Cambridgeshire Community Services NHS Trust

TRUST BOARD

Title:	**QUALITY REPORT**
Action:	**FOR DISCUSSION AND NOTING**
Meeting:	**14th March 2018**

Purpose:
This report gives an overview of Quality related areas of practice and an opinion regarding the level of assurance that the Board can take from the underpinning information. The assurance opinion categories reflect those utilised in the Internal Audit programme, namely substantial, reasonable, partial or no assurance.

The report is supported by a data pack covering the period December 2017 and January 2018 (with any relevant key current updates) and is focused on the CQC five Key Lines of Enquiry. The information is triangulated with our clinical services to ensure a holistic judgement is made.

Detailed local analysis of quality performance is undertaken within the 3 Clinical Operational Boards and points of escalation reported to the Board.

Key areas of risk are identified, recorded on the Risk Register, managed and escalated where appropriate.

Recommendation:
The Board is asked to:

- **Note** the information in this report, the focus on safe staffing, Sepsis and learning from deaths and the actions planned to address areas needing improvement.

	Name	Title
Author:	Julia Sirett Anita Pisani David Vickers	Chief Nurse Deputy CEO and Director of Workforce Medical Director
Executive sponsor:	Julia Sirett Anita Pisani David Vickers	Chief Nurse Deputy CEO and Director of Workforce Medical Director

Trust Objectives

Objective	How the report supports achievement of the Trust objectives:
Provide outstanding care	The data pack demonstrates a good understanding of quality across the organisation
Collaborate with other organisations	A number of sections reference collaboration with relevant partners and stakeholders
Be an excellent employer	Staffing pressures are escalated using our early warning trigger tool and managed at an early stage by teams to prevent negative patient impact. This report highlights a focus on safe staffing, related risks and mitigating actions. A number of staff engagement activities are highlighted which demonstrate an increased focus on this area of support.
Be a sustainable organisation	Patient feedback is consistently high and where concerns are identified, learning is identified and improvements to practice made.

Trust risk register
This report refers predominantly to actions associated with Board risk 1320 and a number of risks related to staffing in section 2.6.

Legal and Regulatory requirements:
All CQC Key Lines of Enquiry and fundamental standards of care are addressed in this report.

Equality and Diversity implications:

Objective	**How the report supports achievement of objectives:**
Achieve an improvement in the percentage of service users who report that they are able to access the Trust services that they require	Compliance with the 18 week Referral to Treatment target is included in the Responsive section of the supporting data pack.
Enhance our approach to involving and capturing the experience of hard to reach / seldom heard / varied community groups	Examples of patient and service user engagement continue to be highlighted in the data pack.
Using the national ‘A Call to Action on Bullying and Aggression’, internally take action to promote our Zero tolerance policy and address bullying and aggression when it occurs.	Staff survey results are reported in the data pack. The underpinning detail is included in a separate report to the Board.
Ensure that the Workforce Race Equality Standard is embedded and undertake proactive work around any areas of under-representation identified. In particular, we will seek innovative methods to have co-opted representation on the Trust Board from more diverse backgrounds.	Cultural Ambassador scheme update is included in the data pack.

Are any of the following protected characteristics impacted by items covered in the paper – not directly impacted but the patient story summary demonstrates consideration of a number of the characteristics i.e. Gender reassignment.

Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
☐	☐	☐	☐	☐	☐	☐	☐	☐

1. EXECUTIVE SUMMARY / KEY POINTS

1.1 The Board can take reasonable assurance from the data presented and consideration of the systems and processes in place to support the delivery of high quality care. This is supported by the information referenced throughout this report from Appendix 1 (Quality Data Pack for December and January 2017).

1.2 Key points:

1.2.1 One Serious Incident (SI) was reported. This related to a confidentiality breach where patient information was faxed to an incorrect recipient outside the organization. It was intended for a care home. Appropriate short term mitigating actions have been put in place until care homes are in a position to use the NHS net communication system.

1.2.2 The Infection Prevention and Control page of the data pack (p5) outlines our approach to identification and management of Sepsis.

1.2.3 A focus on safe staffing is highlighted in section 2.5. This identifies those services which are experiencing continued staffing pressures and the mitigating actions to keep patients and staff safe.

