TRUST BOARD OF DIRECTORS – MAY 2015

QUALITY & SAFETY REPORT (REPORTING PERIOD APRIL 2015)

1. INTRODUCTION

The monthly Quality & Safety report to the Trust Board provides an overview of performance against our key quality priorities for 2015/16 as described within the Quality Report & Accounts (2014/15); in addition highlighting and referencing a range of other quality and safety indicators. This report complements the quarterly Quality & Safety report of which provides a more detailed and comprehensive review of progress against the Trust's quality and safety priorities.

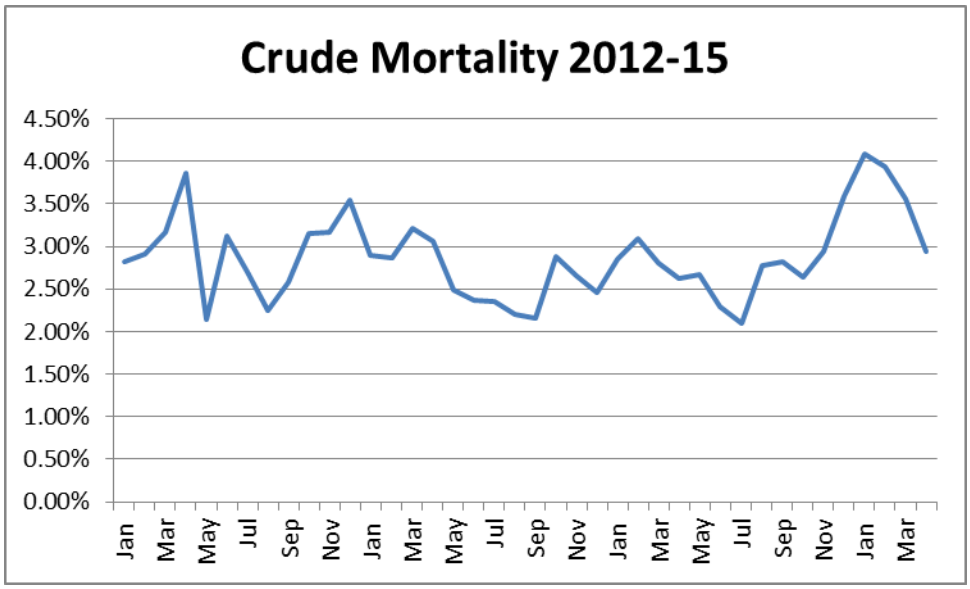
Key quality and safety priorities for 2015/16;

Key Priority 1	To 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 To eliminate the difference in weekend and weekday mortality as measured by HSMR
Key Priority 2	To improve the management of sepsis and reduce sepsis related mortality	Implementation of a recognised local protocol / screening tool within Emergency Department / other units that directly admit emergency patients Administration of intravenous antibiotics to patients presenting with sepsis within one hour of presentation
Key Priority 3	To reduce harm from falls	To reduce the number of inpatients falling in hospital to < 7 per occupied bed day (OBD) To reduce the number of in patients sustaining a fracture as a result of a fall in hospital to <25 To deliver a safety improvement programme, utilising best practice both from a local and national perspective. To establish Registered Nurse / Health Care Assistant focus groups in order to gain a greater understanding regarding the perceived barriers that prevent the outcome of risk assessment being transacted into practice. To undertake a review of the Enhanced Patient Care Tool currently in operation

