TRUST BOARD OF DIRECTORS – September 2015

QUALITY & SAFETY REPORT (REPORTING PERIOD AUGUST 2015)

1. INTRODUCTION

The monthly Quality & Safety report to the Board of Directors provides an overview of performance / achievement 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 (including patient experience) and safety indicators. This report complements the quarterly Quality and Safety report which provides a more detailed and comprehensive review of progress against the Trust's quality and safety priorities. The report also includes an update on nursing revalidation, ward assurance and the procurement of a system to support delivery of the Trusts Friends and Family Test and other patient experience information.

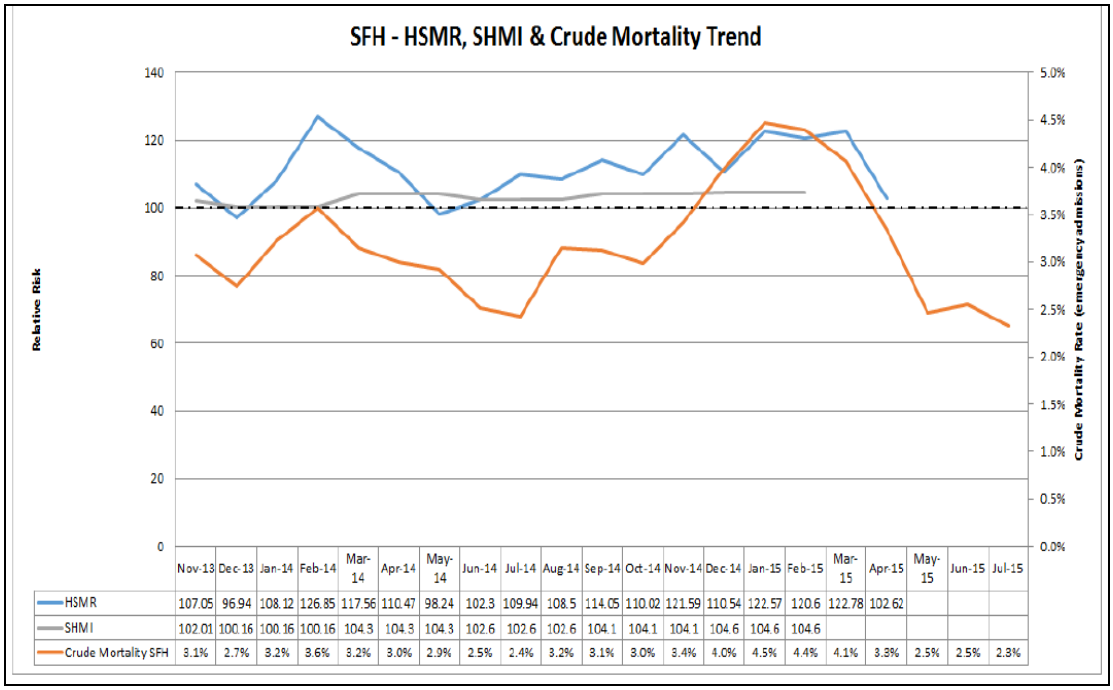
The following section provides an overview of our agreed key quality and safety priorities for 2015/16, they include;

Key Priority 1	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	Reduce mortality from sepsis	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	Reduce harm from falls	Reduce the number of inpatients 'falling in hospital with harm' from Q2 onwards. Reduce the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital' from Q2 onwards. To deliver a safety improvement programme, utilising best practice both from a local and national perspective.

2. QUALITY & SAFETY PRIORITIES

2.1 Priority 1 - Reduce mortality as measured by Hospital Standardised Mortality Ratio (HSMR)

The most up to date reliable data from Dr Foster shows HSMR up to April. The Sherwood Forest Hospitals HSMR for April 2015 is 102. The data available for May suggests that the HSMR may be less than 100, this will be confirmed when the next set of data is released around 23rd September 2015.

