local Sign Up to Safety priorities have been chosen to provide a strong foundation for the Trust to continually promote quality across the organisation.

The measurable improvement targets that we have set ourselves in our Sign up to Safety priorities are as follows;

Table 4: Whittington Health 'Sign up to safety' priorities and quality improvement priorities

Sign up to safety priority	Quality improvement priorities (as agreed in the Trust's Quality Account for 2015/16)
Priority one: Learning Disabilities (LD) • Target one: In Q4, 90 percent of inpatients with learning disabilities will be clearly identified on the electronic patient record, meet the Learning Disabilities Specialist Nurse during their admission and have a personalised care plan ('my purple folder') • Target two: In the Emergency Department (ED) 75% of all staff will have had specific training in the care of people with learning disabilities	**Learning disabilities: Quality Improvement priorities for 2016/17** • We will develop and implement 'Always Events' for patients with Learning Disabilities in a relevant clinical setting. We will aim for 75 percent of inpatients with learning disabilities to meet the Learning Disability specialist nurse during their admission. • We will aim for 75 percent of relevant staff who work in our Emergency Department to have specific training in the care of patients with Learning Disabilities.
Priority two: Falls • Target: We will reduce the number of inpatient falls that result in moderate or severe harm by 50 percent	**Falls: Quality Improvement priorities for 2016/17** • We will reduce the number of inpatient falls that result in severe/moderate harm by 25 percent.
Priority three: Sepsis and Acute Kidney Injury (AKI) • Target one: We will achieve the national CQUIN around giving antibiotics within the first hour to patients with severe sepsis (90 percent). • Target two: We will effectively record our performance in delivering the sepsis six care bundles for all patients with sepsis. We will improve our performance by 50 percent in the course of the year. • Target three: In more than 90% of patients with Acute kidney injury (stage 3) we will ensure correct documentation and assessment has occurred in line with the national AKI CQUIN.	**Sepsis and Acute Kidney Injury (AKI): Quality Improvement priorities for 2016/17** • We will achieve the targets of the new and expanded national sepsis CQUIN in 2016/17
Priority four: Pressure ulcers • Target one: We will have no avoidable grade four pressure ulcers • Target two: We will reduce the number of	**Pressure ulcers: Quality Improvement priorities for 2016/17** • We will implement our 'React to Red' pressure ulcer prevention campaign

avoidable grade three pressure ulcers in the acute setting by 50 percent and we will reduce the number of avoidable grade three pressure ulcers in the community by 30 percent	• We will have no avoidable grade four pressure ulcers. • We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 25 percent. • We will reduce the number of avoidable grade three pressure ulcers in the community by 25 percent.

5.4 Progress against Sign up to Safety priorities – End of year two

The following table (table 6) shows the Trust's progress against the three year priorities at the end of year two.

Table 5: Whittington Health 'Sign up to safety' priorities and progress against these priorities at the end of year two of the three year programme

Sign up to safety priority	Progress against priority at the end of year two
Priority one: Learning Disabilities (LD) • Target one: In Q4, 90 percent of inpatients with learning disabilities will be clearly identified on the electronic patient record, meet the Learning Disabilities Specialist Nurse during their admission and have a personalised care plan ('my purple folder') • Target two: In the Emergency Department (ED) 75% of all staff will have had specific training in the care of people with learning disabilities	• **Target one:** This has been partially achieved. In Quarter 3 2016/17 100% of patients who were known to have a learning disability (either because they had a flag to indicate this on their electronic patient record, or because they were referred to the Learning Disability Nurse by the inpatient clinical team) were seen during their admission by the Learning Disability Nurse. An electronic referral system (using Anglia ICE) has been created and is now being used to make all referrals to the learning disability specialist nurse, which enables activity to now be tracked and audited. • **Target two:** The specific training in the care of people with learning disabilities has been added to the Trust's electronic education portal Moodle. This has enabled us to collect data on the staff completing this training. The Emergency Department has 20 substantive doctors and 83 substantive nurses, and 132 staff have completed this training. Moodle is being updated to allow data to be collected about which department or ward the staff work in. When these improvements are completed we will be able to effectively track our performance against this target.
Priority two: Falls • Target: We will reduce the number of inpatient falls that result in moderate or severe harm by 50 percent	• We are currently achieving this target. Falls resulting in moderate or severe harm: 2014/15 = 11 2015/16 = 6 2016/17 = 5
Priority three: Sepsis and Acute Kidney Injury (AKI) • Target one: We will achieve the national CQUIN around giving antibiotics within the first hour to patients with severe sepsis (90 percent). • Target two: We will effectively record our performance in delivering the sepsis six care bundles for all patients with sepsis. We will	• Target one: Achieved. In March 2016 78% of inpatients diagnosed with severe sepsis received antibiotics within the first hour. In Quarter 2 and Quarter 3 2016/17 93% of inpatients diagnosed with severe sepsis received antibiotics within 60 minutes. • Target two: Achieved. In 2014 42% of inpatients with sepsis were recorded as having received the sepsis six care bundle. In Quarter 4 2016/17 this was 80% of

