Quarterly Patient Safety & Quality Report

Quarter 1 summary 2015/16

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Executive Summary

Within the 2015/16 Quality Account, the Trust set itself a number of key Quality and Safety targets which had also been translated from our Patient Quality and Safety Strategy. This report gives an assessment and future plans against those priorities.

Quality Priority 1: Dr Foster have just released updated data to include March 2015. This shows an overall HSMR of 114 for the period April 2014 to March 2015. However, this figure may change as there are still statistical analyses to be applied by Dr Foster before the year's HSMR figure is finalised. A joint Mortality Action Plan has been developed between Sherwood Forest Hospital Trust and the Mid-Nottinghamshire CCGs. Our aim is to achieve a sustained HSMR at, or below 100. The plan sets out in detail a number of clinical and administrative areas where work is focussed; sepsis, pneumonia, pathways of care such as acute kidney injury, end of life care including ceilings of care and supporting documentation.

Quality Priority 2: Our priority is to improve the management of sepsis and reduce sepsis related mortality. An audit of patients with Bacteraemia and Sepsis is carried out monthly. In addition to the Trust Sepsis group, a Task & Finish group has been set up (with Executive chair) to review and monitor in Sepsis screening and compliance with the Sepsis pathway.

Quality Priority 3: The falls priority is to reduce the number of patients falling and reduce the number of fractures sustained following a fall. The average inpatient fall rate for Quarter 1(April-June) is calculated as 7.95%. and slightly above trajectory.

The focus of the falls work programme is to work with the Nursing teams to understand the perceived barriers that prevent the outcome of risk assessment being transacted into practice.

Clostridium Difficile 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. Delegates from the Infection Prevention and Control Committee visited Royal United Bath Hospitals in June to review and learn from their systems.

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Mortality (Quality Priority 1)

Mortality Targets for 2015/16 are

Quality Priority 1: To reduce mortality as measured by HSMR to within the expected range

To implement a robust mortality reporting system that is visible from service to board

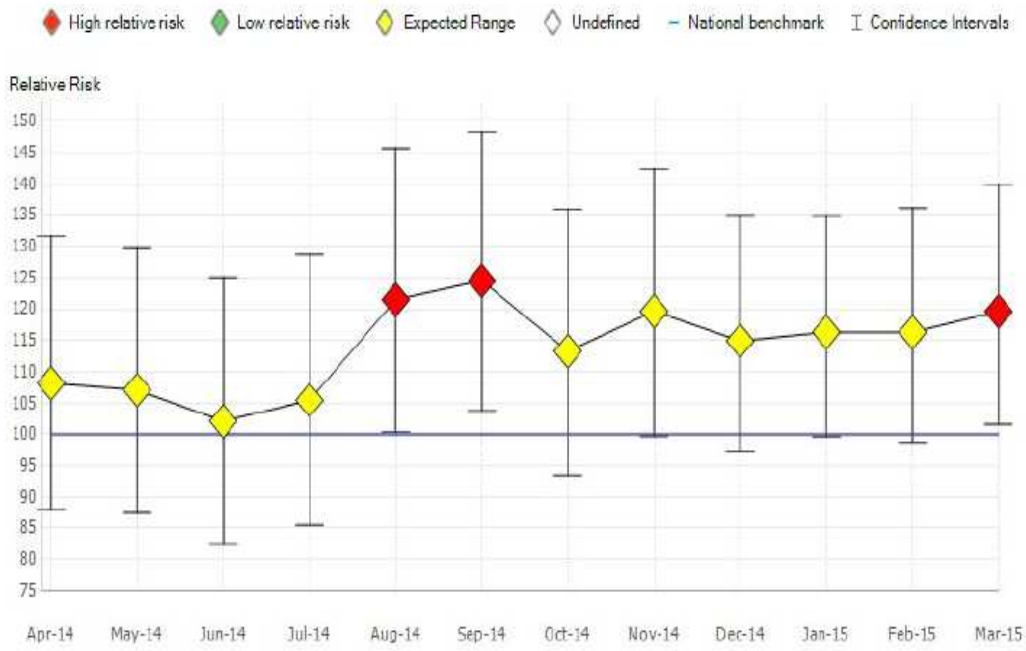
To eliminate the variation between weekend and weekday HSMR

How are we performing against this target

Dr Foster have just released updated data to include March 2015.

