James Paget University Hospitals NHS Foundation Trust

Report to the Board of Directors 2021/22

Date of meeting	August 2021				
Subject	Quality and Safety Report				
Report of	Director of Nursing and Patient Safety Director of Strategic Projects (Health and Safety Element)				
Prepared by	Sharon Boothby, Head of Risk and Safety				
Purpose of report	This Quality and Safety Report provides the Board with an overview of the Trust's Quality and Safety metrics and a summary of performance against the following sections; Patient Safety, Health & Safety, Clinical Audit & Effectiveness and Patient Experience and Engagement.				
Previously considered (Committee/Date)	Patient Quality and Safety Committee – 17/08/21, Patient Safety and Experience Committee, Carer and Patient Experience Committee				
Board Action Required	**Approval**	**X**		**Discussion**	
	Decision			**Information**	
	Assurance	**X**			

Executive Summary

A summary of the exceptions (red rated) contained within the dashboards are as follows:

NHS System Oversight Framework

- Complaints – Performance is 90% for overall complaints responded to within 60 days;
- Emergency Caesarean Section (CS) rates – The combined emergency caesarean section rate was over the Trust expected rate of 20% at a rate of 24.16%.
  Following the publishing of Recommendation 31 from the Health Select Committee report and feedback from regional colleagues, the Maternity clinical Network for the East of England have removed both elective and caesarean section from their report and would like to consider use of the Robson groups for reporting purposes ongoing. The trust E3 system records Robson Group data.

Patient Safety Dashboard

- There have been a total of two externally reportable Serious Incidents (SIs) for July 2021, following five reported in June 2021
- Improvements have been seen in the number of letters being sent within timescale, 71% (five out of seven letters) in July 2021.
- The number of Hospital Acquired Category 2 pressure ulcers has increased to seven in July
- Inpatient falls per 1000 bed days were 4.84 within the locally further reduced target of 5.

Health and Safety (H&S) dashboard

- The number of abuse related incidents has remained higher than target reporting 38 in July 2021
- There has been a continued improvement in compliance with H&S Managers Training for July 2021 to 90%.

Patient Experience and Engagement dashboard

- The Trust received 78 compliments and 14 formal complaints in July 2021.

Dashboards Exception Reports based on performance flagging in June 2021 Data sets out a summary of:

- Emergency Caesarean – Combined and Primips Section Rates
- Complaints Turnaround Times

The Board is asked to **approve** the report as providing sufficient assurance on the actions being taken in relation to patient safety and quality.

Strategic Ambition and Board Assurance Framework (BAF) links		
Strategic Ambitions	1. Deliver the best possible level of safe and effective care	**X**
	2. Provide education, support and development for our staff to deliver excellence in practice and be the employer of choice	
	3. Effectively manage our financial resources, our estate and our infrastructure to ensure we are sustainable	
	4. Actively participate in innovation, research and partnerships to transform our services	**X**
BAF reference(s)	1 and 2	

This paper provides assurance against the Trust ambition(s) identified	**X**
This paper is to close a gap in control/assurance in relation to the ambition(s)	**X**

Legal/regulatory (regulatory/legislation requirement with specific reference where appropriate)	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Health and Safety at Work Act Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)			
Equality Impact/risks (Equality Delivery System 2 – EDS2 Nov 2013)		**Impact**		
		Positive	**Negative**	**Neutral**
		X		
Assurance process and frequency of monitoring	Patient Safety and Quality Committee, with exception reporting to the Board of Directors for any areas requiring additional actions to be taken.			

CONTENTS

SECTION 1 : INTRODUCTION AND CONTEXTUAL INFORMATION

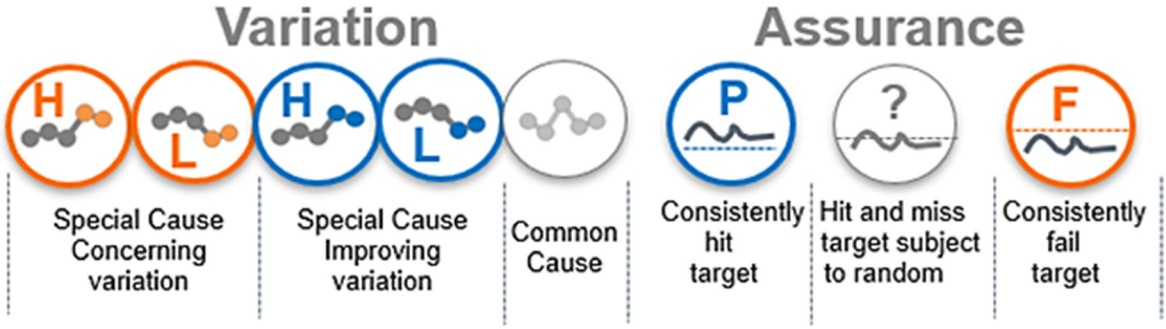
NHS England and NHS Improvement (NHSE/I) are responsible for overseeing NHS Foundation Trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. The System Oversight Framework (OF) developed by NHSI was updated in June 2021 and is mandated.

The OF is designed to help trusts attain, and maintain Care Quality Commission (CQC) ratings of 'good' or 'outstanding'. This Quality and Safety report provides information for the Board of Directors for two of the SOF areas as follows:

- Patient Safety
- Quality

We are in the process of reviewing the new NHSI System Oversight Framework received into the Trust to cover the period 2021/22. In conjunction with this we are also currently reviewing all dashboard key performance indicator targets and reporting parameters. This will enable us to provide updated performance targets to better reflect Trust performance and patient safety and quality indicators over the next financial year

Interpreting Statistical Process Control Charts



Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

SPC is a good technique to use when implementing change as it enables you to understand whether changes you are making are resulting in improvement — a key component of the Model for Improvement widely used within the NHS.

SECTION 3 : CURRENT OVERSIGHT EXCEPTION REPORTS

Emergency Caesarean – Primips Section Rates						
Indicator	**Achieved**	**Regulator**	**BAF Ref**	**Period**	**Target**	**Actual**
Emerg CS rate – Primips		NHSE/I	1	July 2021	20% or less	33.93%

Indicator description: There are three indicators measuring the emergency caesarean sections rates for combined, primips and multips. For all three indicators the Trust expects a rate of 20% or less.

Performance Summary:

Trust position

Emergency Caesarean Section (CS) rates –

- The combined emergency caesarean section rate in July was at a rate of 24.16%.
- The combined Elective and Emergency CS rates for primips and multips was 41.33% in July 2021.

Following recommendation 31 from the Health select committee report and feedback from regional colleagues the Maternity clinical Network for the East of England have removed both elective and caesarean section from their report and would like to consider use of the Robson groups for reporting purposes ongoing.

Recommendation 31:

It is deeply concerning that maternity units appear to have been penalised for high Caesarean Section rates. We recommend an immediate end to the use of total Caesarean Section percentages as a metric for maternity services, and that this is replaced by using the Robson criteria to measure Caesarean Section rates more intelligently. NHS England and Improvement must write to all maternity units to ensure that they are aware of this change.

Robson groups 1, 2 and 5 are those that we know can be reported and have been advised that they are seen as the categories that are most influenced by clinical practice. We would be grateful for your thoughts around reporting these within your systems.

(1) Nulliparous, singleton, cephalic, term (≥37^{+0} weeks) births in spontaneous labour;
(2) Nulliparous, singleton, cephalic, term births with
    (2a) induced labour or
    (2b) prelabour caesarean section;
(3) Multiparous, singleton, cephalic, term births without previous caesarean section in spontaneous labour;
(4) Multiparous, singleton, cephalic, term births without previous caesarean section with
    (4a) induced labour or
    (4b) prelabour caesarean section;
(5) Previous caesarean section, singleton, cephalic, term births;
(6) Nulliparous singleton breech births;
(7) Multiparous singleton breech births, including previous caesarean section;
(8) Multiple pregnancies, including previous caesarean section;
(9) Transverse and oblique lies, including previous caesarean section;
(10) Preterm (<37^{+0} weeks), singleton, cephalic births, including previous caesarean section.

The JPUH E3 System records Robson group data.

Complaints turnaround times						
Indicator	**Achieved**	**Regulator**	**BAF Ref**	**Period**	**Target**	**Actual**
All complaints within 60 days*		DHSC	1	July 2021	100%	90%
Non-complex complaints within 45 days*		DHSC	1	July 2021	100%	100%
Complex complaints within 60 days*		DHSC	1	July 2021	100%	86%

**Please note that the current months reported percentage relates to the complaints received 60 working days previously*

Indicator description: There are three indicators being measured; 1) Percentage of all formal complaints responded to within 60 working days; 2) Non-complex complaints responded to within 45 days; and 3) Complex complaints responded to within 60 working days. The percentage of complaints responded for each indicators should be 100%. The RAG rating categorisation is as follows:

Green	*Amber*	*Red*
90-100%	*80-90%*	*Below 80%*

Performance Summary:

Trust position

This exception report was generated due to the overall Complaints within 60 days KPI dipping to 77.7% in June.

