SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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EXECUTIVE SUMMARY
REPORT TO THE BOARD OF DIRECTORS MEETING
HELD ON 15 JANUARY 2014

Subject	Healthcare Governance Summary – December 2013
Supporting TEG Member	Dr David Throssell, Medical Director
Author	Sandi Carman, Head of Patient and Healthcare Governance
Status	Note

PURPOSE OF THE REPORT

To update the Board of Directors on aspects of Healthcare Governance recently reviewed by the organisation, outline the current position and where appropriate provide an update on performance.

KEY POINTS

This summary aims to provide the Board of Directors with an overview of the significant Healthcare Governance matters reviewed over the last month, these include:

1. Putting Patients back in the picture – Clwyd and Hart Report
2. Hard Truths: The Journey to Putting Patients First
3. Care Quality Commission (CQC) Compliance
4. Clinical Assurance Toolkit (eCAT) Report
5. Emergency Preparedness, Resilience & Response (EPRR) Assurance Process
6. Reported Incidents, Involving Controlled Drugs
7. Serious Incidents Update
8. Orthopaedic Services Improvement Report

Other governance matters discussed by the Trust are included in separate papers submitted to the Board of Directors (for example the Quarterly Trust Hospital Mortality (HSMR) Report)

The Trust has in place an annual Healthcare Governance work plan that ensures regular review of all aspects of Governance and covers the essential requirements of the Care Quality Commission and NHS Litigation Authority.

IMPLICATIONS

	Aim of the STHFT Corporate Strategy 2012-2017	Tick as Appropriate
1	Deliver the best clinical outcomes	✓
2	Provide Patient Centred Care	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATIONS

The Board of Directors are asked to note the contents of this report.

APPROVAL PROCESS

Meeting	Presented	Approved	Date
TEG	Dr David Throssell		January 2014
Board of Directors	Dr David Throssell		15 January 2014

1. PUTTING PATIENTS BACK IN THE PICTURE – CLWYD AND HART

A presentation on the review of the NHS hospital complaints system – Putting patients back in the picture - was given by the Chief Nurse.

This review was commissioned following the Mid-Staffordshire Public Inquiry which made 14 recommendations regarding the management of complaints. The review considered all aspects of the complaints process. In addition, 'whistle-blowing' and the handling of concerns raised by staff were considered. The review concluded that current problems within the complaints process included delays and lack of effectiveness. National recommendations included actions to prevent formal complaints, increase the independence of the process and ensure effective outcomes. STH already complies with a number of the recommendations. In addition, areas for development have been identified and these are being taken forward as part of the patient experience refresh which is reporting to the Healthcare Governance Committee in January.

2. HARD TRUTHS: THE JOURNEY TO PUTTING PATIENTS FIRST

Hard Truths: The Journey to Putting Patients First publication builds on the government's initial response: *Patients First and Foremost,* which was published in March 2013. The publication explains the changes that have been put in place since the initial response, and sets out how the whole health and care system will prioritise and build on this. Volume 2 of the report outlines the responses to each of the 290 recommendations made by the Mid-Staffordshire NHS Foundation Trust Public Inquiry.

The Committee reviewed the Trust's proposed response to the publication: Hard Truths: *The journey to putting patient's first.* For each of the chapters and the associated reports included with the Appendix, key statements have been reviewed and were allocated to three categories: New Action; Due Regard; and Watching Brief.

There are a number of areas which require new action, and these matters will be incorporated into the Trust's final response plan. Using an iterative approach it is proposed that the framework is used for wider communication and discussions with internal and external partners, for example Healthwatch.

3. CARE QUALITY COMMISSION (CQC) COMPLIANCE

The Committee were provided with an update on news and events regarding CQC compliance during the past month. The following information was given:

Information Of Concern

During November the Trust did not receive any new Information of Concern notifications from CQC.

CQC Inspection Reports

The September 2013 inspection reports for Jessop Wing, Hallamshire Hospital, Northern General Hospital and Weston Park Hospital have been published on the CQC website. The inspectors found that the Trust met all of the standards that had been inspected. An internal quality improvement plan has been developed to learn from the inspectors' comments about potential areas for improvement.

Intelligent Monitoring Report

CQC has revised their October 2013 Intelligent Monitoring Reports, changing some of the indicators. The changes have not altered the Trust's total risk score of 4 or place in Band 6 (the lowest risk band).

4. ELECTRONIC CLINICAL ASSURANCE TOOLKIT (eCAT) REPORT

The Electronic Clinical Assurance Toolkit (eCAT) provides clinical areas with a range of standards which enable accurate annual feedback concerning clinical area performance and adherence to governance and quality arrangements. The toolkit includes information from patients, staff, clinical area audit and review activities as well as assessments by matrons. From this information, eCAT generates an objective assessment used by clinical leaders to assess their area's priority development needs for the coming year. Outcomes are also used by the wider Trust with assessment results presented to the Trust Executive Group and Nurse Directors.