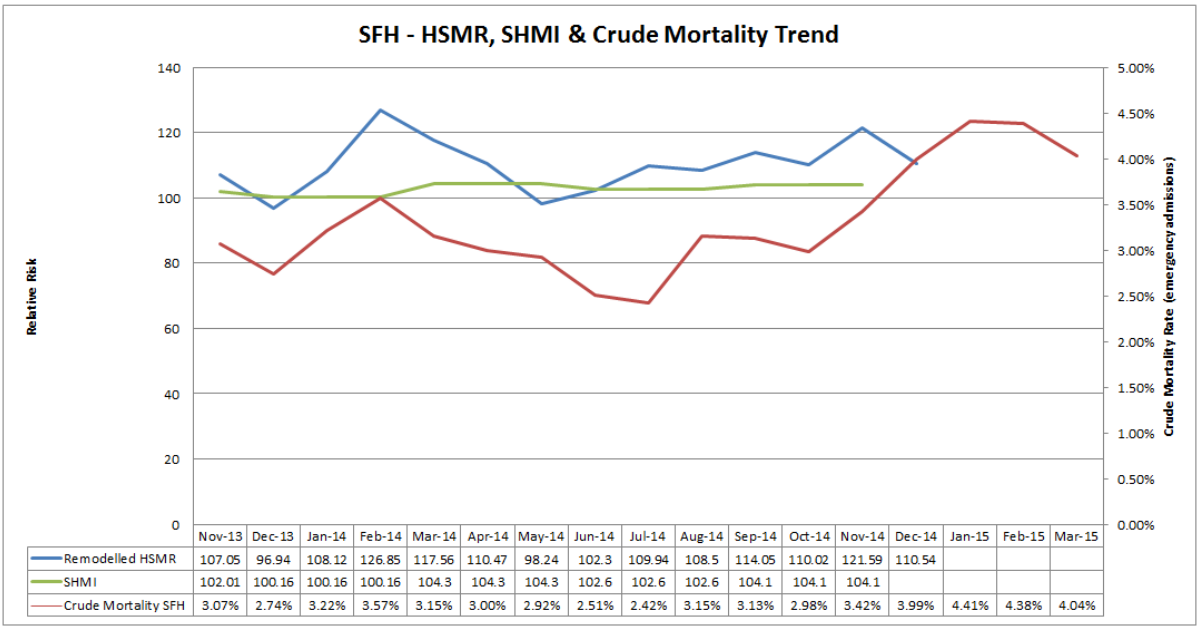
2. QUALITY & SAFETY PRIORITIES

Priority 1 – To reduce mortality as measured by Hospital Standardised Mortality Ratio (HSMR)

The rise in crude mortality seen over December and January has settled back into range for the trust. This has been discussed Clinical Quality and Governance, with the Trust Mortality Group being asked to provide a Deep Dive into the December/January period to aid learning.



There has been a delay in HSCIC data supply to Dr Foster and the data for January 2015 is not expected until 25.05.2105. The December HSMR decreased despite the rise in crude mortality and this was due to a higher number of expected deaths in patients over 75yrs.



	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	Jan-15	Feb-15	Mar-15
Remodelled HSMR	107.05	96.94	108.12	126.85	117.56	110.47	98.24	102.3	109.94	108.5	114.05	110.02	121.59	110.54			
SHMI	102.01	100.16	100.16	100.16	104.3	104.3	104.3	102.6	102.6	102.6	104.1	104.1	104.1				
Crude Mortality SFH	3.07%	2.74%	3.22%	3.57%	3.15%	3.00%	2.92%	2.51%	2.42%	3.15%	3.13%	2.98%	3.42%	3.99%	4.41%	4.38%	4.04%

The most up to date SHMI from November is stable and within the expected range. The external review of casenotes using an independent proforma did not reveal any discrepant

avoidable deaths in a 20 patient random sample.The review of all deaths from October and November will be presented at Trust Mortality Group in June.

The Dr Foster alert for Secondary Malignancies has been discussed at Trust Mortality Group and the End of Life Lead has been asked to conduct a casenote review. We continue to monitor sepsis mortality as outlined in the next section. This was discussed at th Quality Committee and a Deep Dive of the Q1-4 Sepsis Mortality reviews has been requested to identify themes.

The review of Stroke co-morbidity recording will be complete by 22.5.2015 and will impact on the annual Dr Foster HSMR. The audit of the new co-morbidity coding documentation is ongoing weekly and documents improvement but this will not be expected to impact until the August HSMR hence audit will be ongoing.

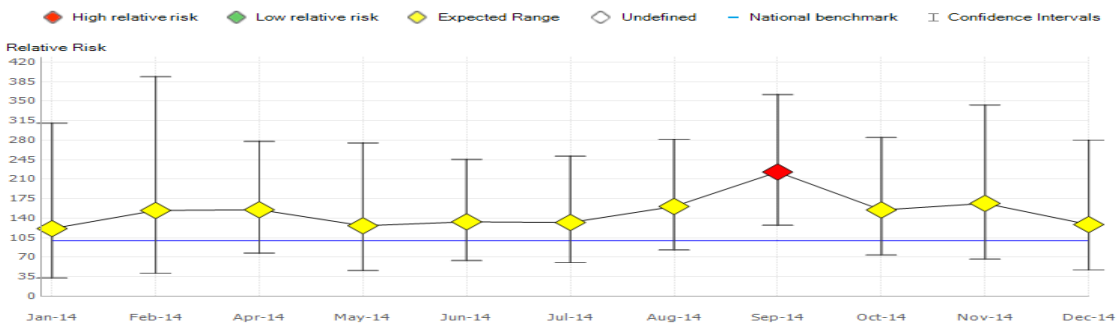
Priority 2 – To improve the management of sepsis and reduce sepsis related mortality

Sepsis is a significant cause of mortality and morbidity. It is thought that problems in achieving consistent recognition and rapid treatment of sepsis contribute to the number of preventable deaths from sepsis. Sepsis is a national priority on the healthcare agenda, having been included in Domains 1 and 5 of the NHS Outcomes Framework and is the goal of a national CQUIN for 2015-16. A high degree of vigilance is required for early identification of the septic patient; hence one area of focus this year is to improve screening of emergency admissions for sepsis. The focus is administration of antibiotics to patients with severe sepsis.