There were 18 complaints due for responses to be sent out during June, eight of which were categorised as complex and ten which were categorised as non-complex. Two of the overdue complex complaints missed the response deadline by one day and were therefore sent at day 61. This impacted overall performance for June 2021. Two of the overdue complex complaints, missed the response deadline by one day and were therefore sent at day 61; this impacted overall performance. Staff leave impacted timely expedition of all responses during June in addition to an increased number of complaints which were due for response

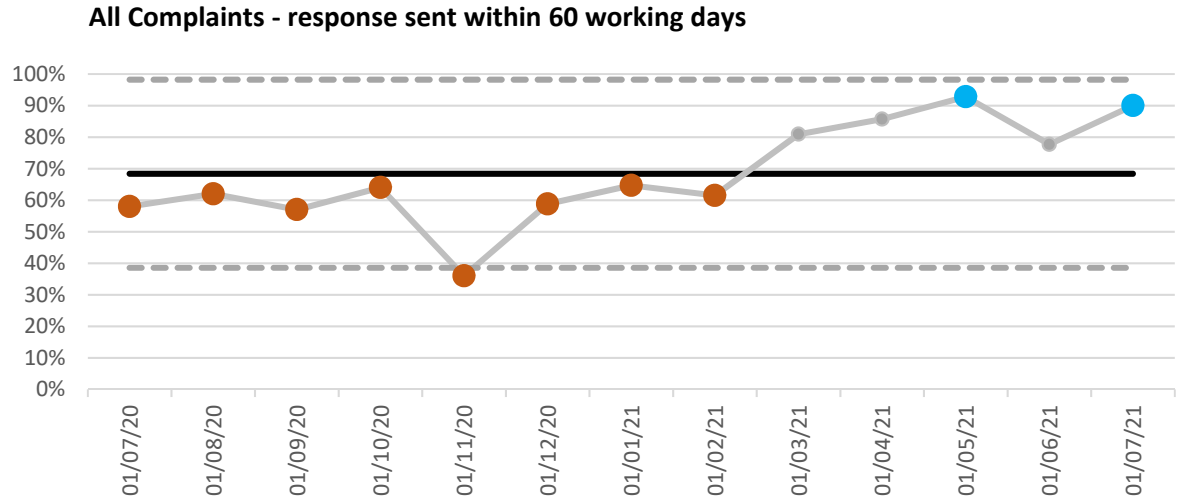
Subsequently, July performance has seen 10 complaints due for responses to be sent out during July; seven of which were categorised as complex and three which were categorised as non-complex. Six out of the seven complex complaints were responded to within 60 days, equating to 86%. All non-complex complaints were achieved within timeframe, equating to 100%. Overall performance for July has improved to 90%.

Benchmarking:

National benchmarking

There is currently no national benchmarking on complaints turnaround times available as each Trust works to different complaint turnaround time-frames.

Compliance Trend



Red Marker = concerning variation from the norm; returns to normal variation from March 2021 with high points (positive) shown for May and now July.

Drivers for performance:	**Actions to recover performance:**
• Response timeframes continue to be exceeded for complex complaints. • Complex complaints often requires input from several clinical colleagues. • Poor service by process. • Staff changes, recruitment and annual leave continues to impact capacity within the Complaints team.	• Weekly touch point meetings to review each complaint to identify areas for escalation and resolution is in place. • Additional resources made available to support with drafting responses and cold reviews of letters whilst substantive recruitment being considered. • Proposed development of a visual dashboard underway to prompt deadline dates at each stage of the complaints process (paused by Information Services currently). • Review of Complaints and PALS Team structure ongoing.; agreed funding for resource which will support further improvements in both quality and timeliness of responses as well ast he family liaison aspect of the complaints process.

Projected compliance timescale
Estimated: October 2021

New Framework For Involving Patients In Patient Safety - June 2021

The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety.
This framework sets out how NHS organisations should involve patients in patient safety.
Hyperlink to the full guidance ;Framework for involving patients in patient safety: full, summary and easy read versions

About the framework
The Framework for involving patients in patient safety is relevant to all NHS trusts and commissioners and should also be useful to other NHS settings, including primary care and community services, that are considering how they can involve patients in safety. Integrated care systems should consider how they can involve patients as part of their safety governance processes as they develop and mature.
Implementation of this framework will take time. Different organisations are in very different places. Some are already delivering over and above what we advocate here, while others will need to carefully plan and work towards these activities. We will work with the wider NHS to understand the pace at which this work can be delivered.
The framework is split into two parts:

Part A: Involving patients in their own safety-
Including;
- Encouraging patients to ask questions
- approaches to involving patients in their own healthcare
- Reporting incidents
- Individual involvement in incident investigation.

Part B: Patient safety partner involvement in organisational safety
Including;
- The benefits of PSP involvement
- The Principles of patient safety partner involvement : Commitment , Role, Tasks, Recruitment, Training, Support and PSP contribution.
- The NHS Patient Safety Strategy states the ambition for all safety-related clinical governance committees (or equivalents) in NHS organisations to include two PSPs by end Q1 2022/23, and for them to have received the required training by end Q1 2023/24.

Forward Plan: The trust need to consider how this guidance aligns with the existing Patient Experience and Engagement Strategy and Patient Safety Strategy. Also whether there is the organisational cultural readiness for the implementation and implications of the guidance recommendations.
In next months committee paper we plan to bring a summary of the recommendations and the options we have as an orginsations for the implementation of this guidance.

Patient Safety Maternity Dashboard

Set out below is the Maternity Safety Dashboard.

KPIs	Period	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Nº. of Internal Serious Incidents	Monthly	Zero	0	0	0	1	1	0	2	1	1	0	1	0
Nº. of External Serious Incidents	Monthly	Zero	0	0	1	0	0	0	0	1	0	0	0	1
Nº. of reported Incidents	Monthly	TBC	39		33	21	25	35	34	33	32	43	52	31
Closure of Central Delivery Suite	Monthly	Zero	0	0	0	0	0	0	0	0	0	0	0	0
No. of Complaints received	Monthly	6 or less	0	1	1	1	3	0	2	3	0	0	3	0
No. of Compliments received	Monthly	TBC		2	1	2		2		3	4	4	4	0

Maternity services

The top five themes emerging from maternity incidents that occurred in July are as follows:

- Unexpected transfers to Neonatal Unit
- PPH> 1500mls
- Treatment/Procedure – Delay/Failure
- Shoulder Dystocia
- Baby <28 days readmission with feeding problems

The above incidents are being picked up and discussed at the maternity service governance meetings to identify the early learning and put in place improvements where required. Please note that these are low in numbers of incidents.

Infection Control Safety Raw Data (Numbers)

KPIs	Period	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Clostridium difficile HOHA cumulative	Monthly	24 or less for the year	4	5	5	6	8	10	13	14	1	8	9	10
Clostridium difficile HOHA total for month	Monthly	N/A	2	3	0	1	2	2	3	1	1	7	1	1
Clostridium difficile COHA cumulative	Monthly	24 or less	0	0	0	2	2	2	2	2	0	0	0	0
Clostridium difficile COHA total for month	Monthly	N/A	0	0	0	2	0	0	0	0	0	0	0	0
MRSA cumulative	Monthly	Zero	0	0	0	0	0	0	0	0	0	0	0	0
MSSA cumulative	Monthly	14 or less	2	5	6	7	8	11	13	14	1	3	3	3
MMSA total for month	Monthly	N/A	1	3	1	1	1	3	2	1	1	2	0	0
E.coli infection cumulative	Monthly	25% reduction by 2021 and 50% reduction by March 2024*	5	8	10	12	15	15	18	23	0	1	2	4
Gram Negative Organisms cumulative	Monthly	25% reduction by 2021 and 50% reduction by March 2024*	7	11	18	22	30	32	36	45	1	4	8	12

*National ambition target – baseline figure to be identified to demonstrate performance against target.
** Cumulative calendar starts in April

Key:

2020/21		2021/22	

Healthcare Associated Infections including COVID-19

COVID-19

The Trust has aligned its hospital segregation in line with national guidance using the Red, Amber and Green categories. Red areas are where COVID-19 patients are expected to attend (suspected or confirmed). Ward 16 is now the only red general ward in use at this time. There are no outbreaks in the Trust as a result of COVID-19 at the time of this report.

COVID-19 acquisition in hospital

NHS England and NHS Improvement use the following definitions:

- <=2 days after hospital admission = Community onset
- 3-7 days after hospital admission = Indeterminate health-care associated
- 8-14 days after hospital admission = Probable health-care associated
- Day 15 day or more after admission = Definite health-care associated

The table below (amended to be in line with dates of other reports) shows possible, probable and likely healthcare-associated Covid19 cases. There were no reported healthcare-associated cases after 18th June 2020 until week of 01st October 2020. Outbreaks between October 2020 and March 2021 resulted in a number of healthcare-associated Covid19 cases. An RCA is undertaken for each case to determine any learning and "serious incident" reports are submitted for each outbreak (defined as two or more cases connected to time and place). In addition, each ward that had an outbreak undergoes an Outbreak learning meeting and a detailed report. These are ongoing at the time of this report.

The 0 cases between 18 June and 01st October 2020 have been excluded from the table over the page.

