| Report to: | Trust Board (Public) | Agenda item: | SFT4121 |
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| Date of Meeting: | 04 October 2018 | | |

| Report Title: | Annual quality governance report 2017 - 2018 | | | |
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| Status: | Information | Discussion | Assurance | Approval |
| | | | ✓ | |
| Prepared by: | Claire Gorzanski, Head of Clinical Effectiveness | | | |
| Executive Sponsor (presenting): | Dr Christine Blanshard, Medical Director<br>Lorna Wilkinson, Director of Nursing | | | |
| Appendices (list if applicable): | Annual quality governance report 2017 - 2018 | | | |

| Recommendation: |
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| The report is presented for assurance that the quality governance arrangements have identified risks to the quality of care and escalated them appropriately along with mitigation and areas for improvements in 18/19. |

| Executive Summary: |
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| Overall, the new Integrated Governance Framework and Accountability Framework has strengthened the quality governance function by ensuring the Board is routinely sighted on and involved in the mitigation of key risks to the strategic objectives of the organisation.<br><br>Achievements, items escalated and areas for improvement in 18/19 are highlighted in the report. |

| Board Assurance Framework – Strategic Priorities | |
|---|---|
| **Local Services -** We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do | ☐ |
| **Specialist Services -** We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population | ☐ |
| **Innovation** - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered | ☐ |
| **Care** - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm | ☒ |
| **People** - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams | ☐ |
| **Resources -** We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources | ☐ |

**SALISBURY NHS FOUNDATION TRUST**

**ANNUAL QUALITY GOVERNANCE REPORT 2017 – 2018**

## 1.0 Purpose

This report sets out the progress made to improve the quality of patient care and provides assurance about the quality and safety of care within the organisation. This is to assure the Board that appropriate governance processes are in place in respect of quality.

## 2.0 Quality governance arrangements

Quality governance provides a framework for organisations and individuals to ensure the delivery of safe, effective and high quality care. Four key elements are essential – strategy, capabilities and culture, processes and structures and measurement. Its purpose is to allow care to flourish, help Trusts and their staff, monitor and improve standards of care and identify areas of weaknesses and risk that might jeopardise quality and thus drive improvement.

A new Integrated Governance Framework and Accountability Framework was introduced in April 17 and describes the quality governance arrangements. These frameworks are a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives. The Accountability Framework specifies how the performance management system is structured and tracked to ensure delivery of the corporate objectives at every level of the organisation focusing on quality, performance, finance and workforce.

The Accountability Framework sets out metrics that each directorate is held accountable for. These are based on the NHS Improvement Single Oversight Framework of quality of care, finance, use of resources, operational performance, strategic change, leadership and improvement capability. For the purposes of oversight, each Directorate is assigned a rating of red, amber or green at the monthly Executive Performance Review meeting. The overall rating for each Directorate acts as a trigger for escalation to ensure the Board is routinely sighted on and involved in the mitigation of key risks.

The Chief Executive is the accountable officer for quality governance. The responsible officers for quality are the Medical Director who leads on clinical effectiveness and the Director of Nursing who leads on patient safety and patient experience.

The Integrated Governance Framework makes it clear that quality governance is the responsibility of the Board supported by the Clinical Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Items for escalation that pose a risk to the quality of care reported to the Board after each Clinical Governance Committee meeting along with mitigation. Quality is also enhanced by Board Safety Walks where staff are able to raise safety concerns with an Executive and Non-Executive Director.

The Clinical Governance Committee's function is to provide assurance to the Board on the quality and safety of care by ensuring the supporting processes are embedded in Directorates and Trust wide groups promote learning, best practice and compliance with all relevant statutory duties. A review of the effectiveness of the Clinical Governance Committee was reported to the Board in December 17.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality report which sets out the progress made in our five quality priorities in 17/18 and the quality priorities selected for 18/19 monitored via the Clinical Governance Committee.

## 3.0 Clinical strategy

In June 2017, in recognition of the changing demographics of the local population, workforce challenges, the need to integrate care and make efficiency gains, as well as reduce the financial deficit, the quality team held engagement events with clinicians and key stakeholders. The aim was to assist each service to develop a clinical strategy for the next five years to enable them to deliver the best outcomes for patients. GP engagement events were also held in March and June 17 along with discussions with local

commissioners. Links with the Sustainability and Transformation Partnership (STP), Dorset clinical service review, University Hospital Southampton strategy and Wiltshire care model review were also established in developing the clinical strategy.

A number of clinical strategy themes emerged with a focus on:

- Easy access for patients and GPs
- Face to face only when necessary
- A hospital without walls
- Short length of stay  where enhanced recovery is the norm
- Consistency of delivery

And a number of key enabling strategies are needed to underpin the clinical strategy:

- Workforce
- Digital
- Estates
- Quality

The outcome of these engagement events will culminate in a Clinical Strategy 2018 – 2023.

