Agenda item: 15
Enclosure no: TB2018/14

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD PAPER
MEETING – 31st January 2018

Details of the Paper

Title	Quality Report
Responsible Director	Tina Kenny, Medical Director Carolyn Morrice, Chief Nurse
Purpose of the paper	To update the board on performance against key quality indicators and continue the development of a refreshed quality report. The new format was presented and discussed at the Quality Committee on 16th January. The committee broadly approved of the new format and offered recommendations for some amendments. These amendments have largely been made within this updated version and include the addition of trend indications, identification of national targets and highlighting as red/high risk those indicators not meeting minimum standards.
Action / decision required (e.g., approve, note, support, endorse)	The Board is asked to note the quality report.

Links to BHT Business and Risks

Implications and issues to which the paper relates (please mark in bold)					
Patient Quality	Financial Performance	**Operational Performance**	Strategy	FT Application	New or elevated risk
Legal	**Regulatory/ Compliance**	Public Engagement /Reputation	Equality & Diversity	Partnership Working	Other
Annual Objective	High quality, safe and compassionate care in patients' homes, the community or one of our hospitals.				
Links to BHT Board Assurance Framework/Corporate Risk Register					
BAF/Corporate Risk Register Reference	This relates to a number of items both on the BAF and on the corporate risk register which stretch across the spectrum of the quality agenda.				
Risk Description					
Author of Paper					
Christine Skeldon, Head of Medical Quality and Development.					
Presenter of Paper: Tina Kenny, Medical Director, Carolyn Morrice, Chief Nurse					
Other committees / groups where this paper / item has been considered					
Quality Committee, 16th January 2018					
Date of Paper					
19th January 2018					

Buckinghamshire Healthcare NHS
NHS Trust

Quality Report
January 2018

Introduction

This is the latest iteration of the new format quality report for trust-wide forums and for the use of the board, executives and senior managers who require monthly updated quality indicators. The purpose of the report is to provide clear and structured quality related data and information in as efficient a way as possible and avoiding duplication wherever possible. The report provides brief assurance on progress, a clear picture of which quality indicators require improvement, the narrative to support this and areas of excellence to celebrate. Indicators included in the report have been agreed by the Medical Director and Chief Nurse and are based on those already reviewed regularly by the board and the Executive Management Committee (EMC).

It is anticipated that the data section of the report will be able to be made available on Qlikview, with the intention that indicators, once reported, will feed into the updated report and be accessible in one place.

A prototype has been reviewed and discussed at Quality Committee on 16th January and this is an update based on the feedback at that committee. Requests made have, mainly, already been incorporated, with two others to be included in the future:

- Development of leading indicators.
- Prevalence of learning disability deaths in the mortality report in future.

Future versions will also include analysis and updates based on CQC Insight Reports and NHS England Specialised Services dashboards.

Summary

The dashboard shows a number of indicators within desired standards or with only slight variations outside of this. The main areas of good practice to note are Friends and Family Test response rate improvements in some areas, work in prevention of healthcare associated complications and the work achieved so far as part of the mortality review project.

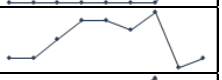
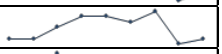
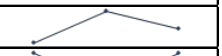
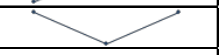
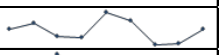
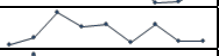
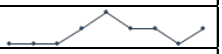
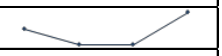
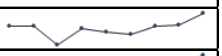
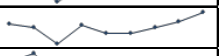
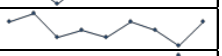
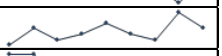
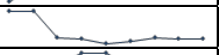
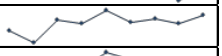
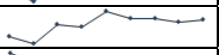
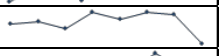
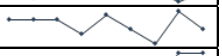
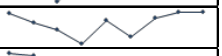
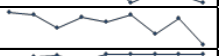
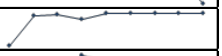
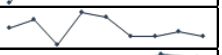
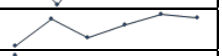
The patient feedback and satisfaction levels in accident and emergency are reduced (as measured via the Friends and Family Test). A number of actions are being taken to help improve these.

Concerns include the reporting of two acquired grade 3 and 4 pressure ulcers. The number of complaints has increased in December, and indeed for the last six months compared with the previous. There is a clear theme of delays and cancellations, as may be expected given the pressures on the system. It is likely this same pressure is also the reason for the fall in achievement of responses within 25 working days.

The maternity dashboard is appended as requested and three indicators have been extracted and appear within the dashboard.

Key to the Dashboard

Latest Data	Within or better than standard/ target		Slightly outside desired range but not significant risk	Outside of desired range and/or consistent trend away from range with associated moderate risk to patient safety/quality	Outside of desired range and/or consistent trend away from range with associated high risk to patient safety / quality
Change	No change	Positive change	Slight adverse change	Moderate Adverse change	High adverse change