June and July 2021 saw a third increase in numbers. Despite this, there were no cases identified over 3 days.

Reporting period (Week commencing)	COVID-19 Positive 3-7 days after admission	COVID-19 Positive 8 - 14 days after admission	COVID-19 Positive >=15 days after admission
Week 52 (13th May 2021)	1	0	0
Week 53 (20th May 2021)	0	0	0
Week 54 (27th May 2021)	0	1	0
Week 55 (03 June 2021)	0	0	0
Week 56 (10 June 2021)	0	1	0
Week 57 (17 June 2021)	0	0	0
Week 58 (24 June 2021)	0	0	0
Week 59 (01 July 2021)	0	0	0
Week 60 (08 July 2021)	0	0	0
Week 61 (15 July 2021)	0	0	0
Week 62 (22 July 2021)	0	0	0
TOTAL	**1**	**2**	**0**

Methicillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia

There have been no reported MRSA Bacteraemia cases since February 2020.

Methicillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

There has been a total of **14** MSSA since April 2020 to March 2021. In July 2021 there were zero cases.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
2021-2022	1	2	0	0									**3**
2020-2021	0	0	1	0	1	3	1	1	1	3	2	1	**14**
2019-2020	3	1	1	0	0	1	1	0	2	0	1	1	**11**

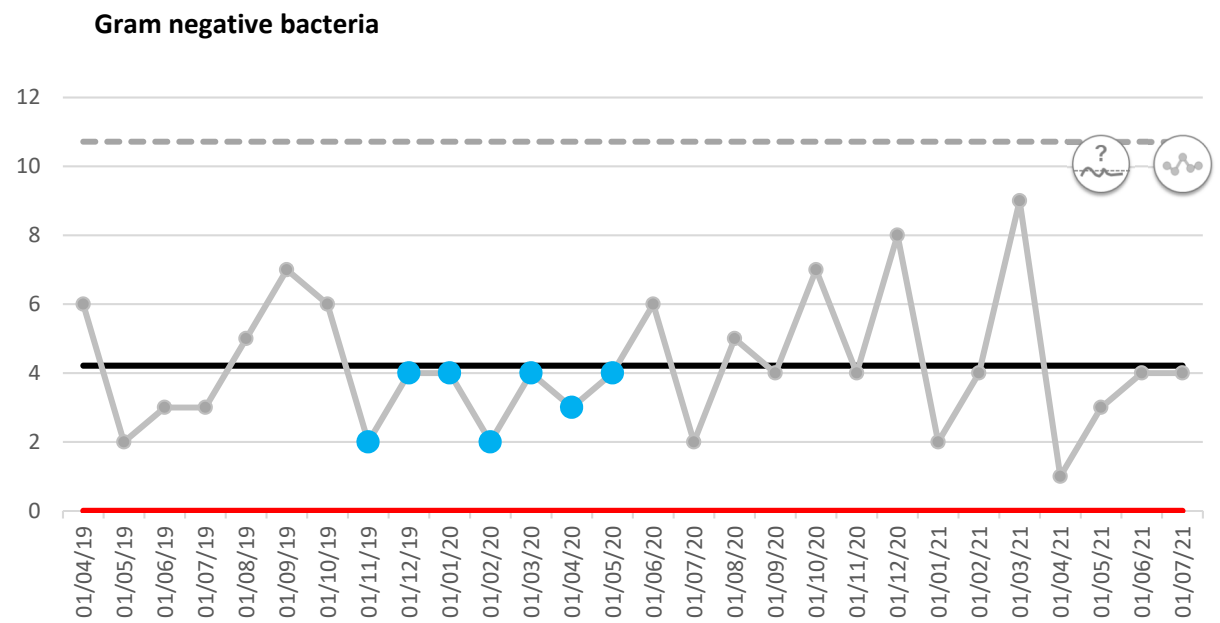
Clostridium difficile (*C.diff*) Infection

Following a sharp increase of seven cases in May 2021, it is pleasing to report only one case of *C.difficile* for June and July 2021 showing this as a spike rather than a developing trend. An RCA has been commenced.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
HOHA	1	7	1	2									**11**
COHA	0	0	0	0									**0**

Gram-Negative Bacteraemia (GNB)

Figure 1 - Total Gram-Negative Bacteraemia



Based on a target of Zero Occurrence. Blue marker = Special Cause Improving variation.

An increase of GNB infections have been seen regionally but this is not reflected in the healthcare-associated cases. There were two *Klebsiella* bacteraemia in July 2021 and two *E.coli*; neither linked to time, place or procedure.

Carbapenemase-producing Enterobacteriaceae (CPE)

To date, there have been no hospital-attributable CPE cases to report.

Influenza

There are currently no cases of Influenza identified in the hospital.

Norovirus

There have been no affected wards or cases since the last Board report.

Statutory Duty of Candour[1]
The reporting of Statutory Duty of Candour (DoC) has moved one month in arrears to provide more accurate reporting and the tables below shows the incidents reported in June.

Division	Incident No.	Incident Date	Reported date	Cause	Incident Panel Date/Outcome	Conversation within 10 days?	Letter within 10 days?
Medicine	108097	25/05/2021	01/06/2021	C-Diff	No panel required trigger reporting	Same Day	55 days
Medicine	108161	02/06/2021 (when identified)	02/06/2021	Referral Process - Failure	09/06/2021 Internal SI and DoC.	8 days	9 days
Medicine	108159	02/06/2021	02/06/2021	Complication Of Treatment	09/06/2021 Internal SI and DoC.	Same Day	8 days
Medicine	108341	08/06/2021	08/06/2021	Found on Floor	No panel required – trigger reporting	Same Day	31 days
Medicine	108805	21/06/2021	21/06/2021	Discharge Poor	23/06/2021 Internal SI and DoC.	2 days	9 days
Surgery	108100	30/05/2021	01/06/2021	C-Diff	No panel required – trigger reporting	3 days	4 days
Surgery	108226	03/06/2021	04/06/2021	Hospital Acquired Pressure Ulcer Cat 3	No panel required – trigger reporting	Same Day	10 days

In June 2021, seven incidents underwent the DoC process:

- Conversation completed within 10 working days – 7/7 (100%)
- DOC letters: Letter sent within 10 working days – 5/7 (71%)

A review of the two cases that have not met the 10 day standard has been undertaken. Both cases relate to incident causes that automatically trigger for Duty of Candour in this case C.difficile and a Fall with a fracture.The reporting and investigation pathways for these incident causes will now be reviewed and any changes required made to ensure that DOC is identified and carried out in line with trust policy.

Serious Incidents (SI)
There were two external SIs reported in July 2021. Set out in the table below is the one incident that occurred and was reported in July.

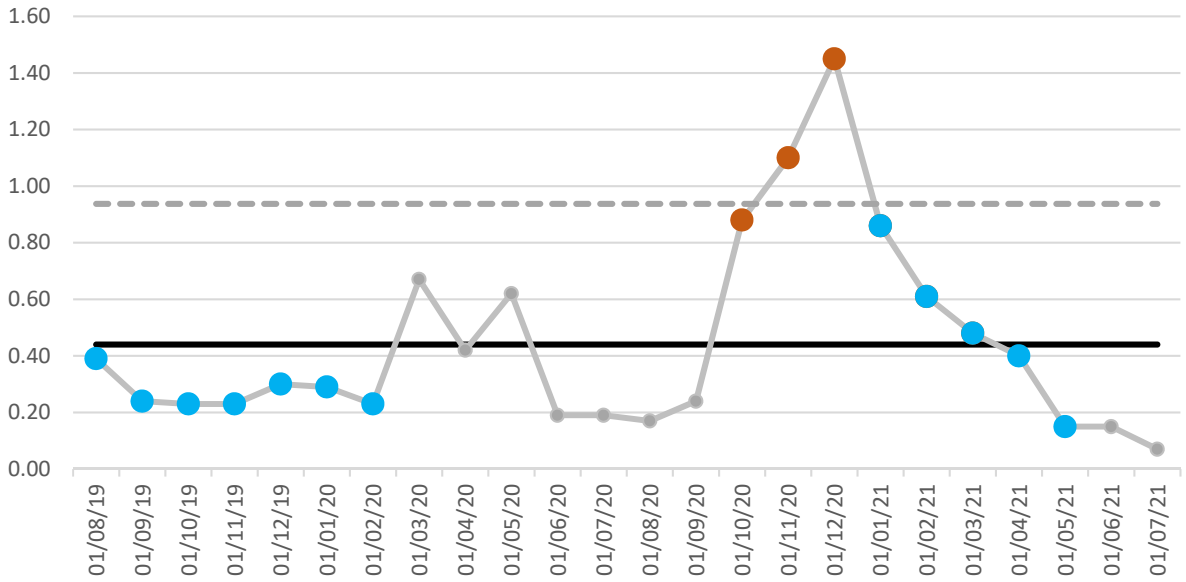
Incident No	Date of incident	Dept/ward	Description	DoC applies
109287	0707/2021	Maternity	Safefuarding Children	No

Set out in the table below is the one incident which occurred in November 2020 and was reported in July.