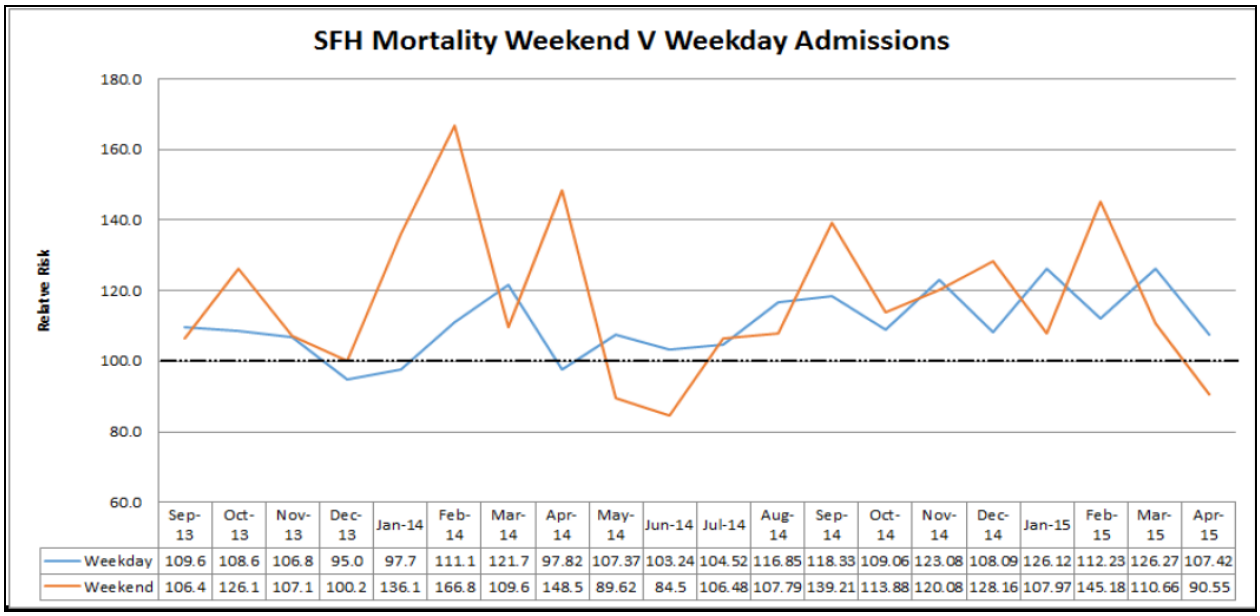


	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
HSMR	107.05	96.94	108.12	126.85	117.56	110.47	98.24	102.3	109.94	108.5	114.05	110.02	121.59	110.54	122.57	120.6	122.78	102.62			
SHMI	102.01	100.16	100.16	100.16	104.3	104.3	104.3	102.6	102.6	102.6	104.1	104.1	104.1	104.6	104.6	104.6					
Crude Mortality SFH	3.1%	2.7%	3.2%	3.6%	3.2%	3.0%	2.9%	2.5%	2.4%	3.2%	3.1%	3.0%	3.4%	4.0%	4.5%	4.4%	4.1%	3.3%	2.5%	2.5%	2.3%

As detailed in the mortality reporting over recent months, we have been putting various measures in place to improve our HSMR. These measures have been based upon analysis of the data generated by our programme of mortality review highlighting areas of improvement that should impact HSMR.

The improved figures for April and May represent the results of some of this work, alongside a reduced crude mortality, after the high figures seen over the winter period.

An HSMR of 102 represents a 2% higher crude mortality than the calculated expected figure. There were 110 deaths recorded in April and the expected figure was calculated at 107. This expected mortality figure is 5.19% of the admissions for that month. The equivalent percentage for April 2014 was 4.26%



	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	Jan-15	Feb-15	Mar-15	Apr-15
Weekday	109.6	108.6	106.8	95.0	97.7	111.1	121.7	97.82	107.37	103.24	104.52	116.85	118.33	109.06	123.08	108.09	126.12	112.23	126.27	107.42
Weekend	106.4	126.1	107.1	100.2	136.1	166.8	109.6	148.5	89.62	84.5	106.48	107.79	139.21	113.88	120.08	128.16	107.97	145.18	110.66	90.55

HSMR for patients who were admitted at the weekend was lower than that for patients admitted on a weekday in April 2015.

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

Background

The effective management of sepsis continues to be crucial for reducing mortality. This programme of work is designed to meet recommendations from the Care Quality Commission and address the National CQUIN requirement.

We now have a focussed team specifically dedicated to developing the care and management of the septic patient, including a Specialist Sepsis Nurse, a Clinical Lead and a Project Manager. A recognised sepsis screening tool has been implemented in the Emergency Department (ED) and all other units that directly admit emergency patients (Surgical, Emergency, Gynaecology Assessment Units, Sherwood Birthing Unit, and Paediatric Ward 25, Kings Mill site and the Minor Injuries Unit at Newark).