Work in Quarter 1 concentrates on ensuring all appropriate emergency admissions are screened for sepsis. This will mainly occur in the Emergency Department (ED) but also smaller numbers of patients on the Surgical Admissions Unit (SAU), Ward 25 and MIU at Newark. A local protocol has been written in line with the CQUIN requirements and a sepsis screening tool adapted to be incorporated into the ED & SAU paperwork. The next steps will introduce the same screening tool to MIU at Newark. A paediatric screening tool needs to also be modified and this will progress through the rest of Quarter 1. A baseline audit will be completed in June and from this a target of improvement will be agreed.

Mortality data extracted from Dr Foster (date range January – December 2014) has identified that sepsis related mortality has remained within expected range with the exception of September.

<u>Sepsis related HSMR for 2014</u>

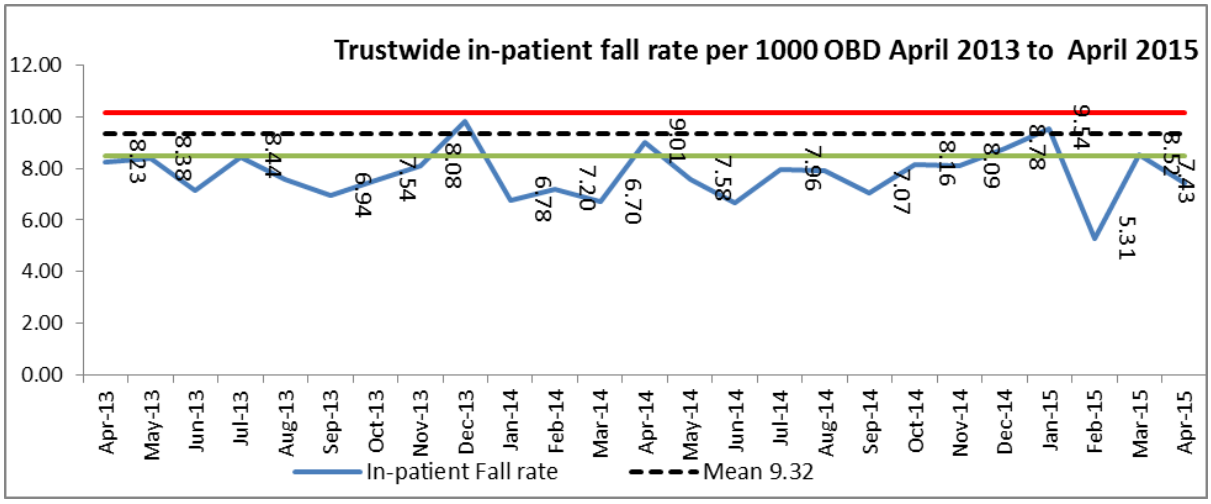


Sepsis related mortality has been monitored since September 2014, whereby case reviews and action plans have been undertaken on a monthly basis. From May 2015 case reviews will be reported to respective divisions and specialties for discussion and organisational learning across pre-existing governance forums. Our aim in 2015-16 is to review all sepsis related deaths, further Dr Foster data will be released at the end of May 2015.

Priority 3 – To reduce harm from falls

To reduce the number of inpatients falling in hospital to < 7 per occupied bed day (OBD)

The challenge to reduce the number of inpatients falling in hospital to <7 per occupied bed days has been used for the April analysis. The harm rate has significantly improved from our performance in March with the harm rate reported as 7.43 per 1000 occupied bed days. Although still slight above trajectory significant improvements are demonstrated.



To reduce the number of in patients sustaining a fracture as a result of a fall in hospital to <25

During April we had a total of 4 patients who fell and sustained a fracture, all of these incidents were escalated and are being investigated appropriately.

To deliver a safety improvement programme, utilising best practice both from a local and national perspective.

In regards to delivering a safety improvement programme the Lead Nurses for Falls continue to deliver up to date training in relation to the Trusts performance on falls management and understanding the themes and trends. Training is delivered on the Trust induction programmes and during April a falls teaching session was delivered to 26 Nurses and carers who attended.

