Quarterly Patient Safety & Quality Report

Quarter 4 summary 2014/15

Susan Bowler, Executive Director of Nursing & Quality
Andrew Haynes, Executive Medical Director

CONTENTS

No:	Item	Page No:	No:	Item	Page No:
1	Executive Summary	3	11	Medication Safety	25
2	HSMR (Quality Priority 1)	4	12	Hydration	27
3	Falls (Quality Priority 2)	8	13	Safeguarding Adults	29
4	FFT (Quality Priority 3)	11	14	Safeguarding Children	31
5	NHS Safety Thermometer	12	15	Learning Disability	33
6	Sepsis	14	16	End of Life Care	35
7	Pressure Ulcers	16	17	Maternity	37
8	Legal Services	18	18	Patient Flow	38
9	Dementia	19	19	Serious incidents & Never Events	39
10	Infection Prevention & Control	21	20	CQUIN targets 2014/15	42

Executive Summary

Within the 2013/14 Quality Account, the Trust agreed a number of key quality and safety priorities that would be achieved over the forthcoming year; the priorities were drawn from 3 core documents namely: the Quality and Safety Strategy, Patient Experience and Involvement Strategy and Organisational Development Strategy. This quarterly report provides an overview of progress against these priorities, highlighting areas where significant improvements have been made and those that require further support to achieve identified outcomes. This report should be read in conjunction with the Quality Improvement Plan

From a mortality perspective we have received data from Dr Foster pertaining to our performance in December 2014, this has demonstrated a reduction in our HSMR. We have seen an increase in our crude mortality rates and this is related to mortality within a frail and elderly patient group over the winter period. From an assurance perspective we have recently received a visit from the Medical Director at Derby who has confirmed from our case note reviews that we had no avoidable deaths in the reporting period

Our falls resulting in harm has marginally increased to 1.82 against a target of <1.70 per 1000 occupied bed days. We have implemented many changes over 2014/15 but are failing to see the reduction we anticipate. We have contacted NHS England to signpost us to an organisation that has been more successful in falls management.

We are pleased to say that we have achieved our Inpatient Family and Friends (FFT) response target for March 2015 – **53.2%.**

Unfortunately we experienced 4 Grade 3 Pressure Ulcers during Q4. This was very disappointing as we have seen fantastic results for hospital acquired pressure ulcers over this year. **There have been no Grade 4 Pressure Ulcers reported in the last 2 years**

The Safety Thermometer is continuing to demonstrate excellent results for those patients in our care. **98.53% of Sherwood Forest Hospital patients were receiving harm free care during Q4.** We have also contributed and observed excellent results within the Medicine Safety Thermometer

We have failed our C difficile target for the year with 67 cases against a target of 37 . We have sought the support of our health community partners to help identify solutions.

The Trust Board is asked to discuss the contents of this report and note the improvements that are being made in relation to a number of quality priorities, however to be aware there are still areas that are receiving focused attention to ensure improvements are maintained and driven further.

Mortality (Quality priority 1)

Key Priority One	**Reduce mortality as measured by HSMR**	**Headline & specific HSMR within the expected range** **To have an embedded mortality reporting system visible from service to board** **Eliminate the difference in weekend and weekday HSMR**

HSMR

Dr Foster have reported HSMR data up to December.

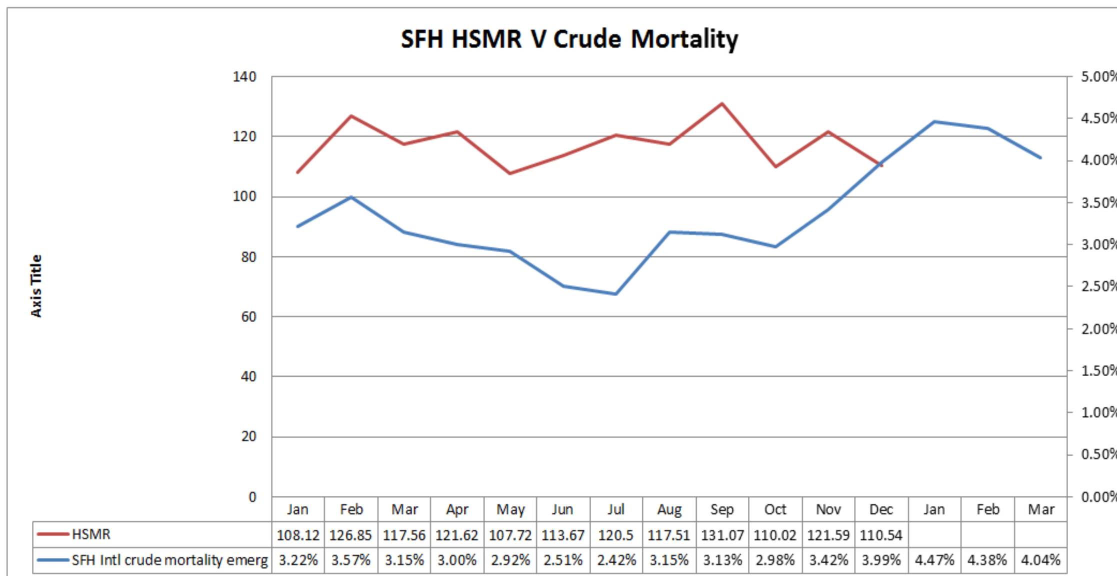
The SFH HSMR for December has come down compared to the previous month despite the raised crude mortality.

Analysis demonstrated this was due to a rise in expected mortality caused by an increase in frail, older patients with multiple co-morbidities. This accords with the findings of the casenote review from deaths in December and January.

The review of deaths from October and November is ongoing and will be reported in May.

An independent validation set of casenote mortality reviews has been performed by the Medical Director from Derby using their proforma. There were no avoidable deaths identified.

We continue to monitor sepsis, cardiac arrests and deteriorating patients via Clinical Quality and Governance Committee and Quality Committee has received a Deep Dive on Sepsis mortality.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HSMR	108.12	126.85	117.56	121.62	107.72	113.67	120.5	117.51	131.07	110.02	121.59	110.54			
SFH Intl crude mortality emerg	3.22%	3.57%	3.15%	3.00%	2.92%	2.51%	2.42%	3.15%	3.13%	2.98%	3.42%	3.99%	4.47%	4.38%	4.04%

Data from Dr Foster Quality Investigator

Mortality (Quality priority 1)

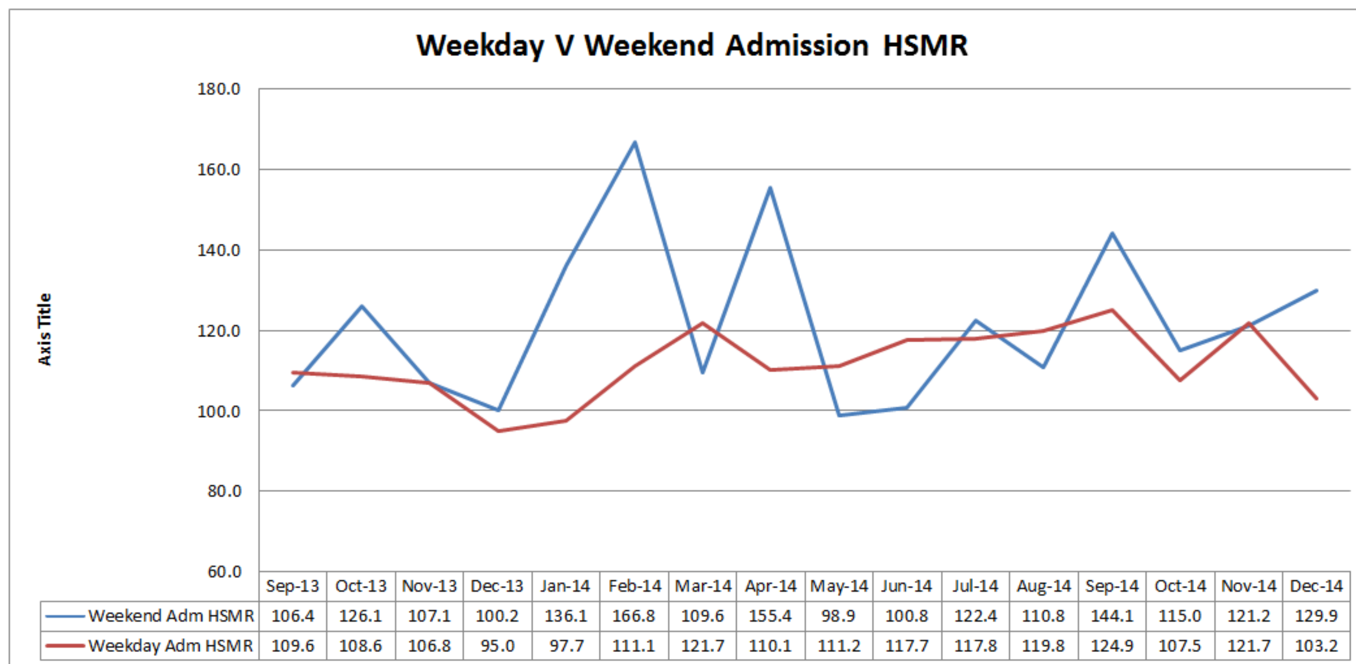
Key Priority One	Reduce mortality as measured by HSMR	Headline & specific HSMR within the expected range To have an embedded mortality reporting system visible from service to board Eliminate the difference in weekend and weekday HSMR

Weekend v Weekday Mortality

The position on this has improved over the year but continues to be monitored quarterly.

Our improved position is a result of the changes we have made towards 7 day working. For example, increased consultant presence at weekends, carrying out ward rounds and providing specialist input at admission in the same way they do on weekdays. There is also improved availability of tests and associated reporting, enabling faster clinical diagnosis and decision making.

Our mortality reviews have not highlighted variance in deaths by day of week or time of day.



	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Weekend Adm HSMR	106.4	126.1	107.1	100.2	136.1	166.8	109.6	155.4	98.9	100.8	122.4	110.8	144.1	115.0	121.2	129.9
Weekday Adm HSMR	109.6	108.6	106.8	95.0	97.7	111.1	121.7	110.1	111.2	117.7	117.8	119.8	124.9	107.5	121.7	103.2

Data from Dr Foster Quality Investigator

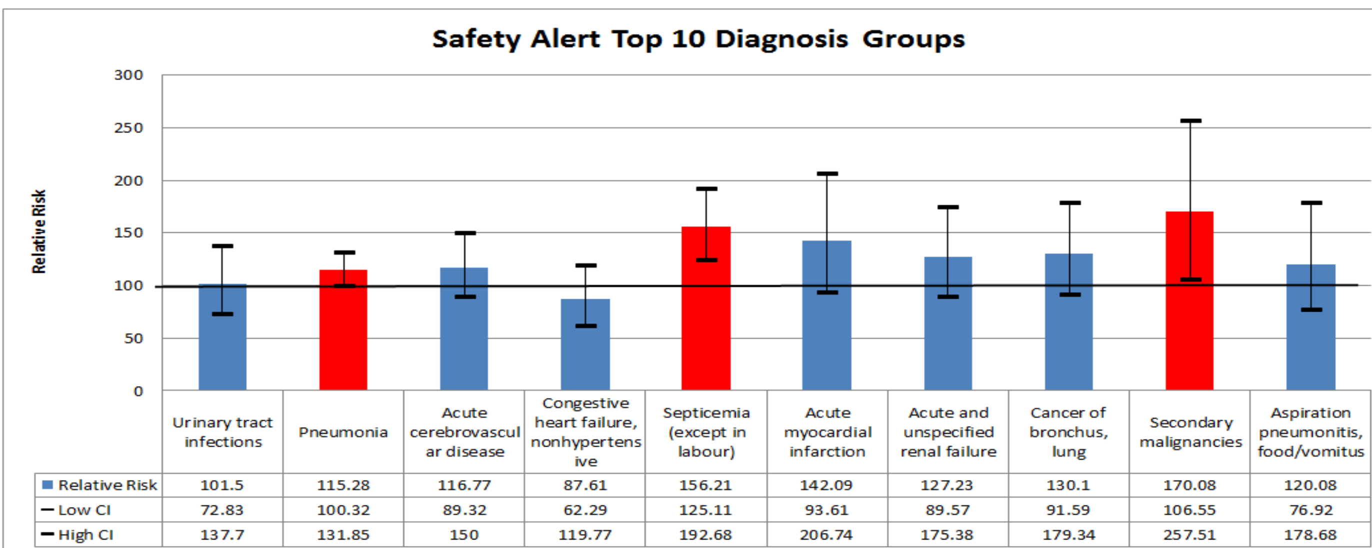
Mortality (Quality priority 1)

Key Priority One	Reduce mortality as measured by HSMR	Headline & specific HSMR within the expected range To have an embedded mortality reporting system visible from service to board Eliminate the difference in weekend and weekday HSMR

Top Ten Diagnoses by HSMR

Sepsis remained above the expected levels for December. There is continuous review of patients with Sepsis to ensure that the deaths are reviewed. This review shows that a high number of patients who have a diagnosis of Sepsis are the frail, elderly patients with multiple co-morbidities. Monthly sepsis audits are fed back at ward level together with mortality reviews. Overall we met **all** elements of the sepsis bundle in 65% of cases; 75% of cases present to the Emergency Department and for these compliance is at 80%. For time to antibiotics, a key element of the sepsis bundle overall compliance was 56% but in ED it was 78%. Sepsis training is now mandatory for nurses and the Sepsis team are visiting all clinical teams including junior doctors to continue our improvement

The chart is based on relative risk, not the actual number of deaths. There were 21 more sepsis deaths observed than expected between
April and December 2014, 12 more than predicted for secondary cancer and 28 for pneumonia. The review of secondary cancer deaths will be reported in May.