1.2.4 We have achieved very positive National Staff Opinion Survey results and will refresh our staff experience improvement plan in response to these in partnership with our staff side colleagues. A brief summary is outlined in the data pack on p19 and separate paper to this Board outlines the detail.

1.2.4 Section 7 outlines our approach to learning from deaths, our agreed screening process for identifying those requiring a Root Cause Analysis investigation and the results of screening patients that died in 2017 / 2018.

1.2.5 Quality Impact Assessments have been undertaken for Cost Improvement schemes that have been implemented in 2017 / 2018 and involved changes in delivery of clinical care. Section 8 outlines the schemes and the assessed impact following delivery.

1.2.6 Key issues from the Quality Improvement and Safety Committee are highlighted in section 9.

1.3 There are no indications of significant breaches of CQC fundamental standards.

Safe

2. Assurance opinion

The Board can be offered ***Reasonable*** assurance overall that patients are kept safe and protected from harm due to the following information:

2.1 *Management of patient safety incidents (including Information Governance)*

2.1.1 One Serious incident (SI) was reported relating to a confidentiality breach where patient information was faxed to an incorrect recipient outside of the organization. Appropriate interim mitigating actions were implemented whilst a system wide programme to ensure that care homes move to NHS net communication is progressed.

2.2 *Safeguarding Adults and Children*

2.2.1 Adults – There have been no inquests or Serious Adult Reviews during this period that have related to the Trust's services. We continue to be active partners in Local Safeguarding Adult Boards.

2.2.2 Page 2 of the Data Pack highlights continued Trust wide compliance with Home Office targets for Prevent training.

2.2.3 Children – Safeguarding Children level 3 training compliance remains below the target at 89%.

2.2.4 Luton based teams have achieved compliance, however, a number of teams have struggled to reach the 2017 / 2018 91% target due to staffing pressures and therefore different approaches to training delivery have been agreed to support staff. These include:

- Holly and SCBU – for medical staff, Peer review sessions will be credited for level 3 training and for nursing staff, in house relevant sessions have been scheduled to supplement external training opportunities
- iCaSH services have a revised model to deliver whole service supervision and training twice a year from April 2018

2.2.5 An increase in compliance is anticipated for February and March and progress will be monitored through the Clinical Operational Boards.

2.2.6 A project to determine a 'best practice' model for safeguarding support to our varied clinical teams has been initiated and involves safeguarding professionals, service managers and clinical leads. Once the model is agreed, a gap analysis will be undertaken for each area and proposals for any changes to structure or ways of working will be developed.

2.2.7 This approach will support standardisation of best practice throughout our services but will also be sensitive to variations in agreed, commissioned models.

2.3 *Infection Prevention and Control*

2.3.1 Page 5 of the data pack highlights the progress with the Seasonal Influenza Vaccination Programme with an uptake position of **62.44 %** of frontline staff vaccinated as at week commencing 25 February. The reporting period finishes at the end of February and although we have not met the 75% national target, we have achieved over 60% for both Luton and Cambridgeshire / Peterborough CCG commissioned services that the national Influenza CQUIN applies to and this will result in a 50% payment.

2.3.2 A focus on our work to identify and respond appropriately to patients who have potentially developed Sepsis is highlighted on page 5 of the data pack.

2.4 *Safety Thermometer – Luton (dashboard p19 data pack)*

2.4.1 The overall harm free result in January dipped to 82.35% (target 96%) and was the lowest percentage for 2017 / 2018. This was mainly due to an increase in the reporting of harms relating to pressure ulcers (13 in total). This metric improved in February (94.05%).

2.4.2 The new harm metric is more indicative of the care directly provided by our staff and similarly the percentage dropped in January to 92.94% (target 98.5%) and increased in February to 98.8%.

2.4.3 The Tissue Viability Nurses are supporting a piece of work to review all recently reported grade 3 and above pressure ulcers and this work will inform the action plan developed by the 'Thinking Differently about Pressure Ulcers' group. This project is overseen by the Luton Clinical Operational Board.