Falls awareness training was further supported through the delivery of 'Molly's Journey' on the Proud to Care study days. 'Molly's Journey' follows the journey of a patient who had an unwitnessed inpatient fall sustaining a hip fracture. This helps staff have a clearer understanding of the reasons that patients fall and what interventions should be applied to reduce the risk. At the same time the session re-enforces staff knowledge on what to do in the event of a serious fall with harm.

The Trust signed up to be part of the Falls and Fragility Audit Programme: National audit of inpatient falls and this was undertaken last week. The results from this audit will be shared nationally and the analysis of findings used as a guide to tailor further training requirements.

In response to utilising best practice locally and from a national perspective the Patient Safety Lead, Older People and Falls NHS England has been contacted and is prepared to support the Falls team in undertaking a review of the Falls management at the Trust.

To establish Registered Nurse / Health Care Assistant focus groups
Registered Nurse / Health Care Assistant focus groups have been established in order to gain a greater understanding regarding the perceived barriers that prevent the outcome of risk assessment being transacted into practice. Falls Champion meetings have been in place since September 2014 and the meeting in April went ahead. Staff in attendance were given training in the correct application of the anti-embolism stockings with 'Grip soles' which the Trust has introduced. These new stockings are clinically proven to reduce the incidence of slips. Training on the wards is being introduced and supported further by G+N Medical and the Falls Nurses through practical demonstrations.

During April, Ward Sisters and Charge Nurses were invited to attend a brainstorming session to try and understand why our Patients are falling. The information shared in this session was discussed in the Falls and Safety Improvement group. It was agreed that the documentation used for internal transfer of a patient, needs to be developed to include information that would support the receiving wards falls risk assessment of the patient.

To undertake a review of the Enhanced Patient Care Tool currently in operation
The Enhanced Patient Support guideline is currently being reviewed in response to listening to feedback from the Falls Champions. The documentation kept by the member of staff providing enhanced care may need to be re-designed to allow for a more descriptive account of the patients activity to be recorded.

3. Clostridium Difficile Update

During April the Trust reported 4 Trust attributable Clostridium Difficile infections; this aligns with the monthly target set. Root Cause Analysis has been undertaken regarding all of the cases reported in April of which identified one case of a lapse in care related to antibiotic prescribing practice.

The Patient Safety Collaborative have undertaken a review of the Trust processes regarding the management of infections; based on the recommendations an action plan is in the process of being developed.

4. Safeguarding (Adults and Children)

4.1 Safeguarding Adults

The Adult and Children's teams have had an initial meeting with Mandy Ashton (Director of Mandy Ashton consultants Ltd). Mandy has many years of working in the NHS and expert skills in managing safeguarding teams. The initial meeting was held in April with scheduled meetings in May, July, august and September. The overall aim is to review safeguarding

leadership capability and capacity building at SFHFT. The team are working with Mandy to produce an action plan for the trust.

Training

During April safeguarding training has continued (Induction/Orientation and Mandatory). In addition we delivered a doctor's training session for learning disability; the doctors demonstrated keen interest as all participants had cared for patients with a learning disability but never received formal training on the topic. The training can be accessed face to face for 30 minutes via training and development webpage or the GMC (General Medical Council) eLearning module can be completed.

Policies

- Safeguarding Adults policy and the Deprivation of liberty policy have been revised to comply with the care act – Icare2 bulletin sent to all staff to raise awareness of the changes.

- NEW – Restrictive practices policy. The policy provides a framework for making and documenting decisions regarding the use of restrictive practices in adult patients which balances the risks between the rights to freedom against the rights to be free from physical harm and complies with the Mental Capacity Act (2005) Code of Practice. The policy frameworks good practice, ensuring that legal, ethical and professional issues have been considered.

Risks

There are 5 areas of concern for vulnerable adults which have been escalated onto the SFHFT Risk Register. The areas of concern are;

1. Lack of adherence to MCA/hospital policy leading to safeguarding concerns. There is a risk that if staff are not following the Mental Capacity Act/Trust policy there could be a negative impact on patient experience/care, the Trust could face prosecution/litigation and the reputation of the Trust adversely affected.

2. The Trust has a restrictive practice policy in place. The Maybo PL Assault Reduction, Disengagement and Holding Skills course has been provided to 11 higher risk areas.

3. The trust is at risk of litigation around Deprivation of Liberty (DOL), as trust staff may not always identify patients that all at risk of DOL

4. Poor communication for vulnerable patients regarding their care needs to on-going healthcare providers via the Orion transfer letters and discharge letters.