	Urinary tract infections	Pneumonia	Acute cerebrovascular disease	Congestive heart failure, nonhypertensive	Septicemia (except in labour)	Acute myocardial infarction	Acute and unspecified renal failure	Cancer of bronchus, lung	Secondary malignancies	Aspiration pneumonitis, food/vomitus
Relative Risk	101.5	115.28	116.77	87.61	156.21	142.09	127.23	130.1	170.08	120.08
Low CI	72.83	100.32	89.32	62.29	125.11	93.61	89.57	91.59	106.55	76.92
High CI	137.7	131.85	150	119.77	192.68	206.74	175.38	179.34	257.51	178.68

Data from Dr Foster Quality Investigator

Mortality (Quality priority 1)

Key Priority One	Reduce mortality as measured by HSMR	Headline & specific HSMR within the expected range To have an embedded mortality reporting system visible from service to board Eliminate the difference in weekend and weekday HSMR

Coding

With regards to HSMR, coding of patients' co-morbidities is vital to allow an accurate calculation of the expected risk of mortality that is used to calculate the HSMR statistic.

We are currently re-coding around stroke as a risk factor, where the code patients were previously assigned did not reflect the high risk that a previous stroke presents to any patient. This will be uploaded at the end of this month and its overall impact on the data will be seen in September.

We have introduced new admissions paperwork in March that, among other things, is designed to improve the capture of co-morbidities and therefore improve coding, which will, in turn, affect the HSMR. The importance of coding has been raised at Medical Managers, Grand Round, with juniors and in the Acute Admissions Unit.

The new documentation is being audited weekly in EAU for completion. In the first week of use, 25% of the documents audited had co-morbidities highlighted in the document. After the second week of use, 50% of the notes reviewed had co-morbidities highlighted in the document. This will be monitored weekly.

Maternity

There was an increase in incidents in Maternity noted in March which brought the total for the year to 21 which included 6 intrauterine deaths, 3 unplanned maternal ITU admissions (no maternal deaths) and 6 suspensions of service. The intrauterine deaths have been subject to internal investigation and care followed RCOG and NICE guidance. There was evidence of organisational learning; a new Growth Assessment Programme has been introduced, additional training is in place relating to the recognition and management of deteriorating patients, problems with national guidance relating to Obstetric infection have been raised nationally. An external review of all of the incidents is taking place on the 27th April. The stillbirth rate for the unit is 3.79/1000 which is below the national average and there have been no staffing issues in midwifery.

Falls (Quality priority 2)
FALLS targets for 2014/15 are to:

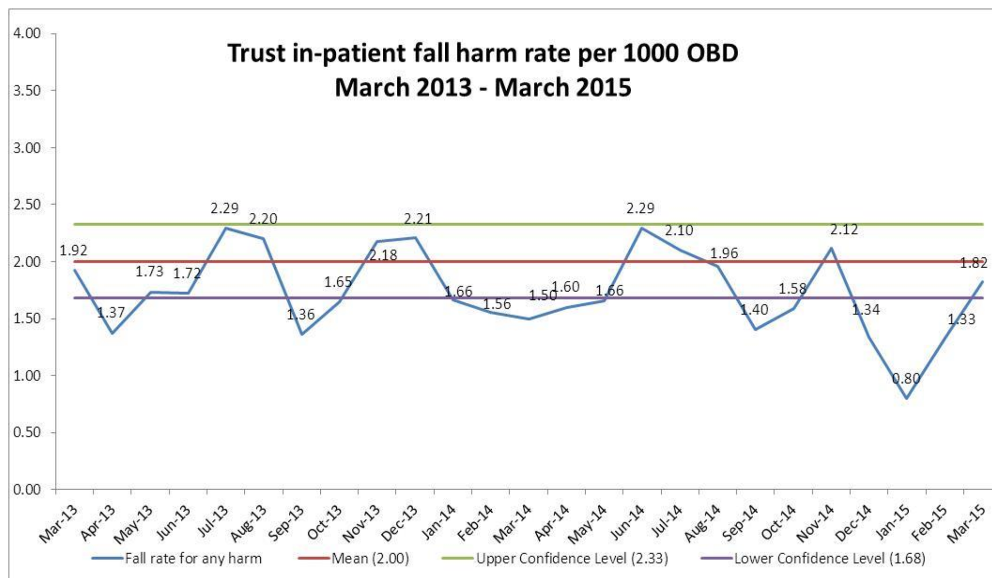
- Capture the number of fallers (non-elective admissions via the Emergency Admissions Unit) in the age group 65 years and over, to enable the whole health community to understand the extent of the work required going forward
- Reduce the number of patients who fall resulting in harm to **<1.7 per 1000 occupied bed days** by quarter 4
- Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
- Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15)
- Reduce the number of fractures from falls to **<25** for 2014/15
- Reduction in repeat fallers and undertaking falls assessment is a CQUIN for 2014/15

How are we performing against this target?

We continued to consistently capture the number of fallers in the age group 65 years and over.

Reduce the number of patients who fall resulting in harm to <1.7 per 1000 occupied bed days by quarter 4
As evidenced in the graph 1 the number of falls Reported in March resulting in harm was recorded as 1.82 falls/1000OBDs, slightly higher than previous two preceding months and above the 1.7 standard set. There have been 6 moderate harms reported. The Lead nurses for falls have validated the March severity codes to enable accurate data.

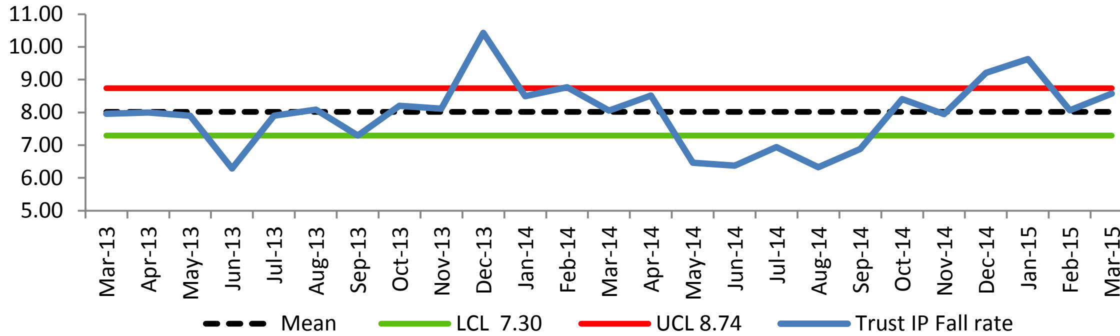
Graph 1



Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15)
A total of 10 patients fell more than twice in Quarter4 against a target of 16.

Reduce the total number of patients who fall to < 7 per 1000 occupied bed days by quarter 4 (quarter on quarter reduction)

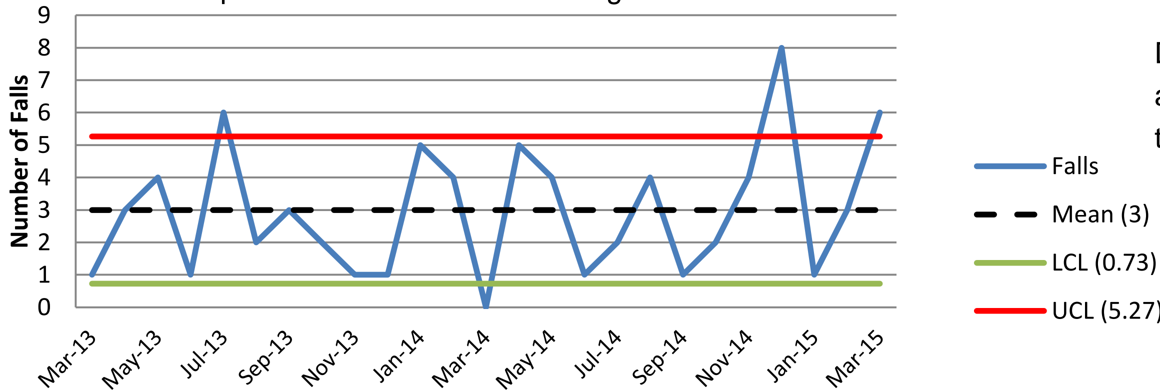
Graph 2 Total Inpatient Fall Rate per 1000 Occupied Bed-Days
March 13 – March 15



As evidenced in the above graph the total number of falls per 1000 bed days reported in March increased but to a level that was below the upper control limit. The incidents have all been severity coded and validated by the Falls Lead Nurses. The number of falls recorded in March was reported as 8.57 per 1000 bed days, this was again above trajectory.

Reduce the number of fractures from falls to <25 for 2014/15

Graph 3 Number of Falls Resulting in a Fracture March 13 – March 15



During March a total Of 6 patients sustained a fracture following a Fall this has bought the trust total to 38 from a year to date.

Actions to reduce falls/challenges

The Falls Lead Nurses have:-

- Begun weekend/ bank holiday working to provide out of hours rapid response to falls to enable visible support alongside education to staff. This time will also be used to work alongside staff within areas of concerns to further understand the reasons for falls rates.

- Begun visiting those areas where patients have fallen more than twice as part of a rapid response review and challenging staff. Discussions will also be held with ward sisters as to their plans for these patients to mitigate further risk. Issues raised have been escalated to the Matrons and will to be discussed at the Falls Group Meeting In April. Although not part of the CQUIN for 2015/6 this work will be part of quality and safety initiatives.

- Started to liaise with Dartford NHS trust – who complete a mini RCA on patient's who have fallen more than once. This recently published Nursing article is to be presented to the Falls Group in April for discussion.

- Recently attended the British Geriatric Society Conference in a response to the falls rate, to enable shared learning and knowledge. Learning/linking with other organisations is part of the CQUIN for 2015/16.

- In response to the rise in falls causing a fracture in March, a review of the root causes and learning points from all completed RCAs was undertaken to highlight any themes/trends. There are no obvious trends to report. The Falls Lead Nurse is also involved at the SI group.

- When the team become aware of any immediate learning actions from the rapid falls RCA meetings held, they look further into learning from RCAs when reports are completed.

- The serious falls support group was reinstated in April. RCA reports will be presented by ward staff and learning and recommendations will be shared.

- In response and recognition to the rise in falls causing a fracture, a meeting has been arranged for April with ward leaders to obtain an understanding of why patients fall. This will work in conjunction with the proposed focus groups developing within the Patient Safety Team.

- Highlighted trends/themes to be used to formulate educational requirements and appropriate interventions.

- Used the Trust Proud To Care study session, as an opportunity to discuss and highlight trends/themes that are very current, to enable immediate learning. The Lead nurses for falls prevention will also speak at the Trust induction sessions .

- As part of quality initiatives, liaison will take place with the relatives/next of kin of the patients who have fallen and sustained a fracture, whereby a discussion is held about the RCA process, who to contact, the patients' journey and an opportunity to ask questions. It is hoped that the open and honest approach, in conjunction with the ward communication, may reduce inpatient complaints. Comments received from relatives have been positive and they were pleased to have the chance to discuss further.

- We are mindful that despite all the work being undertaken the number of patients falling has not reduced.

  NHS England has been approached to sign post the Trust to organisations that have successfully reduced the number of patients falling.

Friends and Family (Quality Priority 3)

Friends and Family targets for 2014/15 are :

- **CQUIN** – 1. Phased Friends and Family expansion to outpatients and daycase
  2. Increase response rate & improve performance
  3. Staff Friends and Family
- **Internal** – Increase Inpatient and Accident and Emergency Friends and Family response rate to 50% by October 14.