2.5 *Safe Staffing*

2.5.1 The Board can be offered ***Reasonable*** assurance that patients are kept safe and protected from harm due to the following information related to staffing:

2.5.2 Staffing pressures have continued since the last report in a number of services with oversight by the Clinical Operational Boards. The sections below identify current areas under most pressure and the associated risks alongside the mitigating actions that are being taken to maintain both patient and staff safety. This includes use of bank and agency staff and a variety of approaches to recruitment. Where relevant, Quality Early Warning Trigger Tool scores are highlighted.

2.5.3 **Luton Unit**

2.5.3.1 Community Paediatric services report continued service pressures due to increased demand. A draft business case was expected in December following a service capacity review and although the service are working to minimise the impact on children, breaches of the 18 week target are anticipated from April.

2.5.3.2 Risk – this risk is scored at 16 and mitigating actions include prioritisation of clinical activity and cleansing of waiting list data to ensure no children are lost to follow up. There is constant adjustment of clinical resource and ongoing monitoring of clinical capacity.

2.5.3.3 The QEWTT score has reduced slightly to 12 due to improved mandatory training compliance.

2.5.3.4 The Audiology service continues to report 6 week diagnostic breaches. All actions reported previously continue to be in place, although locum support has been challenging.

2.5.3.5 Risk – this is rated at 9 and has a number of mitigating actions in place including constant review of clinical priority of cases, secured long term agency staff, working with universities to encourage new graduates to the service and appropriate use of skill mix Audiology support workers. Comparable services in acute settings are also experiencing similar staffing issues and there is a growing recognition that there needs to be a provider alliance system solution.

2.5.3.6 The QEWTT score has reduced slightly since November due to use of consistent agency staff

2.5.3.7 0-19 Teams in Luton are currently experiencing staffing pressures due to sickness and recruitment challenges. This risk is being assessed and will take into consideration the QEWTT scores for all

four teams ranging from 10 – 14. Mitigating actions currently include identifying different roles that could support the team and continued targeted recruitment.

2.5.3.8 Two teams in our Adult services have identified risks rated 12 due to staffing challenges:

- MDT Coordination where mitigating actions include skill mix with allied Health Professionals, review of capacity and capability of all adult community services to manage Intensive Case Management
- The Falls Team - mitigating actions include part time staff working additional hours, regular review of off duty to ensure service cover during peak activity times.

2.5.4 0-19 services (Cambridgeshire and Norfolk)

2.5.4.1 The Cambridgeshire based 5-19 service has experienced continued staffing pressures which have been overseen by the Clinical Operational Board.

2.5.4.2 Their risk is rated at 12 and QEWTT continues to increase (19 in January and 22 in February).

2.5.4.3 Mitigating actions include introduction of a rolling recruitment programme and involvement of staff in service redesign including recent introduction of a duty desk. Recent appointment of a Team leader has had a positive effect.

2.5.4.4 Health visiting teams also continue to experience pressures with an identified risk of 12 relating to difficulties in recruitment. Mitigating actions include a new rolling recruitment programme, review of staff deployment and implementation of Business Impact assessment (similar to Norfolk model). These teams have merged a number of smaller team submissions for QEWTT with the Cambridge City / South Team highest at 17.

2.5.5 Norfolk

2.5.5.1 Pressures with staffing in Norfolk based 0-19 teams have improved slightly with City and Breckland localities reporting high QEWTT scores in January (16 and 17) and an improved position in February (15 and 13). This has been due to recruitment and slightly improved sickness rates.

2.5.5.2 Staffing compliance on the Acute Paediatric unit is reported on page 6 of the data pack.

2.5.5.3 SCBU reports an improved staffing position with recruitment to 4 x staff nurse vacancies. QEWTT score is 5.

2.5.5.4 Holly Ward reported restrictions to admissions on 2 occasions in January due to capacity and staffing ratios. Recruitment remains the greatest challenge with 3 x Registered Nurse (Child) vacancies and 2 staff on maternity leave. One experienced staff nurse has just been

recruited and one student has provisionally expressed interest in a post from September.