Indicator		Date(s) of Latest Data	Standard / Target *(n = national)*	Latest Data	Change (from last data point)	Trend
Healthcare Associated Infection (HCAI)	Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia	Dec-17	0	1	⇔	
	Clostridium difficile infection	Year to date (to Dec)	Maximum 32 cases in 2017/18 (n)	35	⇧	
		Dec-17	2	2	⇧	
	Peripheral line infection	Dec-17	0	0	⇔	
Sepsis	Sepsis screening in the emergency department	Dec-17	95%	85%	⇩	
	1 hour suspicion to needle time (STNT)	Quarter 3	Not set	88%	⇩	
	3 hour STNT	Quarter 3	≥ 95%	100%	⇧	
Patient Safety Incidents	Never Events	Dec-17	0 (n)	0	⇔	
	Overall percentage of patient safety incidents reported causing any level of	Dec-17	< 35%	33%	⇧	
	Medication errors	Dec-17	Not set	81	⇩	
	Medication errors causing moderate or severe harm	Dec-17	0	0	⇔	
Venous Thromboembolism (VTE)	VTE risk assessments	Dec-17	95% (n)	97%	⇧	
	Hospital Acquired Thromboses (HATs)	Dec-17	0	1	⇧	
Pressure Ulcers	Avoidable pressure ulcers, grade 2	Dec-17	< 18 per month	22	⇩	
	Avoidable pressure ulcers, grade 3 and 4	Dec-17	0	2	⇧	
Safety Thermometer	Overall Harm-Free Care	Oct-17	≥ 95%	92%	⇩	
Falls	Total number of reported falls	Dec-17	≤ 75 per month	117%	⇧	
	Falls per 1,000 bed days	Nov-17	≤ 3.5	5.1	⇧	
	Falls with moderate or severe harm	Nov-17	≤ 2	3	⇧	
Cardiac Arrests	Number of cardiac arrests in non-critical areas	Dec-17	≤ 4	4	⇧	
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Oct 16 - Sept 17	< 100 (n)	91.9	⇔	
	Standardised Hospital-level Mortality Indicator (SHMI)	Sept 16 - Aug 17	< 100 (n)	94.75	⇩	
	Mortality Review Rates	Dec-17	100% (n)	75%		Transition to new process in Dec 17
Maternity and Neonatal	Term babies admitted to the neonatal unit	Dec-17	≤ 4% (n)	4.0%	⇧	
	Extended perinatal mortality rate	Rolling year to Dec 17	≤ 5.61 per 1,000 (n)	5.42	⇧	
	Still born babies ≥ 24 weeks gestation	Rolling year to Dec 17	< 3.87 per 1,000 (n)	3.87	⇧	
	Neonatal death	Rolling year to Nov 17	< 1.74 per 1,000 (n)	1.36	⇔	
Complaints	Complaints (number received)	Dec-17	Not set	46	⇧	
	Complaint responses within 25 working days	Nov-17	≥ 85%	80%	⇩	
	Complaints open at 90 days or beyond	Dec-17	0	16	⇩	
Friends and Family Test (FFT)	Inpatients - response rate	Dec-17	≥30%	29%	⇧	
	Inpatients - recommended	Dec-17	≥ 95%	94%	⇩	
	Accident & Emergency - response rate	Dec-17	≥30%	9%	⇔	
	Accident & Emergency - recommended	Dec-17	≥ 95%	81%	⇔	
	Maternity - response rate	Dec-17	≥30%	17%	⇩	
	Maternity - recommended	Dec-17	≥ 95%	93%	⇩	
	Community - recommended	Dec-17	≥ 95%	98%	⇩	
	Outpatients - recommended	Dec-17	≥ 95%	95%	⇩	
Frailty (patients age >75 yrs; wards 8 & 9 + 1 & 2)	Patients with a frailty assessment completed	Dec-17	75.0%	61.8%	⇩	
	Patients with a frailty care plan completed	Dec-17	75.0%	40.5%	⇩	
Fractured Neck of Femur (#nof)	Time to theatre (within 36 hours)	Dec-17	90%	80%	⇧	
Cancelled Operations	Operations cancelled on the day for non-clinical reasons	Dec-17	< 114	68	⇧	
	Patient cancelled on the day offered a binding new date within 28 days	Dec-17	100%	100%	⇔	

Areas of Good Practice

Community and Outpatient FFT Scores

Feedback on Community and Outpatient services via the Friends and Family Test continues to show a high level of patients would recommend the services to others.

Prevention of Complications

There have been no peripheral line infections for six months and no Never Events reported year to date 2017/18.

Compliance in carrying out risk assessments to help prevent venous thromboembolism has been maintained at a high level.

Patient Safety Incidents

Incident and Near Miss reporting continues to be encouraged and the most recent information shows that the percentage of incidents causing any level of harm (the majority of which were classified as low level harm) has decreased. There have been fewer medication related incidents reported.

Mortality

The two mortality indicators (SHMI and HSMR – see table above) continue to be below expected.

The new mortality review process was launched on 1st December with a revised process incorporating the role of Medical Examiner (ME) to independently screen all deaths. The project lead has worked closely with the bereavement office staff to streamline the process and further ME sessions are being put in place for January to cope with the higher number of deaths in the winter months.

Board reporting obligations are to ensure the numbers and learning are reported to the board and initial findings are in the table below.

Initial Findings- December 2017

Total Number BHT Deaths	131
Total Medical Examiner (ME) Screens	98 (75%)
Total Number of patients with a Learning Disability who died	2
Total selected for SJR review at M & M	15 (15%)
Compliments/Excellence Reports	55

The benefits of the ME role has been clearly evidenced and include increased accuracy in death certification, closer relationships with the coroner, increased support and training for junior doctors. Most importantly, it helps bring greater engagement with bereaved families and carers and a greater emphasis on learning.

The project started at a busy time of year and early learning has resulted in minor changes to increase ME support. Following ME screen, deaths are selected against national criteria to inform further learning. The Royal College of Physicians anticipated 10-20% of patients reviewed will be selected for Structured Judgement Review (SJR) case note review. Our screens so far have selected 15% in the first month of data, suggesting that these initial screens are in line with recommendations.

Communications with bereaved families has also resulted in commendations from families on how well they felt relatives were cared for in the trust. In particular 55 excellence reports have been fed back to the teams involved in the patients' care.

At the request of Quality Committee, future reports will include the prevalence of patients with a learning disability who have died.

The National Mortality Case Record Review programme is overseen by the Royal College of Physicians. This programme supports the implementation of the SJR as the standardized methodology for reviewing the care records of adults who have died in acute hospitals in England and Scotland. It is important to note that the NMCRR programme SJR methodology does not allow the calculation of whether a death has a probability of being avoidable. The RCP circulated its updated view confirming this position in January 2018. We are working with the Academic Health Sciences Network to understand what this may mean with respect to reporting avoidability and to aim for a consistent approach within local trusts.

