Agenda Item No.1

NHS
The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Emma Hardwick Chief Nurse	Decision		High	Med	Low
	Discussion	√	√		
	Information				
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Valerie Newton Deputy Chief Nurse	Strategic				
	Operational	√			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				
Debbie Frost Recruitment & Retention Sister					
CQC Domain: (safe, caring, effective, responsive, well-led)					

Meeting Date: 30 January 2018

Report Title: Quality Exceptions for Trust Board

PURPOSE:

To update the Trust Board on exceptions for quality metrics presented in the Integrated Performance report for January 2018 in which data for December 2017 is presented.

SUMMARY:

- The Trust has had 36 cases of C. difficile to date (23/1/18) against a trajectory of 53 for the year ending March 2018.
- The Trust reports falls at 5.5 /1000 bed days this month this was a total of 73 falls, 1 which the harm was major, 23 with minor harm and 49 with negligible harm.
- The Trust has had 3 pressure ulcers, 1 was avoidable and 2 were unavoidable.
- The Trust has had no EMSA breaches in December.
- The continued use of Leverington as an escalation area has increased the challenges with regards to maintaining nurse staffing levels and quality metrics Trust wide
- The nursing indicators demonstrate a deterioration in a number of nursing quality metrics in month particularly regarding completion of body maps, moving and handling assessments and assessment for bed rails for those at risk.

RISK ASSESSMENT (CROSS-REFERENCE WITH RISK REGISTER WHERE APPROPRIATE):

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
√	√	√	√	√	√

RECOMMENDATION/S:

The Trust Board is requested to note this report.