2.5.5.5 The risk is rated at 12 and mitigating actions include the Ward Manager working clinically if required and review of the escalation process with colleagues from North West Anglia Foundation Trust to determine if bed capacity can be more flexible when staffing falls below minimum agreed safe staffing levels. Further criteria have now been developed and implemented to manage patient safety when the demand for high dependency / 1:1 nursing is above contracted levels leading to further reduction of bed numbers. Further mitigation includes continued utilization of bank and agency staff when available.

2.5.6 **Ambulatory Care services**

2.5.6.1 A common theme amongst our clinic based services is staffing pressures due to over activity against contract. Particular pressures have been experienced in:

- iCaSH Bedfordshire (QEWTT 13 January and 15 Feb) due to vacancies.
- The service is seeking to directly employ a number of staff currently subcontracted from a partner organization to encourage applicants. Mandatory training compliance has improved over the last few months with 7 out of 10 subjects at 100%. The current focus is appraisals (44.4%).
- Dental service at Brookfields – QEWTT score of 17 in January due to staff sickness and difficulty in identifying appropriate agency cover. The score has reduced to 10 in February.

Effective

3. Assurance opinion

The Board can be offered ***Reasonable*** assurance that all elements of this Key Line of Enquiry are being actively managed.

3.1 ***Workforce metrics*** are outlined on page 7 of the data pack and assurance is based on the following:

3.1.1 Mandatory training compliance has remained stable at 95% (target 91%) for 3 months with a number of teams reaching full compliance in all subjects.

3.1.2 The exception is Level 3 safeguarding and remedial actions are outlined in section 2.2.

3.1.3 Information Governance compliance reached 95% Trust wide in January for the first time this year.

3.1.4 Individual service rates of compliance are monitored by the Clinical Operational Boards.

3.1.5 The overall appraisal target of 91% has been met in January. Of note are the Luton based services who all achieved compliance. Non compliant services have plans in place to complete appraisals.

3.1.6 Sickness rates across services remain a challenge with the highest rate in Luton Children and Young People's services at 7.84%. The HR Team are undertaking a review in order to target support. The most common reason cited for sickness during this winter period was coughs, colds and influenza. Work will continue into 2018 / 2019 to raise awareness with staff of the influenza vaccination programme and responsibilities to their patients, families and themselves.

Caring

4 Assurance opinion

The Board can be offered ***Reasonable*** assurance that staff treat people with compassion, kindness, dignity and respect due to the following:

4.1 *Patient feedback*

The patient experience story due to be discussed with the Board at this meeting is being shared by a parent who was involved with our staff in the 'Norfolk Nurture Group'. This is a collaboration between CCS 0-19 service, Norfolk and Norwich University Hospital and Norfolk County Council to support parents of babies who have been discharged from both Special Care and the Neonatal Intensive Care Units. The positive impact of the work of the teams involved with the group will be shared.

4.2 *Friends and Families Test (FFT)*

4.2.1 Results are highlighted on page 10 of the data pack. Comments relating to negative scores are reviewed by teams.

4.2.2 A selection of positive comments received regarding our services is included in the data pack on page 9.

4.3 *Outcomes from Patient Stories*

Patient stories are a key aspect of every public board meeting agenda and offer us an opportunity to hear first hand when things have gone well and where we can improve. Below is a brief summary of the stories heard during 2017 / 2018 and updates on any actions identified.

Board meeting	Patient story	Outcomes
May 2017	Staff attended the May Board to highlight the excellent care our Macmillan Specialist Palliative Care and District Nurses provide and the impact their integrated care has on patients, family and friends. The experience of a patient and his partner was shared with the Board the positive effect that the caring, sensitive behaviours and attitudes of the staff involved had during the last days of life.	The impact of the story was shared widely and the staff involved received the Trust's Kate Granger staff award for compassionate, patient centred care.
July 2017	A focus on how the Norfolk 0-19 service has actively sought and responded to patient and service user feedback through a number of social media platforms and actively engaged with their local communities was discussed with the Board by a number of staff. One example was a change to	The activity has been shared with other teams and a number of connections were made subsequently with different 0-19 services across our geography relating to some of the innovative methods of communication.