How are we performing against this target

Staff training and support was required following the implementation of the Friends and Family in Outpatient and Day Case Unit. The training needs have been addressed and this has resulted in an increase in response rates:

- Outpatient Clinic 2.4% (30.7%)
- Day Case Unit 10.3% (21%) at Kings Mill Hospital,
- Mansfield Community Hospital 2.4% (18.4%)
- Newark Hospital 3.3% (30.3%). There is currently no internal target agreed for this area.

The Inpatient Friends and Family has seen a 23.6% increase in response rates in March 2015 from 29.6% to **53.2%,** which exceeds the internal target of 50%.

The response rates in the Emergency Department for March 2015 has increased significantly to 17.2% which indicates a 10.5% rise from February 2015, however as reported in March 2015, there were a number of anomalies regarding the data received by the external provider, responsible for providing the response rates.

The Maternity service continues to increase the response rates, in March 2015, an increase of 2% from 36% to **38%.**

Mitigation plan (actions to date and future planning)

- A dedicated CQUiN Support Worker collates and monitors completed surveys from all relevant wards and departments in the Trust, continuing to utilise the Android Application in the Emergency Department and Outpatient Clinic. Staff have demonstrated a positive response in the introduction of the worker, ensuring training and support issues are addressed and resolved in a timely manner to ensure eligible patients are asked to complete the Friends and Family Test. All completed Friends and Family surveys are analysed prior to sending to the external provider to identify positive and negative feedback Areas of negative feedback are reported to the relevant ward/departments and addressed given the limited anonymised information provided.

- The Trust is currently exploring the option of upgrading the provider package for the duration of the contract, (the current service provider is due for renewal in January 2016) to provide additional modes of collection of data, in particular in the Out Patient and the Day Case Unit, from April 2015. In addition, this should provide real time feedback for staff, to shape service improvements, furthermore, influence patient experience at that time. Further discussions are on-going regarding longer term solutions to manage FFT across the organisation.

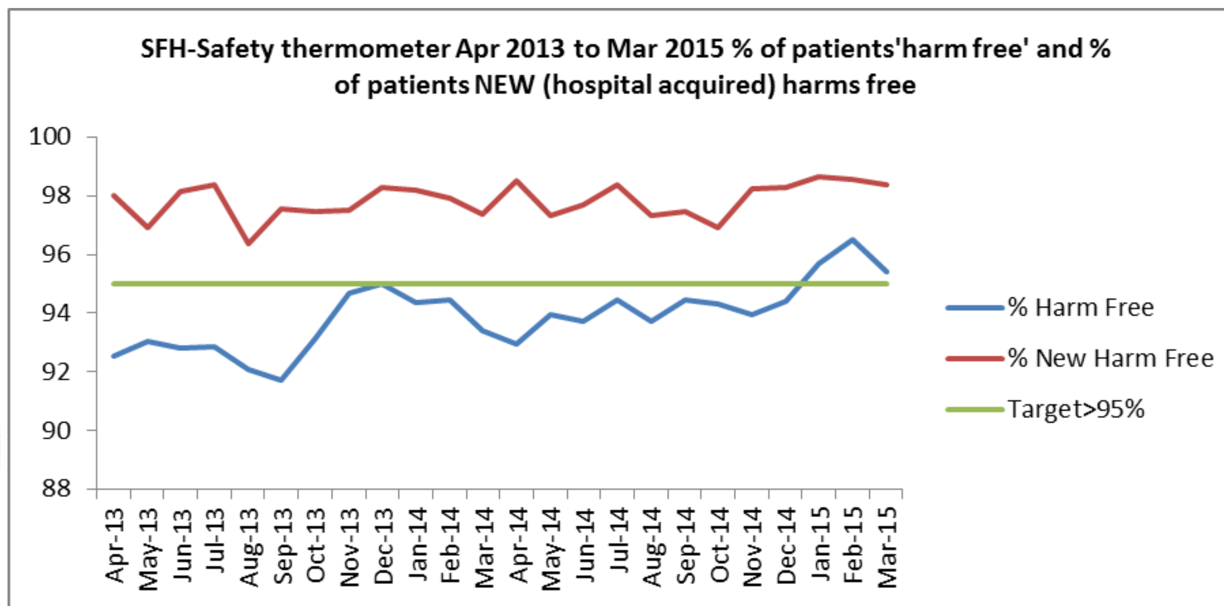
Safety Thermometer

Safety Thermometer targets for 2014/15 are :

Aim to : ensure harm free care for patients (>95%), as measured by safety thermometer .

Q4 Safety Thermometer
A total of 1908 patients were assessed using the Safety Thermometer during Q4.
The Trust continues to achieve 100% compliance in submitting data to the NHS Safety Thermometer.

How are we performing against this target



The graph above shows the % patients classified as "harms free" and "NEW (hospital acquired)harms free by month and indicates that for Quarter 4 we have achieved the 95% target and consistently remain above 95% for patients who have acquired new harms

In Q4 the result for harm free care is an average of **95.85%**,this is an improvement on the average of **94.22%** in Q3 and exceeds the national goal of **95%** This includes patients who have been admitted with a degree of harm.

Q4 Monthly breakdown of harm free care by %

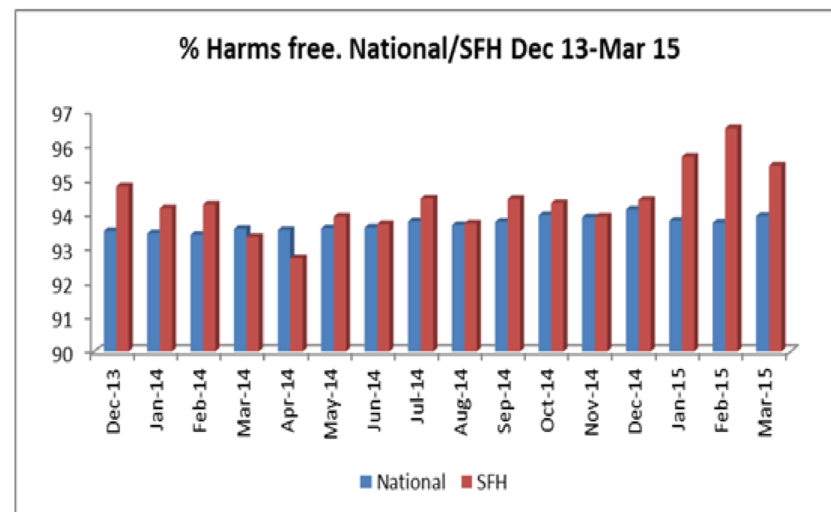
January
95.67%* -harm free care
98.66% - new harm free care
1.34% of our patients suffered a new harm
New CAUTI – 3 New Fall with harm - 3
New Pressure ulcer PU –1

February
96.50%* - harm free care
98.57% - new harm free care
1.43% of our patients suffered a new harm
New CAUTI -2 New Fall with harm- 0
New Pressure ulcer - 6

March
95.41%*- harm free care
98.36% -new harm free care
1.64% of our patients suffered a new harm
New CAUTI-0 New Fall with harm -2
New Pressure ulcer -5

95.85%
Harm Free Care in Q4

98.53%
New Harm Free Care in Q4



The graph above illustrates the Trust position of harm free care alongside the national average performance

*Please note that the percentage shown is the overall percentage of harm free care, this includes patients admitted into the Trust with pre - existing pressure ulcers, 'old' UTIs in patients with catheters. Old UTIs are defined as those where treatment had started outside of the Trust.

What do the results tell us ?
For each month of Q4 2014 our reported 'harms' rate was less than the national average reported rate this includes pre-hospital (old)as well as hospital acquired harms(new)

Mitigation Plans

The monthly information will be shared more widely through the use of the new 'I care 2 share I care to learn' learning boards . The appointment of a second Falls nurse is allowing for the service to be extended to include weekends .The Falls nurses are able to provided an increasingly responsive service attending wards to work with patients and teams following an incident of a fall . Improvement work is being undertaken with wards that have a higher incidence of falls .This will include training of staff and trials of falls prevention methods such as bed sensors and hip protectors.

The medicines safety thermometer has been introduced and the data at this early stage shows no statistical trend and the overall picture is improving. The number of patients with missed doses is 6.9% against a National picture of 11%. Critical doses missed is at 4.8% against a National average of 6.8%. This is an emerging picture and requires monitoring as it develops.

Sepsis

Sepsis Targets for 2014/15 are :

CQUIN – To achieve 75% compliance with the sepsis care bundle in Quarter 2, improving incrementally to 95% by Quarter 4 2014/15. We require all 6 elements of the Sepsis Bundle to be implemented to achieve full compliance and not just antibiotic treatment time; this is the highest standard possible

	% Compliance Against The Sepsis Care Bundle
Q1	48.8
Q2	51.3
Q3	56.3
Q4	65

How are we performing against this target:

The validated audit data for 2014/15 evidences a trust-wide compliance rate of 55.3%. Further analysis has evidenced that the Emergency Department has recorded a compliance rate of 66.3% in comparison to a rate of 32.6% being recorded across the base wards. Further improvements are required within this area to improve overall compliance rates

How did we achieve this?

1. Implementation of and achievement of the sepsis care bundle has been multi-disciplinary in nature and has been driven simultaneously through governance and professional accountability
2. The Sepsis Working Group have lead and driven the sepsis improvement plan through audit, root cause analysis and education
3. Establishment of robust reporting mechanisms via divisional / speciality governance meetings and Patient Safety Improvement group
4. An increase in the Sepsis Lead Nurse hours and appointment of a clinical lead has supported overall improvements regarding compliance over the latter part of the year

Monitoring and reporting for sustained improvement

1. Sepsis related HSMR is monitored monthly. Deep-dive mortality reviews with action plans have focused on Q2 & Q3 of 2014. A further review is currently underway for Q4 of 2014 and will report in May 2015.
2. The Trust Sepsis Policy has recently been amended to include paediatric patients & a paediatric sepsis six screening tool is being implemented. Paediatric sepsis will now be scrutinized with the same methodology as adult sepsis.
3. The Lead Sepsis Nurse is working with the NHS England Sepsis Collaborative to improve sepsis care nationally and with the CCG to improve sepsis care across both primary & secondary care.

Further improvements identified for 2015/16

1. Sepsis has been selected as a national CQUIN for 2015/16 with measurement against antibiotic treatment time which is one element of the Sepsis Six bundle. The Sepsis Working Group will action plan further work to meet these goals which will involve both our adult and paediatric patients.
2. The Trust has selected sepsis as one of its key quality priorities for 2015/16, progress will be formally monitored and reported to the board on a monthly basis

Pressure Ulcers

Pressure Ulcer targets for 2014/15 are :

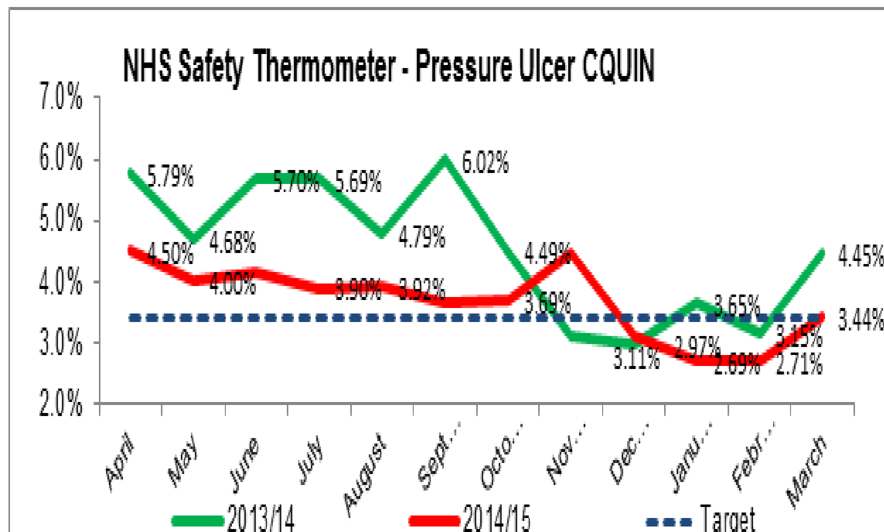
1. **CQUIN** – A 50% reduction in all PU's (both inherited and hospital acquired) using the safety thermometer data
2. **Contractual** – A 50% reduction in avoidable PU's
3. **Internal** – The elimination of grade 3 and 4 avoidable hospital acquired PU's by October 2014 and achieve zero by March 2015