Areas for Improvement

Emergency Admissions for Fractured Neck of Femur

80% of patients with fractured neck of femur (#nof) went to theatre within 36 hours of admission in December, despite system pressures. December saw the highest monthly number of patients with #nof admitted for 2017/18 (50 patients). The Board requested the target be stretched to 90% and that has been reflected in this paper.

Pressure Ulcer Prevention

One grade 3 and one grade 4 hospital acquired pressure ulcers have been reported as serious incidents. Both have initial, 72 hour, reports completed, with initial recommendations and actions. Full root cause analysis of these incidents will be carried out.

The number of acquired grade two pressure ulcers is beginning to reduce; however further work continues including the introduction of electronic prompts in the care record, a refresh of patient leaflets, revision of a core care plan for ulcer prevention and enhanced conversations with patients and carers about prevention. Training for staff on prevention and dressing use has been rolled out.

Friends and Family Test (FFT)

Response rates in several areas have decreased. The patient experience team is exploring the introduction of an electronic FFT/patient experience platform in the longer term. In the short term, the team has started to attend the A and E service delivery unit meetings where patient experience is a standing agenda item.

The identification of patient experience champions within the department is to be supported by the patient experience manager and there is a plan to work with the volunteer manager to develop a dedicated A&E volunteer role that will call 15 patients per day using the telephone to collect feedback directly.

Falls

A number of interventions are in place to help reduce falls; these include 'Stay in the Bay' initiatives whereby organisation of work and allocation of staff allows more time to be spent in direct sight of patients, including use computers on wheels. Other initiatives being implemented include the use of specialist equipment, such as ultra-low beds, reviewing risk assessment processes and extended visiting hours.

Complaints

Speed of response has reduced and this is particularly so for December. This may be as a result of the competing pressures within the system at this time.

The lead subjects for the 46 complaints received in December showed a clear theme of delays and cancellations, which although normally in the top 3, included a disproportionate increase in the number of complaints about cancellation of surgery.

Christine Skeldon, Head of Medical Quality and Development, 19th January 2018

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
31 January 2018

Details of the Paper

Title	Maternity Dashboard
Responsible Director	Carolyn Morrice
Purpose of the paper	To provide the Board with narrative regarding the maternity dashboard including the top three highlights and top three areas for improvement.
Action / decision required (e.g., approve, support, endorse)	Endorse

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	***Workforce performance***	*New or elevated risk*
Legal	*Regulatory/ Compliance*	***Public Engagement /Reputation***	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
Quality
People

Please summarise the potential benefit or value arising from this paper:
The Board will be sited on the maternity uniots performance in relation to the key quality, operational and workforce indicators.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: No
	Financial Risk: No

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Safe Responsive Effective

Author of paper: Heidi Beddall

Presenter of Paper: Carolyn Morrice

Other committees / groups where this paper / item has been considered:

Date of Paper: 23/01/18

Maternity Dashboard January 18 (reporting on ytd April 17 – December 17)

Positives

CS rate

The year to date caesarean section rate is below national average and 2.5% lower than the previous year. The focus on caesarean section rate as a performance indicator is evolving and it is essential to view it not solely as a number but triangulated with outcomes and patient experience.

Neonatal morbidity and mortality

There have been no cases of HIE grade 2 or 3, there is a lower than national average neonatal death rate and lower than national average stillbirth rate.

Maternal morbidity

There has been significant reduction in third degree tear rates. It was highlighted by the dashboard 15/16 and 16/17 that BHNHST were an outlier. A quality improvement project was undertaken involving education of staff, audit and implementation of a new care bundle. This has yielded a 1.2% reduction (from 3.1% to 1.9%).

Areas for improvement

FFT response rates

Whilst FFT response rates are above target and positive response above target there has been a decrease in the number of response compared to 16/17. The department has recruited a patient experience midwife to drive up FFT response rates and gather patient experience using a range of approaches in line with the Trust patient experience strategy.

Induction of labour rate

BHNHST is an outlier nationally, with a higher than average induction rate. However national data recognises that Bucks has a higher proportion of older mothers than England average and higher detection rate of small for gestational age babies. Ongoing work is in progress to ensure inductions are audited and indications justified.

Staff sickness rates

Sickness rates are above target and the clinical leads need to ensure sickness is being supported and managed effectively, respond to staff feedback and provide a positive working environment. It is recognised that obstetrics and midwifery are areas of high stress levels amongst staff, safe staffing and escalation guidelines are being reviewed. A manager on call rota has been implemented and the department will be implementing the new professional midwifery advocate role that replaces supervision of midwives) to support staff through restorative clinical supervision.