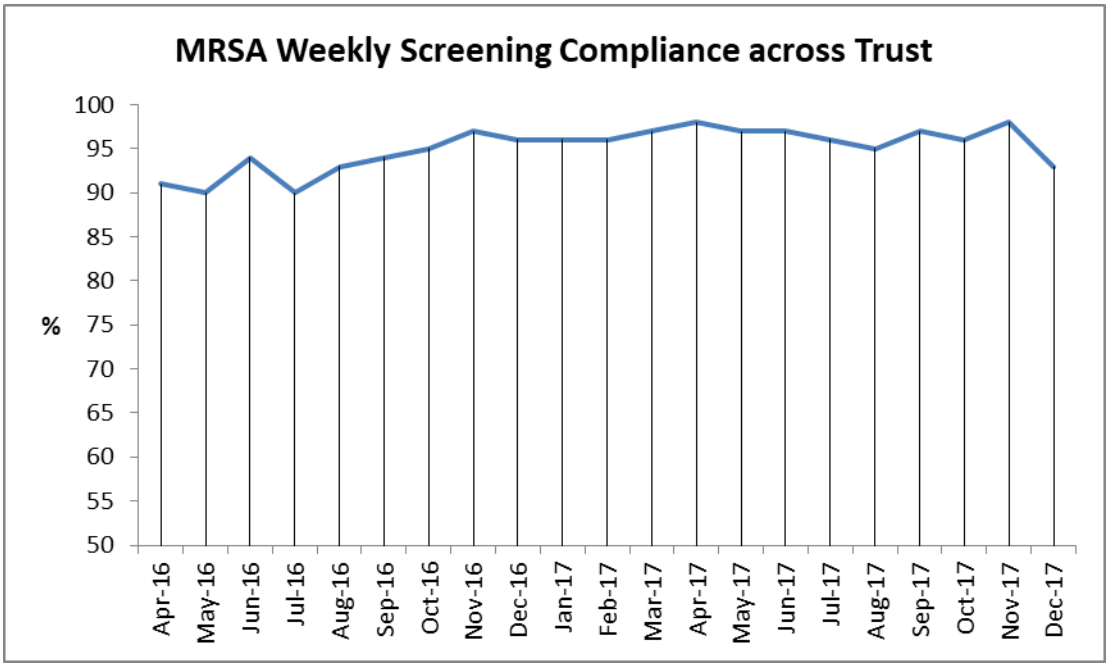
1. INFECTION CONROL

1.1. Influenza

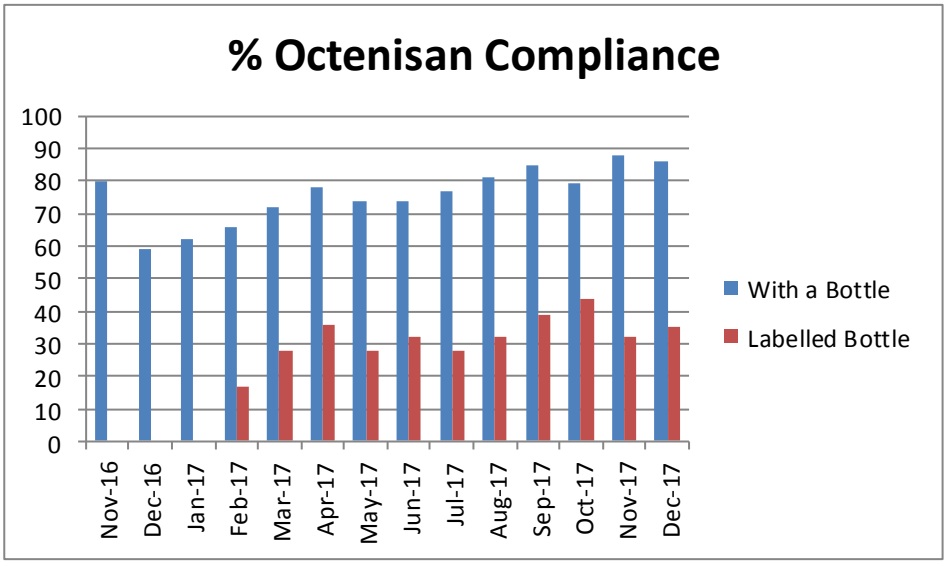
At the latter end of December 2017 influenza cases rose both nationally and locally. Awareness of this was raised within the Trust and advice given regarding criteria for testing for influenza. In December there were no confirmed cases of 'flu reported in the Trust.

1.2. MRSA

MRSA bacteraemia ceiling for 2017/18 is zero avoidable Trust acquired cases. There are no cases of MRSA blood stream infection (BSI) apportioned to the Trust this year. MRSA screening across the Trust (both weekly and admission) continues to remain high.

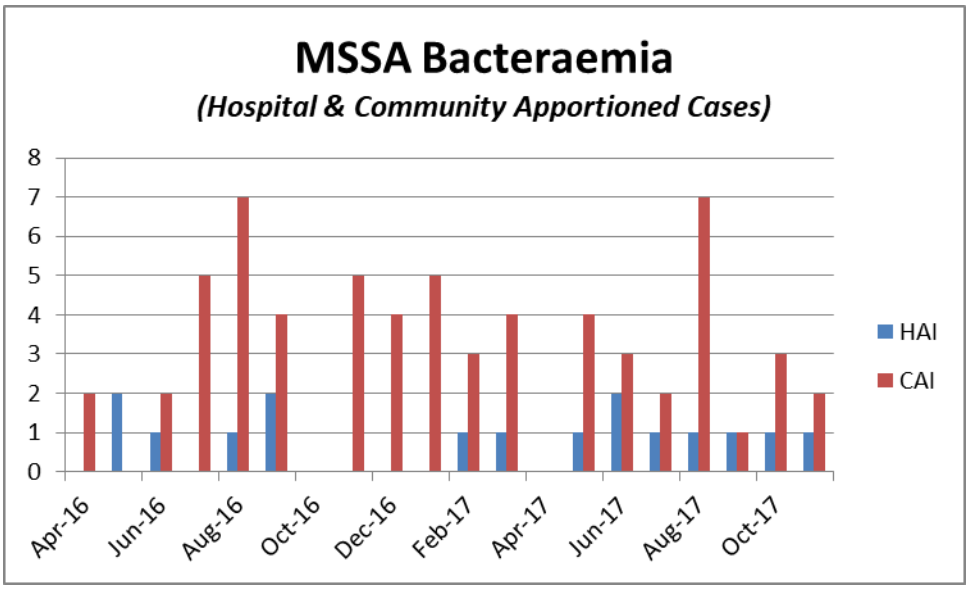


In addition to weekly screening all inpatients (with exception of admission areas) are offered Octenisan body wash for the duration of their stay. Compliance with this is audited across the Trust. For rates of compliance please see below. Each ward manager is sent their individual data to discuss where compliance requires improvement.