Progress

Over the last two months, daily audits have shown increasing compliance with use of the screening tool for emergency admissions. All areas now demonstrate an average weekly compliance in excess of 90% with screening. Furthermore, over the same period, daily monitoring of compliance with the Sepsis Six treatment bundle, of which intravenous antibiotic administration within one hour of presentation, a key life-saving element, has shown improvements. For the audit week 2/9/15 to 7/9/15, there were four missed opportunities to administer antibiotics within the hour in ED, but in all other areas, all patients identified with sepsis received treatment within 60 minutes. Work has now been completed on the development of screening tool documentation for all patients in ward areas across the Trust. Roll out of this important paperwork will commence next week.

The 2015-16 CQUIN is in two parts:

Part A of the CQUIN focuses on screening for sepsis and all the work described above ensures all emergency admissions are screened appropriately.

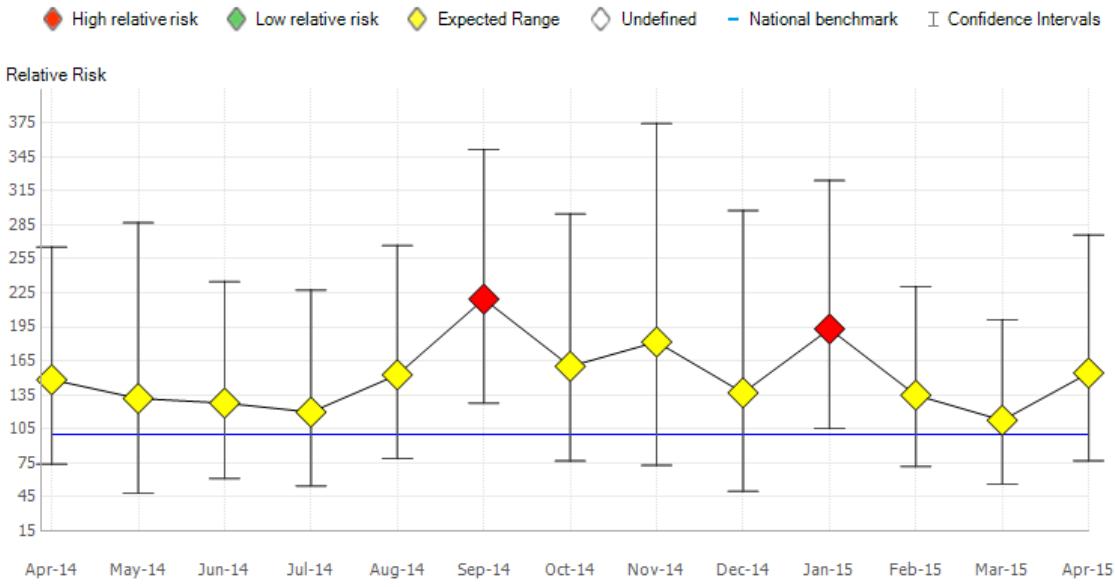
The audit for Part A showed compliance of 92.4% in August.

Part B of the CQUIN focuses on antibiotic administration in patients with severe sepsis. Evidence indicates delays in antibiotic administration are linked to an increase in mortality.

The Part B CQUIN goal is to achieve 90% antibiotic administration within 1 hour of arrival at hospital by the end on the year. Initial data collection in July showed a starting point of 55.5%.

The mortality data from Dr Foster - released up to April 2015.

Sepsis related HSMR for April 2014 - April 2015



The 11 deaths in April 2015 have been reviewed as part of the on-going monitoring of sepsis mortality. None were avoidable and the review found some coding discrepancies which may have negatively impacted on the HSMR. The Sepsis Lead Nurse is now supporting the coding department.

2.3 Priority 3 – Reduce harm from falls

Background

Reducing the patient's level of harm following a fall in hospital remains a Trust priority. The falls improvement programme includes a CQUIN element. Following discussions with commissioners the definition of the CQUIN target has been redefined.

Part 1. Reduce the number of inpatients falling in hospital with harm' from Quarter 2 onwards replaces 'Reduce the number of inpatients falling in hospital'

Part 2. Reduce the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital' from Quarter 2 onwards replaces 'Reduce the number of inpatients sustaining a fracture as a result of a fall in hospital to <25'

Progress against the revised definitions

Part 1. Reduce the number of inpatients falling in hospital with harm' from Quarter 2 onwards.