improve our performance by 50 percent in the course of the year. • Target three: In more than 90% of patients with Acute kidney injury (stage 3) we will ensure correct documentation and assessment has occurred in line with the national AKI CQUIN.	patients. The national sepsis CQUIN data for Quarter 2 of 2016/17 showed this Trust as being one of the top 5 performing Trusts in England for meeting the sepsis CQUIN quality standards for both emergency admissions and inpatients. • Target three: The performance against this target is on trajectory, with continuing improvement through 2016/17. The percentage of patients with AKI who had correct documentation and assessment in line with the national CQUIN were: Quarter 1 2016/17 = 48% Quarter 2 2016/17 = 56% Quarter 3 2016/17 = 56% January 2017 = 67%
Priority four: Pressure ulcers • Target one: We will have no avoidable grade four pressure ulcers • Target two: We will reduce the number of avoidable grade three pressure ulcers in the acute setting by 50 percent and we will reduce the number of avoidable grade three pressure ulcers in the community by 30 percent	• Target one: Not achieved. Grade four pressure ulcers reported: 2015/16 = 3 2016/17 = 3 • Target two: Partially achieved. Grade three pressure ulcers reported in the acute setting: 2014/15 = 4 2015/16 = 13 April – December 2016 = 6 Grade three pressure ulcers reported in the community setting: 2014/15 = 62 2015/16 = 38 April – December 2016 = 13

6 National guidance on learning from deaths

A paper came to the Trust Board on 5th April 2017 (agenda item 5) that set out national expectation for acute provide Trusts from the National Quality Board. This section of the report, which will appear quarterly from now on, provides an update on our progress against the National Quality Board expectations.

Since 1st April 2017 there have been 30 inpatient deaths at Whittington Health. All have been briefly reviewed by Dr Julie Andrews, Associate Medical Director for Patient Safety and Trust Mortality Lead, and added to the Trust mortality database.

Under the provisions of the National Quality Board guidance, 21 of the 30 inpatient deaths in April 2017 require a formal structured case review (because they meet the specified criteria of concerns having been expressed by the family, death having occurred in the context of surgery, the case having been referred to the coroner, or death with pulmonary embolism).

Staff members to lead on each of these structure case reviews have been identified (these are always staff who are not involved in the patients care). 25% of the remaining deaths will be formally investigated too and leads have been found for these. The initial reviews are mainly being carried out by junior doctors/nursing staff with Trust consultants acting in the role of second reviewer.

All the structured case reviews will be reviewed and retrievably electronically stored and each month a learning report will be compiled. The learning from these mortality reviews will be shared through the patient safety newsletter, reports to ICSU boards and to clinical leads. Any structured case review that identifies any possible or probable failings in care will be forwarded to the Serious Incident Executive Advisory Group (SIEAG) so that the SIEAG panel can decide whether or not the case should be declared as a Serious Incident (SI). A full board paper outlining progress will be available for Q3 in line with national mortality reporting timeline.

While it is not mandated in the national guidance that this process should be in place for the investigation of deaths in patients that have been discharged in the last 30 days, it is desirable that these deaths should also be included in due course. Again, while it is not mandated that the process should involve deaths of patients receiving care from this Trust in the community, it is again desirable that these deaths are included in due course, and possible approaches to this are currently under consideration.