1.3. **MSSA BSI**

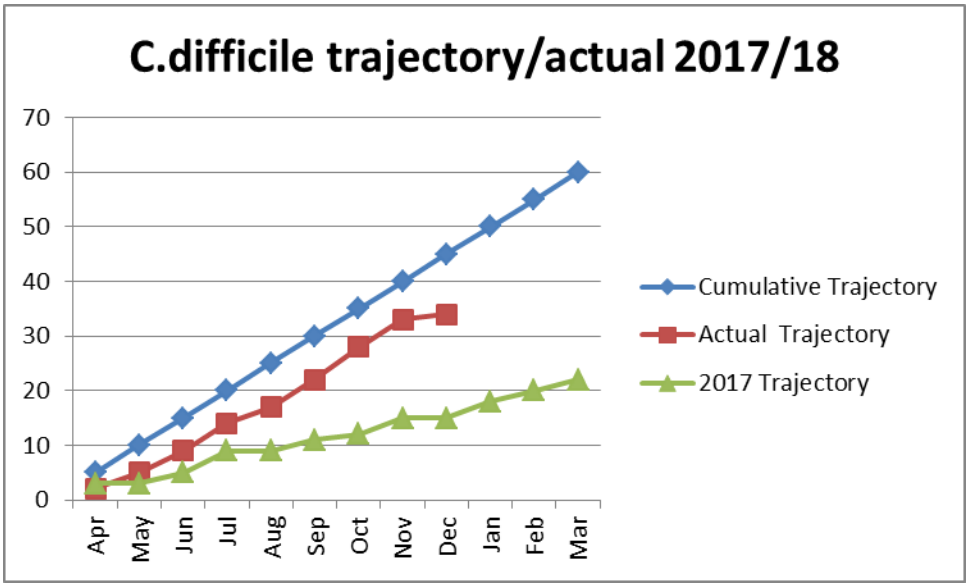
No formal target has been set for MSSA BSI but mandatory reporting is required for all cases. Any HAI cases are analysed for lapses in care.



1.4. **C difficile**

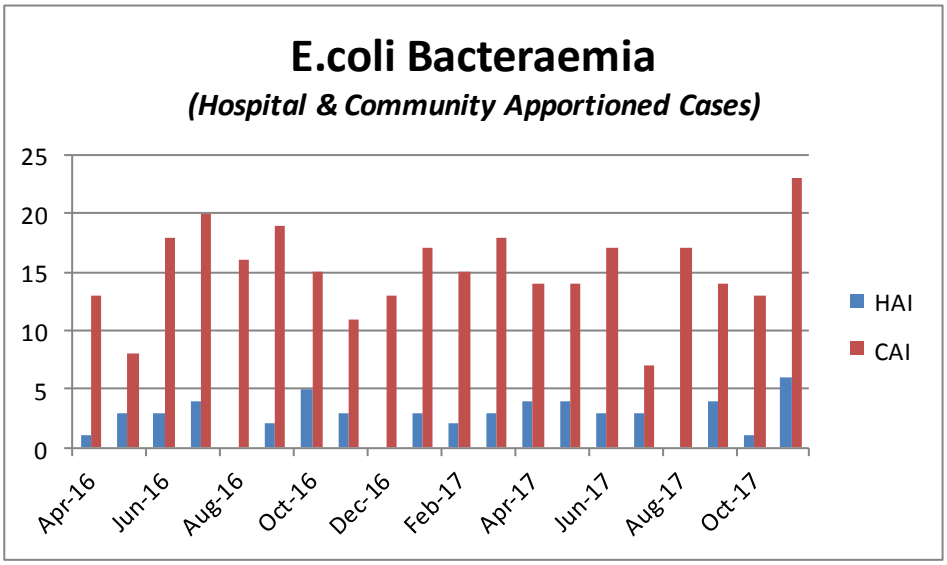
To date (18th Jan 2018) 36 cases of Hospital acquired infection, the trajectory for this year is 53 cases. Following a CCG review 6 cases have been deemed non trajectory, all measures were taken in line with national and local policies. Cases of C. diff from between August and December 2017 are pending review by the CCG but the Trust has completed all RCAs and any actions required have been undertaken.