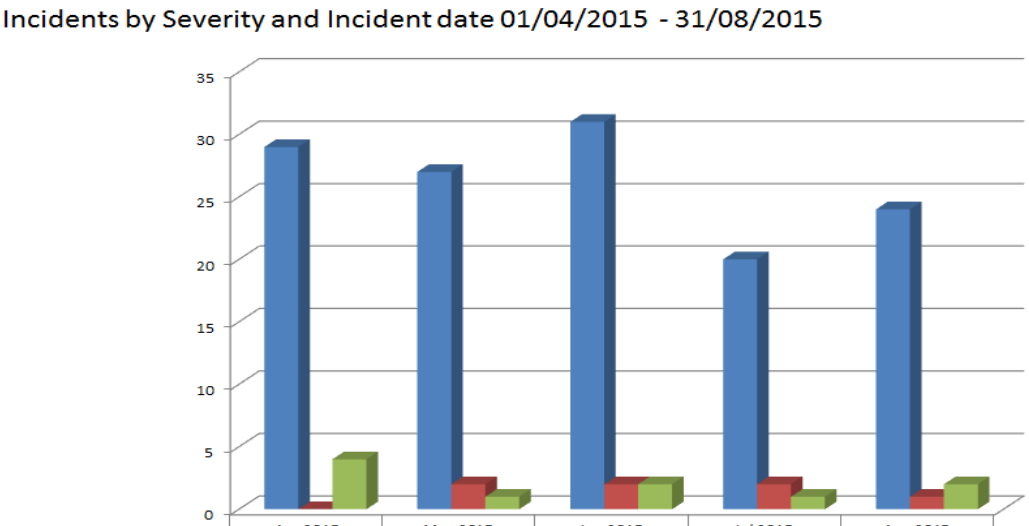
There were a total of 164 inpatient falls reported for August with 137 of these being No Harm. The overall number of falls was an increase on the previous month and an analysis of the timelines from the Datix incidents highlights peaks were between the following time bands:

2000 - 2100 with 13 falls

2300 - 0000 with 13 falls

0500 - 0600 with 11 falls

Further analysis is being undertaken to establish if there is any correlation with the times of the falls and any potential causes.



	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
(Grade 2) Low - Minimal Harm Patient required extra obs or minor treatment	29	27	31	20	24
(Grade 3) Moderate - Short term harm pt required further treatment procedure	0	2	2	2	1
(Grade 4) Severe - Permenant or long term harm	4	1	2	1	2

Part 2. Reduce the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital' from Quarter 2 onwards.

One patient who fell and sustained a head injury has been reported as a moderate harm. The incident was scoped to established if this was a serious incident and this found that the patients management had been in line with expected practice, the circumstances of the fall was not due to lapses in care. As with any incident the opportunity for learning is required and the internal investigation will be reviewed within the divisional governance forums.

Two patients sustained a fractured neck of femur following a fall and these have been severity coded as severe and reported on STEIS with the investigation in progress.

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

To improve the communication of key messages the Falls Champions for each ward will be responsible for disseminating information to the ward areas with support from the Falls Lead Nurses. A monthly theme based on issues raised from incident reports is being used as a platform for learning and key messages shared with the ward teams.

Corporately through induction, mandatory training falls study days and the Proud to Care study days, a general falls education programme continues.

Understanding the themes and trends of individual wards and divisions from information gleaned from incident reports will support specific, tailored teaching programmes at ward level for the multidisciplinary team to improve patient safety.

Severity and grading of harms

A monthly meeting which involves the Governance team, Falls Nurses and led by the Deputy Director of Nursing and Quality has been instated. The purpose of the meeting is to monitor progress against the CQUIN target providing a forum to discuss progress and constraints.

As a result of the first meeting it was agreed that on consideration of guidance from the National Patient Safety Agency and National Reporting and Learning System (NRLS) that the severity coding of patients who fall and sustain a fractured hip should initially be graded as a severe harm until the full investigation process has been completed and the patient outcome is known. This is in response to an improved understanding that statistically up to 90% of older patients who fall and fracture their Neck of Femur fail to recover their previous level of mobility or independence. It should also be noted that other trusts also record hip fractures as a severe/catastrophic harm dependent on the patient outcome. The information from April 2015 has been updated to reflect this coding and a process has been put in place to ensure the severity coding will be checked and updated post conclusion of serious incident investigations.

