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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY
REPORT TO THE BOARD OF DIRECTORS MEETING
HELD ON 17 APRIL 2013

Subject	Healthcare Governance Summary - March
Supporting TEG Member	Dr David Throssell, Medical Director
Author	Sandi Carman, Head of Patient and Healthcare Governance
Status[1]	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. Quality and Francis Report Update
2. Care Quality Commission Compliance
3. Electronic Clinical Assurance Toolkit (eCAT) Annual Report
4. External Visits, Accreditations and Inspections Feedback
5. Patient Records Report
6. Consent, Mental Capacity, Restraint and Deprivation of Liberty
7. Management of Controlled Drugs
8. Decontamination Services
9. Annual Report of the Hospital Transfusion Committee
10. Patient Incidents, Concerns, Claims and Inquests update
11. Staff Incidents and Personal Injury Claims update

Other governance matters discussed by the Trust are included in separate papers submitted to the Board of Directors (for example the Patient Experience and Involvement Annual Report 2012)

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[2]

	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		10 April 2013
Board of Directors	Dr David Throssell		17 April 2013

1. QUALITY AND FRANCIS REPORT UPDATE

The Trust has established a short term Working Group to look at the most effective way of engaging individuals, services and external partners in the development work required as a result of The Mid-Staffordshire NHS Foundation Trust Public Inquiry, the 'Francis Report'. The first meeting will take place on 24 April 2013.

Many other partners would need to be involved in the development plans, for example, Healthwatch, Overview and Scrutiny Committee, etc. this aspect will be considered by the Working Group. At the time of these discussions the Government response to the report was awaited, this has now being published on the 26 March 2013. The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry will be incorporated into the development work required.

2. CARE QUALITY COMMISSION (CQC) COMPLIANCE

CQC Unannounced Visit – 17 January 2013

The Trust had received a very positive report from CQC following the routine unannounced inspection at the Royal Hallamshire Hospital on 17 January 2013. The CQC found the Trust to be meeting the essential standards.

Quality Governance Inspections

In October 2012 an internal quality governance inspection was carried out in Weston Park Hospital to look at compliance with CQC Outcome 21 (records management) with particular reference to the Falls Risk Assessment documentation. A summary of the report was presented to the February 2013 Healthcare Governance Committee. The summary highlighted areas of good practice and areas for improvement.

CQC Visit 21 March 2013

A routine visit had been made to the Trust to monitor systems in place for detaining people under the Mental Health Act as part of a national programme. This visit was conducted by the MHA Commission which is now part of CQC.

The Inspector had visited two areas of the Trust, A&E and Hadfield 1. Positive feedback from the Inspector had been given regarding staff in both areas.

The Trust only has a small number of patients with complex needs who need to be detained under the MHA each year and it is important to make sure that the processes in place are correct.

Work is required to ensure full compliance with the MHA Code of Conduct. Some areas for improvement had been identified during the visit and these have been combined with plans the Trust had in place from previous internal work. The Trust is working closely with Sheffield Health and Social Care Trust to take forward this workstream.

Quality and Risk Profile

The overall outcome ratings in the Quality and Risk Profile (QRP) published in February 2013 are either green (better than expected) or yellow (similar to expected).

The volume of underpinning data items in the February QRP has increased from the volume in the December QRP. However, the proportion of data items rated as green (better than expected), yellow (similar to expected), amber (tending towards worse than expected) or red (worse than expected) in the February QRP is similar to the proportion in the December QRP.

3. eCAT ANNUAL REPORT

The purpose of this report was to summarise the processes, outcomes and developments of eCAT over the last year.

The key points highlighted were:

- Overall improvement of 2% compliance with standards from 86% average to 88%
- An increased average performance against 15 of the 22 standard statements
- Largest increases in relation to Lifestyle, Communication and Wellbeing; Patient Information; and Amenities standards

eCAT covers the hospital wards, outpatients and departments and will be in use in the community from April 2013.