Clinical Performance & Governance Score Card Maternity Dashboard

Buckinghamshire Hospitals NHS Trust

		BHT Apr 17 - March 18	Goal	Red Flag	Measure	Comment / Target set	Data source	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date Average	Previous year monthly average	Year to date Total	previous year total	Comments, actions or prediction
Operational	Births	Total Deliveries	<484	>492	Deliveries	Local	DC/ CBeetham	441	449	414	424	413	422	463	417	420				429	456	3863	5235	5151
		Total Births	<500	>520	Births	Local	DC/ CBeetham	447	454	416	429	413	425	472	423	426				434	463	3905	5324	5207
		Planned Home Births	>2.3%	<2.3%	Births	National average ONS 2015	DC/ CBeetham	1.6%	0.7%	0.7%	0.7%	1.7%	1.9%	1.7%	1.9%	0.7%				1.3%	0.8%	NA	NA	
		Wycombe Birth Centre Deliveries	≥30	≤25	Births	Local	DC/ CBeetham	21	16	17	13	13	16	28	15	17				17	22	156	261	208
		Aylesbury Birth Centre Deliveries	≥80	≤70	Births	Local	DC/ CBeetham	64	62	48	53	60	51	61	49	52				56	60	500	719	667
		Predicted Deliveries from booking figures	<484	>492	Deliveries	Local	DC	486	500	470	430	456	423	527	454	452	444	480	453	465	427	5575	5128	5575
	Bookings	Bookings (1st visit) scheduled	<500	>550	Bookings (1st visit)	Local	Carole Beetham	512	493	456	492	423	515	492	532	416				481	474	4331	5692	5775
		Women booked before 12+6 weeks	>90%	90% or less	Bookings (1st visit)	BHT Quality Schedule	Carole Beetham	94.53%	93.1%	94.1%	92.48%	93.14%	92.43%	93.70%	94.92%	92.31%				93.4%	94.2%	NA	NA	
Workforce	Staffing, Education and Training	Average weekly hours of dedicated consultant cover on labour ward	>98		Hours	average from first 4 full weeks of Cons rota		100	100	100	100	100	100	100	100	100				100	100	NA	NA	
		Midwife/del ratio worked	1:34 or less	1:38 or more	Hours worked	BHT Quality Schedule	Rosie Sheppard	31.86	31.78	31.43	31.06	30.93	30.75	30.75	30.81	30.91				31.14	32.4	NA	NA	rolling year figure
		Midwife/del ratio fund/est	1:34 or less	1:38 or more	Funded est	BHT Quality Schedule	Rosie Sheppard	30.46	30.24	29.91	29.55	29.42	29.26	29.41	29.54	29.68				29.72	31.2	NA	NA	rolling year figure
		Number of midwifery vacancies	<5%	≥5%	169 WTE		Devi Jackson	11.1%	12.7%	11.8%	13.5%	15.3%	14.6%	5.0%	5.7%	5.9%				10.62%	10.10%	NA	NA	Data capture issues
		Sickness Obsterics	<3%	>5%		Local	Devi Jackson	4.6%	4.0%	4.9%	5.7%	6.4%	7.2%	5.6%	5.5%	NYA				5.48%	5.10%	NA	NA	
		%of Staff appraised Obsterics	>95%	<80%		Local	Devi Jackson	1%	5%	10%	60%	63%	79%	79%	79%	80%				NA	NA	10.0%	85.0%	
		Midwife attendance at mandatory training Day A **Rolling year %**	>95% (209)	<75% (165)	220	Local	MPDT	85.3%	84.6%	85.0%	90.6%	90.5%	84.8%	85.1%	86.8%	96.4%								
		Midwife attendance at mandatory training Day C (includes FM) **Rolling year %**	>95% (209)	<75% (165)	220	Local	MPDT	93.9%	91.9%	92.4%	97.1%	98.0%	91.2%	87.3%	84.8%	93.9%								
		Current Doctor attendance at mandatory training Day A %	>95%	<75%	65	Local	MPDT	59.5%	66.7%	69.8%	72.1%	33.3%	39.5%	44.2%	68.2%	88.6%								
		% of current Cons & Regs completing CTG assessment in last year	>95%	<75%	29	Local	MPDT	93.9%	63.6%	64.7%	64.7%	75.0%	84.6%	92.6%	100.0%	100.0%								
	Antental screening	Women who cannot be offered first trimester screening booked before 13+5	0	1	first trimester screening	Local	A Wainwright	0	0	0	0	0	0	0	0	0				NA	NA	0	0	
		HIV Testing coverage	>90%	<90%	% tested	National Screening Committee	A Wainwright	99.9%			99.9%										99.90%	NA	NA	data due 31/12/17
		referral of Hep B Postive women for specialist assessment	≥90%	<70%	%referred and seen in timescale	National Screening Committee	A Wainwright	no cases			100.0%										100.00%	NA	NA	data due 31/12/17
		Downs syndrome screening completion of forms	100%	<97%	% tested	National Screening Committee	A Wainwright	98.2%			97.7%										96.80%	NA	NA	data due 31/12/17
		Sickle Cell and Thalassemia Screening coverage	≥99%	<95%	% tested	National Screening Committee	A Wainwright	99.9%			99.7%										100.00%	NA	NA	data due 31/12/17
		Sickle Cell and Thalassemia Screening timelness	≥75%	<50%	% meeting timescale	National Screening Committee	A Wainwright	76.4%			72.7%										82.20%	NA	NA	data due 31/12/17