Board meeting	Patient story	Outcomes
	the format of the 'baby One Stop' clinics following feedback on their Facebook pages.	The Norfolk 0-19 service developed the Chat Health medium for young people to access the 5-19 service and approach is being rolled out in our other children and young people's services. The teams were also connected to our Research support team to explore possibilities for research in this area.
September 2017	The father of a 4 yr old child with sight difficulties joined the Board by Skype link to share his very positive experience with our dental service in Cambridge. The Dentist and other staff demonstrated exceptionally sensitive behaviours towards both the child and his father when they attended for an appointment, treating him with dignity and respect and sensitive to his needs.	The positive impact of the behaviours and attitudes of the dental team have been shared. The discussion raised important challenges for the coordination of children's services as the child had experienced care from a number of other healthcare providers with differing experiences of coordination. We are focusing on co - locating staff in a more integrated way when considering physical moves of staff base to facilitate increased opportunities for integrated care i.e. Peacock Centre and The Poynt in Luton. We are also actively seeking ways to work collaboratively with other organisations involved in care for our population i.e. work with a local Community based NHS trust to develop a consistent model of service delivery across Cambridgeshire and Peterborough.
November 2017	A video was shown to the Board which involved the wife of a patient who had died sharing her experiences of our Community Nursing service and described the impact of attitudes and actions of staff on both herself and her husband during a very difficult time for them prior to his death.	The patient's wife gave permission for the film to be shared with other staff in a supported way to raise awareness of the potential impact of poor communication and attitude on patients and their families. This has been shared with staff involved and is currently being used as part of an ongoing programme to raise

Board meeting	Patient story	Outcomes
		awareness of both the negative and positive impact that our behaviours can have. A detailed subsequent action plan is overseen by the Luton management Team.
January 2018	The Dynamic Health team demonstrated the Trust's values and expected behaviours and their commitment to the CCS Quality Way by tailoring care they provided to a specific patient's needs linked to gender reassignment. The patient talked to the Board about the very caring and sensitive way that she was enabled and supported to attend group sessions following initial one to one appointments.	The patient raised a number of points to consider when planning the environment where clinical activity is undertaken including provision of gender appropriate toilet and changing facilities and sensitive signage. The Estates Team are reviewing current and new provision to ensure that this is taken into account i.e. new environment at the Peacock Centre Cambridge.

Responsive

5. Assurance opinion

The Board can be offered ***Reasonable*** assurance that servces are organised to meet people's needs beacuse of the following:

5.1 *Complaints*

5.1.1 In January, the one complaint response due was sent within the 25 day timeframe. Pages 11 – 12 highlight our performance relating to managing complaints. Learning from complaints is discussed and disseminated at team meetings and Clinical Operational Boards. Learning is also shared with staff groups and at team meetings specific to the complaint. Quality Boards are on display in patient areas showing learning from complaints, concerns and patient feedback.

5.1.2 Actions / learning from investigations are highlighted in the Trust's Governance Log which is circulated weekly to members of the Leadership Forum to ensure appropriate oversight and monitoring by service leads. Themes are also shared on the staff intranet learning pages where a high level themed summary of all complaints is also highlighted. The annual Patient Experience report was discussed at the Quality Improvement and Safety Committee which highlighted a review of all complaints that were not upheld.

5.2 ***Access to our services*** to which the 18 week Referral to Treatment timings apply, is outlined on page 13 of the data pack.

5.2.1 All consultant-led services are operating above the 92% target. Paediatric Physio performance dipped to 89% due to data inaccuracy regarding timings for 'stop the clock.

5.2.2 A summary of the improvements to the times that patients have to wait for MSK physio services is highlighted on page 14 of the data pack. The initial extensive waiting list was due to excessive demand for the service and has been actioned by operating weekend clinics, increased, appropriate skill mix and a comprehensive service redesign programme.

5.2.3 6 week waiting time breaches continue with the Luton Paediatric Audiology service – a summary of mitigating actions is given in section 2.5.2.2

Well-led

6. Assurance opinion

The Board can be offered ***Reasonable*** assurance that the leadership, management and governance of the organisation assures the delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture.

6.1 *Quality Early Warning Trigger Tool*

This established tool (summarized on pages 15 & 16 of the data pack) is based on a number of metrics that mainly relate to staffing pressures and the impact on quality when staffing is compromised. The details are covered in section 2.5 (safe staffing) of this report.