Incident No	Date of incident	Dept/ward	Description	DoC applies
101771	18/11/2020	Ward 15	Diagnosis Delay/Failure	Yes

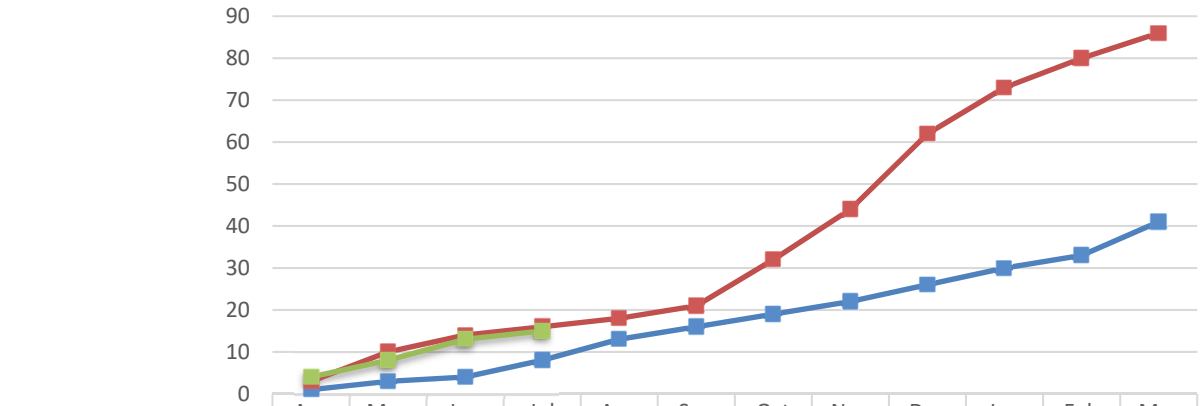
[1] A statutory Duty of Candour is a legal obligation to ensure that patients and their families are apologised to, and communicated with, openly and honestly when things may have gone wrong in their care. All incidents resulting in harm and are classified as moderate or severe or where 'prolonged psychological harm' has arisen gives rise to a Duty of Candour. The Duty of Candour will also apply in cases of death, if the death relates to the incident of harm rather than to the natural course of the service user's illness or underlying condition.

Figure 2 – Serious Incidents per 1,000 bed days



The cumulative SIs reported in 2020/21 (86) remains above the reported figures for 2018/19 and 2019/20, see Figure 3.

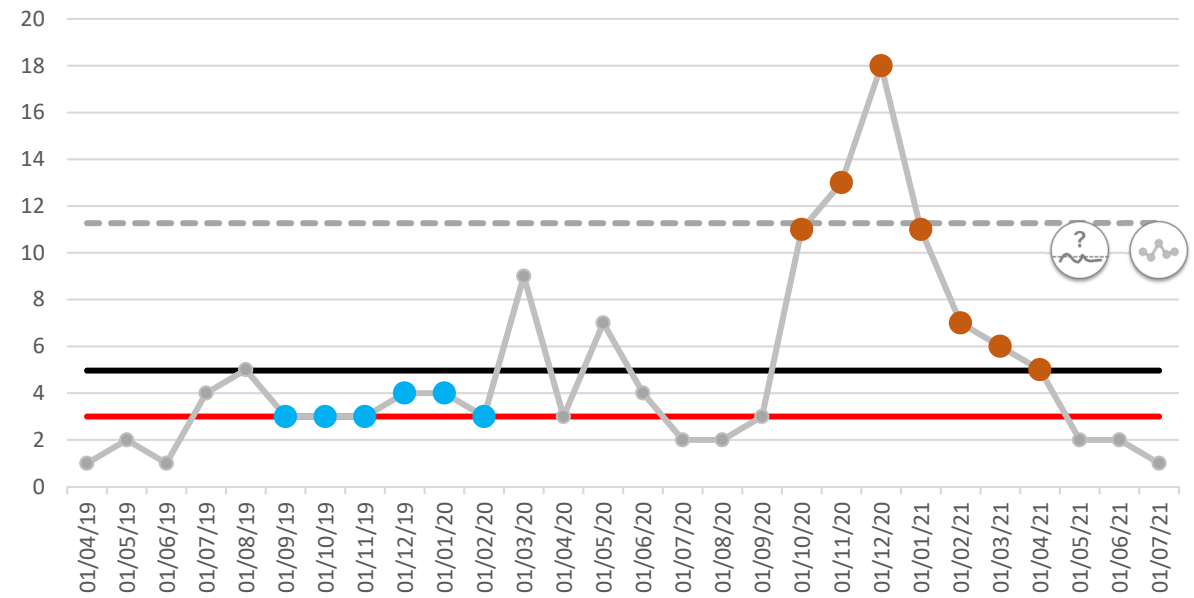
Figure 3 - Cumulative SIs reported in 2019/20, 2020/21 and 2021/22



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 (Total = 41)	1	3	4	8	13	16	19	22	26	30	33	41
2020/21 (Total = 86)	3	10	14	16	18	21	32	44	62	73	80	86
2021/22 (Total = 15)	4	8	13	15								

Set out in Figure 4 below is a Statistical Process Control (SPC) chart covering data from April 2019 to July 2021

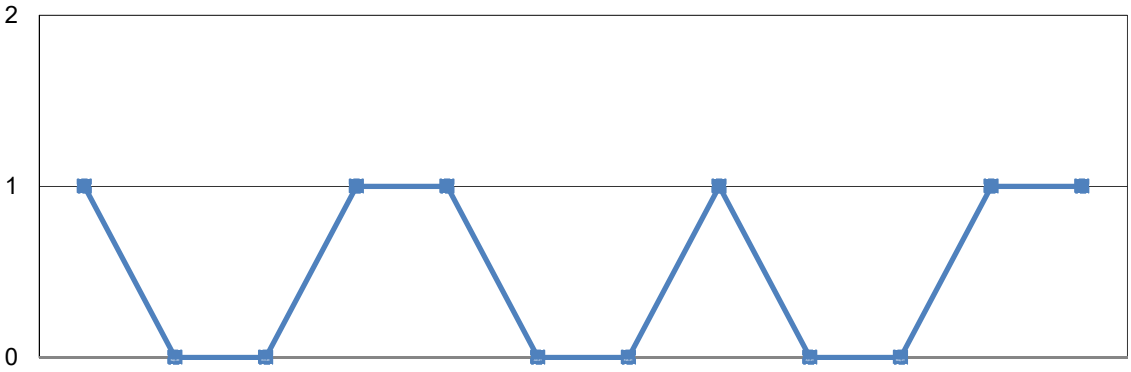
Figure 4 – Statistical Process Control – number of SIs



Red marker = special cause variation (negative trend)
Blue marker = improving variation
NB: Caution should be applied to interpretation of SPC charts for data with small numbers

Pressure Ulcers
For the last 12 months (August 2020 to July 2021), there have been six hospital acquired category 3 pressure ulcer incidents with one reported in July 2021, see Figure 5.

Figure 5 – Hospital Acquired Category 3 Pressure Ulcers

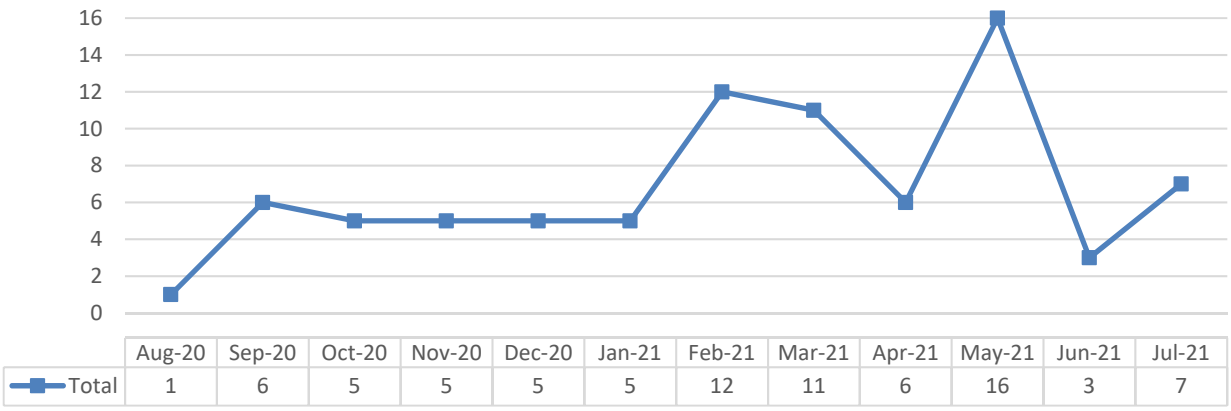


	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Total	1	0	0	1	1	0	0	1	0	0	1	1

A Statistical Process chart should not be used for data of low numbers so one has not been provided for this metric. We are looking to move to a control chart that measures the time between events (G chart or similar).

For the same reporting period (August 2020 to July 2021), there have been 82 hospital acquired category 2 pressure ulcers, two of these which were related to Medical Devices. Of the total 82 cases, seven occurred in July 2021, an increase of four compared to June 2021, see Figure 7.