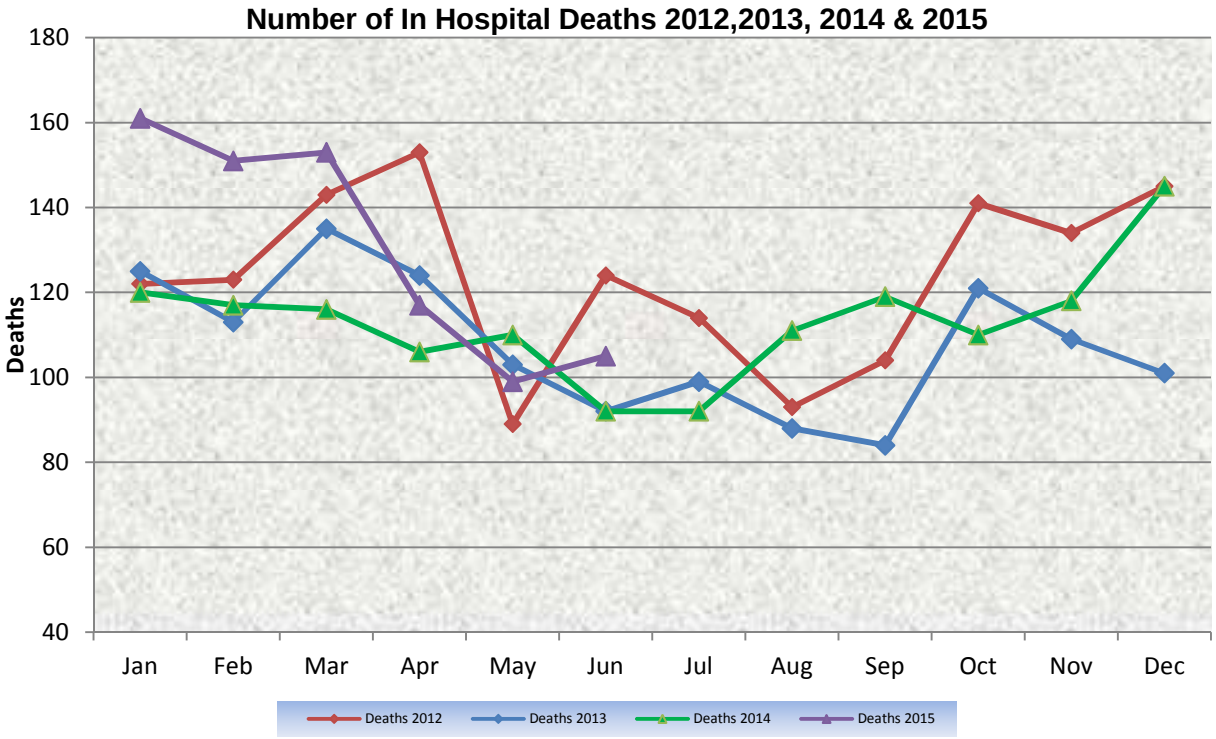
This shows an overall HSMR of 114 for the period April 2014 to March 2015. However, this figure may change as there are still statistical analyses to be applied by Dr Foster before the year's HSMR figure is finalised.

The HSMR for March is raised at 119. this represents a crude mortality for March of 156 deaths against an expected of 130. The reasons for this will be discussed at Trust Mortality Group where a decision will be taken as to what would be the most valuable investigation into this.



Mortality (Quality Priority 1)

Mitigation plan (actions to date and future planning)



Crude mortality was high in the early part of the year, the winter months (Purple line).