How are we performing against this target

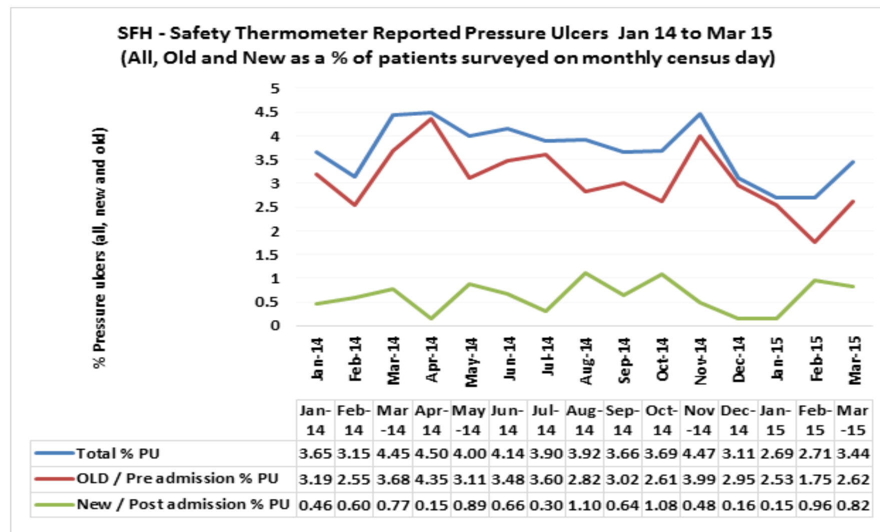
CQUIN

Overall in 2014 there has been a gradual downward trend in all inherited and hospital acquired Pressure Ulcers, with the exception of November and March as demonstrated in Graph 1. However in March there was a slight decrease in hospital acquired Pressure Ulcers (Graph 2)

Graph: 1 NHS Safety Thermometer



Graph: 2 NHS Safety Thermometer



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Total % PU	3.65	3.15	4.45	4.50	4.00	4.14	3.90	3.92	3.66	3.69	4.47	3.11	2.69	2.71	3.44
OLD / Pre admission % PU	3.19	2.55	3.68	4.35	3.11	3.48	3.60	2.82	3.02	2.61	3.99	2.95	2.53	1.75	2.62
New / Post admission % PU	0.46	0.60	0.77	0.15	0.89	0.66	0.30	1.10	0.64	1.08	0.48	0.16	0.15	0.96	0.82

Pressure Ulcers

Contractual

9 avoidable Grade 2 (superficial) Pressure Ulcer's developed in Q4, achieving the target of **<12.**

During 2014 -2015 a total of 64 Grade 2 Pressure Ulcer's have been reported against an annual target of 53.

4 avoidable grade 3 Pressure Ulcers developed in January and February against a target of zero.

During 2014 -2015 however the grade 3 target of **< 9** has been achieved, with **6** developing throughout the year.

Table: 1 Total Number of avoidable Pressure Ulcers Reported.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Totals
GRADE 2 - is superficial and may look like an abrasion or blister													
2013-14	14	13	16	8	7	5	9	6	7	9	5	7	**106**
2014 -2015	5	10	12	8	9	2	6	3	0	2	3	3	**64**
Target No.	5	5	5	5	5	4	4	4	4	4	4	4	**53**
GRADE 3 - goes through the whole layer of skin and there is damage to the tissues underneath the skin													
2013-14	5	4	2	0	1	0	2	1	1	2	0	0	**18**
Target No.	3	3	2	2	2	2	2	1	1	1	1	0	**20**
2014 -2015	2	0	0	0	0	0	0	0	0	2	2	0	**6**
Target No.	2	2	2	1	1	1	0	0	0	0	0	0	**9**
GRADE 4 – is the most severe form, it is deep and there is damage to the muscle / bone underneath													
2013-14	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Target No.	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2014 -2015	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Target No.	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Internal

No grade 4 PUs have developed this year, however the target of zero grade 3 PUs has not been achieved, as the four developed in January and February.

Mitigation plan (actions to date and future planning)

- A mini RCA is completed for all avoidable Grade 2 pressure ulcers with the same emphasis on sharing and learning as full RCA's
- All wards are being audited by the TVT and the Ward Leaders with individual feedback for display on the wards
- Analysis of all hospital acquired grade 3 (avoidable and unavoidable) by the Tissue Viability Nurse Consultant including ulcer location sites, dimensions of the wounds and photographs, to ascertain severity of the ulcers, common aetiology, themes etc. Electronic Action Plan tracker to be developed by the Tissue Viability Nurse Consultant for Pressure Ulcer RCA to ensure the cycle investigation and learning processes are complete
- Continued work with bed hire advisory group to analyse cost effective and timely solution to dynamic mattress provision across the trust whilst also ensuring infection control and moving and handling standards are met as well as contributing to improving patient flow

Legal Services Report – Quarter 4 2014/15

This report provides details of Claims made under the Clinical Negligence Scheme for Trusts (CNST) and feedback on Inquests held in Quarter 4 of 2014/15.

1. Clinical Negligence Scheme for Trusts (CNST) Claims received in Quarter 4 by Division

CNST Claims	Emergency Care & Medicine	Planned Care & Surgery	Diagnostics & Rehab	Number with linked Datix incident	Number investigated via SI process	Number with complaint linked	Total number of CNST claims
Quarter 3	4 (0 incidents)	7 (3 incidents)	2 (0 incidents)	3	0	**6**	**13**
Quarter 4	1 (0 incidents)	11 (4 incidents)	1 (0 incidents)	4	4	**9**	**13**
Totals:	**5**	**18**	**3**	**7**	**4**	**15**	**26**

The table to the left shows the number of CNST claims received by Quarter and indicates which are linked to an incident recorded on Datix, or an RCA investigation.

2. Coroner's Inquests held during Quarter 4

Inquests	Emergency Care & Medicine	Planned Care & Surgery	Diagnostics & Rehab	Number with linked Datix incident	Number investigated via SI process	Total number of Inquests held
Quarter 3	3	1	0	3	3	4
Quarter 4	4	3	0	3	4	7
Totals:	7	4	0	6	7	11

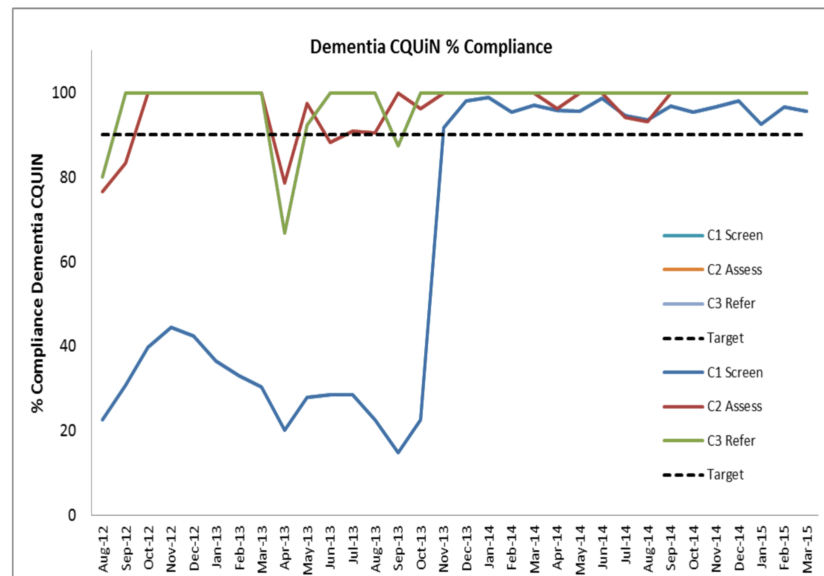
The above table shows that four out of seven Inquests held in Quarter 4 were subject to a full RCA investigation, which were shared with the Coroner. The duty of candour was applied and the reports were shared with the family of the deceased.

The Coroner is keen to ensure, and receive evidence to confirm that, where an RCA has been undertaken, the resultant action plans are monitored to ensure that they are fully implemented and learning takes place.

For the first time since the implementation of the Coroner's and Justice Act 2009, the Coroner issued a "Regulation 28 – Report to Prevent Future Deaths" to the Trust. The response is being prepared and will be shared with the Quality Committee.

Dementia

Graph 1



Dementia targets for 2014/15 are :

CQUIN – 1. 90% of emergency admissions aged 75 years & over are screened, assessed and referred on to specialist services.

2. Named lead clinician and appropriate training for staff.
3. Carer support audit

How are we performing against this target

We have met our target and successfully screened, assessed, investigated and referred over 90% of our patients, aged over 75, that were admitted as an emergency between January 2015 and March 2015

For the whole of quarter 4 we have achieved 100% in C2- assess and C3 – referrals. (Graph 1)

Training

Tier 1 Dementia awareness training has been delivered to 693 of our staff via the Mandatory update and staff induction programmes between January and March.

Wards and units have identified dementia champions to attend study days and to cascade knowledge across their own areas in addition to the mandatory training.

Carers Audit

From a carers audit perspective we have continued to survey carers on a face to face basis. Where this is not possible we have devised a paper survey which is left with the patient for carers to complete when they visit we envisage this will improve our response rates to this survey and drawn meaning full conclusions.

During Q4 a total of 26 responses were received:

- 10 respondent were well supported
- 14 were supported
- 1 was neither supported or unsupported
- 1 response was unsupported.

Dementia

Here is a brief outline of work and activities being undertaken at Sherwood Forest Hospitals to improve the experience of our dementia patients.

Training

Staff have the opportunity to attend the Meaningful Activities study day to learn more about person centred care and the benefits of activities on the ward.

Dementia awareness sessions have been delivered to pharmacy, to the new intake of student nurses and to medical students.

More specialist dementia care training in the form of the Stirling Universities Best Practice Course has been facilitated by one of the Heads of Nursing with the first cohort currently on the programme.

Dementia Friendly Environment

In addition to new clearer signage and improved toileting aids for all the wards and areas, work has commenced on the development of the Geriatric Medical and Mental health unit.

One of the existing elderly care wards at the Kings mill site will be refurbished and employ both registered general and registered mental health nurses to provide the optimum care environment for our patients with dementia.

A collaboration between Sherwood Forest Hospitals Trust and Medirest has led to the purchase of coloured drinking beakers for our patients in response to research that shows patients living with dementia will drink more from a coloured vessel.

Alzheimer's Society

Carer support and information sessions (CRISP) have been held at the Kingsmill site facilitated by staff from the Alzheimer's Society, Mansfield with refreshments kindly donated by he League of Friends.

Dementia Care Appeal

In February the Clinical lead for psychiatry arranged a Winter Ball, raising a massive £5000 and the League of Friends raised over £1000 at Easter. These are merely 2 examples of the dedication and hard work that is contributing to the care appeal on a daily basis.

Infection control

Infection control targets for 2014/15 are :

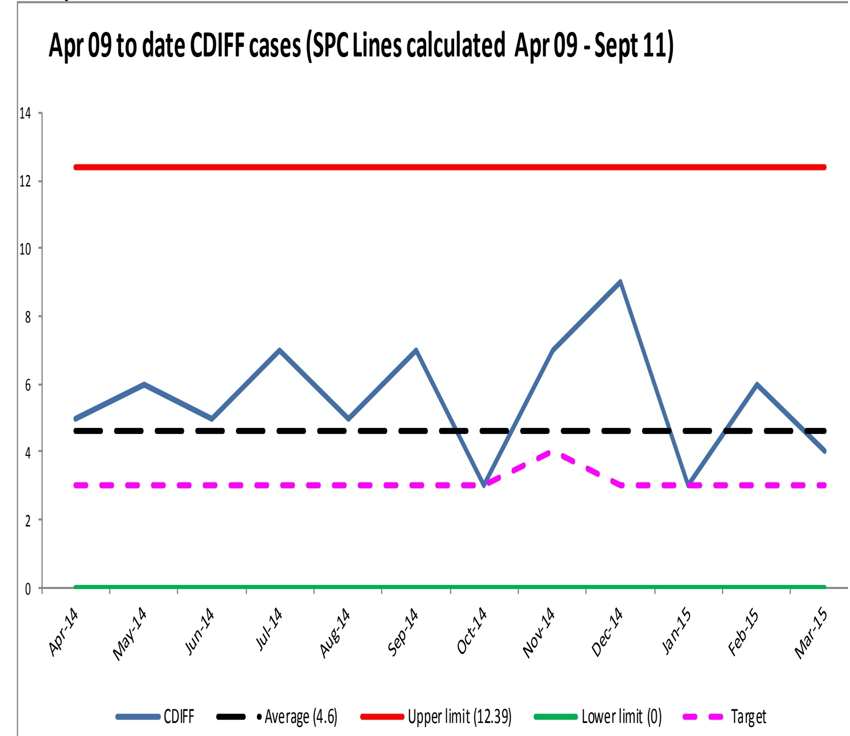
- **Contractual** – 1. Zero tolerance Hospital Acquired MRSA
  2. Minimise rates of Clostridium difficile – No more than 37 cases.
- **Internal** – No more than 5 Urinary Catheter Related bacteraemia

How are we performing against this target?