Through a partnership between STHFT and Sheffield Hallam University (SHU), the CAT has been evaluated in terms of both its utility and acceptability and its impact at a number of organisational levels within the organisation. The evaluation team from SHU has worked closely with the Trust's Development Team to ensure information is shared in a timely manner in order to direct the development and changes to the 2011-2012 version of the eCAT. Recommendations from the evaluation have been discussed at both the CAT Operational and Strategy Groups and will form a separate paper to the Nurse Executive Group with an action plan.

A second evaluation has been undertaken by Internal Audit. This report made a number of recommendations which have been actioned by the CAT central team resulting in an A rated final report.

Consideration for inclusion of additional tools:

- Evidence drawn from Student Nurse evaluations – this is something that all clinical areas accommodating students will have and is a potentially powerful source of evidence concerning the quality of the clinical environment

- Inclusion of a 'Compassionate Care Observation' which will provide qualitative evidence of how the clinical environment operates. This would be linked to the DH Commissioning Board, Compassion in Practice (2012) and the Institute for Innovation and Improvement, The Fifteen Steps Challenge (2012)

5. EXTERNAL VISITS, ACCREDITATION AND INSPECTIONS FEEDBACK

The Healthcare Governance Committee reviewed the feedback received as a result of external visits, accreditations and inspections and the report on progress with action plans.

Key points raised were:

- CQC carried out a routine inspection of 4 wards at Northern General Hospital and interviewed governance staff (December 2012). CQC found the Trust to be meeting all three standards that were inspected. Four minor areas for improvement were drawn to the Trust's attention. CQC did not require an action plan to be produced.

- NHS Yorkshire & the Humber Stroke Accreditation External Team completed the Stroke Services Accreditation Annual Review (December 2012). The service was praised and was successful in retaining Level 1 accreditation. 6 recommendations were made for quality improvement during the next 12 months and an action plan will be produced to achieve this.

- The Royal College of Obstetricians and Gynaecologists (RCOG) completed an external review of maternal deaths (November 2012). They found the service to be safe and well-managed. 9 recommendations were made for quality improvement and an action plan is in place to address these.

- The Cancer Peer Review Zonal Team Visit (June 2012) identified some areas for development that were reported to the Committee in October 2012. An update was provided to show that action plans had been implemented and a satisfactory progress report had been submitted to the Zonal team in December 2012.

- Cancer Peer Review Zonal Team Visit (October 2012) assessed compliance against measures specific to each selected cancer MDT. One area for improvement was raised regarding the Neurosciences MDT. This matter has been entered onto the Trust's Risk Register and the Cancer Peer Review Team is satisfied that completion of the Action Plan will address the issue. The Zonal Team recommended that the report be drawn to the attention of the Board.

- Cancer Peer Review Zonal Team External Validation (December 2012) looked at robustness and outcomes of the Trust's Internal Validation process for 5 Cancer MDTs. The Zonal Team required a risk assessment to be completed. An Action Plan is awaited from the plastic surgery MDT.

6. PATIENT RECORDS REPORT

This report update the Healthcare Governance Committee on the roles and responsibilities of the groups that govern patient records.

There are three operational groups for patient records. These are the Patient Records Committee and two sub-groups - the New Documents Group and the Nursing Record Keeping Group. The Patient Records Committee aims for innovation and quality in clinical records.

The following points were highlighted:

- Medical clerking proformas are now in place across the Trust. The VTE risk assessment has been incorporated, together with the cognitive screening assessment. Both are CQUIN targets.

- Electronic Archiving has been introduced successfully in South Yorkshire Regional Services and Head and Neck. Work continues with Urology and Respiratory Medicine. The process has been staged to ensure that demand can be met and to develop key standards appropriate for a range of clinical services. There is a need to drive archiving forward to manage the bulk of patient notes and to be able to view older documents on-line rather than as print-outs.