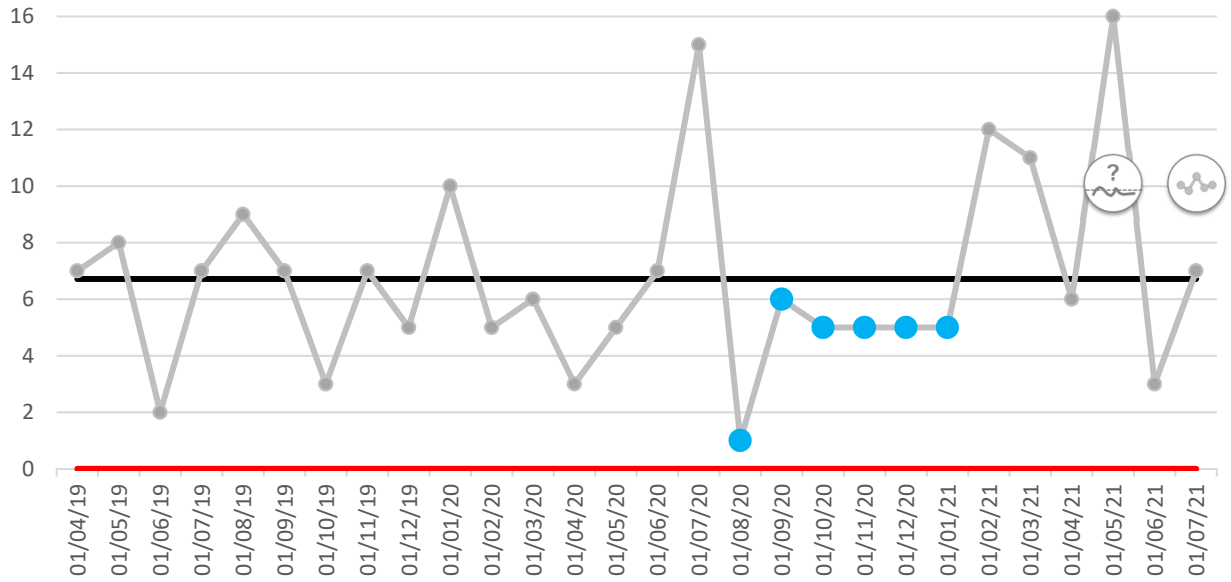
Figure 7 – Hospital Acquired Category 2 Pressure Ulcers



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Total	1	6	5	5	5	5	12	11	6	16	3	7

Set out in Figure 8 below is a Statistical Process Control (SPC) chart covering data from April 2019 to July 2021.

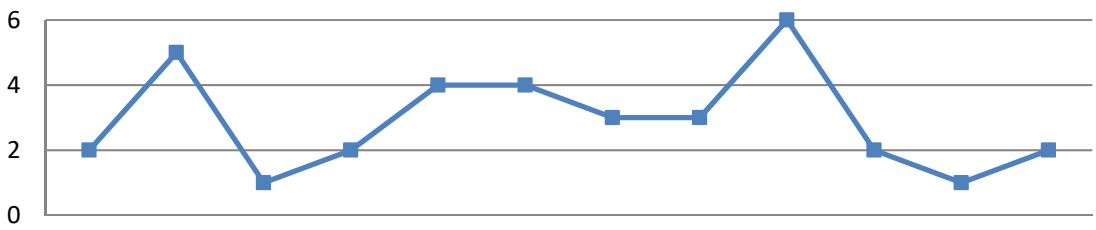
Figure 8 – Statistical Process Control – Number of Category 2 Hospital Acquired Pressure Ulcers



Blue marker = improving variation but recognising that the target for hospital-acquired category 2 pressure ulcers is zero.

For the same reporting period (August 2020 to July 2021), there have been 35 hospital acquired moisture lesions with two reported in July 2021, see Figure 9.

Figure 9 – Hospital Acquired Moisture Lesions.

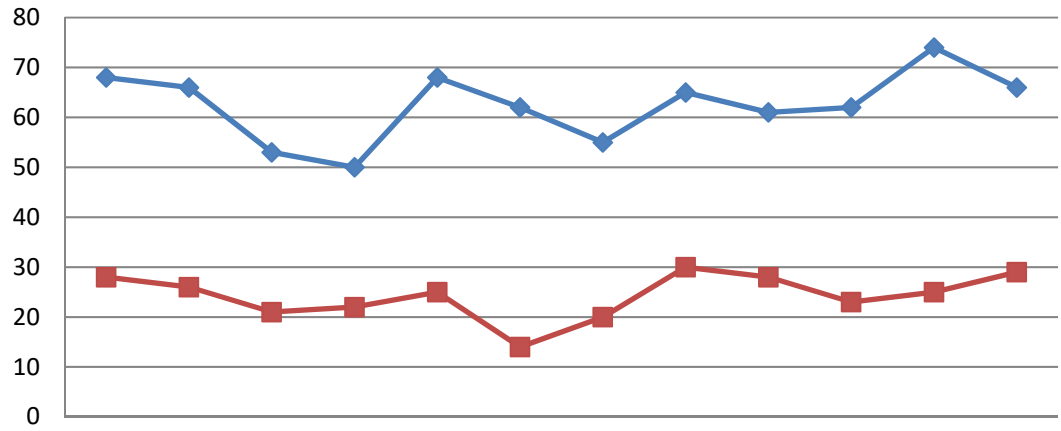


	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Total	2	5	1	2	4	4	3	3	6	2	1	2

Falls

For July 2021, the total number of falls has decreased by eight to 66 from 74 compared to the previous month, see Figure 10. Of the 66 falls reported, 29 were with harm, an increase of four compared to the previous month.

Figure 10 – Total inpatient falls and falls with harm.

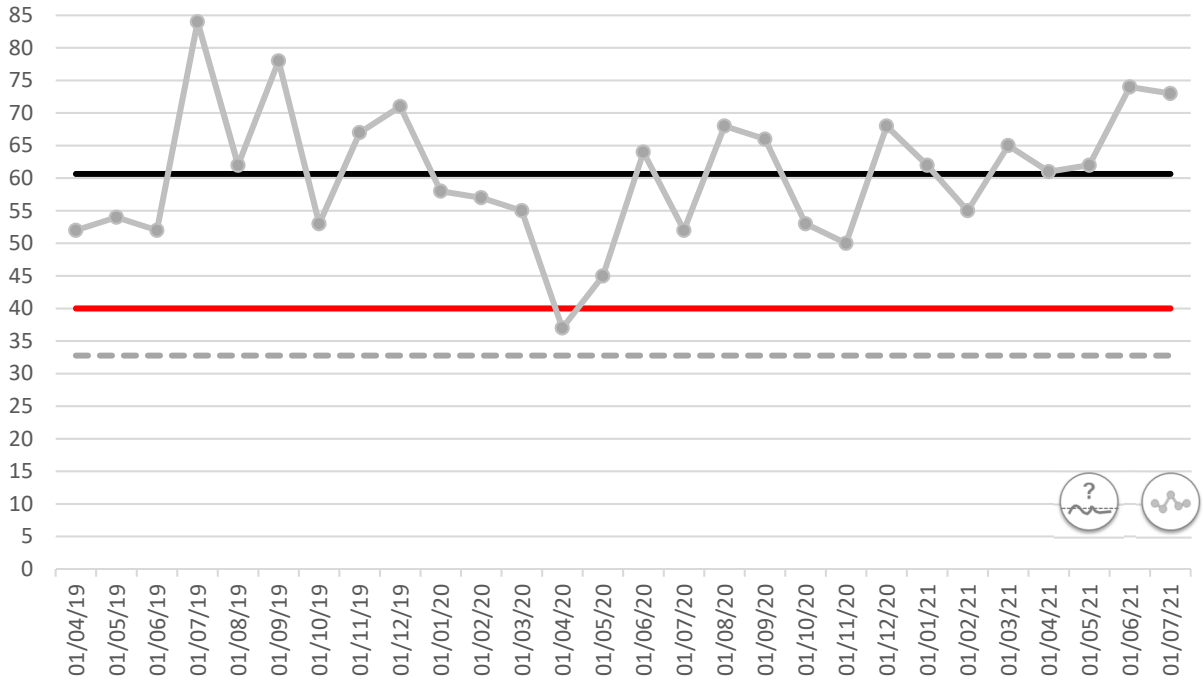


	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Total Falls	68	66	53	50	68	62	55	65	61	62	74	66
Falls with Harm	28	26	21	22	25	14	20	30	28	23	25	29

Set out in Figure 11 below is a Statistical Process Control (SPC) chart covering data from April 2019 to July 2021, This information shows that reporting of patient falls has been statistically consistent since April 2019.