MRSA bacteraemia: There have been zero cases of hospital acquired MRSA bacteraemia during 2014/15

Clostridium Difficile: There have been 13 incidents of *clostridium difficile* toxin during Q4 bringing the rolling total to 67. This breaches our annual target of 37 (Graph 1) RCA's have been performed and on one occasion there was a delay in sampling: 4 cases were identified as part of a period of increased incidence of *norovirus* and were not treated for their *clostridium difficile* toxin diagnosis.

Graph 1



Catheter associated bacteraemia: There have been 4 cases of hospital acquired catheter associated bacteraemia during quarter 4 bringing the annual total to 12. RCA's have identified problems with catheter management and issues surrounding choice of device. Consideration of alternative continence systems are under discussion and procurement have been asked to consider systems that improve practice compliance problems. Mandatory reporting of all bacteraemia caused by either methicillin sensitive *staphylococcus aureus* and *eschericia coli* is required. E.coli bacteraemia were the causative organism in the 2 of the catheter related bacteraemia identified.

Infection Control

Mitigation plan (actions to date and future planning)

Clostridium Difficile: this remains high on the agenda and a comprehensive action plan is in place with clear, measurable goals. A meeting has taken place to discuss future management across the whole health economy, identifying triggers and practice issues. Actions taken:

- SFH joined the area prescribing group and a collaborative new policy is near to completion
- Arrangements have been made to facilitate a training programme with local G.P's in anti-microbial stewardship and *clostridium difficile* this is planned for September 2015.
- A new sampling proforma has been disseminated to improve patient assessments of patients with diarrhoea.
- The patient safety collaborative visited in March 2015 to review the internal measures present to reduce HCAI including CDI, Report is still outstanding at present.

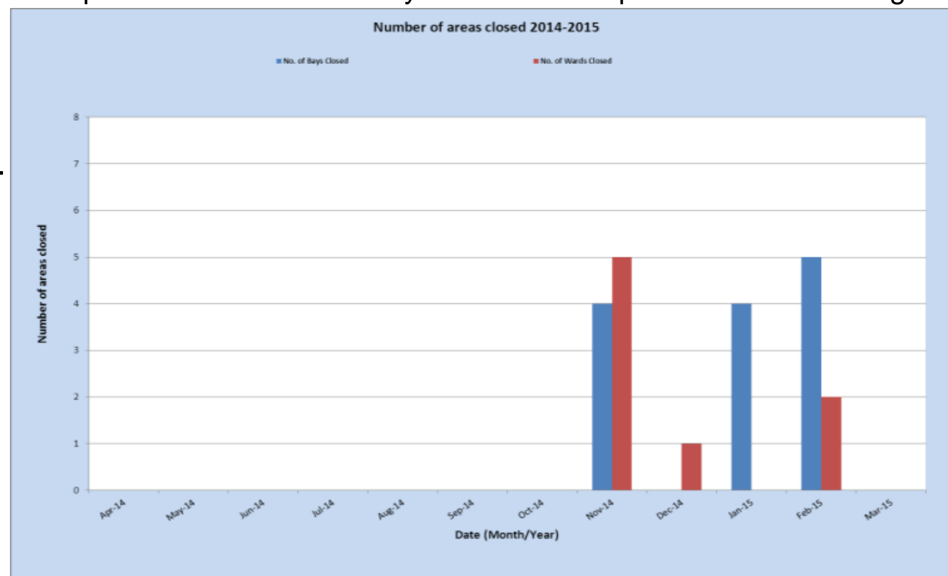
Bacteraemia: Any bacteraemia are reviewed by an IPCN and a consultant microbiologist, where identified as Trust acquired and/or device related, an RCA is undertaken in order to identify potential lapses in care and facilitate organisational learning.

Catheter Associated Bacteraemia: Cross health economy working has identified that there are communication shortfalls between primary and secondary care. The catheter passport has been completed and the community staff are in the process of introducing it.

Outbreak management: The problem with *norovirus* outbreaks continued within the first 2 months of Q4 and 11 wards (Graph 4) across the trust were fully or partially closed due to *norovirus* the outbreaks affecting 62 Patients.

Two areas identified positive patients but were able to fully contain the infection.

A total of 66 bed days were lost and 7 patients had a delay in discharge. However service continuity was maintained during this time. Throughout Q4 the IPCN's provided a weekend on-call service to assist with issues surrounding capacity and flow relating to infections.



Infection Control

Audit

A programme of Bi-weekly audits are performed by the IPCT in all clinical areas. Table 2 shows the results by division and provides the overall percentage score for the organisation. To be considered fully compliant the minimum score should sit at 90%, between 80-89% is partially compliant and below 80% urgent actions are required. Newark continues to achieve good responses in all areas, only in Sharps is the score reduced.

The severe pressures on capacity may have had an impact on commode cleanliness, poor standards were immediately rectified and action plans developed to ensure standards are maintained. This has subsequently been shared and highlighted with respective divisional governance teams. The IPCT are re-auditing all areas within the 6 weeks and performing random checks on the areas that were poor.

Table 2 Planned Audits: January- March 2015

Audit	Total Areas	ECM	PCS	NWK	%Trust Score
Hand Hygiene	36	65	83	100	75
Commodes	36	50	35	100	47
PPE	36	85	100	100	91
Linen	36	85	83	100	86
Isolation	36	100	58	100	86
Sharps	36	89	91	87	86

Education and Training

- Mandatory Hand Hygiene training, compliance overall 83% and mandatory infection prevention education compliance overall is 86% across all clinical groups includes key information relating to all aspects of standard precautions. Medical staff training rates was identified as being low during the quarter and remedial action in terms of increased training opportunities were put in place to improve compliance during March 2015, which has improved the compliance rate to 63% by the end of Quarter 4, work is on-going to improve these rates further.

Decontamination

- A trial of new chemicals for high level cleaning has been completed and a preferred option identified. This is now undergoing further testing as required by CNH to identify if there are any problems with the flooring. A system to clarify 'what clean is required' has been devised and will be formally introduced in April. It is using a RAG system: R, for fogging and disinfectant; A, disinfectant only; G, standard clean. These are all timed to enable clinicians know their responsibilities and enable patient flow to be accurately gauged.

Infection Control

Surgical Site Infections

Mandatory surveillance of Total Hip and Total Knee replacements:

- In 2013-14 we had 2 Surgical site infections
- In 2014-15 we had 5 Surgical site infections

These 5 were identified as different organisms except 2 which where MRSA infections and part of an outbreak on the ward. Root cause analysis are requested for all mandatory Surgical site infections from the Consultants, these are not always completed in a timely manner.

Actions that have been put in place following these Surgical site infections are:

- Changes to cleaning process's on Ward 11 have been implemented recognising changes to elective and non elective patient flows within this area. No patients will be admitted/transferred to Ward 11 without 1 negative MRSA screen with results available.
- Nurse will accompany Doctors on ward rounds to look at wounds and ensure dressing are replaced in a timely manner.
- ANTT and Hand hygiene practices monitored.

Good practice points one patient was managed at home by the Orthopaedic outreach team and outpatient appointment with the Consultant and readmission was prevented due to this.

Medicine Safety

Medicine safety targets for 2014/15 are :

Internal:

1. Zero medication-related 'never-events'.
2. To increase the number of reported medication-related incidents by **20%** (compared to 2013/14 data).
3. To reduce the number of medication-related incidents resulting in moderate/severe harm by **25%** (compared to 2013/14 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation etc.

How are we performing against this target

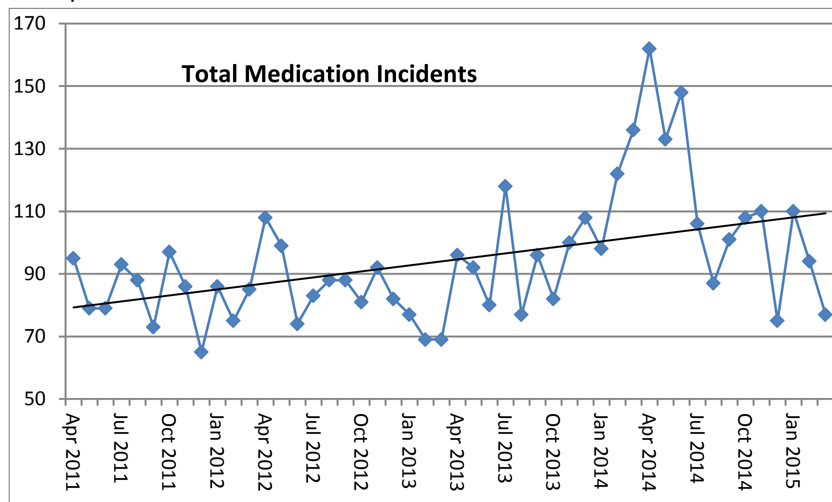
1. **Zero medication-related 'never-events':** There have been no reported medicines-related 'never-events' during Quarter 4 of 2014/15. It is noted that the 'never-events' list (including medication-related content) has been revised at the end of March 2015.

2. **To increase the number of reported medication-related incidents by 20% (compared to 2013/14 data):** There has been a 21% reduction in such reporting in Q4 2014/15 compared to the same period in 2013/14. There has, however, been an overall increase in reporting of approx. 9% for the full year 2014/15 compared to 2013/14. See Graph 1 for medication-related incident monthly totals reported since April 2011. Most incidents reported in 2014/15 related to **medicine administration/supply**, of which **medicine non-administration** (particularly of *critical* medicines e.g. antibiotics, antiepileptics etc.) is most reported. Such omissions contributed over 26% of all medication-related incidents in 2014/15 compared to 21% in 2013/14, and reflects a significant amount of work undertaken in year to raise awareness and improve reporting. It does, however, remain a concern locally and nationally, and will be the focus of on-going work during 2015/16 (including monthly monitoring in the Medicines Safety Thermometer).

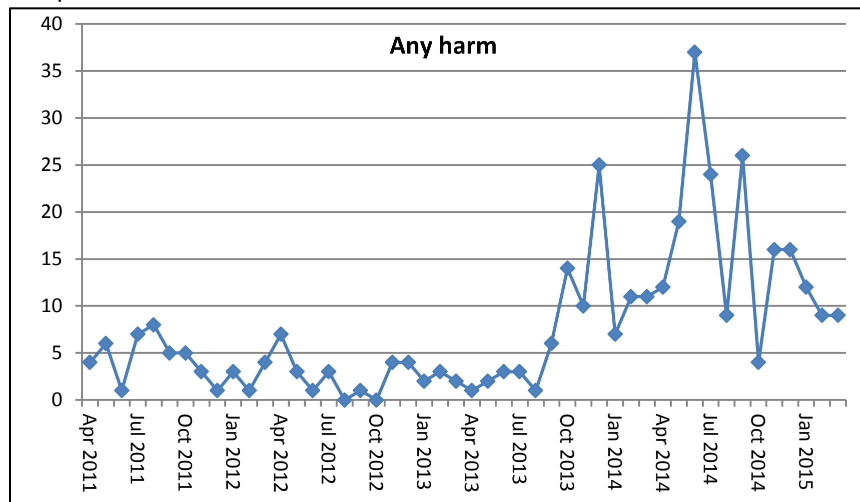
3. **To reduce the number of medication-related incidents resulting in moderate/severe harm by 25%, particularly for high-risk medicines:** Overall numbers of such incidents resulting in *any* harm remain very low (see Graph 2); only 4 incidents of 'moderate' harm were reported in Q4 2014/15 compared to 5 in the same period 2013/14, but there was an **increase** in reporting of such incidents of 28% in the full year. Overall, 85% of medication-related incidents where severity was reported were classed as causing 'no harm' in 2014/15 compared to 92% in 2013/14, and where harm was reported, 91% were classed as 'low' in 2014/15 compared to 84% in 2013/14. There were no 'severe' or 'catastrophic' harm outcomes in 2014/15. There has been a significant and maintained shift in harm reporting since Sept 2013, which reflects a more consistent application of NPSA harm definitions to incidents reviewed by the medicines safety team in Pharmacy, and improved quality of incident report content provided by reporters. Analysis of medicines incident reporting rates from the National Reporting and Learning System (NRLS) data continues to demonstrate reporting rates at the Trust which are comparable to other medium acute Trusts in the region.