7. CONSENT, MENTAL CAPACITY, RESTRAINT AND DEPRIVATION OF LIBERTY

This report informs the Board regarding Trust arrangements for managing risks associated with consent and deprivation of liberty safeguards (DOLS). It was noted that there is some overlap between this paper and the paper on vulnerable adults and safeguarding which now covers arrangements for managing risks associated with mental capacity and restraint.

The following points were highlighted:

- The Trust has established policies and processes in place for seeking informed consent and for deprivation of liberty safeguards. The policies are supported by information on the

intranet and training material which is included in induction and job-specific training updates.

- Consent and DOLS do not appear as frequent themes in DATIX incident, complaints, claims or inquest reporting. This is positive.

- Although both processes are included in the CQC essential standards of quality and safety there is limited monitoring information about them captured in the Quality and Risk Profile (QRP). The data available is all rated as "similar to expected".

- 53 DOLS applications were initiated in 2012, which is a similar number to previous years. 29 of these were granted; 16 were deemed as being no longer required before approval could be granted - because the patient's condition or circumstances changed; and 8 applications were turned down by the PCT. This is in line with national trends.

- Clinicians have requested modernisation of the consent form and this will be explored during 2013.

8. MANAGEMENT OF CONTROLLED DRUGS

This Healthcare Governance Committee reviewed the incidents involving controlled drugs which occurred between 1 October 2012 and 31 December 2012.

The following key points were highlighted:

- there were 23 incidents involving controlled drugs in the quarter, with no incidents reported from Community Services
- of these 23 incidents, 17 were classed insignificant, 6 as minor
- all incidents were fully investigated at the time or have been followed up later
- no incidents were reported to the police
- work is being completed to make sure any under-reporting is addressed.

9. DECONTAMINATION SERVICES

The Healthcare Governance Committee discussed current position of the Sheffield Decontamination Project and the provision of non-supercentre decontamination and sterilisation facilities.

The following key points were highlighted:

- a full service transfer was completed in August 2012. There were some areas that are being reviewed within Charles Clifford Dental Hospital regarding service turnaround time
- endoscopy Services will be visited by the Board of Directors later in the year
- there were some areas for development for Community Services at the time of their transfer into the Trust, these are now being addressed
- there is an ongoing programme to replace the Northern Site bed pan washers with macerators.

10. ANNUAL REPORT OF THE HOSPITAL TRANSFUSION COMMITTEE (HTC)

This report informs the Healthcare Governance Committee of the progress made during 2012 towards safer blood transfusion and the key objectives for 2013.

The report contained ten themes with key action points, a lead for each action and deadlines.

The following points were highlighted:

- relocation of the Blood Bank has taken place successfully
- all policies have been updated
- there are some areas for review around progression of the Electronic Blood Tracking system which are now being addressed
- the initial training and competency assessments were very successful and work is continuing to ensure compliance with training updates.

11. PATIENT INCIDENTS, CONCERNS, CLAIMS AND INQUESTS UPDATE

The Healthcare Governance Committee reviewed the trends relating to incidents, concerns, claims and inquests for the quarter 1 October 2012 – 31 December 2012. This included summary information, analyses and outcomes across complaints, patient incidents, claims and inquests. The report also allows the triangulation of key areas of risk.

The time series data for incidents remains stable at about 800 events reported per month, with the significant majority being reported as minor or insignificant. This level of incident reporting is positive as a high level of incident reporting is aligned with a positive patient safety culture within the organisation.

12. STAFF INCIDENTS AND PERSONAL INJURY CLAIMS

The following key points were noted:

- staff and student incidents in the period July to December 2012 totalled 786 staff incidents and 36 student incidents reported on Datix.
- 17 RIDDORs (reporting of injuries, diseases and dangerous occurrences) were reported for staff incidents in this period. 9 were moving and handling, 7 were falls and 1 was violence and aggression.
- the number of staff personal injury claims opened in this six month period is 31 received claims, all of these are fully investigated and appropriate action taken.