## 4.0 Quality strategy

The Quality strategy will focus on the clinical strategy themes and emphasise that:

- Quality is our number one priority where we will continually strive to deliver safe, effective and compassionate care to ensure that every patient has an outstanding experience of care every time.
- We continuously measure quality and patient outcomes to analyse trends and compare ourselves with the best to drive improvement.
- Our patients will benefit from advances in treatment and new models of care.
- We will maintain our regulatory and registration requirements as defined by NHS Improvement and the Care Quality Commission.

The Quality Strategy will need to be written in the light of the new Clinical Strategy 2018 – 2023.

## 5.0 Quality account

The quality account provides information on the quality of services the Trust provides for patients and the public.

The key message in the quality account is that quality is our number one priority. It shows a positive picture of improvements in quality and safety in 17/18, particularly in the care of frail, older people and early supported discharge.

Areas for improvement in 18/19 are set out in section 7 of this report. Progress of the priorities will be monitored via a mid-year report and an annual report to the Clinical Governance Committee.

## 6.0 Achievements in 17/18

- An Older Person's Assessment and Liaison team (OPAL) was introduced in January 17 and assessed 1098 patients, of which 49% went home on the same day with community support.
- A 12% reduction in the number of patients who had a fall in hospital which resulted in a fracture.
- A 40% reduction of patients with a catheter with a new urinary tract infection.
- A reduction in HSMR to within the expected range along with a declining trend in the relative risk of deaths in high risk groups as an outcome of learning from deaths.
- Improvements in end of life care and support for bereaved families and carers.
- Improvements in sepsis screening, antibiotic administration and review of patients admitted as an emergency.
- 95% of all patients admitted as an emergency were assessed by a consultant within 14 hours of admission and 92% were reviewed at the weekend.
- Patient stories told directly at the Board.

## 7.0 Items escalated from the Clinical Governance Committee to the Board in 17/18

The aim is to ensure the Board are routinely sighted on and involved in the mitigation of key risks are escalated to the Board after each meeting. Items escalated:

- Awareness of GDPR training to meet the new regulations from May 18 onwards.
- Significant improvement in the Child and Adolescent Mental Health Service (CAMHS) provision since the introduction of a clinical nurse specialist. Developmental improvement journey continued within the core service.
- Electronic Prescribing and Administration of Medicines. Acknowledging that it was part of the Lorenzo business case it is apparent that there is a significant delay in this module being available nationally. The CGC were concerned that the delay had implications for the Trust and its patient safety aspirations. A business case is written and is awaiting alignment with the Digital Strategy.
- Entonox levels in the Maternity Unit had been identified and had been reported to the Board previously. Despite historical work, there was an ongoing concern and high levels recorded in some rooms on labour ward. A capital bid had been submitted for a phased approach to building work to ensure appropriate scavenging systems are in place. The work commences week beginning 18 June 18.
- Inability to staff and open the new ward following the site reconfiguration and the financial consequences associated with loss of income. Mitigated by delayed opening to Q3 18/19 and ongoing recruitment campaign.
- ED navigator pilot has come to an end and new systems are being tested whilst recruitment is underway.
- A cluster of incidents related to the cancer pathway. A task and finish group set up to review pathways and processes. Aggregated themes will be reviewed by the Clinical Risk Group and Cancer Board.

## 8.0 Areas for improvement 18/19

These are described in the quality account priority work streams for 18/19 and our CQC Trust wide improvement plan. The headlines are:

- Further reduce falls resulting in harm
- Improve the management of deterioration and sepsis in inpatients.
- Sustain the improvements in the management of sepsis in the Emergency Department.
- Improve the identification and management of delirium.
- Increase rapid discharge of patients at the end of life who wish to return to their own home to die.
- Increase the rate of patient safety incidents reported.
- Continue to improve surgical safety.

- Engage with the other acute Trusts in the STP and stroke network to improve stroke performance sustainably.
- Finalise the clinical and quality strategies in 18/19.

## 9.0 Care Quality Commission

Good progress has been sustained in the areas of 'must do' and 'should do' since the December 15 inspection. The Trust was rated as requires improvement. Achievements are:

- Continuation of six monthly skill mix reviews to ensure safe staffing on all the wards. The analysis shows our establishments are set to achieve appropriate staffing levels on our wards. We continue to have vacancies, particularly amongst registered nurses and are working hard to recruit permanent staff and reduce reliance on temporary staff.
- Improved uptake of mandatory training to 85.4% against the Trust target of 85%.
- Improved from 59% of staff receiving an annual appraisal to 84.7% in 17/18.
- Governance arrangements strengthened in the Emergency Department and Critical Care.
- Improved the triage process in the Emergency Department with a pilot of a navigator role which came to an end in March 2018. New systems are being tested whilst recruitment is underway.
- Extended hours of the 7 day service adult mental health team.
- Improved access to the Child and Adolescent Mental Health Service.
- Sustained improvement in the processing and availability of surgical instruments for operations.
- Improved compliance with the World Health Organisation surgical safety checklist following intensive support and human factors training.
- No patients discharged directly from main theatre recovery since the end of September 2017.