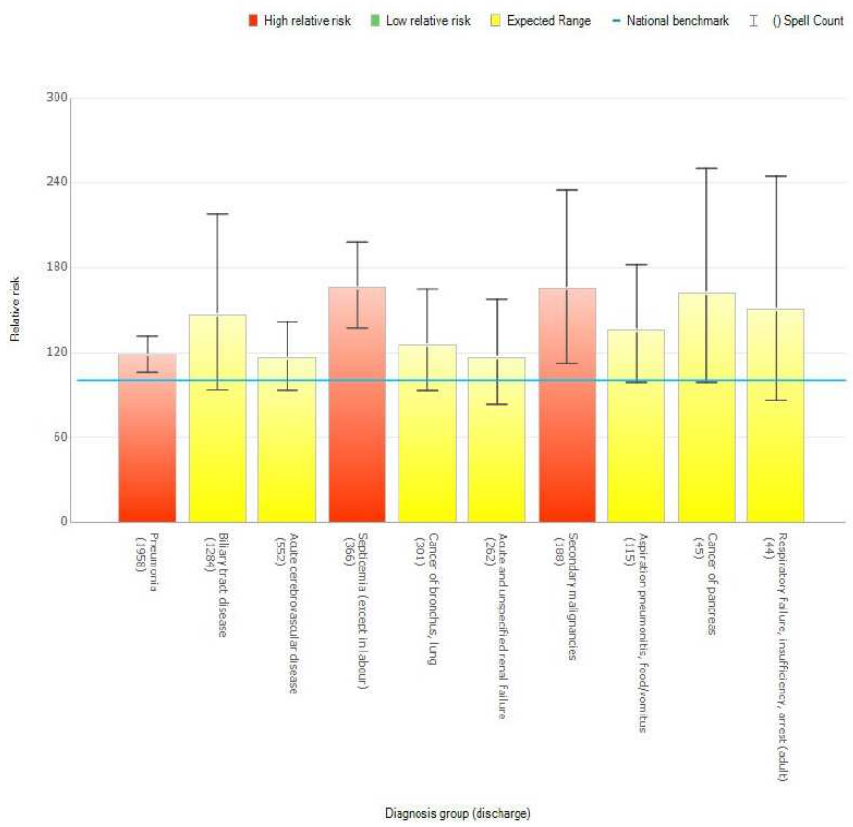
However, the mortality since April has come down and it is expected that the HSMR will reflect this when the figures become available.

A joint Mortality Action Plan has been developed between Sherwood Forest Hospital Trust and the Mid-Nottinghamshire CCGs. Our aim is to achieve a sustained HSMR at, or below 100. This can be achieved by reducing the number of observed deaths which relates to clinical issues or increasing the number of expected deaths which relates to documentation and coding issues. Our main focus is the on the clinical issues but, for a sustainable solution, we do have to deal with our coding issues in a robust manner.
The plan sets out in detail a number of clinical and administrative areas where work is focussed; sepsis, pneumonia, pathways of care such as acute kidney injury, end of life care including ceilings of care and supporting documentation. The delivery of the plan will be monitored via the Trust Mortality Group and Clinical Quality and Governance Committee.

There will continue to be regular mortality meetings between the CCGs and SFH to review progress and update the plan as required.

Mortality (Quality Priority 1)

Mitigation plan (actions to date and future planning)



This graph shows the ten diagnoses with the highest number of observed to expected deaths for the year April 2014-March 2015.

Pneumonia – this is likely raised in part due to the large number of frail elderly patients admitted over the winter months. There are three actions around Pneumonia mortality under way as agreed with the CCGs in the Joint Mortality Action Plan. These include a case note review of pneumonia deaths between January and March, a walkthrough review of the Pneumonia Pathway from ED to EAU by the Patient Safety team and Medical Director, and a monthly audit going forward of performance against the Pneumonia pathway.

There is a review taking place now of patients whose primary diagnosis was a secondary malignancy (22 patients for the year 14/15). This will be reporting to the Trust Mortality Group.

Sepsis mortality remains a priority area. An audit of patients with Bacteraemia and Sepsis is carried out monthly. In addition to the Trust Sepsis group, a Task & Finish group has been set up (with Executive chair) to review and monitor in Sepsis screening and compliance with the Sepsis pathway.