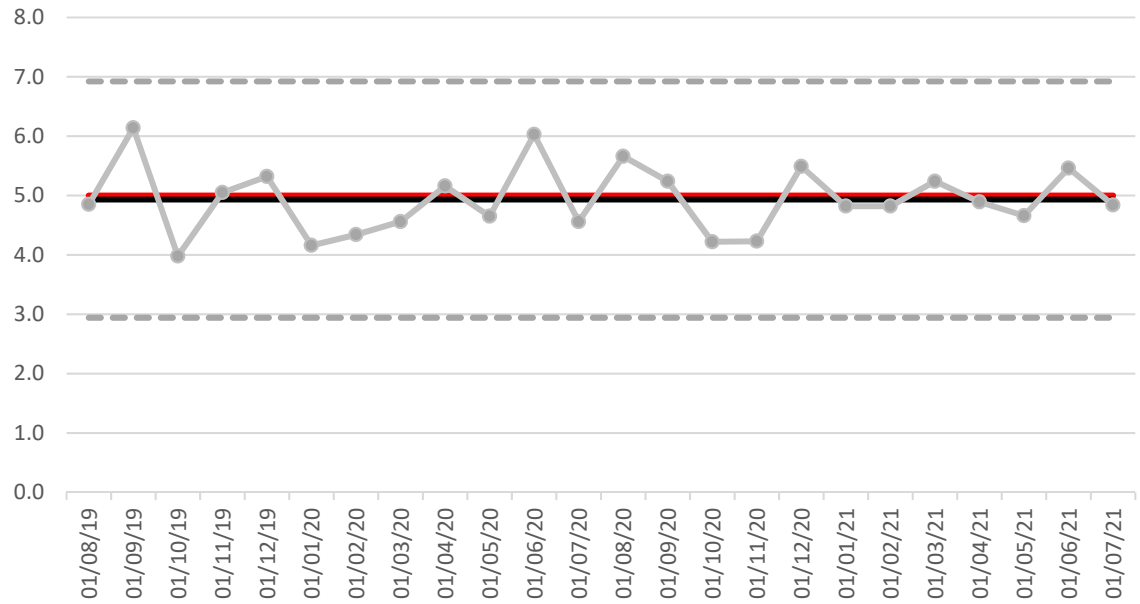
As it is demonstrated that the average falls per month over the past two years is a mean of 60, our new mean is a five percent reduction which means 57 will be our new target in line with our falls per 1000 bed days being adjusted to five instead of 6.65.

Figure 11 – Statistical Process Control – Number of patient falls



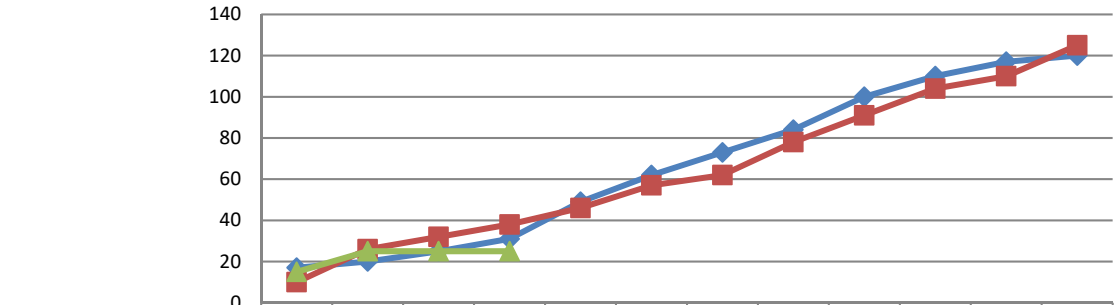
For July 2021, the number of patient falls per 1000 bed days was reported as 4.84, see Figure 12.

Figure 12 – Number of falls per 1000 bed days



Hospital Acquired Thrombosis (HAT)
For 2020/21, the cumulative number of HAT incidents reported is 125. This is slightly higher compared to the previous year in 2019/20, see Figure 13.

Figure 13 - Cumulative Hospital Acquired Thrombosis (HAT)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 (Total = 120)	17	20	25	31	49	62	73	84	100	110	117	120
2020/21 (Total = 125)	10	26	32	38	46	57	62	78	91	104	110	125
2021/22 (Total = 25)	15	25	25	25								

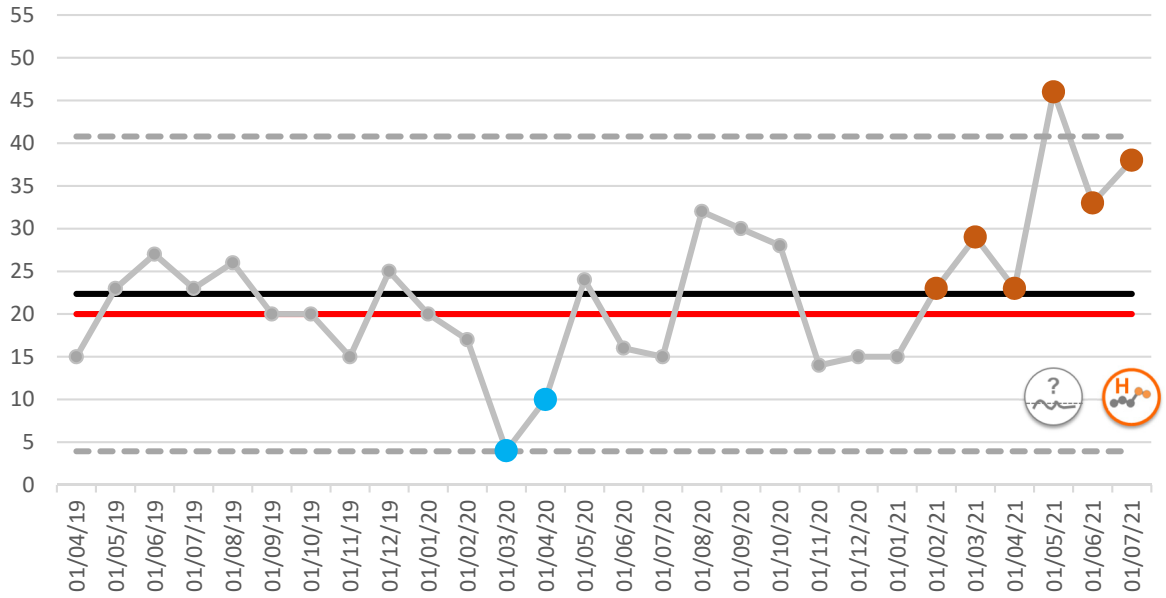
Inquests
As at 06/08/2021, the Trust had 33 open inquests, some of which have been listed for hearing and others are awaiting a date. The Trust had nine inquests closed in July with witnesses called to give evidence at two hearings. The Coroner did not issue a Prevention of Future Deaths report to the Trust. The Trust shared Root Cause Analysis (RCA) investigation reports with the Coroner for two inquests in July.

Clinical prioritisation and Clinical Harm Update
The COVID-19 pandemic continues to have a significant impact on waiting times across the NHS, leading to a backlog of patients waiting beyond statutory timescales for both Referral to Treat (RTT) and cancer pathways. NHS Improvement require all trusts to undertake a clinical prioritisation and clinical harm review. With effect form 01/07/2021 there is also a requirement to priority code Diagnostic patients. The progress as at the end of July 2021 is as follows:

- Clinical prioritisation review across the relevant admitted RTT waiting list remains at 96%, consistent with last month
- Clinical harm reviews for patients waiting more than 52 weeks on a RTT pathway increased to 54%, from 45% the last month.
- Clinical harm reviews for patients waiting more than 104 days on the cancer pathway decreased to 56%

Health and Safety Data Analysis
There were two exceptions from the Health and Safety (H&S) Dashboard in July 2021, including:

- A high number of H&S incidents – the highest cause group was needle/scalpel inappropriate disposal and needle stick/sharps contact with a total of nine, a sharps injury investigation form is sent to managers for completion following needle stick/sharp contact incidents. The second highest cause group was manual handling patients/objects/equipment which accounted for eight. The department who reported the most H&S related incidents was HSDU with a total of four.
- A high number of abuse incidents, 10 of which were attributed to one ward area; three of those 10 were attributed to one patient. There were no other themes identified on analysis. A monthly Violence and Aggression Prevention Standards Task and Finish Group is set up which is currently developing a Trust strategy and reviewing the existing policies. Graph below shows a deteriorating picture with one point outside of the upper control limits.



Health and Safety (H&S) Audits
All areas of the Trust continue to undertake H&S self-assessments with progress monitored through the Health, Safety and Staff Welfare Committee. All audits are saved centrally by Divisional Governance and Risk and Safety who then share the trends and themes from the H&S audits to all areas via Health and Safety Forums. Following on from a health and safety self-assessment it was identified that some administration areas should also complete health and safety audits, a new template has been developed and distributed to these areas for completion.