7 Getting It Right First Time – National Surgical Site Infection Audit

The Getting It Right First Time (GIRFT) Programme is a national programme sponsored by NHS Improvement which engages frontline clinicians working in acute care with their own data to accelerate the adoption of evidence-based practice through peer to peer discussion and review.

The GIRFT programme is currently in place for 13 surgical specialties and will roll-out to an additional 19 medical/surgical specialties.

On 19th April 2017 senior medical and nursing staff from across NHS Improvement, Public Health England and the Department of Health wrote to Medical Directors of acute trusts in England to inform them of the new audit, from 8 May 2017, of patients with surgical site infections (SSIs), particularly examining their care peri- and post-operatively.

The audit has thus been established to:

1. Identify the surgical site infection rates of specific procedures within key surgical specialties
2. Assess local practice in the prevention of surgical site infection for the specified procedures

The audit is designed to be run by junior doctors working within the surgical specialties in individual trusts and serves as a unique opportunity for them to be involved in a national audit. The proposed timeline for the audit is as follows:

Table 6: Timeline for National Surgical Site Infection Audit

Target period	Task
Apr – May 2017	• Medical directors of each trust, in conjunction with the clinical leads for each specialty to identify lead junior doctors to be in charge of the audit locally and to submit their names and contact details to the GIRFT team.
8 May 2017	Audit Start Date
May – Aug 2017	• Lead junior doctor to undertake a retrospective data collection and analysis for the 6-month period from 1 Nov 2016 to 7 May 2017 • Lead junior doctor undertake prospective data collection and analysis for the period 8 May 2017 – 1 Aug 2017
8 Aug 2017	• Submit data returns to GIRFT programme
Aug – Oct 2017	• (Doctor changeover) • Lead junior doctor undertake prospective data collection and analysis for the period 2 Aug 2017 – 31 Oct 2017
3 Nov 2017	• Submit data returns to GIRFT programme
Nov – Jan 2017	• Preparation and publication of national report • Certificate of participation sent out to junior doctors involved

Arrangements to carry out this audit are currently being made.

8 Dissemination of learning from Serious Incidents, near misses, inquests, complaints and claims

8.1 Learning together sessions

The Trust continues to provide "Learning together" educational events monthly that cover in depth the learning made from one patient story in detail and determine ways all staff (including staff that are not employed by WH such as council staff) can work and learn together to reduce patient safety incidents in the future.

Attendance and engagement with these events is steadily growing, and becoming increasingly multidisciplinary. As an example, a major learning event on sepsis that took place as part of the Trust's refreshed Grand Round programme on 26th April 2017 attracted an attendance of 263 people, who included hospital and community Trust staff from multiple disciplines, local general practitioners and the husband and friends of a patient who died from sepsis, whose story her husband generously gave us permission to use for learning. The scale of this event was unprecedented.

Afternoons are planned for the forthcoming months covering complex discharge planning, adult and child safeguarding and challenging issues in patients with mental health conditions.

8.2 Spotlight on safety newsletter

Volume 4 patient safety newsletter "Spotlight on safety" has been distributed to all staff and there are specific newsletters covering other relevant areas such as maternity and medicines safety. The content of the newsletter is reviewed and agreed by the Trust's Patient Safety Committee.

8.3 Schwartz Round

A Schwartz Round is a structured forum that provides an opportunity for staff from all disciplines, both clinical and non-clinical, to reflect on the emotional aspects of their work.

The Trust has launched its own Schwartz Rounds programme.

The first three Rounds will be held on:

- Thursday 4th May
- Tuesday 20th June
- Monday 3rd July

9 References

1. NHS Digital Indicator Portal, NHS Digital, available from https://indicators.hscic.gov.uk/webview/
2. Schwartz Rounds, Point of Care Foundation, available from https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/
3. '*National Guidance on Learning from Deaths*', National Quality Board (March 2017), available from https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
4. '*Learning, candour and accountability'*, Care Quality Commission (December 2016), available from https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
5. Letter sent from across NHS Improvement, Public Health England and the Department of Health to all Medical Directors of Acute Trusts dated 19th April 2017 to launch Getting It Right First Time (GIRFT) national surgical site infection audit.