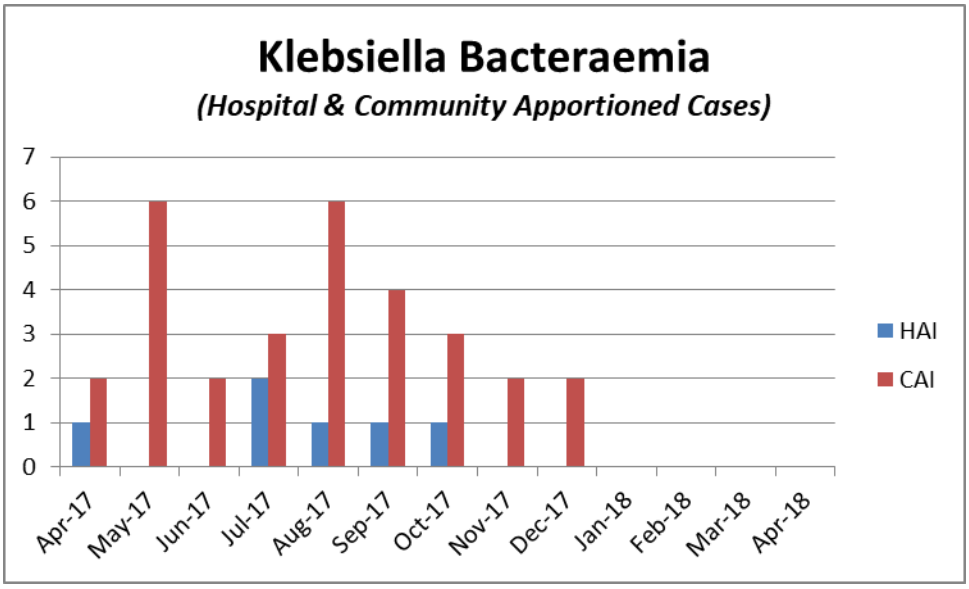
The IP&C lead from NHSI will be undertaking a return visit to the Trust on 13th February 2018 following on from her visit in October 2017. The purpose of the visit is to monitor the progress of actions from the recommendations made from the October 2017 visit.

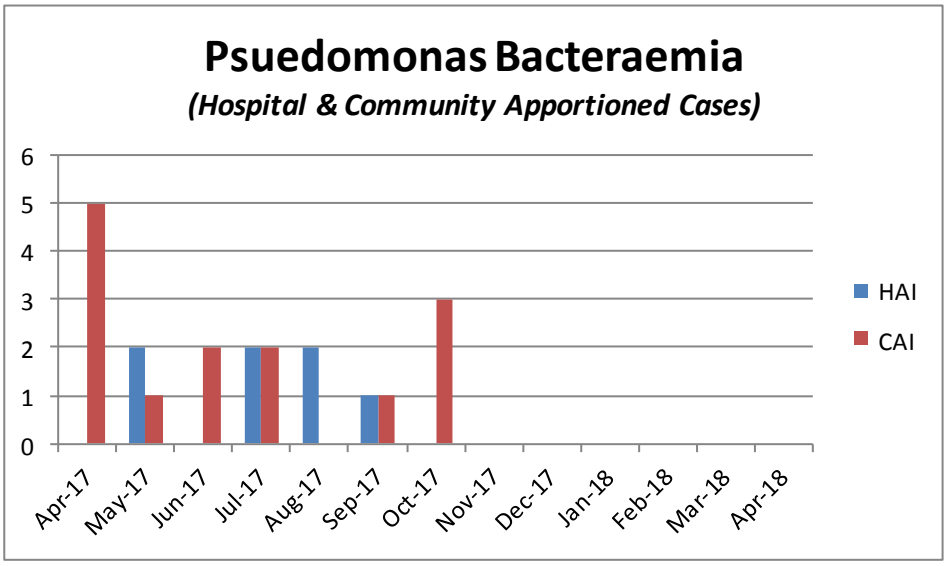


1.5 **Gram Negative BSI**

The IP&C Team are working with CCG and other Acute Trusts across Norfolk at reducing numbers of BSI, a quality premium of a 10% reduction has been set for the CCG for this year. Data collection of themes and numbers are reported via the PHE Data Capture System.