H&S Policy Update
Policies in the process of being updated and reviewed include:

- The Control of Substances Hazardous to Health (CoSHH) Policy has been uploaded on to the intranet;
- The New and Expectant Mothers at Work Policy has been revised as a Supplementary document to the 'Maternity, Maternity Support (Paternity), Adoption and Parental Leave and Pay Policy' – this has been sent to Workforce for review and inclusion into the main Policy (All Workforce Policies were extended to 1st June 2021);

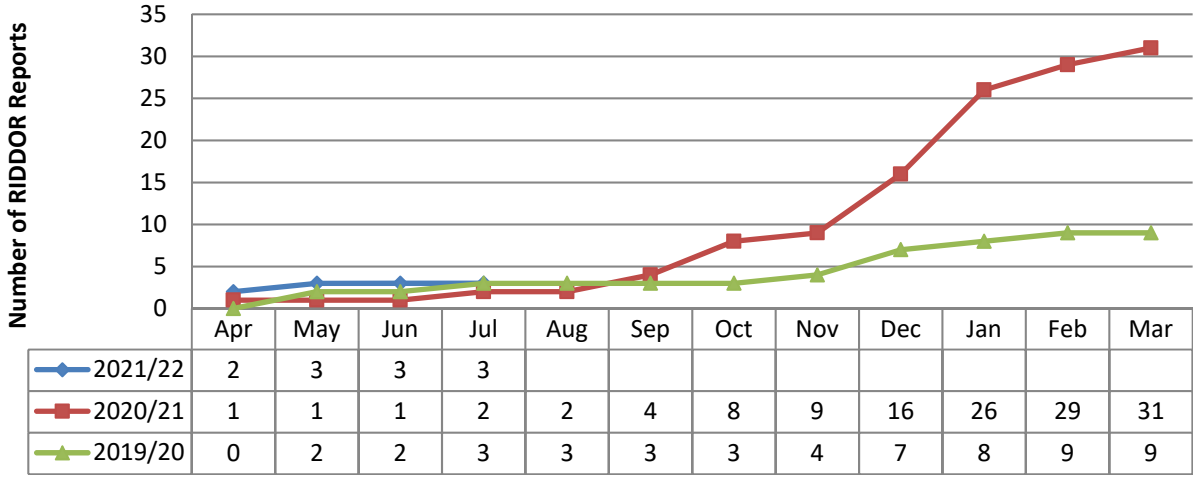
- The Health Surveillance Policy & Procedure is currently with the reader panel for review.
- The Trust Health and Safety Policy is currently under review following the restructure of the department.

Reporting of RIDDOR Incidents (Staff and Patients)

The health and safety department were retrospectively made aware of an outbreak of COVID that occured in HSDU in January 2021. When investigating, it was reported that although staff members were adhering to the two-metre social distancing rule whilst at work, staff members were congregating in cars, the rest room and changing area. It was therefore concluded that the disease was more than likely attributed to an occupational exposure and the nine staff members who tested positive for COVID were reported as a case of disease under RIDDOR.
Since April 2021, there have been three reported incidents which meet the RIDDOR criteria, these are set out below:

Month and Year	Date Reported to the HSE	Days to report to the HSE[2]	Injury / Reason reportable	Details of the incident
Apr - 21	14/04/21	10	Needle stick/ Sharps Contact	Member of staff sustained a needle stick injury whilst performing Venepuncture on a high risk patient (HIV).
Apr - 21	23/04/21	2	7+ Day Injury	Member of staff slipped on stairs whilst going to work, resulting in concussion, sprain of right knee lcl and sprain to right hip
May - 21	27/05/21	5	7+ Day Injury	HCA defending a punch from patient, resulted in possible fracture to hand/finger requiring over 7 days off from work

Figure 15 – Cumulative number of RIDDOR incidents reported for 2019/20, 2020/21 and 2021/22



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	2	3	3	3								
2020/21	1	1	1	2	2	4	8	9	16	26	29	31
2019/20	0	2	2	3	3	3	3	4	7	8	9	9

Fire Safety

The first familiarisation visit by Suffolk Fire and Rescue Service (Lowestoft) took place at the hospital on 27th July. The visiting crews were impressed with the safety features including fire alarm system we have installed here at the hospital.

A new addressable fire alarm system has been installed and commissioned at Newberry Clinic and all rooms are now covered with automatic smoke/heat detection. This has also improved working conditions for staff as ventilation has been improved because the first floor office area self-closing fire doors can be kept open as they are connected to the fire alarm system and will close automatically on actuation of the alarm.

[2] Reportable deaths, specified injuries or dangerous occurrence must be reported to HSE within 10 days. Over seven day injuries must be reported to HSE within 15 days.

Clinical Audit and Effectiveness Data Analysis

National Audit Self-Assessments Awaiting Review

ID	Audit Title	Division
259.1	National Diabetes Audit - National Core Diabetes Audit (Collection of 2017-18 Data)	Medicine, Diagnostics and Clinical Support
260.1	National Diabetes Audit - National Diabetes Inpatient Audit (NaDIA) 2018	Medicine, Diagnostics and Clinical Support
270.2	National Cardiac Audit Programme – Myocardial Ischaemia National Audit Project (MINAP	Medicine, Diagnostics and Clinical Support
271.2	National Cardiac Audit Programme - National Heart Failure Audit	Medicine, Diagnostics and Clinical Support
273.1	National Diabetes Audit - National Core Diabetes Audit	Medicine, Diagnostics and Clinical Support
280.1	National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation	Medicine, Diagnostics and Clinical Support
324.1	UK Parkinson's Audit	Medicine, Diagnostics and Clinical Support
304.1	National Prostate Cancer Audit (NPCA)	Division of Surgery, Women and Child Health
405.1	NCEPOD - Highs and Lows (Perioperative diabetes 2018)	Division of Surgery, Women and Child Health

Clinical Audit Forward Plan

The Clinical Audit Forward Plan for 2021/22 consists of all the national clinical audits listed on the NHS England Quality Accounts list, including mandatory National Clinical Audits and Patient Outcomes Programme (NCAPOP) audits, relevant to the Trust. The figures below show progress to the audits on the Forward Plan (excluding continuous National Audits and Confidential Enquiries):

Healthcare Quality Improvement Partnership (HQIP) National Audit Completion Rate to 31/07/2021				
	Division of Surgery etc.	**Division of Medicine etc.**	**Corporate**	**Total**
Number of Audits on Plan	1	7	1	9
Due to start by 31/07/21	1	4	1	6
Started	1	3	1	5
% Started	100%	75%	100%	83%
Completion by 31/07/21	0	2	0	2
Completed	0	2	0	2
% Completed	0%	100%	-	100%

The national audit overdue for starting is the BTS National Smoking Cessation Audit. Dr Cotter has confirmed the Trust's intention to participate in this audit – awaiting formal registration.

Actions from Clinical Audits

An audit to assess the Management of Diabetic Ketoacidosis (DKA) identified the following recommendations:

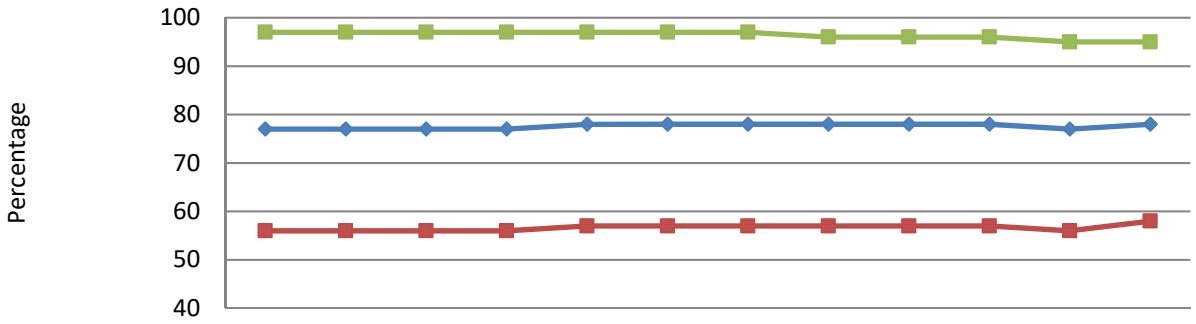
- Improvements to DKA proforma including the inclusion of a column for identification of precipitants and embolden the rate of dextrose infusion
- Cambridge Diabetes Education Programme (online) to be recommended to staff.

NICE Guidelines

As of the end of July 2021, the implementation of all types of relevant NICE guidance stands at 78% (586/755). There are seven NICE guidelines awaiting initial review by the relevant clinicians. The breakdown of NICE guidance with substantial recommendations include:

- Clinical Guidelines (CGs), Public Health Guidelines (PHGs) and NICE Guidelines (NGs) – the implementation figure stands at 58% (151/260).
- For Technology Appraisals (TAs), concerning adding drugs to the Trust formulary, the figure is 95% (284/299).
- For Interventional Procedures Guidelines (IPGs) and Diagnostics Guidelines (DGs), which make recommendations relating to the safety of certain procedures and equipment but generally do not contain any other clinical recommendations, the implementation figure stands at 100% (43/43).