The delivery of the CQC action plan continues to be monitored and managed via the following routes:

- At the monthly Executive Performance Review Meetings and delivery of the Trust wide actions at the CQC Steering Group, chaired by the Director of Nursing.
- Board oversight of progress is through the Trust Management Committee.
- The Action Learning Group continues to assess levels of compliance to assure improvements are embedded in practice.
- Preparation of the organisation for an unannounced inspection in 2018/19.

## 10.0 Leadership and well-led framework

Deloitte's completed a well-led review in line with the NHSI well-led framework and reported their findings in May 18. They found that the Board of Directors had a good blend of experience, skills and length of service. Development activity was already taking place and the review suggested further work to change the focus to corporate oversight and build greater cohesion.

It commented on a clear and concise strategic framework, but with more to do on internal engagement on the objectives to support delivery. It recognised that quality and safety issues are a top priority for the Trust. The report recognised the challenges faced by the Trust in relation to its data quality and the quality of the information available to support decision-making.

The Trust had made good progress with its risk management arrangements and the Trust needed to continue with embedding risk management at all levels. There is a proactive approach to patient engagement.

An action plan is subsequently being developed and will be progressed by the Board and Directorate Management Team development programme.

## 11.0 Culture

The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse incidents and near misses to ensure learning and improvement actions are taken. Our national staff survey 2017 showed that the hospital is better than average of Trusts for staff feeling that procedures for reporting errors, near misses or incidents are fair and effective and staff feel confident and secure in reporting errors, near misses and incidents. However, the national staff survey 2017 also showed that we are in the lowest 20% of acute Trusts for the percentage of staff reporting errors, near misses or incidents in the last month. We will do more to encourage staff to report adverse incidents and near misses in 18/19 using education sessions and social media.

We will also do more to engage and involve our staff in improvements through our new 'Let's Get Engaged' programme and continue to focus on equipping staff with quality improvement skills.

## 12.0 Data quality

Good quality data underpins the effective delivery of patient care and is essential if improvements in the quality of care are to be made. The Trust went live with a new Electronic Patient Record (EPR) and data warehouse at the end of October 2016. The Trust moved from Referral to Treatment (RTT) being managed by the data warehouse to an EPR that was specifically designed and configured to manage RTT within the system itself, removing the need for the warehouse to maintain the RTT dataset and the Patient Tracking List (PTL).This enforced a significant change in practice across all staff to ensure accurate RTT information was recorded within the patient record and training staff to better understand the patient pathway.

The months following go live saw a significant rise in our PTL of patients who were on an active RTT pathway which took nearly 7 months to validate the PTL, correct data quality issues, undertake further training and put in place a robust reporting function to allow the PTL to be monitored in detail. New reporting functions have been put in place, including a daily PTL snapshot, an action list for monitoring the current RTT incomplete position, a booking list and regular reports to allow operational monitoring of RTT progress. BDO, external auditors, undertook an audit of the RTT incomplete pathway in March 18 and were able to issue a limited assurance opinion.

To ensure our data quality is able to support the assurance of overall quality of care the Trust manages a Data Quality Service which aims to ensure staff record clinical information accurately on every occasion. The Data Quality Service, in partnership with the IT training team, spend time working with staff to demonstrate best practice, as well as investigating and correcting errors and providing refresher training. The use of these techniques gives the Trust assurance that the information regarding the quality of care given is an accurate representation of performance.

## 13.0 Sharing the learning

### 13.1 Clinical Governance half days

There are 6 clinical governance half days a year. They are protected time to allow teams to meet together to discuss, review and improve safety and quality as well as attending the 4 core sessions which cover patient safety, effectiveness and patient experience. Core sessions are well evaluated by attendees; on average 95% of participants rate them as good or excellent.

| Date | Topic |
|---|---|
| June 2017 | GP engagement event |
| July 2017 | Patient Safety |
| November 2017 | Healthcare Improvement Programme – junior doctor presentations |
| January 2018 | Armed Forces Covenant |

### 13.2 Quality bulletins

- All available on the intranet and link sent to staff:
- Quality governance newsletter – publicises good practice and areas for improvement
- Mortality matters quarterly bulletin – learning from deaths.
- Patient safety bulletin – learning from safety initiatives.

### 13.3 Striving for excellence awards

The Trust held its 11th annual awards day in December 2017 to recognise the achievements of staff and the way they have improved services for patients across the hospital. There were 9 categories which included service improvement projects, equality and diversity, customer care, as well as the Chairman's outstanding contribution award, the Chief Executive's leadership award, a Governor's volunteer of the year award, and an unsung hero award.

The professionalism and dedication of our staff was recognised by politicians, national leaders and the media in our response to the major incident in March 18.

## 14. Summary

Overall, the new Integrated Governance Framework and Accountability Framework has strengthened the quality governance function by ensuring the Board is routinely sighted on and involved in the mitigation of key risks to the strategic objectives of the organisation.

## 15. Recommendation

The report is presented for assurance that the quality governance arrangements have identified risks to the quality of care and escalated them appropriately along with mitigation and areas for improvements in 18/19.

**Claire Gorzanski**
**Head of Clinical Effectiveness**
**15 June 2018**