2. PRESSURE ULCERS

We are pleased to report there has again been a reduction on the previous month's figures, 3 in total for December. Only 1 was avoidable, the remaining 2 were unavoidable meaning the ASKINS bundle was implemented appropriately and in a timely manner. This is particularly significant considering the challenges the trust continues to experience.

Avoidable:

Oxborough – 1 x grade 2
Due to failure to risk assess accurately and subsequently failure to provide appropriate equipment.

Unavoidable:

Necton– 1 x grade 2, ASKINS bundle was implemented appropriately and in a timely manner.

Terrington – 1 x grade 3, ASKINS bundle was implemented appropriately and in a timely manner.

There has been a 42% reduction on Hospital acquired pressure ulcers (HAPU's) during January -December 2017 compared to January-December 2016. Pressure ulcer prevention training continues on induction, NA training, mandatory training and adhoc where possible.

3. LEVERINGTON

The continued use of Leverington as an escalation area has increased the challenges with regards to maintaining nurse staffing levels.

As Leverington ward is an escalation area, it has no substantive staff – nursing, medical, AHPs, neither clerical nor domestic and is staffed by moving personnel from other areas or the use of temporary staff from the Bank or Agency. This impacts on the staffing levels for all areas where staff are moved from to ensure a balance of Trust substantive and temporary workforce are maintained. It is recognised that since early December 2017 this has placed additional demands on the overall nurse staffing levels across the organisation.

Due to the increased capacity demands on the Trust the numbers of patients in this area have at times stretched to 32. Staffing plans are made on a daily basis and all efforts are made to ensure the placement of an experienced substantive nurse on Leverington at all times. However, due to sickness levels over the past month it has not always been possible to have a senior substantive member of staff on every shift.

There have been logistical challenges with operating at this level of bed capacity such as the need for additional equipment, supplies and ensure that the area is recognised as a 'reporting area' for Nursing Quality Metrics and other reportable functions. Work is ongoing to address these issues which include furnishings, ward equipment and the ability to secure the area and equipment when area not in use.

A full risk assessment of the area was conducted by the ACN for CQC implementation and actions in place to address the risks raised.

An experienced Band 7 Ward Manager is being seconded to lead the escalation area from 29th January for a period of 4 months and a plan is in place to develop a team of substantive staff to provide stability and continuity in this area.

This plan had previously been implemented but was disbanded when the ward was closed. It should be noted that this team will comprise of staff moved from other wards within the Trust many of which have existing vacancies. It is intended that staff form Tilney, Stanhoe, Windsor and west Raynham will be moved to support staffing in this area going forward.

4. NURSING INDICATORS

The nursing indictors for December 2017 indicate deterioration in performance in relation to completion of body map, moving and handling assessments and bed rails assessments. This comes during a very challenging month with increased acuity and extra capacity in place.

Where there are white gaps on the indicators, clinical audit have indicated that this is due to non-receipt of data in relation to fluid charts and care rounds. It should be noted that the MUST assessment is only undertaken initially in Mau and SAU, which is why these two areas are the only places where this has been assessed.

A revised process will be put into place to ensure that data is received by the audit department in a timely manner.

The Trust is currently scoping the use of an alternative ward quality metric tool called 'Perfect Ward'. This is an electronic reporting tool which provides capability for enhanced reporting and real time feedback both at ward and corporate levels.