6.3 *Patient Engagement*

A number of examples of patient engagement activity are included on page 17 of the data pack.

6.4 *Staff Engagement*

Page 17 of the data pack highlights the continued focus on staff engagement throughout December and January. The key highlight is the publication of the staff survey report 2017 / 2018 with 29 out of 32 key findings rated better than average compared to other community trusts and 19 findings rated best in the country. A full, detailed summary is shown in a separate paper to this Board.

6.5 *Research*

A summary of active participation in research studies is highlighted on page 19 of the data pack. Of note is the increased recruitment in a number of studies and increased success in staff achieving research based Internships and Fellowships.

6.6 *Quality Dashboard*

The Trust wide dashboard (pages 20 - 21 of the data pack) is underpinned by service level data which is utilised at both local and Trust level to give an overview of a number of areas of quality performance. These metrics have been used to inform analysis throughout the report.

7.0 Learning from Deaths

7.1 In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths1'. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and

learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

7.2 The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish specified information on deaths quarterly. This should be through a paper to a public board meeting in each quarter to set out the Trusts policy and approach (by end of Q2) and publication of the data and learning points from Quarter 3. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, how many of these deaths were judged more likely than not to have been due to problems in care.

7.3 The guidance is very specific relating to patients who die in an in patient setting and work continues nationally to standardise reporting for community based services. We have taken the approach of reviewing a number of deaths recorded in our Adults Community nursing services and if concerns are identified then full Root Cause Analysis is undertaken.

7.4 Analysis of the data

An analysis of our clinical records system, SystmOne, revealed that there were 291 adult deaths of patients known to our services in Luton during 2017. The breakdown of the data showed that the majority of the patients died at home:

Place of death	**No.**
Home	149
Nursing/Care Home	67
Hospital	55
Hospices	20
Total	**291**

7.5 The ages of the patients were in the following banding:

30s	40s	50s	60s	70s	80s	90s	100s	**TOTAL**
2	8	27	43	80	101	26	4	**291**

7.6 62% of the patients were under the care of the Palliative Care Service and the remainder were cared for by the District or Specialist nursing services.

7.7 Children deaths are reported via the Child Death Overview Panel annual reports and are any deaths that our services have been involved in through Serious Case Review and Serious Incident processes are discussed at our Safeguarding Group and Learning from Death group.

7.8 A review of the adult deaths

44 deaths were reviewed to ascertain whether:

- The care were delivered as planned
- There were any gaps or omissions
- There were lessons to be learnt
- Further actions to be taken

7.9 The 44 patients were randomly selected from the list using NHS number and the services that they had been under to ensure a comprehensive distribution. Staff who were not directly involved in the care of the patients reviewed the SystmOne entries.

7.10 The key messages from the review are:

7.10.1 The care pathway was followed and the Gold Standard Framework (GSF is a practical systematic, evidence based approach to optimising care for all people nearing end of life) was followed.

7.10.2 There was excellent communication and liaison between the teams in the Trust, including the District Nursing, Macmillan Services, Specialist Nursing and Out of Hours Services.

7.10.3 There was evidence of excellent liaison and communication between organisations including the Trust, the GPs, the Hospital and My Care Co-ordination at the hospice.

7.10.4 The patient records were kept up-to-date and contained sufficient information about the care and treatment of the patients. The DNAR (Do Not Attempt Resuscitation) document was referenced in the patient records where it existed.

7.10.5 Palliative care symptom control medications were available in the patients' residences.

7.10.6 There were seamless transfer from the hospital to the community services and the quality of the discharge planning was good.

7.10.7 The relatives were involved and there were excellent communication between the staff and the relatives. They were kept informed of the situation. Many families thanked the staff for the excellent care. Staff held difficult conversations with the families.

7.10.8 Many records showed that the patients died in their preferred place of death.

7.11 It was also noted that staff reported some deaths on the incident reporting system (DATIX) and 3 DATIX records were reviewed where the staff reported the deaths because they had arrived at the patients' home for visits and the patients had died.