Medicine Safety

Graph 1



Graph 2



Mitigation plan (actions to date and future planning)

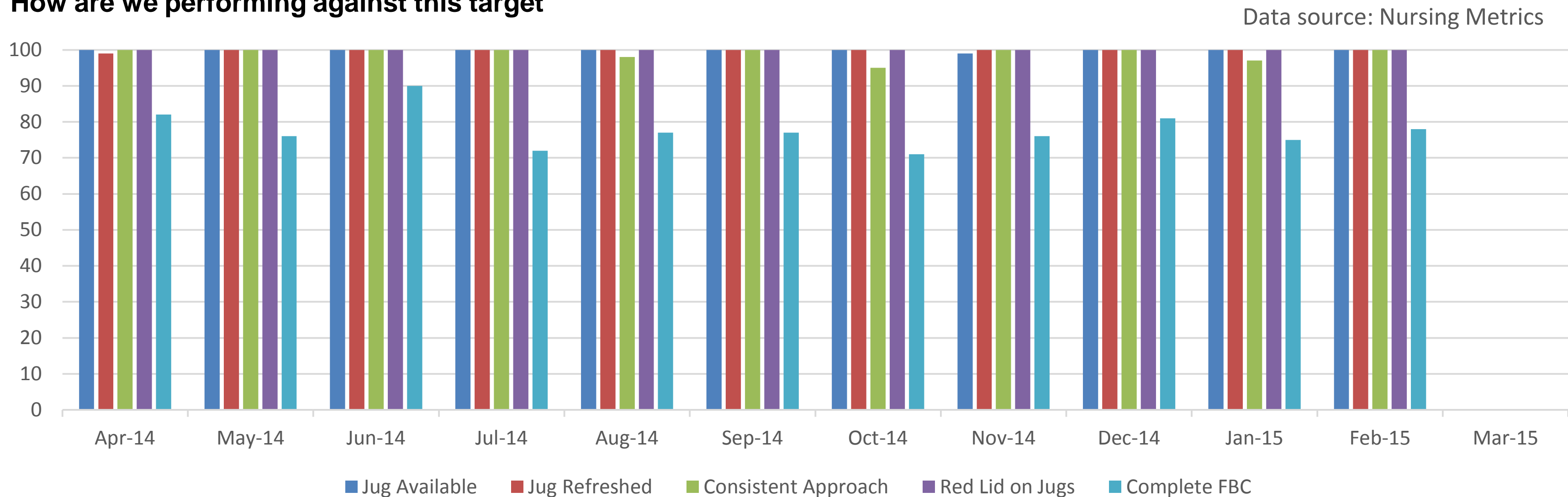
- Medicines-related ‘never-events’ categories continue to be included in induction and mandatory update training for nursing staff, and information remains on display in clinical areas (although this needs revision in view of the new 2015/16 list).
- Data on medicines omissions (with a focus on critical medicines) and potential harm are now collected and reported (locally and nationally) on a monthly basis across the Trust using the Medicines Safety Thermometer tool, which is building on work targeting omitted medicines initiated by the Medicines Management Task/Finish Group. Medicines ‘champions’ are now in place in clinical areas to continue to monitor and drive good medicines management practice. The revised Trust drug chart launched in Dec 2014 provides space for staff to document reasons for medicine omission and remedial actions taken.
- The Trust Medicines Safety Officer role is now established and should provide opportunities to increase the number of root cause analysis (RCA) investigations and associated learning being undertaken for significant medication incidents or near-misses, although quoracy of and adequate clinical representation on the Trust Medicines Safety Group remains a significant challenge going forward.
- Nursing and Pharmacy staff continue to report the vast majority of medicines-related incidents – other clinical groups, especially medical staff, need to be encouraged and supported to report incidents when encountered.
- Medicines safety is now a core content of multidisciplinary training and information relating to patient safety across the Trust, including the newly established Nursing & AHP Grand Round.
- A lot of work around medicines safety has been undertaken in 2014/15 and the details of this is included within the Quality Improvement plan
- The Quality Committee received assurance on Medicines Safety in the March 2015 meeting.

Hydration

Hydration targets for 2014/15 are :

- **Internal –** **Our focus is to ensure that all patients in our hospitals receive adequate hydration and that their needs are assessed, monitored and optimised correctly .**

How are we performing against this target



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Jug Available	100	100	100	100	100	100	100	99	100	100	100	
Jug Refreshed	99	100	100	100	100	100	100	100	100	100	100	
Consistent Approach	100	100	100	100	98	100	95	100	100	97	100	
Red Lid on Jugs	100	100	100	100	100	100	100	100	100	100	100	
Complete FBC	82	76	90	72	77	77	71	76	81	75	78	

These results continue to show a similar picture. Nursing metrics scores indicate that patients are catered for in relation to their hydration needs. However, fluid balance charts are not fully completed.

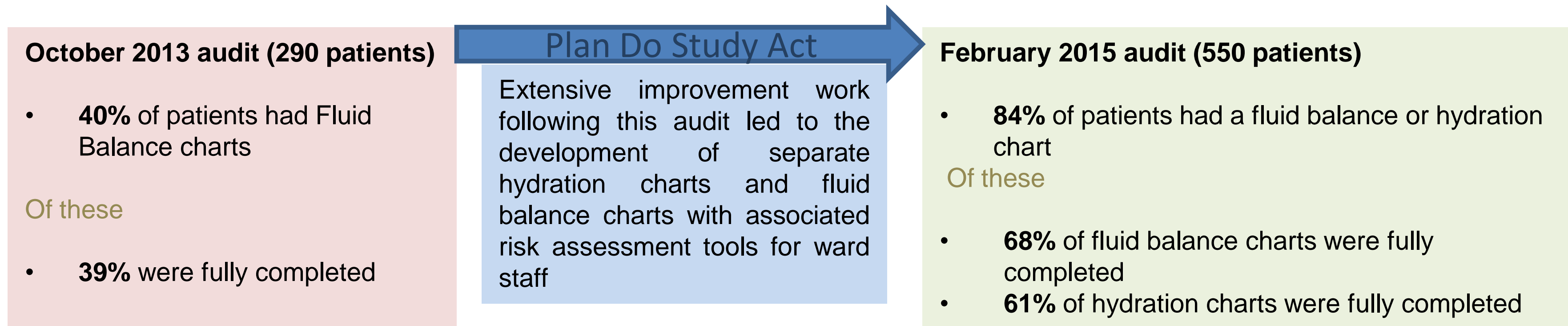
Hydration

A Trust-wide audit was undertaken in order that we find the root cause of this issue and be able to highlight areas of good practice that can be shared across the Trust.

The audit showed:

Recording of IV fluids	**96%**	Totals calculated	**68%**
Recording of oral fluids	**92%**	Balance Calculated	**61%**
Catheter emptying	**88%**	Balance transferred onto next day	**47%**

These results indicate that the issues lie with a lack of accurate and contemporaneous record keeping. These results have been shared with wards and departments during a recent Sisters development day to devise practical actions to address the core issues. Good progress has however been made in recent months if we compare the results of this audit with previously undertaken audits:



Mitigation plan (actions to date and future planning)

- Accountability handover continues to be a key tool for nursing staff to ensure that fluid balance charts are completed adequately
- Medics are being actively encouraged to prompt the completion of fluid balance charts as they are an integral part of any ward round.
- We plan to repeat the audit in the near future to show improvement in completion of fluid balance charts.
- Full implementation of the fluid management module within the VitalPac system will address much of this issue but, with the module currently delayed, staff are being reminded of their obligations to maintain accurate records pertaining to patients hydration status.
- Hydration risk assessment tools are being re-launched with a slightly revised poster to ensure that staff are aware of the robust systems that are in place to manage patients hydration needs.
- Practice development matrons are currently supporting staff education utilising the existing educational resources within clinical areas.

Safeguarding Adults

Safeguarding Adults targets for 2014/15 are :

1. Undertake and report against The Safeguarding Adults Self Assessment (SAFF)
2. Implement the National Capability framework
3. Actively participate in the Multiagency Safeguarding Hub (MASH)

How are we performing against this target (Quarter 4)

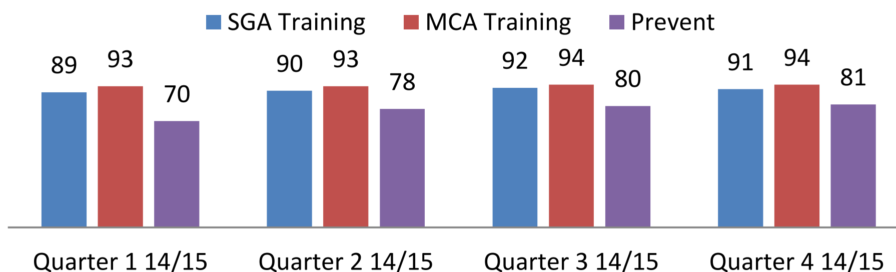
Target 1 : The Safeguarding Adults Self Assessment (SAFF)

This was completed for 2014/15 and submitted to the Nottinghamshire Safeguarding Adults Board (NSAB) and Clinical Commissioning Group (CCG). The output of the self assessment forms the basis of the safeguarding adult's work plan. Progress against this plan is monitored via the joint SFH / CCG Quality and Performance meeting.

Update on actions outstanding at the end of quarter 4 from the Safeguarding Adults Work Plan.

1. The Mental capacity audit across high risk areas has been completed. Audit results will be presented at the operational Safeguarding meeting.
2. To have a process in place to provide reasonable adjustments for vulnerable people is progressing. This will be carried over to 2015/16 work plan.

Target 2: Implement the National Capability framework



All Trust Safeguarding Adults Training has been updated in line with the care act and remains compliant with the capability framework.

31 Safeguarding Adult Champions have received a two days training.

Three study days are planned for 2015/16

Target 3: Actively participate in the Multiagency Safeguarding Hub MASH

The Trust's Safeguarding Adults Team has a close working relationship with the Multi Agency Safeguarding Hub (MASH) and the Safeguarding Adults Advisor attends the quarterly MASH health meetings.

There have been 150 referrals to the safeguarding team in quarter 4 - 25 of these referrals were referred to MASH for investigation

There have been 11 referrals with concerns regarding the Trust.

Themes from the internal incidents are;

- Staff not following the mental capacity act
- Lack of written communication with on-going care provider. (transfer letters not sent when patient discharged)
- Clear documentation needed for patients who sustain / are admitted with bruising.

The reporting process for internal incidents has changed to ensure that all safeguarding incidents are now considered within the serious incident reporting process. All external reports are signed off at the SI sign off group.

- ➢ Action plans will be shared across divisions and delivery tracked.
- ➢ Key themes have formed part of the shared organisational learning boards.

Internal assurance visit to EAU (March 2015)

During March the Adult Safeguarding team undertook an unannounced visit to the Emergency Assessment Unit. In order to seek assurance that Safeguarding policy procedure and systems were in place.

The visit highlighted the following themes of which have been included in the Adult Safeguarding work plan.

- Documentation and record keeping (medical and nursing)
- Individual patient care plans
- Organisational learning form incidents

Mitigation Plan (actions to date and future planning)

- A Restrictive practices policy has been written and a training programme of clinical holding skills for staff is being explored
- Safeguarding Adults training and policy has been updated in line with the care act.
- The trusts mental capacity study day has been reviewed and will run monthly throughout 2015/16
- An EAU action planning meeting has been planned in response to the visit.
- The annual Safeguarding Adults report has been written. This will be presented at the Safeguarding Board in quarter 1.
- The Safeguarding work plan has been developed for 2015/16 which includes the themes from internal safeguarding referrals.
- A detailed safeguarding report was presented to the March Quality Committee and they were assured by the work being undertaken.
- Expert advise has been sought by the Trust in shaping the Safeguarding service provision.