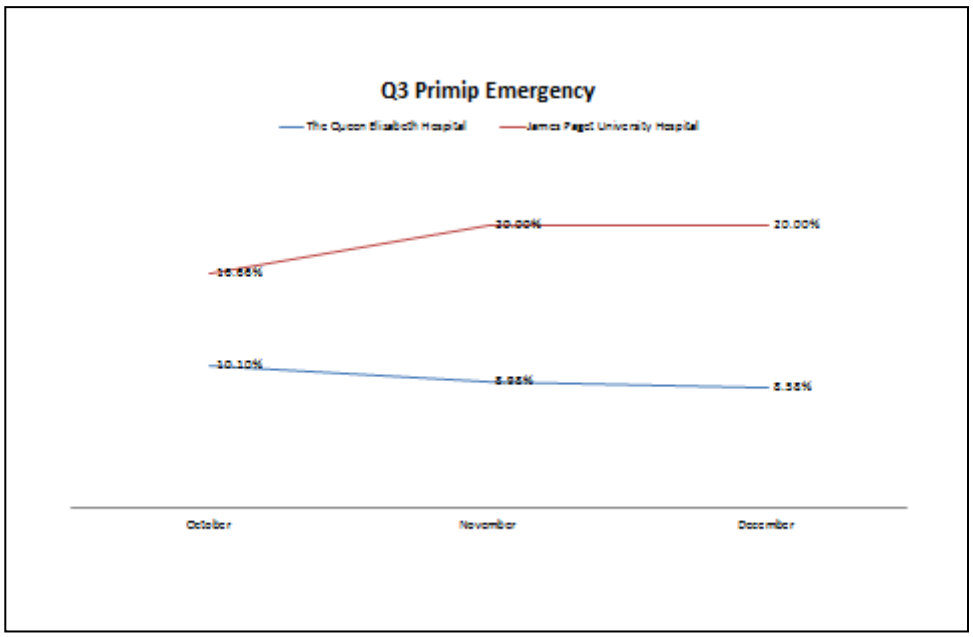
The Chief Nurse will be meeting with all ward managers to revise individual plans to improve the current results.