		BHT Apr 17 - March 18	Goal	Red Flag	Measure	Comment / Target set	Data source	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date Average	Previous year monthly average	Year to date Total	previous year total	Comments, actions or prediction
Quality		Sickle Cell and Thalassemia Screening FOO	≥95%	<90%	% Completed	National Screening Committee	A Wainwright		99.7%			99.7%									100.00%	NA	NA	data due 31/12/17
		Newborn Blood Spot Screening avoidable repeats	≤1.0%	>2%	% repeated	National Screening Committee	A Wainwright		1.8%			1.7%									2.30%	NA	NA	data due 31/12/17
		Newborn Hearing Screening coverage (NH1)	≥99.5%	<95%	% Completed	National Screening Committee	A Wainwright		99.9%			99.9%									99.70%	NA	NA	
	ND	Maintain normal Vaginal Delivery rate	40%	30% or less		Local	DC/ CBeetham	33.6%	28.7%	33.1%	34.2%	33.4%	35.3%	39.1%	35.5%	35.7%				34.3%	29.4%	NA	NA	
	SVD	including epidural, syntocinon, episiotomy (inc. ND)	>60%	60% or less	Overall SVD	BHT Quality Schedule	DC/ CBeetham	60.5%	52.6%	54.6%	56.6%	59.6%	56.4%	60.0%	54.4%	57.1%				56.9%	55.0%	NA	NA	
	Instrumental deliveries	All instrumental deliveries	<12.9%	>15%	Instrumental delivery rate	National HMA Data 15-16	D Curtis	16.1%	17.8%	19.6%	18.6%	16.0%	17.1%	16.2%	14.9%	14.3%				16.7%	16.3%	NA	NA	
	C/S	Total rate (planned & unscheduled)	≤25.5%	≥26.5%	C/S rate overall	Local	D Curtis	23.1%	29.4%	25.4%	24.8%	24.2%	26.5%	23.8%	30.2%	28.6%				26.2%	28.7%	NA	NA	
	EL c/s	% of deliveries planned c/s	<11.5%	>11.5%	Elective C/S rate	NHS Digital Data 15-16	D Curtis	9.3%	12.2%	12.3%	10.1%	10.2%	10.9%	9.9%	14.1%	10.0%				11.0%	11.0%	NA	NA	
	EM c/s	% of deliveries emergency c/s	<15.6%	>15.6%	Emergency C/S rate	NHS Digital Data 15-17	D Curtis	13.8%	17.1%	13.0%	14.6%	14.0%	15.6%	13.8%	16.1%	18.6%				15.2%	17.7%	NA	NA	
	VBAC	Success Rate of Women Attempting VBAC	≥70%	≤60%	VBAC success rate	Local	D Curtis	73.9%	57.1%	75.0%	75.0%	83.7%	85.6%	84.6%	85.9%	84.3%				78.3%	60.5%	NA	NA	
	IOL	Induction of labour rate	<27.9%	>27.9%		National HMA Data 15-16	D Curtis	25.4%	31.0%	28.0%	31.1%	34.4%	28.4%	32.0%	30.2%	34.8%				30.6%	31.1%	NA	NA	
	Breast feeding	% of women breast feeding initiation figures not collected on	<1	>1%	Total per month	BHT Quality Schedule	Sailesh Ghedia	0.45%	0.00%	0.00%	0.24%	0.73%	0.24%	0.43%	0.00%	NYA				0.3%	0.4%	NA	NA	
		% of women known to have initiated breastfeeding in the first 48 hours	>80%	<76%	Total per month	BHT Quality Schedule	Sailesh Ghedia	81.2%	83.7%	81.4%	84.67%	83.3%	80.8%	82.7%	85.3%	NYA				82.9%	83.4%	NA	NA	
	Smoking Cessation	% of women smoking data not collected on	<2%	>2%	Total per month	BHT Quality Schedule	SG/CB	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	NYA				0.0%	0.0%	NA	NA	
		%of women smoking at delivery	<12%	>12%	Total per month	BHT Quality Schedule	Sailesh Ghedia	7.7%	8.9%	6.5%	8.02%	6.54%	10.69%	8.21%	5.04%	NYA				7.7%	7.5%	NA	NA	
		% of women smokers offered referral to stop smoking services	100%	95%	Total per month	BHT Quality Schedule	Carole Beetham	100%	100%	100%	100%	100%	100%	100%	100%	100%				100.0%	100%	NA	NA	
		No. of women smokers declining referral to smoking cess service			Total per month	BHT Quality Schedule	Carole Beetham	12	7	7	6	3	7	6	8	3				NA	NA	NA	NA	
		% of women smokers declining referral to smoking cess service	0%	<5%	% per month	BHT Quality Schedule	Carole Beetham	36.4%	30.4%	18.9%	17.1%	12.5%	28.0%	21.4%	27.6%	15.8%				23.1%	20.0%	NA	NA	
	Hand Hygiene	Labour Ward	100%	≤94%	% per month	Local Target	BHT Hand Hygiene Report	96%	98%	96%	98%	99%	98%	98%	99%	98%				97.8%	99.1%	NA	NA	
		Aylesbury Birth Centre	100%	≤94%	% per month	Local Target		100%	99%	100%	100%	99%	100%	100%	100%	98%				99.6%	99.8%	NA	NA	
		Wycombe Birth Centre	100%	≤94%	% per month	Local Target		100%	100%	100%	100%	100%	100%	100%	100%	100%				100.0%	99.9%	NA	NA	
		Rothschild Ward	100%	≤94%	% per month	Local Target		98%	98%	98%	97%	98%	97%	99%	99%	99%				98.1%	98.2%	NA	NA	
		SMH ANC	100%	≤94%	% per month	Local Target		100%	100%	100%	100%	100%	90%	100%	100%	98%				98.7%	99.6%	NA	NA	
		WGH ANC	100%	≤94%	% per month	Local Target		100%	100%	100%	100%	100%	100%	100%	100%	100%				100.0%	98.9%	NA	NA	
	VTE	VTE Obs	>90%		% per month	National average	Sailesh Ghedia	96.0%	98.0%	99.0%	97.0%	98.0%	96.0%	97.0%	99.0%	NYA				97.5%	97.1%	NA	NA	
Quality		Eclampsia	0	1 or more	No. of patients	Local Target	DC/ Cbeetham	0	0	0	1	0	0	0	0	0				NA	NA	1	0	