Safeguarding Children

Safeguarding Children targets for 2014/15 are :

- Trust to continue to assess & report to CCGs against the annual **NSCB Markers of Good Practice**
- Trust to implement **Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document,** RCPCH (2014)
- Active participation in **MASH**

How are we performing against this target

The annual self-assessment against the NSCB Markers of Good Practice showed that as a Trust, we are green against 57 of the 61 outcomes. There were no 'red' areas. 4 Amber areas were highlighted for action as below -

1. A system is in place to review named professionals competencies against the Roles and Competencies of Health Care Staff Intercollegiate Document 2014 – (compliance 66.6% - there are only 3 named professionals within the Trust)
2. All new starters to organisation attend a safeguarding children awareness session within an induction programme or within 6 weeks of taking up post within a new organisation
3. Supervisors should be trained in supervision skills and have an up to date knowledge of legislation, policy and research relevant to safeguarding children – (compliance 89%)
4. Supervision should take place on a minimum of a quarterly basis – we do not fully meet this target

Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document –

Staff	Level 2		Level 3	
	Q3	Q4	Q3	Q4
Medical	65%	65%	46%	59%
Other	93%	93%	52%	61%

Staff compliant with mandatory training Q3 & Q4 14-15

Safeguarding Children

From a minimum staffing standard perspective we employ a part time (0.5 WTE) organisational wide Named Nurse for safeguarding children and young people (the National Standard is 1.0 WTE) - we have recruited a safeguarding nurse specialist and she will have completed her induction programme and will commence on the 5 May 2015.

MASH
The safeguarding team actively participate in MASH and are signed up to being an information point for health.

Mitigation plan (actions to date and future planning)

NSCB Markers of Good Practice -

1. The Named Nurse is undertaking training to ensure that all competencies are achieved.
2. Whilst a report is produced, continued non-compliance needs to be followed up by TED in the longer term and reports produced for action.
3. Some supervisors require training to be updated. Training is planned for Q1 of 2015-2016, with the CCG Designated Nurse, for all untrained supervisors and to refresh current supervisors.
4. Compliance rates are 100% for 1:1 supervision, but not all staff attend group supervision. Supervision sessions for ED and MIU staff are being reviewed. Sessions will continue to be offered on a drop in basis and additional timetabled sessions will be run.

Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document,

1. Safeguarding CYP training offered at levels 2 & 3 will meet RCPCH standards from April 2015. Compliance of staff in attending training however remains an issue across the trust.
2. All staff who do not have up to date Level 3 training have been / will be contacted personally by the Medical Director and Executive Nurse and advised of their obligation to undertake training and how to access this.

Learning Disability (LD)

Learning Disability targets for 2014/15 are :

External : 1. Ensure the Trust provide evidence to the annual Learning Disability self assessment. 2. Provide evidence for the 6 Learning Disability standards for monitor.

Internal: 1.To deliver Learning Disability awareness training on the trust induction and mandatory training programme, 2.To facilitate a Learning Disability Steering Group meeting on a quarterly basis in order to drive this agenda forward within the trust, involving patients with a Learning Disability and involving their family and carers. 3.To provide support and expertise to patients with a Learning Disability and their family and carers during an acute hospital admission and / or attendance at an outpatient clinic appointment 4. To continue to fulfil the requirements of the annual Safeguarding Adults & Learning Disability work plan.

How are we performing against this target

External: Learning Disability SAF information collected for submission to NHS England, this self assessment will collate information across Nottinghamshire. During Q4 SFHFT provided evidence for the Health & Social Care Learning Disability self assessment and the RAG rating were as follows:

- Green - SFHFT having a LD nurse in post.
- Amber - Complaint led changes.
- Red - Primary care communication of learning disability status to other healthcare providers. The measure for this indicator is SFHFT having information on a patients LD status and the reasonable adjustments they need for attending the hospital being highlighted by GPs and our trust ensuring this is acted on. Currently GP's do not inform the hospital when referring into our services that the patient has a LD and they do not make any recommendations for what adjustments the patient may need to get an equitable service (such as: Double appointment, quiet waiting area) therefore these adjustments are not provided. SFHFT has a paper system within a patients medical notes so that when we are aware of the reasonable adjustments needed they are listed in the patient notes and the LD Specialist nurse makes appropriate arrangements. We are currently looking at our IT systems to see if there is a way of collecting this information and making these needs known to other professionals that are responsible for booking appointments, managing clinics etc. This is a national problem and regionally other hospitals have rated red for this indicator.
- Data was requested on how many inpatient admissions took place, how many outpatients attendances and how many attendances in ED
- Our RAG rated scores were amalgamated and sent to NHS England.
- The final RAG ratings were agreed with people with Learning Disability and family carers at the Nottinghamshire LD partnership board on the 29th January 2015.

2. We continue to be compliant with the 6 standards. During this quarter we identified that some of the data requested for the Learning Disability self assessment had not been captured via SystmOne (number of Learning Disability attendances at ED) A read code has now been added to the system to enable the attendances to be counted and data collected.

Learning Disability (LD)

Internal: 1.Learning disability awareness training: 81% compliance achieved during Q4 (1815 staff members trained).

2. Learning Disability Steering Group Meeting was held on the March 31st. The focus of the meeting was on initial discussions for a 'transitions pathway' between paediatrics and adult services for people with Learning Disability and complex health issues. A task & finish group was established to feed back to the June Learning Disability steering group meeting.

The adults changing places facility opened on the day of the meeting and members attended the launch, this is a really positive achievement and will make a vast difference to patients and visitors requiring this facility.

3. 65 referrals were made to Learning Disability Nurse during Quarter 4.

Most referrals received were for support with Liaison/communication over different care agencies, to help assess the needs of patients and make recommendations for management on the ward. Also for outpatient support with communicating at the correct level for the patient and for accessible information. To help support the ward staff to understand the individual patients level of participation and understanding. Help with planning for complex individuals coming into hospital for care/treatment and to support staff with mental capacity assessment & best interest planning.

Mitigation plan (actions to date and future planning)

- Draft Vulnerable Adults work plan in place for 2015/16 to be reviewed at the Safeguarding Board on 21st April 2015, this includes Safeguarding Adults, Learning Disability and Domestic Violence work streams.

- Work is underway to improve our Red RAG rating, this work is looking at improving both external & internal processes and a task and finish group has had an initial meeting an identified 3 areas of work to address the issue.
- Internal: Looking at Medway PAS and surveillance system in outpatients in alerting staff to the adjustments needed, and looking at making sure our internal referrals from doctor to doctor in a different speciality list adjustments required for the patient.
- External: GP communication regarding LD work being led by Rose Melvin (CCG lead for LD&MH) looking at adaptions and changes to IT systems and producing a reasonable adjustments proforma. This is expected to be a large piece of work and is a long-term action. Progress will be monitored at the safeguarding adults steering group and is on the work plan for this year.

End Of Life Care

End of life care targets for 2014/15 are :

1.To produce an overarching End of Life Care (EOLC) Strategy.

2.To continue to deliver EOLC training on the SFHFT induction and mandatory training programme in conjunction with the provision of communication skills training for staff

3.To facilitate the following EOLC key enablers within the Transforming End of Life Care in Acute Hospitals Programme:

- Last Days of Life
- Gold Standards Framework Register & Advance Care Planning
- AMBER care bundle
- Rapid Discharge Home to Die – including Preferred Place of Care; Anticipatory Prescribing
- Electronic Palliative Care Coordination System (EPaCCS)

4.To capture patient/carers experience in the last days/hours of life by conducting a bereavement survey

How are we performing against this target (please refer to QIP for detailed information):

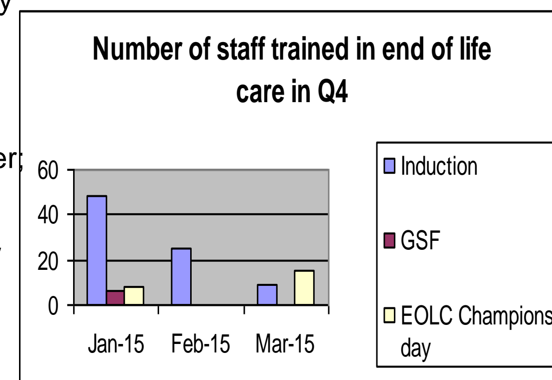
The establishment within the end of life care team has been increased during this quarter to allow for increased pace of change. Resources within the IDAT have also increased to accommodate improved working within the rapid discharges and fast track continuing care processes. However, a period of induction has been underway this quarter.

1. The end of life care strategy has been implemented and progress is monitored via the Quality Improvement Plan (QIP)

2. End of Life Care education and training:

The data opposite (graph 1) shows the number of nursing staff inducted to the Trust this Quarter; the number of staff who attended the 1st Gold Standards Framework training session for Wards 34 & 52; and the number of End of Life Care Champions who attended 2 study days. Face to face clinical support to ward based staff has improved with the additional resource now available. Communication skills training was not provided this quarter due to the availability of the Facilitators. Access to end of life care e-learning has been made available to all staff.

Graph 1



End Of Life Care

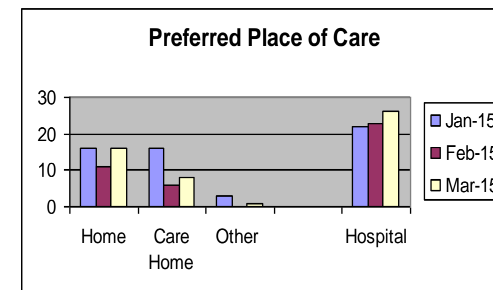
3. Transforming End of Life care:

As evidenced opposite (graph 2) the hospital remains the preferred place of care.
End of life has been identified as a CQUiN (15/16) and a key feature of this scheme will be to gain a greater understanding of preferred place of care choices and to identify whether there are any constraints that inhibit this.

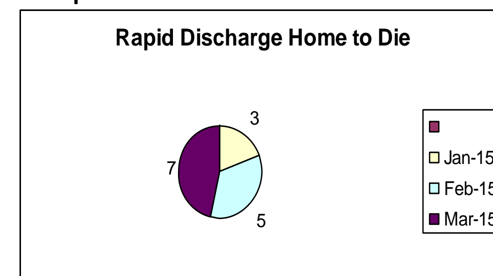
Rapid Discharge Home to Die: the evidence opposite (graph 3) shows the number of patients Successfully rapidly discharged home to die to their preferred place of care in this quarter.

The phased implementation of AMBER care bundle has been delayed to focus the teams efforts on embedding the last days of life guidelines and care plans.
Electronic Palliative Care Coordination System: the Trust continues to work in partnership with Primary Care on the implementation of EPaCCS.

Graph 2



Graph 3



4. Overall the findings from the bereavement survey have been very positive.

203 questionnaires were sent out between October 2014 and December 2014.
56 questionnaires have been returned giving a 26% response rate.

Mitigation plan (actions to date and future planning)

- EOLC MDT training & education – delivering a 5 week programme of education sessions for all ward staff on the 5 Priorities of Care in quarter 1. Communication skills training days are now confirmed for the coming year. Dying to Communicate sessions are in June, September, November 2015 and March 2016; Advance Communication Skills Training sessions to be confirmed July and October 2015. End of Life Care module now in mandatory training booklet commencing April. Priorities of Care rolling programme for generalists is planned over a 5 week period commencing in May 2015. Monitoring the number of staff who access to end of life care e-learning is to be determined. Fast Track Continuing Care and End of Life Care Training for Integrated Discharge Advisory Team will commence in April 2015.
- Last Days of Life - Re-launch guidelines and supporting documentation this quarter.
- Gold Standards Framework – delivering x3 study days for staff working on wards implementing GSF.
- AMBER care bundle roll out – as a result of additional resources and support the AMBER care bundle training for staff on ward 24 and EAU will commence in Quarter 1. However this will still only achieve 18% of wards using ACB by May 2015.
- EPaCCS – currently the focus on implementation is within Primary Care. Plans to commence implementation within the Trust are yet to be established.
- Patient and Carer Experience – Continue to measure patient and carer experience and report findings quarterly to the Patient Experience Team.
- Complaints, clinical incidents – Continue to monitor through Datix system and report findings quarterly to EOLC Steering Group.

Maternity

Maternity targets for 2014/15 are :

- **CQUIN –** 1. 8% Reduction in Smoking at the Time of Delivery (SATOD) to achieve 21% by March 2015.
  2. To deliver smoking cessation support (Rotherham Model) by March 2015.
- **Contractual –** Midwife to birth ratio of 1:28

How are we performing against this target

- 1. The Trust achieved a 22.95% year to date reduction in smoking at the time of delivery. The table below demonstrates that some months we achieved the target or missed it by a small margin.

Year to DATE	April 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
22.95%	17.99%	29.43%	26.25%	23.89%	20.15%	17.98%	21.77%	22.43%	24.35%	21.48%	28.74%	22.14%

- 2. The Risk Perception Intervention (Rotherham Model) is now embedded into the smoking cessation support pathway.

- We are currently at a ratio of 1:30 as we have seen a sustained increase in birth numbers. Service provision has been maintained with no unit closures during quarter 4.

Mitigation plan (actions to date and future planning)

- We continue to offer smoking cessation advice as per pathway including Risk Perception intervention (Rotherham model)

- We plan to undertake a Smoking in Pregnancy Self assessment, with Public Health England in July 2015

- We continue to monitor the birth activity and ratios quarterly.