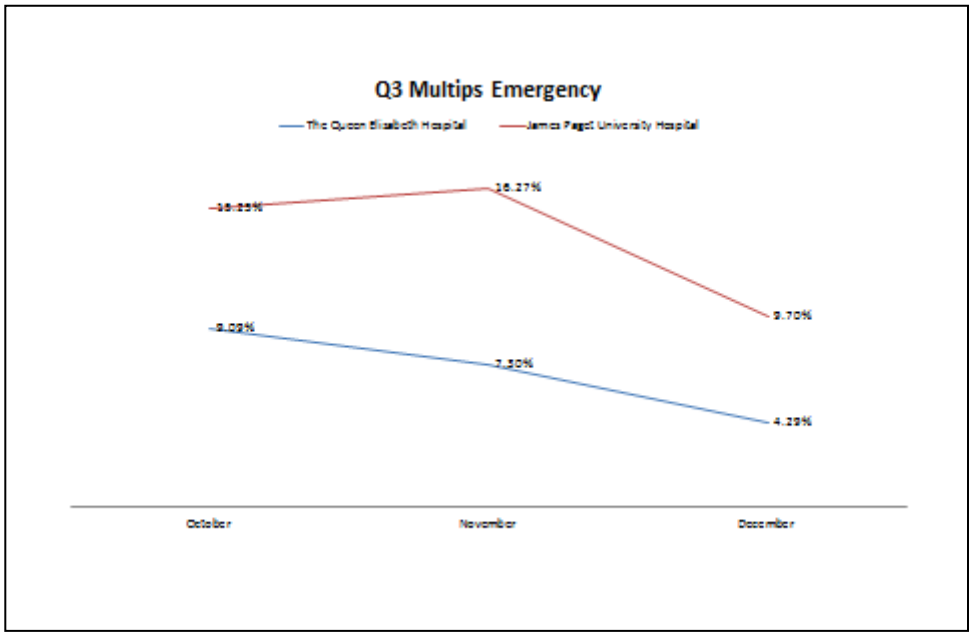
5. CAESAREAN RATE ACTION PLAN

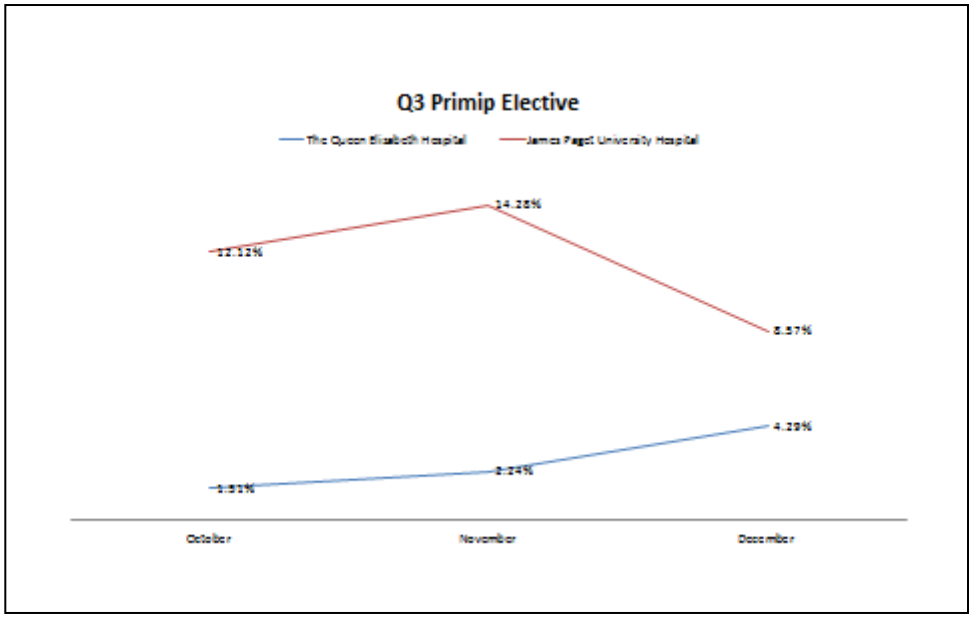
An action plan is in place to reduce any unnecessary intervention. A team of staff; a Consultant Obstetrician/CDS Manager and CDS Co-ordinators will be attending Birmingham Leaders project in February 2018. There is also a plan for a named team of obstetricians and CDS senior midwifery staff to review all proposed elective work prior to booking.

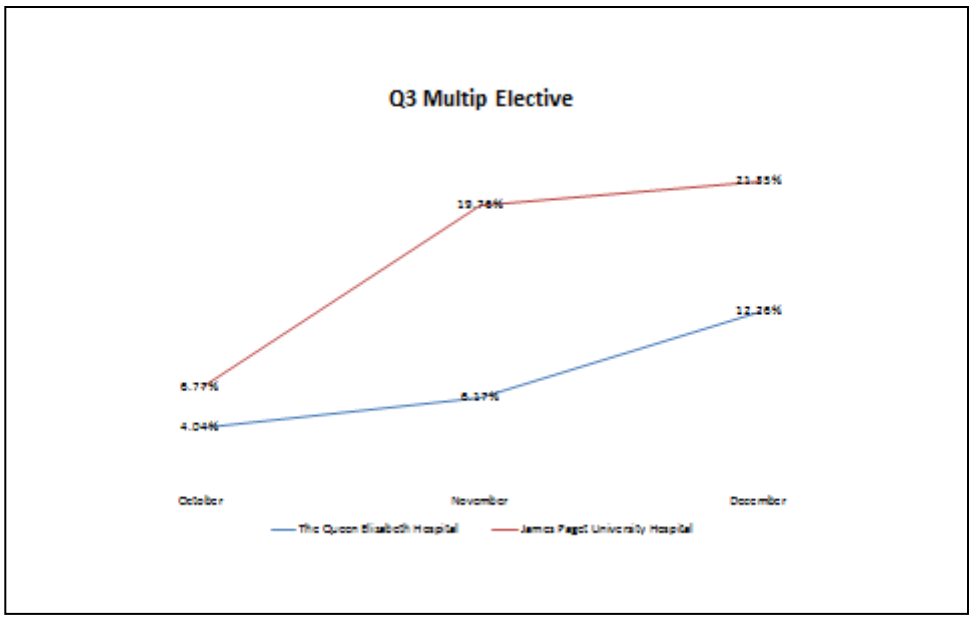
Snapshot Comparison

(April 2017– Dec 2018)	The Queen Elizabeth Hospital	James Paget University Hospital
Women Delivered	1714	1614
Babies Born	1739	1635
Homebirths	52	15
MLBU Deliveries	335	156
BBA	15	5


Q3 Primip Emergency
The Queen Elizabeth Hospital
James Paget University Hospital
16.66%
20.00%
20.00%
10.10%
8.95%
8.55%
October
November
December


Q3 Multips Emergency
The Queen Elizabeth Hospital
James Paget University Hospital
16.25%
16.27%
9.70%
9.09%
7.50%
4.29%
October
November
December





Emma Hardwick
Chief Nurse

24 January 2018