Figure 16 – NICE Guidelines implementation rates



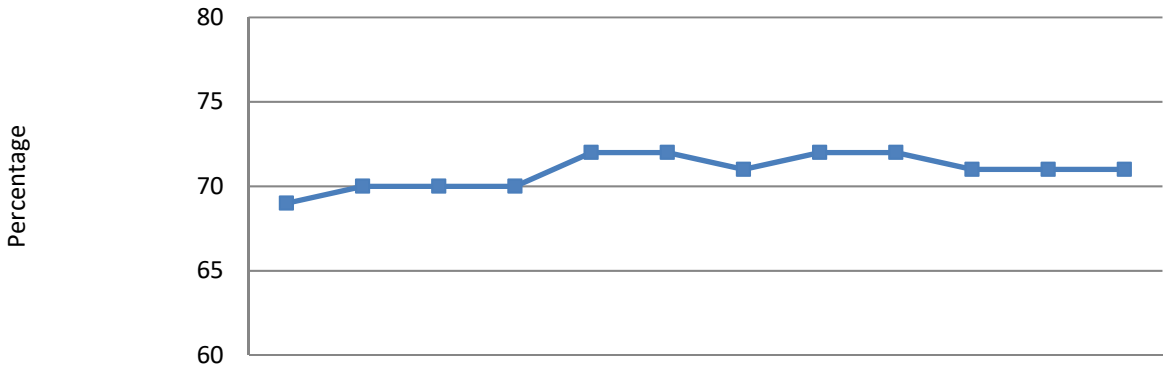
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Overall NICE Implementation	77	77	77	77	78	78	78	78	78	78	77	78
NG/CG/PH	56	56	56	56	57	57	57	57	57	57	56	58
TA	97	97	97	97	97	97	97	96	96	96	95	95

NICE Quality Standards (QS)

The NICE Quality Standards are based on best practice guidance and lay out processes and measures for quality improvement. The current position on the Trust's Quality Standard implementation is as follows:

- 154 relevant to the Trust;
- 109 implemented, 107 with a full review; two with implementation inferred from previous linked NICE guideline reviews; and
- 45 not implemented, 43 with full gap analyses; two to be reviewed by clinicians to complete gap analyses.

Figure 17 – Quality Standards implementation rates



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
QS Implementation	69	70	70	70	72	72	71	72	72	71	71	71

Clinical Guidelines

As of 30th July 2021, there are 106 Clinical Guidelines out of date, of which four are for the Trust to deal with and the remaining 102 are either Joint, Network or National guidelines. A detailed breakdown of the Trust specific guidelines shows 98% are in date as set out below:

Trust specific guidelines	No of guidelines
Number of Trust guidelines out of date	4
Total number of guidelines in date	238
Total number of guidelines	242

Set out below are the four guideline out of date:

Guideline Title	Reference No.	Speciality
Hyperemesis Gravidarum Management	JPLCG0022	Obstetrics
Cervical Screening in Pregnancy	JPLCG0029	Obstetrics
Learning Disability & Autism Management	JPLCG0061	Learning Disabilities
Out of hours Diabetic Service Flowchart	JPLCG0169	Paediatrics

Patient Experience and Engagement Data Analysis

Framework for Involving Patients in Patient Safety

The new framework has been published across the NHS in July 2021. The background and context to this framework is that this is a key part of the NHS patient safety strategy, and as safety leaders, Patient Safety Specialists are likely to be key to its success and the introduction of Patient Safety Partners.

The framework sets out how NHS organisations should involve patients in patient safety and is split into two sections:

- **Part A: Involving patients in their own safety** – setting out approaches NHS organisations should use to involve patients, their families and carers in their own safety. This could include initiatives to encourage patients to ask questions; individual information-sharing sessions; safety information campaigns; and supporting patients to raise concerns and to be involved in incident investigations.

- **Part B: Patient safety partner (PSP) involvement in organisational safety** – relating to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Our Trust Patient Experience and Patient Safety Leads will be working together to provide an options appraisal paper for the next meeting of the Board of Directors, in September.

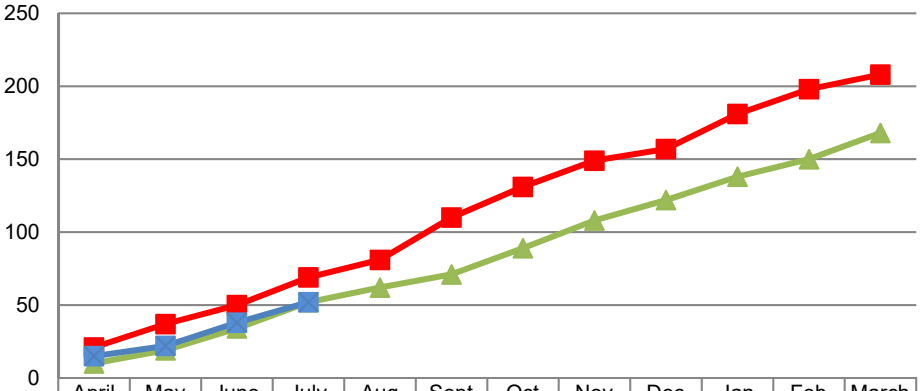
Social Media/NHS Website/Care Opinion

The Trust regularly receives feedback via social media (Facebook, Twitter), NHS Website (previously NHS Choices) and Care Opinion. The primary route for on line feedback continues to be via Facebook. For July, the Trust received 6 feedback entries in total, of which one was negative and 5 were positive. All feedback is discussed at divisional/departmental level to explore opportunities for improvement regarding any of the issues raised and for exploration of themes and trends; where applicable. Teams will then provide updates via their Divisional reports to Carer and Patient Experience Committee.

Complaints

For July 2021, a total of 14 complaints were received, of which two were categorised as complex and 12 were categorised as non-complex complaints. All aspects of clinical treatment continues to present as the primary theme (n = 26) and Values and Behaviours (staff) is the secondary theme this month (n=7). Communication/Information to Patient/Carer is the third theme (n=4). This year's cumulative complaints is currently level with last year's trend (see Figure 18).

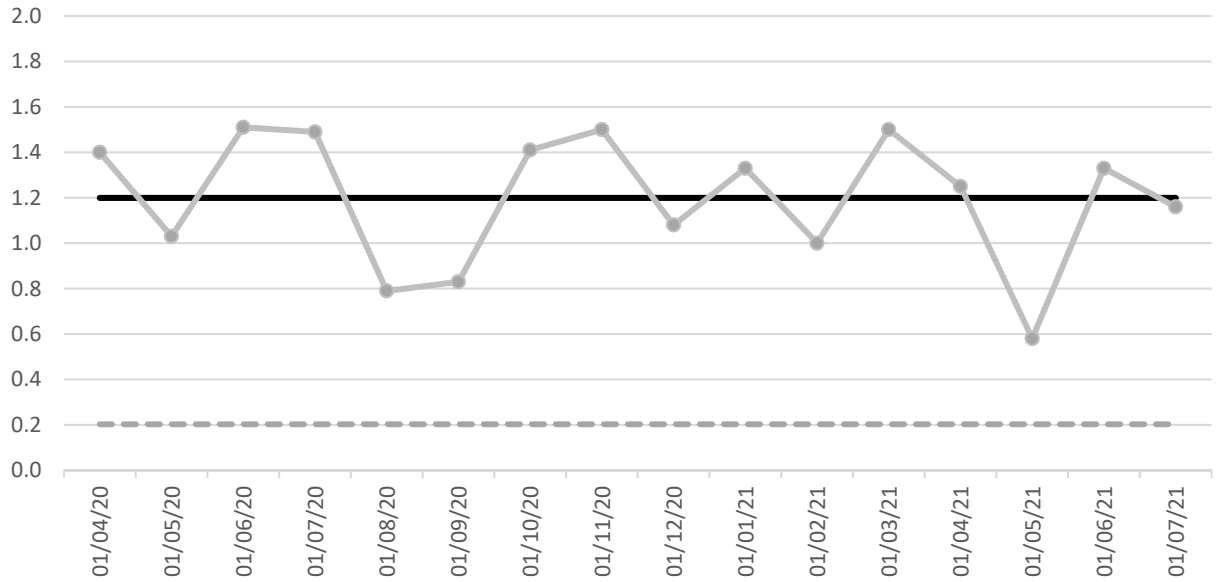
Figure 18 – Complaints Cumulative



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2019/20 (Total = 208)	21	37	50	69	81	110	131	149	157	181	198	208
2020/21 (Total = 168)	10	19	34	52	62	71	89	108	122	138	150	168
2020/21 dated 04/08/21 = 52	15	22	38	52								

The number of complaints per 1,000 bed days for July 2021 is lower, when compared to the previous month, see Figure 19 below.

Figure 19 – Complaints per 1000 bed days



Theres were 10 complaints due for responses to be sent out during July, seven of which were categorised as complex and three which were categorised as non-complex. Six out of the seven complex complaints were responded to within 60 days, equating to 85.7%. All non-complex complaints were achieved within timeframe, equating to 100%.

Patient Experience Updates

Support for marginalised carers- Restitute

The Trust has recently started working with restitute, an organisation that offers support to third party victims of crime and marginalised carers. Work is currently underway to explore how we can support staff training and awareness of marginalised carers and signpost patients that access our services.

PATIENT SAFETY AND QUALITY REPORT DEVELOPMENT

- We are in the process of reviewing all reporting metric KPIs within the report to either align with national targets or standards, or agree our own local KPIs based on Trust data. Data will be provided per 1000 bed days where actual numbers fluctuate from month to month. This will provide a comparable metric across reporting periods. The review of metrics will be carried out annually to ensure they are current and relevant.

- The process for this review is underway but will require consultation and agreement with lead for each KPI. We will provide a table containing the current KPI, the proposed evidence-based KPI for each metric within the report

- NHS England and NHS Improvement have updated the System Oversight Framework for 2021/22. We will be reviewing the new/revised metrics as part of the overarching review.