BHT Apr 17 - March 18			Goal	Red Flag	Measure	Comment / Target set	Data source	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year to Date Average	Previous year monthly average	Year to date Total	previous year total	Comments, actions or prediction
Quality	Maternal Morbidity	ITU/HDU Admissions in Obstetrics	0	1 or more	No. of patients	Local Target	DC/ Cbeetham	1	1	0	2	1	0	0	0	0				NA	NA	5	3	
		Post partum Hysterectomies	0	1 or more	No. of patients	Local Target	DC/ Cbeetham	0	0	0	0	0	0	0	0	0				NA	NA	0	1	
		Massive PPH >1.5L	< 3.9% month	> 4.5% month	% Total deliveries	National average	DC	4.8%	2.2%	1.9%	3.1%	1.9%	2.8%	3.7%	2.9%	1.9%				2.8%	2.1%	NA	NA	
		Total 3rd degree tear SVD	<1%	>3%	% of ND+SVD	National average	DC	1.1%	2.1%	3.1%	1.7%	1.6%	2.9%	1.4%	2.2%	0.8%				1.9%	3.1%	NA	NA	
		3rd deg tear SVD Primip	≤6.5%	>6.5%	% of ND+SVD	National maternity and perinatal audit	DC	1.4%	4.5%	4.5%	4.2%	4.1%	6.0%	1.1%	1.3%	1.4%				3.1%				data from Medway
		3rd deg tear SVD Multip	≤2.1%	>2.1%	% of ND+SVD	National maternity and perinatal audit	DC	1.2%	1.2%	2.5%	0.6%	0.6%	1.3%	1.6%	2.6%	0.6%				1.3%				data from Medway
		Total 3rd degree tear at instrumental delivery	< 7%	>7%	% of Instrumental births	National average	DC	4.2%	7.5%	3.7%	1.3%	3.0%	2.8%	5.3%	0.0%	6.7%				3.8%	6.3%	NA	NA	
		3rd degree tear at instrumental del Primip	≤6.4%	>6.4%	% of Instrumental births	National maternity and perinatal audit	DC	6.0%	8.9%	4.6%	0.0%	1.8%	4.2%	6.7%	0.0%	8.5%				4.5%				data from Medway
		3rd degree tear at instrumental del Multip	≤4.1%	>4.1%	% of Instrumental births	National maternity and perinatal audit	DC	0.0%	4.0%	0.0%	5.0%	10.0%	0.0%	0.0%	0.0%	0.0%				2.1%				data from Medway
		Total 3rd degree rate	<4%	>6%	%of all vaginal deliveries	RCOG Patterns of Maternity Care	DC	1.8%	3.5%	3.3%	1.6%	1.9%	2.9%	2.3%	1.7%	2.0%				2.3%	3.8%	NA	NA	
		Total 3rd deg rate Primip	<6%	>6%	%of all vaginal deliveries	RCOG	DC	3.2%	6.6%	4.5%	2.3%	3.1%	5.3%	3.2%	0.8%	4.2%				3.7%				data from Medway
		Total 3rd deg rate Multip	<2%	>2%	%of all vaginal deliveries	RCOG	DC	1.1%	1.5%	2.3%	1.0%	1.1%	1.1%	1.5%	2.4%	0.5%				1.4%				data from Medway
		Pressure Ulcers	0	1	No. of patients	Local Target	Sharon Welch	2	2	0	2	0	0	0	0	0				NA	NA	6	1	
	Neonatal morbidity	Birth Weight≤2500g	≤6%	10%≥	% of term birth rate	BHT Quality Schedule	DC/ Cbeetham	6.7%	6.2%	5.0%	7.5%	6.5%	5.6%	7.6%	7.3%	6.6%				6.6%	6.6%	NA	NA	
		Meconium aspiration	0	3 or more	No. of patients	Local Target	NNU	0	1	1	1	2	1	0	0	0				NA	NA	6	7	
		% Term babies admitted to NNU	≤4.0%	>4%	% of births	BHT Quality Schedule	NNU	4.06%	4.13%	4.04%	5.38%	3.87%	3.50%	5.18%	2.72%	4.00%				4.1%	4.00%	NA	NA	
		HIE (Grades 2&3)	0	3 or more	No. of patients	1.5/1000	NNU	0	0	0	0	0	0	0	0	0				NA	NA	0	5	
		NND per month	≤1	≥3		MBRRACE 2017	NNU/Debbie Curtis	0	0	0	0	0	0	1	0	1				NA	NA	2	9	A liveborn baby > 20+0 weeks or with a birthweight of > 400g where an accurate gestation is not available < 28 completed days after birth.
		NND rolling year rate	<1.74 per 1000	>1.74 per 1000	Annual Rolling Average	MBRRACE 2017	NNU/Debbie Curtis	1.69	1.51	1.53	1.55	1.36	1.17	1.36	1.36	1.55				1.5	1.5	NA	NA	
		Stillbirth per month	≤1	≥3		MBRRACE 2017	Debbie Curtis	2	0	5	0	4	0	2	0	1				1.6	1.7	14	20	A baby delivered ≥ 24+0 weeks showing no signs of life,
		Rolling year babies stillborn ≥ 24 weeks gestation (antenatal)	<3.87 per 1000	>3.87 per 1000	Annual Rolling Average	MBRRACE 2017	Debbie Curtis	3.00	2.64	3.63	3.48	4.28	3.91	3.89	3.68	3.87				3.6	2.70	NA	NA	A baby delivered ≥ 24+0 weeks showing no signs of life and known to have died before the onset of labour
		Rolling babies stillborn ≥ 24 weeks gestation (intrapartum)	0	1 or more	No. of patients	MBRRACE 2017	Debbie Curtis	0	0	0	0	0	0	0	0	0				0.0	0	0	0	A baby delivered ≥ 24+0 weeks showing no signs of life and known to have been alive before the onset of labour
		% extended Perinatal Mortality (Rolling Year)	≤5.61 per 1000	>5.61 per 1000	Annual Rolling Average	MBRRACE 2017	Debbie Curtis	4.68	4.15	5.16	5.03	5.64	5.09	5.25	5.04	5.42				5.1	4.20	NA	NA	A stillbirth or neonatal death before 28 days.
		Baby Readmissions ≤ 28 days age	<25		incidence	local	Debbie Curtis	15	11	11	17	10	25	13	16	18				15.1	16.67	136	200	
	Risk Management	Number of SIs Declared	0	1	Incidence	local	Jayne Poole	3	0	0	0	1	0	1	0	0				0.6	1.17	5	14	
		No. of open SI's overdue	0	1	Incidence	local	Jayne Poole	0	0	0	0	0	0	0	0	0				0.0	0.00	NA	NA	
		Overdue Incidents in Datix		≥100	Incidence	local	Sharon Welch	137	169	136	113	67	83	82	94	89				107.8	76.33	NA	NA	
		Medication Errors	≤ 4	≥ 6	Incidence	local	Sharon Welch	1	2	5	1	3	0	2	1	0				1.7	1.92	15	23	
	Feedback	Friends and Family Test Response	≥20%	<20%	Response rate	National average	Intranet	40.2%	38.0%	26.1%	35.4%	32.0%	17.0%	24.3%	23.0%	16.6%				28.1%	27.70%	NA	NA	
		Friends and Family Test Positive response	≥82%	≤40%	Postive feedback rate	National average	Intranet	98.3%	97.9%	95.7%	97.4%	96.6%	97.9%	94.8%	97.2%	97.3%				97.0%	98.10%	NA	NA	
	Complaints	Number of new complaints	< 2 month	> 4 month	Incidence	local	Sharon Welch	2	3	5	1	3	1	0	1	1				1.9	1.7	17	20	
		Complaints overdue	0	>1	Incidence	local	Sharon Welch	0	0	0	0	0	0	0	0	0				0	0	0	0	