5. Patients with a learning disability are not having their individual care needs risk assessed.

Each concern has mitigation measures in place and an action plan to improve and lower the risks.

4.2 Safeguarding Children

The self-assessment against the NSCB Markers of Good Practice showed that as a Trust, we are green against 58 of the 61 outcomes. There were no 'red' areas. 3 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 to review competencies)

Action – Named nurse to enrol on Level 4 training to increase capacity.

2. All new starters to the organisation attend a safeguarding children awareness session within an induction programme or within 6 weeks of taking up post within a new organisation

Action – Inductees complete on-line safeguarding children training. Non-compliance is followed up by TED.

3. Supervision should take place on a minimum of a quarterly basis – we do not fully meet this target. Compliance rates are 100% for 1:1 supervision, and all other applicable staff are offered a minimum of 3-montlhy supervision.

Action - Supervision sessions for ED and MIU staff are being reviewed and whilst this is underway sessions will continue to be offered on a drop in basis as advertised in the clinical areas.

The safeguarding children & young people's champions have been active in clinical areas for some time and are involved in providing front-line support to staff and in disseminating information and training opportunities. Moving forward the champions role will be developed and their involvement in training delivery extended to involve scenario-based safeguarding children training at level 3.

5. End of Life

5.1 End of Life Strategy

Good progress is maintained in delivering the current Trust End of Life Care Strategy ratified 2014-15.

The last update to CQGC January 2015 concluded with these next steps.

- Launch strategy
- Deliver MDT training
- Fully embed Last Days of Life Care
- Continue to support the implementation of Gold Standard Framework and roll out of ACB
- Review and refine the rapid discharge home to die and fast track continuing care process

We can now report that these actions have been taken with the learning and delivery support continuing in 2015-16. Details of these actions are reported through the End of Life Strategy Steering Group.

A new Trust Clinical Champion started employment in the Trust. This Consultant Geriatrician is a national expert and has led a rapid review of the short and longer term strategy and is supporting the process of planning further improvements. He is giving new support to the front door frailty team (F.I.T), including rapid discharge for end of life patient's. Additional short term clinical and educational support has been achieved from an Integrated Discharge / End of Life Care Specialist nurse. This colleague works across all care settings focussing on rapid discharge (to their preferred place of care) and last days of life care.

As part of our 'buddy' relationship with Bath Trust, we are sharing practice with their End of Life Lead at the end of May 2015. We are also participating in a meeting with our commissioners to ensure all of our end of life strategies (inside and outside of hospital) offers all patients uninterrupted and seamless care, during their last days of life.

5.2 End of Life - Clinical, Quality Governance and Regulation

- Updates have been given on progress on the Quality Improvement Plan to executive leads. Actions are being completed and risks where identified are being mitigated. Provider Information Requests (PIR) have been received from the CQC and submissions have been completed with support of the Specialist Palliative Care Team.

- Internal Audit Report (360 Assurance) - End of Life Care: a draft report has been received by the Trust. It highlights significant achievements and areas for improvement. Since the audit was performed many actions have been completed, and we expect that the moderate and low level risks described can be further downgraded.

- Significant changes to improve inter-professional and directorate working have been facilitated by the new clinical champion. Planned improvements in clinical governance systems at service, directorate and divisional level will help measure, report and improve quality of end of life care linking it to resuscitation, patient safety and safeguarding / mental capacity issues.

6. Complaint service development

A revised Complaints and Concerns Policy was approved at the Clinical Quality and Governance Committee in May 2015, reflecting the revisions to complaints management process and procedure in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and a NHS Complaints Procedure in England, House of Commons notes in January 2014. This policy has been shared with the Quality Committee.

The Trust has historically provided a Complainant Satisfaction Survey to a selection of complainants following the closure of a complaint case, to establish how the complaint management felt for the complainant. Due to the low response rate during Quarter 2 and 3, the Patient Experience Manager has developed and introduced a new survey in Quarter 4 and this will be distributed to closed complainants. The survey is underpinned by the Patients Association Satisfaction Survey used throughout NHS Trusts nationally and locally, and provides detailed feedback to strengthen the Trust processes and improve the experience for the complainants

The Patient Experience Team met with the Parliamentary and Health Service Ombudsman (PHSO**)** in March 2015 to discuss and review our recently revised complaint processes in

place and for them to provide feedback relating to their new approach and structure. The new arrangements will ensure timely and effective communication between the Trust and the PHSO, providing information electronically and direct dialogue between the PHSO and Case Managers to prevent delays in the investigation processes.

Susan Bowler Executive Director of Nursing and Quality

Andy Haynes Executive Medical Director