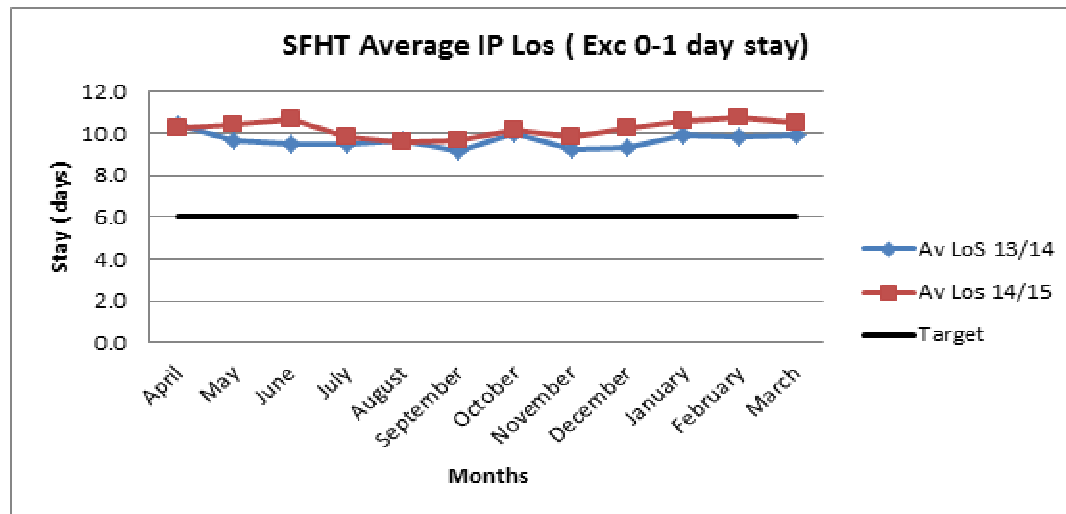
- The escalation policy is used to manage peaks and troughs of activity and acuity within the Maternity unit.
  Service continuity has been maintained since September 2014.

Improving Patient flow and discharge processes

Improving Patient Flow targets for 2014/15 are :

- **CQUIN -** To reduce LOS (excluding 0-1 day LOS) to **6 days**

How are we performing against this target



Mitigation plan (actions to date and future planning)

- Reducing length of stay is a key objective as part of the Emergency Flow Programme.
- Each ward now has a trajectory that enables them to reduce their length of stay.
- These trajectories will be updated weekly in order to give objective timely feedback about the management of discharges.
- The Discharge Co-ordinators who are part of the Integrated Discharge Team are now ward based, so they become part of the MDT.
- There will be a re-launch of Board Rounds that are recognised as national best practice in terms of the management of discharges.
- The Transfer to Assess is now an established process.
- The establishment of a multi-disciplinary, multi-agency discharge hub has now been established that focuses on the management of all patients who are deemed to have ‘complex discharge needs’ at admission.

Never Events, Incidents and Serious Incidents

Never Events

There have been **no** 'Never Events' reported since December 2013.

Incidents

Table 1 shows the top ten incidents reported by category and the associated harm for Quarter 4.

Falls remain the highest reported incident with either low or minimal harm. Two of the moderate falls incidents relates to visitors.

All have been subject to an investigation - 9 were reported on STEIS and 3 were investigated as an internal Serious Incident.

Action plans are tracked to ensure that all actions are completed and lessons learnt are presented at Divisional and Speciality Governance meetings.

Table 1

	(Grade 1) No Harm	(Grade 2) Low	(Grade 3) Moderate	(Grade 4) Severe	(Grade 5) Catastrophic - Death	Total
Falls	469	95	14	0	0	578
Pressure Ulcers	202	72	9	0	0	283
Medication	251	27	4	0	0	282
Skin Damage	159	61	3	0	0	223
Delays in Care	163	12	12	0	0	187
Security or unacceptable behaviour	120	11	3	0	0	134
Treatment	77	24	8	1	1	111
Health and Safety	67	20	9	1	0	97
Pathology / Specimen related	54	12	5	0	0	71
Staff injuries / illness at work	35	27	3	0	0	65
Totals:	1597	361	70	2	1	2031

All moderate, severe and catastrophic incidents are reviewed to ensure they are correctly severity coded and where appropriate scoped as potential Serious Incidents.

Incidents – Datix

To improve our systems and processes we initiated an upgrade to Datix version 12.3 on the 18 March 2015, the upgrade failed due to technical issues and we were advised to go back to Version 12. The database is currently with Datix as our Information Technology (IT) team with the support of Datix IT were not able to rectify the problem. The Trust continues to have a fully functioning integrated Risk Management System and incidents continue to be captured and managed. We continue to have the ability to extract data manually but there are some functions in version12.3 that would allows us to extract Information more efficiently and this does impact on the Patient Experience reports and automated feedback to the reporter. Feedback is currently being facilitated by the Handler or the Datix Administrator.

Never Events, Incidents and Serious Incidents

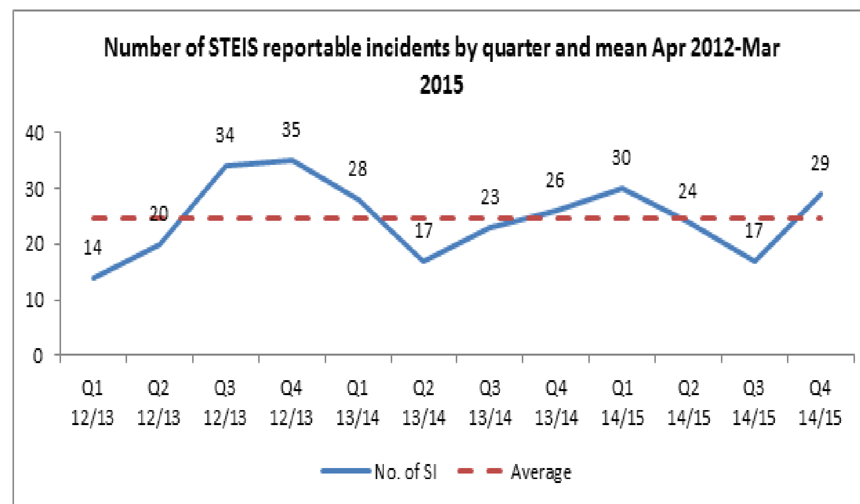
Serious Incidents

The number of STEIS reportable SI's reported during Q4 14/15 (Graph1) is slightly higher than Q4 13/14 but fewer than Q4 12/13.

The Quality Committee receives a monthly paper detailing the STEIS reportable and Internally investigated serious incidents. The report provides the information by division and speciality with a summary of the initial incident details. It also provides examples of lessons learnt from reports that have been submitted to the CCG for Closure on STEIS and any subsequent feedback that the Trust receives for the CCG.
A section on shared learning is included and future reports will Include a section on Organisation Learning.

A detailed report on Organisational Learning was presented to the March Quality Committee.

Graph 1



Learning from serious incidents

Within the Planned Care & Surgery Division since October 2014 every month a specific speciality has been asked to present a case history of a patient where there has been an Internal investigation, STEIS reportable incident or Coroners case. These presentations have looked at the presenting complaints and the management of the patients, where lessons have been learnt for both medical and nursing personnel and the actions that have come out of these incidents. These presentations have provided excellent opportunities for shared learning within the Division and have provided the team with the opportunity to have open and honest discussions and sharing of experiences. Following the December presentation the division have now developed a "Learning Board" which looks at "What happened? Why did this happen? What did we learn? and Actions. This will be completed after each presentation and then will be disseminated to all the Governance leads to share at the Speciality Governance meetings.

Within the Emergency Care and Medicine division, whenever a serious investigation has been closed by the CCG (or in the case of internal SIs, signed off by the Trust), the investigation report is sent to the author, and to the clinical areas and governance leads to share the learning from the investigation with the clinical and nursing teams, and for inclusion on the agenda at the Specialty Governance meetings. The Speciality Governance leads are also asked to present the findings of the investigation to members of the division at the monthly Emergency Care and Medicine Clinical Governance meeting, to ensure there is learning throughout the division.

Never Events, Incidents and Serious Incidents

Learning from serious incidents

Any investigation findings and shared learning that is considered to benefit being shared with the other divisions, is requested to be an agenda item on the respective Divisional Clinical Governance meeting (via that division's Clinical Governance Co-ordinator). Findings and learning from coroner's inquests are disseminated in the same fashion. Members of the Emergency Care and Medicine Clinical Governance Group have fed back to the Clinical Governance Co-ordinator that they have found this to be a useful and meaningful way of sharing learning across the division, and indeed where appropriate, across the Trust.

Organisational Learning events

Patient Safety briefing held on 6th March

The third patient safety briefing on 6th March focused on good record keeping and the importance of reporting incidents.

Shared Learning event held on 17th March

The first Shared Learning Event was held on Tuesday 17th March. It gave a chance to hear about some of the patient safety work that teams are delivering, ask questions and share any ideas and work. Presentations were held throughout the day in Lecture theatre 1 on Patient safety awareness.

Nursing & AHP Grand Round

The Nursing & AHP Grand Rounds are being held to support the on-going Improving Organisational learning work and have developed from a previous Ward Leader Forum where the idea was originally suggested.

The first session in January was on the **Deteriorating patient in our hospitals**

The second in session February was on **Falls**

The third session in March was **Medicines Safety**

Nursing and AHP grand rounds will provide a forum to share learning from a clinical case study, clinical expertise and experience, best practices and other topics of interest that help improve patient outcomes and enhance the patient experience.

The Shared Organisational Learning improvements and practice report was presented at March's Quality Committee

Overview of Achievement of CQUIN Targets 2014/15

Summary of Acute Schemes for 2014/15			Delivery			
CQUIN Scheme		**Requirement**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Forecasted**
1a	Staff Friends & Family Test (FFT)	Implementation of staff FFT				
1b	Patient Friends & Family Test (FFT)	Implementation of patient FFT into outpatient and day case facilities by 1.10.2014				
1c		Increasing or maintaining response rates in in patient areas				
		Emergency Department				
2		Reducing / maintaining negative response rates				
2.1	Reduction in the prevalence of pressure ulcers	To achieve 5 consecutive monthly data points below the median value **(As measured by The Safety Thermometer)**				
3.1	Dementia	90% of emergency admission patients aged 75 and over screened, assessed and referred onto specialist services				
3.2		Named lead clinician and appropriate training for staff				
3.3		Supporting carers				
4	Complaints management	To complete 1 internal and 1 external complaint peer review To undertake a complainant satisfaction survey To develop an improvement plan with agreed milestones				
5	Falls	To capture the number of patients aged 65 and over who have a history of falls within the past 12 months				
		To reduce the number of patients falling more than twice during their in-patient stay				

Overview of Achievement of CQUIN Targets 2014/15

6a	Improving patient safety at the time of transfer of care	Evidence of provider wide communication tool / document for use in internal patient transfers Identification of champion / lead clinician for the over 65's Partnership working with key stakeholders to strengthen patient safety at the point of transfer				
6b		PDD to be implemented within 24 hours of admission Evidence of discharge summary audit Evidence of staff competency to care for patients transferred				
7a	Information sharing	Evidence of Information sharing protocol established and in place				
7b		Attendance and participation in the NRIG				
7c		Audit of services against NICE 138				
7d		Information sharing audit undertaken				
7e		Technical plan in place to deliver information messaging				
7f		Technical solution in place to deliver CGA & EPaCCS				
8	Smoking at the time of delivery	To achieve national ambition of 5% by end of 2014/15 To deliver smoking cessation support				
9	Sepsis	To achieve compliance with sepsis bundle				

Overview of Achievement of CQUIN Targets 2014/15

10a	Mid Notts Better Together Programme	Increase primary and secondary care working in ED				
10b		Increase in ambulatory care pathways				
10c		Systematization of self-care and care planning (training)				
10d		Systematization of self-care and care planning (Information)				
10e		System-wide working to support the provision of LTC and frailty				
10f		System-wide working to deliver a reduction in non-elective admission in the 65 years and over age group				
	Specialised CQUIN's					
CB02	HIV	GP registration and communication				
	Specialist services quality dashboards	Evidence of / and use of dashboards				
	Improved access to breast milk in pre-term infants	To increase uptake by 5% (Target 56%)				

Venous Thromboembolism (VTE)

2014/15 Performance Targets:

Contractual - 95% of patients who have been identified as being at risk of venous thromboembolism (VTE) to receive appropriate preventative treatment

During 2014/15 we have consistently achieved / exceeded the 95% screening target