A list of the types of injury in relation to slips, trips and falls in hospital has been produced to help guide the handlers with the initial severity coding.

We are continually learning from information and research presented at National Falls Conferences so that we are in line with the National picture. The information from Datix reporting system will be refined further to ensure any rolls from ultra-low beds onto crash mats, patients who are lowered to the fall and faints and fits are investigated thoroughly but not counted in the overall falls numbers reported. Plans are in place for additional support from the Datix Administrator to produce specific information for each ward that provides a breakdown of incidents by location on the ward. To further understand their performance in relation to falls and adherence to interventions.

Ward Specific training

One of the emerging themes relates to the number of patients found at the side of the bed and these patients were being nursed on pressure relief mattresses. In response to reducing the risk of patients slipping from this type of mattress work is on-going with the Tissue Viability Consultant Nurse. The Falls nurse are also raising awareness with the ward teams

in relation to the potential for patients with increased risk from ‘slipping' at the side of the bed and anti-slip mats have been introduced for patients identified in this category.

Targeted training has been the approach in August for those areas who have alerted due to an increase in the number of falls or the number of patients requiring enhanced support. The particular focus has been on identifying the risk factors and ensuring early escalation for when there is increased risk on the ward.

On-going developments and improvements

- An agreed list of safety equipment has been submitted for purchase through charitable funds.
- A review of the membership of the Falls and Safety Group to include representation from all appropriate disciplines including physiotherapy, pharmacy, moving and handling specialists.
- It is acknowledged that we require a Falls Strategy which incorporates meaningful engagement of staff from other disciplines so that falls prevention is not an isolated harm reduction but part of a wider safety initiative. This is currently being developed and will include a clear programme for improvement at corporate, divisional and ward/department level.

3. NMC REVALIDATION FOR NURSES AND MIDWIFES

Introduction

From April 2016 the Nursing and Midwifery Council (NMC) are introducing revalidation. The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to be fit to practise throughout their career. Without successful revalidation, nurses and midwives will no longer remain registered and therefore no longer able to legally practice. This report aims to provide the Board with an overview of these new professional regulatory requirements. It will also update the Board on work already underway within Sherwood Forest Hospital to prepare our nursing and midwifery workforce, assess for risks and lead the strategic elements to revalidation.

Background

Revalidation is a continuous process that nurses and midwives will engage with throughout their career. It aims to enable increased positive affirmation of an individuals practice based on the new NMC Code of Conduct (2015). It is about promoting good practice across the whole population of nurses and midwives. It’s not an assessment of a nurse or midwife’s fitness to practise and it’s not intended to address bad practice. Poor practice will continue to be managed through performance, capability and fitness to practice routes.

Requirement

Set out in the table below are the differences between the current system of registration and revalidation

Current NMC registration	Revalidation
All nurses and midwives (N&M) to pay an annual registration fee to NMC	No Change
Every 3 years N&M submit a Notification of Practice (NoP) to the NMC signing a declaration to say they have completed the required practice hours and required continuing professional development (CPD)	
Demonstrate 450 hours of practice related to their role. 900 hours for dual registered nurses and midwives	No Change
35 hours of CPD	40 hours of CPD 20 of which should be participatory learning
Nurses and midwives have previously been required to reflect on practice but there is no mechanism for monitoring this	5 piece of reflection (minimum) related to • CPD and its application to practice and the Code of Conduct • Practice related feedback e.g. complaint, incident, changes in evidence base around an element of care, service user feedback
Maintain a professional portfolio to demonstrate practice, which in principle could be requested for audit check and challenge purposes, however in practice this did not happen	Maintain a professional portfolio which will be presented during the 3rd part confirming process as evidence of completion of above elements
No standard currently	Third party confirmation on the registrants continuing fitness to practice and compliance with the code

It is expected that the introduction of the new requirements within revalidation will strengthen the renewal process by focusing on providing evidence.

The responsibility for revalidation remains with the registrant however as a responsible employer it is expected that we have in place mechanisms to support revalidation and confirm registrants continuing fitness to practice.

At the beginning of September the NMC announced changes to rules on lapsed NMC registration which will come into effect from November 2015.Previously, registrants who failed to re-register before their expiry could take advantage of an administrative window which allowed late submissions to be processed within a couple of days. However, from November anyone who allows their registration to lapse will be taken off the register immediately. There is no longer a grace period for late payment. Readmission to the register may take between two to six weeks.