Agenda item: 16
Enclosure no: TB2018/15

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
31 January 2018

Details of the Paper

Title	Infection Prevention & Control Report
Responsible Director	Medical Director
Purpose of the paper	To provide the Board with Infection Prevention data for December, an update on Gram negative infections and to share comments made by patients who had experienced C.Difficile infection.
Action / decision required (e.g., approve, support, endorse)	For information

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?

Annual HCAI objectives
MRSA bacteraemia: Zero cases 2017/18
Clostridium Difficile: 32 cases 2017/18

Please summarise the potential benefit or value arising from this paper:
The report outlines Healthcare Associated Infection data for December

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	15 (2)

Author of paper: Niamh Whittome

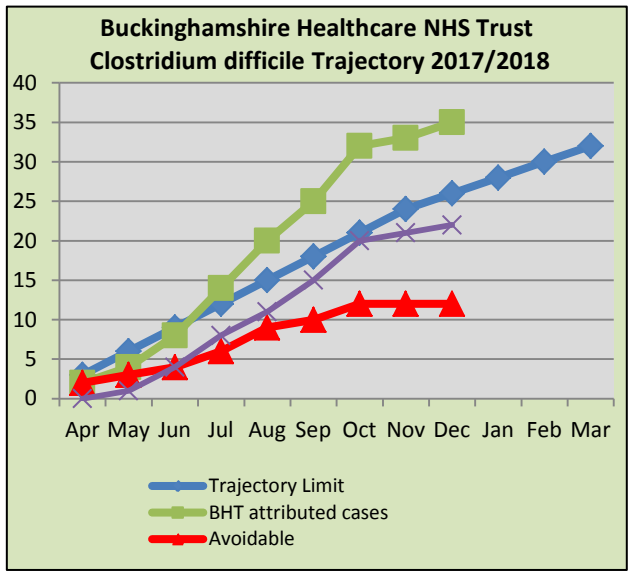
Presenter of Paper: Dr Tina Kenny

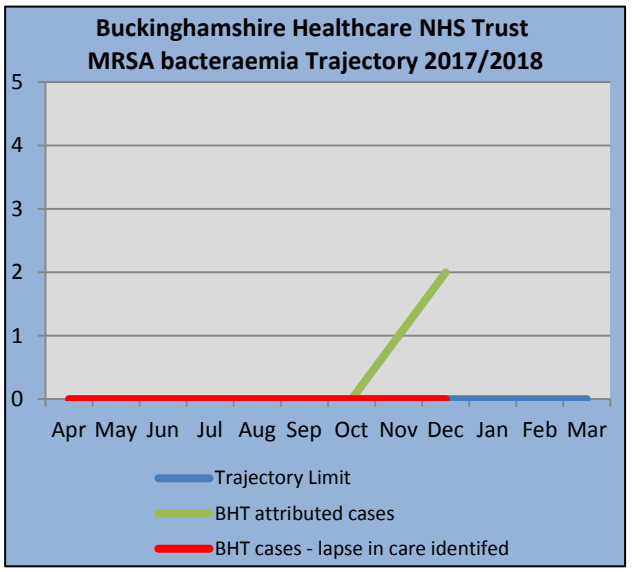
Other committees / groups where this paper / item has been considered:
Quality Committee and IPC committee

Date of Paper: January 2018

Infection Prevention & Control Report – December 2017

December 2017	Limits set by PHE	Trust Total from April 2017	Integrated Medicine	Integrated Elderly & Community Care	Women, Children & Sexual Health Service	Surgery & Critical Care	Specialist Services
Clostridium difficile	32	35	0	1	0	1	0
MRSA Bacteraemia	0	2	1	0	0	0	0
MSSA Bacteraemia (BHT associated (post 48 hours))	n/a	18	1	0	0	0	0
Gram-negative bacteraemias (E.Coli , Klebsiella & Pseudomonas aeruginosa) (post 48 hours)	n/a	From Dec 17 4	1	0	0	2	1
Line Infections	n/a	30	0	0	0	0	1
Hand Hygiene Observational Audit Compliance %	n/a	n/a	99%	99%	99%	99%	99%





For 2017/2018 the Trust objectives are

Clostridium difficile 32 cases

MRSA bacteraemia 0 cases

MRSA Bacteraemia – One

Post infection review arranged to discuss this case.

Clostridium difficile - 2 cases identified in December

Post infection review has been undertaken for one case and is arranged for the other case.

Learning from PIR for case 1 - no lapses in care, unavoidable case.

Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia – 1 case identified in December. Not device related.

Those that are BHT associated with devices will have a Root Cause Analysis (RCA) carried out.

Gram-negative bacteraemias (E.coli, Klebsiella & Pseudomonas aeruginosa). Previously the hospital acquired cases were determined if the case was catheter related. In accordance with the PHE Mandatory Enhanced Gram-negative Bacteraemia Surveillance hospital cases will now be determined as those detected post 48hr of admission.

Line Infections - One

1 Specialist Services/Oxford University Hospitals Foundation Trust.

The root cause analysis meeting arranged to discuss this case.