The Clinical Assurance Toolkit (CAT) was launched within Sheffield Teaching Hospitals in June 2007 led by key individuals within nursing. Originally paper-based and employed to inpatient areas only, the tool developed to an electronic version (eCAT) in its third year, involving collaboration with the Clinical Informatics Team. The number and types of areas using the toolkit has expanded each year and currently involves 143 clinical areas of seven different types (Inpatient, Outpatient, Day Case, Critical Care, Obstetric, Theatre, Theatre Admission Unit). To accommodate differences in clinical settings, each type of area has its own version of the toolkit.

The eCAT is updated annually to reflect new initiatives both at local and national level, feedback from users as well as outcomes from each successive year. The results refer to standards based on the Standards for Better Health framework, which has been the framework used since the inception of CAT.

The committee noted that:

- Overall there has been a fall in Trust eCAT scores by 4%.
- Poor scores and/or recording of the staff training record have had a significant impact upon overall scores.
- OSCCA improved its overall score by 2%, Head and Neck remains unchanged, and all other Care Groups had reduced scores.
- The area of greatest improvement is 3% in respect of standard (3.5) Evidence Based Practice.
- The area of greatest reduction in scores is 20% (3.2) Training and Development

The eCAT results show that there has been an overall deterioration of performance against the standards compared with the previous year (2011/12). These are most significant for standards linking to staff training, development and appraisal. Whilst the overall scores for individual areas are generally lower than the previous year, it is however difficult to assess whether the reason for this is poor performance in terms of quality or poor compliance with completing the elements of eCAT (e.g. the staff training log, matron's survey, matron's spot check).

The central eCAT team, in collaboration with the Patient Partnership Department, are supporting the action planning process and through the eCAT operational and eCAT development groups, will continue to update the systems and tools to reflect national and local requirements.

5. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ASSURANCE PROCESS

The Committee was provided with an update and improvement plan on the EPRR checklist in relation to Trust compliance against the core standards. A review of all the Core Standards had been undertaken and rated as Red, Amber or Green when compared against the Trust's current position. Any areas rated as requiring action have been combined into an Improvement Plan and actions have been proposed to improve compliance. There were not significant areas of concern noted.

6. REPORTED INCIDENTS INVOLVING CONTROLLED DRUGS

The Committee received a report covering the incidents involving controlled drugs, which occurred from the 1 April 2013 to 30 September 2013.

The key points noted were:

- There were 78 incidents involving controlled drugs in the quarters 1 April to 30 June 2013 (40) and 1 July to 30 September 2013 (38). Of these 6 incidents were reported from Community Services
- Of these 78 incidents, 40 were classed as insignificant, 34 as minor and 4 as moderate.
- All incidents were fully investigated at the time or have been followed up later
- No incidents were required to be reported to the police.

7. SERIOUS INCIDENT UPDATE

Three new serious incidents have been reported and are under investigation following the November HCGC meeting.

Incorrect blood transfusion

Blood was incorrectly administered to a patient with the same surname as the intended recipient. Within a very short period of time the clinician realised that the wrong patient had been identified and the blood was stopped. Unfortunately the patient was already very seriously ill and died a short time later. Following detailed review it has been agreed with the coroner that the cause of death was not connected to the incident. The patient's family were informed of the incident at the time.

Missed findings on CT Scan

The patient attended the Trust four years ago for a CT scan. The Consultant Radiologist reporting the CT failed to report on a lung nodule which was subsequently found to be cancer. The patient has since sadly died and the Trust are liaising with the patient's family about this incident.

Insulin given to wrong patient

A patient, who is not diabetic, was administered one dose of subcutaneous insulin in error. The insulin had been prescribed for another patient on the correct drug card. The correct patient was in the same bay. Medical staff were informed and the patient's blood sugars were monitored. The patient was informed about the incident and did not suffer any ill effects.

Never Event Review

The external review team visited the Trust on 10 – 12 December to meet with individuals and to review practice across a range of theatre environments. They are in the process of writing their report which should be available in January 2014.

8. ORTHOPAEDIC SERVICES IMPROVEMENT REPORT

The report was submitted to the Healthcare Governance Committee as part of the monitoring arrangements for the implementation of the recommendations of the Orthopaedic Services Improvement work.

The report focused on the Fractured Neck of Femur Pathway, which is recognised as a complex and challenging service which requires a comprehensive multidisciplinary approach to deliver high quality clinical care.

The report and accompanying Action Plan seek to provide assurance to the Healthcare Governance Committee that the majority of recommendations within the plan have been achieved and where this is not the case actions have been agreed to address the outstanding concerns.

The Action Plan is operationally driven through the "Fragility Fracture Group" with senior clinical leadership from the multidisciplinary team. The implementation of the plan is performance managed, locally by the Orthopaedic Executive Management Team and centrally by the Medical Director and Chief Nurse.