Progress so far

Nationally: there have been 19 pilot sites across the country from varying care settings. It is expected that following the collation and reporting from the pilot sites the NMC are expected to give their approval for the launch of revalidation in October 2015. The NMC have increased the communication around the regulatory change and revalidation there are resources available on the website for use by individuals and organisations.

Locally: the work to start preparing for the launch of the new code and revalidation began at Sherwood Forest Hospitals in February 2015. Recent communication from Monitor has requested information around our "organisational readiness" this has been provided. A gap analysis on organisational readiness has been prepared and a first draft can be found Appendix 1.

It is intended that a letter will be sent to all registered nurses and midwives within the organisation from the Director of Nursing reminding them of their responsibilities to maintain registration under the new ruling and how and where they can gain support to ensure they are fully prepared for revalidation.

Governance arrangements

A Nursing and Midwifery Revalidation Task & Finish Group has been formed chaired by the Deputy Director of Nursing with key stakeholders. The group reports to the Nursing and Midwifery Board where revalidation is a standing agenda item where exceptions, emerging themes and developments will be reported. Minutes of the meeting will also be shared with Workforce and OD committee.

Systems and process

The electronic staff record (ESR) will be used to monitor and record revalidation status. The workforce information manager is currently undertaking further investigations with McKesson to explore if the revalidation date of individual registrants will be made available via the current data transfer method or if a manual upload is required.

The workforce information team have identified the individuals who are due to re-register for the first quarter after the NMC requirement comes into place, these are:

April 2016 = 54 individuals
May 2016 = 82 individuals
June 2016 = 49 individuals

Next steps

Professional revalidation for N&M at Sherwood Forest Hospitals provides opportunities to further enhance the delivery of high quality patient care across SFH. There are significant opportunities to further promote and share good practice. Registered nurses and midwives remain personally accountable for their professional registration, however as a change to existing professional regulation requirements there is a need to actively work to support our registered nurses and midwives to ensure they are prepared, feel confident and competent within the new revalidation process and continue to provide the best quality care to our patients.

4. WARD ASSURANCE

Background

Updated monthly, the Ward Assurance Dashboard provides oversight of performance against a range of quality indicators for wards and departments delivering nursing care at Sherwood Forest Hospitals. The dashboard has been in existence for 3 years and has continued to evolve and develop in this time. The quality dashboard currently includes 50 indicators pertinent to nursing performance ranging from infection control, medication related indicators, pressure area care, falls, patient experience, vacancies, training and nursing quality metrics. Numerical data is rated as green or red according to standards set by the Nursing and Midwifery (N&M) Board with data trends being available on an individual ward and departmental basis using spreadsheet tabs.

Analysis of this data is undertaken as part of the standing agenda items of the Nursing and Midwifery Board each calendar month. Ward Sisters/Charge nurses are required to attend with their respective Matrons to account for results and provide assurance that actions are being undertaken where needed and to share and support peers when required in order that inconsistencies across areas and divisions can be dealt with. These actions are recorded and monitored monthly by the N&M board which is chaired by the Executive Director for Nursing and Quality.

An appreciative enquiry approach is adopted when reviewing the dashboard, ensuring that lessons are learned when things are going well and root causes are pinpointed at the earliest opportunity to be shared across all divisions. The meetings are well attended and feedback from those in attendance is positive.

A monthly focus on an area of nursing quality is being adopted as part of the N&M board work plan. The focus for September's board is safeguarding and dementia. This focus requires an in depth scrutiny of outlier wards with performance that is either exceptional or in need of rapid improvement.

A brief outline of performance

Safeguarding: Primarily taken from nursing metrics results, 19 areas are achieving the required standard of 90% with 6 areas falling below the expected standard for Augusts performance data (n=35). Areas not meeting the required standard commonly have issues with demonstrating the use of personalised care planning and adequate recording of capacity testing and best interest check-listing. The safeguarding lead nurse will be in

attendance for September's N&M board in order that specific actions can be identified for improvements in this performance and the appropriateness of indicators used.

Dementia: 16 areas are achieving the set standard with 3 performing below 85% (n=35). It is important to identify the limitations of this particular indicator; this indicator consists of two questions relating to, identification of patients with dementia on handover sheets and availability of 'This is me' supporting documentation. This metric is currently under review by or new lead nurse for dementia in order that a more suitable set of indicators can be developed that are more sensitive to individualised, patient centred care planning and delivery. The Lead Nurse for Dementia will be in attendance at Septembers N&M Board to provide an update on progress.