7.12 The lessons learnt from reviewing the 44 patient records are:

- To continue to improve the communication between the staff and the patients and their relatives
- To ensure that that there are no delays in confirming the deaths
- To ensure that all the details about who to contact are up-to-date and reviewed regularly
- To close the care plan of the patient once the death is confirmed
- To prioritise the visit to see the patient if the relatives are concerned

7.13 Next steps

The review showed the very high quality of care to patients who died whilst under the care of our services. A number of actions will be undertaken:

- Staff will continue to be made aware of, and supported to use the Learning From Death Screening Tool (Appendix 2) to ensure that learning is continuous
- A Standard Operating Procedure for prioritising urgent clinical needs include the needs of patients who are nearing end of life
- Staff will be continually supported and trained to hold difficult conversations with patients and relatives
- The revised End of Life Policy will be communicated to staff

8.0 Quality Impact Assessment review for Cost Improvement Plans 2017 / 2018

8.1 Approved schemes for 2017 / 2018 that required Quality Impact assessments have been reviewed to determine positive and negative impacts using the post implementation review process.

8.2 A number of schemes were implemented that did not involve changes to delivery of care affecting either patients or staff. These include examples such as realignment of budgets

and standardisation of invoicing for services and were not subject to formal Quality Impact Assessments.

8.3 The table below outlines each implemented scheme that underwent Quality Impact Assessment at the outset and summarises key points.

Unit	Service	Description of scheme	Transformational/ Transactional	Summary of outcome
Children & Young People	Cambs Children's services	Improving efficiencies in Administration service	Transformational	A number of negative impacts were identified including reduced staff morale, higher staff turnover and reduced financial release. A lessons learnt event has been held with key staff. A key factor was a base move at the time of implementing the changes.
Children & Young People	Paediatric Occupational Therapy	These transformational schemes were combined as they related to the introduction of a Therapy Assistant role that would undertake both physio and OT support for patients. The financial savings were realised by the Physio service only as the OT service identified savings through consistency in applying service level agreements. This relates to one staff member who commenced in post in February 2018 and the impact of this will be assessed in August 2018 when the role is embedded in the service.		
Children & Young People	Paediatric Physiotherapy			
Children & Young People	Norfolk 0-19 service	Efficiencies in the 0-19 service	Transformational	Implementation of model through skill mix as part of a robust service redesign programme which was discussed and agreed widely with young people, staff and commissioners. No negative impact identified to date.
Luton	Children's services	Reduction in Breast Feeding Team – Breast Feeding Support Workers re distributed to 0-19 teams.	Transactional	No negative impact – workers now integrated with 0-19 teams ensuring service wrapped around the family. Previous Team Leader redeployed to Community Paediatrics service in a clinical support role.
Luton	Unit wide	Restructure	This is a complex Cost Improvement scheme involving a number of posts in different services. A comprehensive QIA is still to be undertaken to understand the impact.	

9.0. Summary from Quality Improvement and Safety Committee

9.1 The Committee met on 28 February 2018. There were no points for escalation. The following items are for information:

- From the safety update - one Serious Incident was reported relating to a confidentiality breach where patient information was faxed outside of the organization. Appropriate mitigating actions were implemented
- The annual Patient Experience report was received and highlighted learning from complaints and feedback that has resulted in improvements i.e. 'you said, we did'
- The committee was updated on the prevention and management of pressure ulcers work that has been undertaken in Luton. The Clinical Operational Board had discussed the detail of the action plan and will monitor progress
- Updates were given for the Quality and Workforce strategies – no exceptions to escalate
- The Committee reviewed the results from the effectiveness survey of members. Recommendations and development points will be fed into our Well Led programme of work

10. RECOMMENDATION

10.1 The Board is asked to note the assurance given relating to each of the 5 Key Lines of Enquiry based Quality topic areas of this report and the actions being taken to address areas of concern.

10.2 The Board is also asked to note the particular focus on sepsis, safe staffing, Learning from deaths and Quality Impact assessments from 2017 / 2018 Cost Improvement Plans.

End of report

APPENDICES

- Appendix 1 - Quality Data Pack
- Appendix 2 - Learning from Deaths screening tool