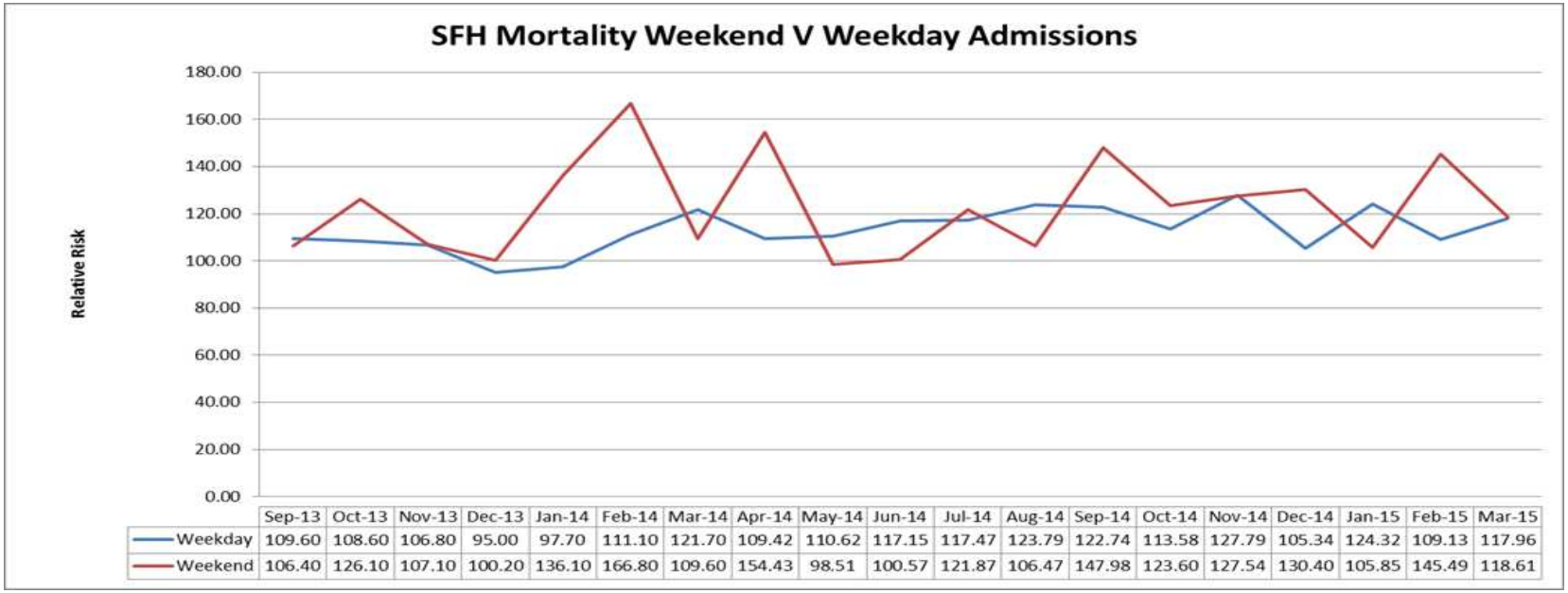
Mortality (Quality Priority 1)

Mitigation plan (actions to date and future planning)

The weekend v weekday mortality data is based upon the day of admission. It varies according to the number of admissions. For the year April 14 to March 15 it shows that the HSMR across the 7 days is very similar with the highest HSMR for day of admission actually being Tuesdays.

The trust has taken steps to optimise access to senior decision makers across the whole week. This is reflected in our weekend – weekday mortality gap which has significantly reduced across the last 15 months.

At Sherwood Forest, we have consultant ward rounds at weekends across the trust & specialist reviews at weekends in our emergency assessment unit, so patients are frequently seen twice by consultants in the 24 hours following their admission. We have also improved availability of radiology and reporting of the radiology along with improvements in availability of pathology results. These can aid earlier definitive diagnosis by the clinicians and commencement of appropriate treatment.