Planned developments for the assurance dashboard

- Further development and structured appraisal of data displayed enabling demonstration of trending within data alongside current performance.
- Linked SMART actions relating to areas of required improvement with monthly reporting back to the N&M board.
- Strengthened partnership working with specialist leads supported by the monthly focus on indicators as part of the defined yearly work plan of the board.
- Integration with planed patient experience metrics that closely map nursing quality metrics.

The area of focus for October will be pain and will be supported by the Trust's pain nurse specialists.

Ultimately, it is anticipated that the ward assurance dashboard will provide the backbone for development of a Trust-wide ward accreditation scheme to be used along with a recognised model for improvement. By learning from and building on the success of other Trusts across the country who have successfully implemented ward accreditation, standards can be quickly met and exceeded, leading to improved patient care and experience.

5. FRIENDS AND FAMILY TEST

Background

The current contract with the external provider for the Friends and Family Test (FFT) terminates with the Trust in January 2016; this 3 year contract was free of charge as an introduction to the FFT at its infancy in 2013. Throughout the additional roll out of the FFT and as an early implementer as part of the local CQUIN in October 2014, the Trust has provided internal mechanisms to collate feedback from additional services.

The Trust has experienced a number of challenges relating to the provision and delivery of the package with the current provider's, and although a procurement exercise commenced in 2014, the Trust was initially unsuccessful in securing a provider from 2016. Further scoping and procurement work, led by the Deputy Director of Nursing and Quality, which pulls together the staff and patient FFT has resulted in two options being explore to deliver the Trust FFT requirement. It is expected that a solution will be in place before the expiry of the Trusts current contract.

The two options the Trust is currently exploring are:

1. Inpatient and staff FFT: Optimum Health Technology, who provide the Meridian Software to the Trust for the nursing ward assurance metrics. This package is a bolt on package which will fulfil our FFT Patient and Staff requirements, and all aspects of Patient Experience including real-time patient surveys and triangulation of feedback to provide a comprehensive picture of our services. This data will allow overlap with the ward assurance metric and the CQC domains. The package will include various formats to collate the real time feedback, including paper, tablet application, text and email methods.

2. Outpatients and the Emergency Department FFT: As part of the Outpatient Programme Board, the Trust is exploring a refreshed package relating to Saviance, the providers for the electronic booking in system. FFT and patient experience would be incorporated into this system, with a centralised electronic feed into the Meridian systems to ensure a single portal for all FFT and patient experience intelligence. The Saviance system will be piloted in September 2015 in Clinic 6.

The overarching Meridian system is able to incorporate data from Saviance and together with the information collected through its own system, provide real time feedback, and allow daily access to response rates and valuable patient feedback. Additionally this information can easily transfer/capture information into associated action plans and facilitates auditing of service improvements as a result of this feedback. This solution allows the FFT to be reviewed alongside other elements of patient experience to provide a sound understanding of the services, which has been reflected in National Department of Health reports relating to FFT.

Next steps

A paper will be submitted to the Finance Committee during September 2015 for Trust approval for the bolt on package.

6. CONCLUSION

There is an improving picture for the Sherwood Forest Hospitals HSMR for April 2015 and it is expected that this with be continued when the May data is made available. The effective management of sepsis continues to be crucial for reducing mortality with a dedicated programme of work designed to meet recommendations from the Care Quality Commission and address the National CQUIN requirement.

A Falls Strategy is being developed which incorporates meaningful engagement of staff from other disciplines so that falls prevention is not an isolated harm reduction but part of a wider safety initiative. As this is being developed the Falls Nurses continue to work with the clinical teams to help mitigate the risk of harm from falls and the 2015/16 CQUIN is now refocused to reflect this.

Work to prepare the Trust for the changes to the Nursing and Midwifery Council, Nurses and Midwifes revalidation process is being completed and are detailed above.

There is an intention that the ward assurance dashboard will provide the backbone for development of a Trust-wide ward accreditation scheme to be used along with a recognised model for improvement.

Systems to help the Trust Improve from Patient Experience including real-time patient surveys and triangulation of feedback to provide a comprehensive picture of our services are being option appraised.

7. RECOMMENDATIONS

The Trust Board are asked to discuss the information provided and the actions being taken to mitigate the areas of concern.

Susan Bowler Executive Director of Nursing and Quality

Andy Haynes Executive Medical Director