Gram Negative Blood Stream Infections (GNBSIs)

In May 2017 Secretary of State launched an ambition to reduce healthcare associated GNBSIs 50% by 2021

- 5,500 NHS patient deaths in 2015 associated to GNBSIs
- The initial focus is on reducing Escherichia coli (Ecoli) BSI as they represent 55% of all GNBSI
- Urinary tract or catheter associated urinary tract are the most common source of infection (50%)

To date: Improvement actions - whole systems approach

- Implement urinary catheter passport countywide (draft out for patient evaluation)
- BHT part of the national Community Catheter Management Study (data collection completed in November 17)
- Updated Urinary Catheter Assessment Monitoring Form (UCAM) – complete
- Implementation of a joint catheter product formulary – complete
- Introduced catheter discharge pack to ensure every patient discharged with a new catheter has sufficient supplies until further assessment by District Nursing teams – complete
- Guidance for care homes on diagnosis of CAUTI issued – complete
- Joint liaison with the Clinical Innovation Adoption Manager and the Oxford Health Science Network and across the wider STP footprint.

Gram Negative Blood Stream Infections (GNBSIs) cont..

Public Health England

All Trust Cases E.coli by Financial Year

Organisation Name	Code	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	RXQ	181	200	229	236	244	243
FRIMLEY HEALTH NHS FOUNDATION TRUST	RDU	289	382	376	451	531	605
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RC9	136	192	176	198	184	205
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RD8	94	148	141	174	177	210
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	RTH	308	371	410	394	456	515
ROYAL BERKSHIRE NHS FOUNDATION TRUST	RHW	179	231	245	255	261	274

Year	BHT Inpatient admissions	Positive E.coli Bacteraemias reported	Post 48 hour as inpatient positive E.coli bacteraemias	Percentage of post 48 hour E.coli bacteraemias/ Inpatient admissions
16/17	50956	243	46	0.09
15/16	53117	244	38	0.07
14/15	55015	236	40	0.07
13/14	45648	229	33	0.07
12/13	50412	200	40	0.07
11/12	52235	181	37	0.07

- 2017/18 data will give us our baseline
- April 1st 2017 reporting has included *klebsiella* and *pseudomonas*
- Further enhanced surveillance required

Post 48 hours

Public Health England

Trust Apportioned E.coli Cases by Financial Year

Organisation Name	Code	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	RXQ	37	40	33	40	38	46
FRIMLEY HEALTH NHS FOUNDATION TRUST	RDU	41	69	58	67	88	91
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RC9	22	29	26	34	28	16
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RD8	11	15	18	21	26	32
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	RTH	73	92	90	64	94	114
ROYAL BERKSHIRE NHS FOUNDATION TRUST	RHW	41	46	50	38	62	60

Information taken from PHE HCAI Database

C.difficile: What our patients have told us

Worry	Will I recover? I hear such bad news in the press about healthcare associated infections.
Isolation	Studies have shown that there are adverse mental health consequences of isolation. 'I feel I'm being ignored and healthcare workers are avoiding coming in to see me' I feel 'like a leper', staff having to gown up with gloves and aprons.
Having severe diarrhoea	This is very inconvenient for me, I have to get out of bed frequently, or have a bed-pan. I'm embarrassed about the smell.
The risk of relapse	I worry about this, is it likely to happen again. I feel anxious about taking antibiotics in the future.

Best estimate of cost to NHS per case £10,000

Agenda item: 17
Enclosure no: TB2018/16

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Buckinghamshire Healthcare NHS
NHS Trust

BOARD COMMITTEE SUMMARY REPORT FOR QUALITY COMMITTEE

Name of Committee	Quality Committee
Committee Chair	Professor Mary Lovegrove
Meeting date:	5th December 2017
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Mrs Bridget O'Kelly; Miss Elizabeth Hollman; Mr Tom Roche No representation from allied health professionals.

KEY AREAS OF DISCUSSION:

The Committee received assurance on the following:

- Focus on improving staff uptake of the flu vaccine
- Progress report on improvements in theatres for which Mrs Jenny Ricketts was commended
- Plans to put in place mock Chief Inspector of Hospitals' inspections due to start in January 2018 to provide greater assurance on compliance with Key Lines of Enquiry
- Improvements in pathology services including reference to recent external reviews
- Development of a systematic approach to shared organisational learning
- Learning from incident trends and litigation trends
- Winter Planning 2017
- Metrics relating to quality of care
- Terms of Reference review
- Infection control including an update on cleaning audits
- Medicines management action plan
- Safeguarding Q2
- Seven day clinical services
- Corporate Risk Register
- Organ and Tissue Donation Committee

AREAS OF RISK:

- Flu vaccination
- Cultural issues in theatres
- C diff trajectory
- A&E quality and patient experience
- Anti-coagulant compliance

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

AUTHOR OF PAPER:	Liz Hollman, Director for Governance

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BOARD COMMITTEE SUMMARY REPORT FOR QUALITY COMMITTEE

Name of Committee	Quality Committee
Committee Chair	Professor Mary Lovegrove
Meeting date:	16th January 2017
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Mr Neil Macdonald. (Ms Fox attended in his place); Mrs J Sturgess

KEY AREAS OF DISCUSSION:

The Committee received assurance on the following:

- Progress with red and amber clinical audits
- Progress with the Frailty Strategy
- Current status in terms of percentage of staff with a flu vaccination
- Key quality metrics within the quality report (also on Board agenda)
- Progress with the Perfect Ward app – a way of systematically monitoring quality in clinical areas in a timely way and in a way that keeps people informed about findings and key actions
- Community paediatric waiting times – new models of care and improved patient experience
- The challenges of 'Winter' on the urgent care pathway and how staff have been managing pressures on a day to day basis
- Infection control – concerns around number of cases of Clostridium difficile and MRSA bacteraemia and assurance as to how this is being managed
- Compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards
- Preparation of the Quality Accounts for 17/18
- Progress with the introduction of the new mortality review process
- Quality related risks
-

AREAS OF RISK:

- Flu vaccination
- C diff trajectory and MRSA bacteraemia trajectory
- A&E quality and patient experience

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

System working around reducing waiting times for community paediatrics.

Perfect Ward app. and quality rounds.

AUTHOR OF PAPER:	Liz Hollman, Director for Governance