	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
Weekday	109.60	108.60	106.80	95.00	97.70	111.10	121.70	109.42	110.62	117.15	117.47	123.79	122.74	113.58	127.79	105.34	124.32	109.13	117.96
Weekend	106.40	126.10	107.10	100.20	136.10	166.80	109.60	154.43	98.51	100.57	121.87	106.47	147.98	123.60	127.54	130.40	105.85	145.49	118.61

Sepsis (Quality Priority 2)

Sepsis targets for 2015/16 are :

Our priority is to improve the management of sepsis and reduce sepsis related mortality

- A. To implement a recognised local protocol / screening tool within emergency department / other units that directly admit emergency patients
- B. To administer intravenous antibiotics to patients presenting with severe sepsis within one hour of presentation

How are we performing against this target

A. Quarter 1 performance

During Quarter 1 a sepsis screening tool was introduced for emergency admissions. A high degree of vigilance is required for early recognition of a patient with sepsis, a screening tool can aide identification of patients that will require rapid medical review, assessment for severity of sepsis and timely delivery of the sepsis treatment bundle. The baseline audit evidenced 57.1% compliance in ED and this increased to 71% in the first week of July. From this point we can now set targets in order to reach 90% compliance by the end of 2015.

We have achieved our Quarter 1 CQUIN target

B. Commences in Q2

The second half of the CQUIN focuses on antibiotic administration in severe sepsis. This audit has now started and will give clinicians a baseline performance level from which to improve. The goal is that 90% of patients with severe sepsis will receive first dose antibiotics within 1 hour of presentation at hospital.

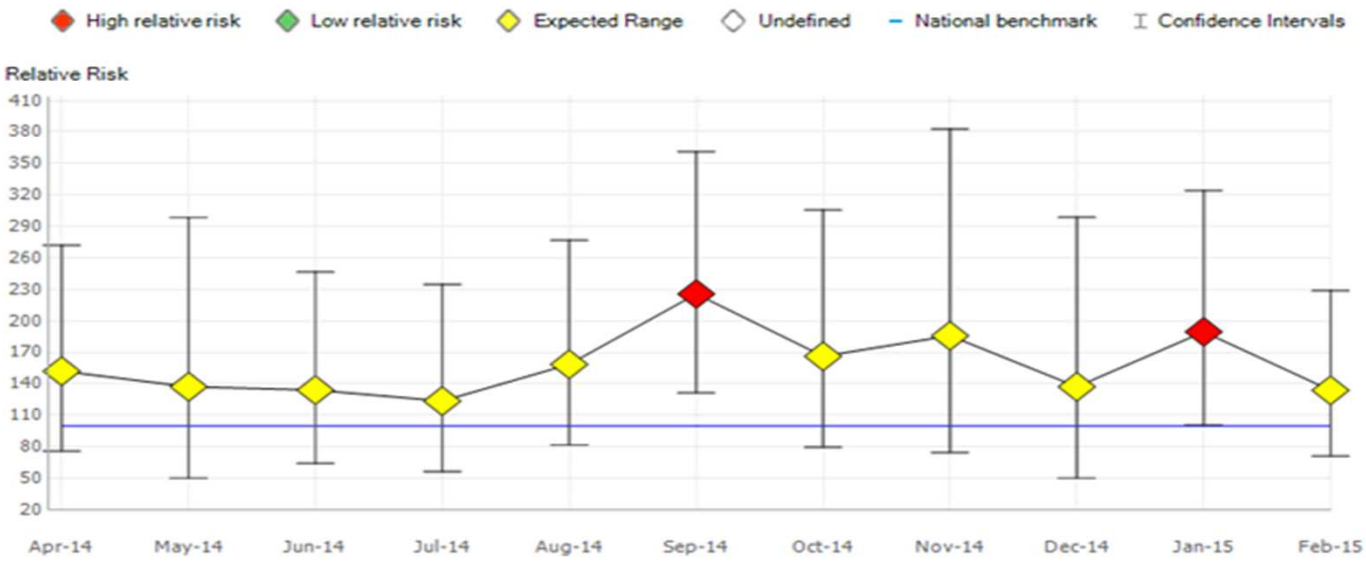
Mitigation plan (actions to date and future planning)

- The Sepsis Working group meets monthly to review & coordinate sepsis projects. A Sepsis Action Plan has been created to accelerate the screening for, documentation of and compliance with the Sepsis Six Bundle and achieve >90% compliance in admission areas by the end of August. A new Sepsis Task Force group with a wider input including ED, EAU, SAU and junior doctors has been created to oversee the delivery of the action plan. This group will escalate weekly to Divisional teams and report monthly to Clinical Quality and Governance Committee
- All sepsis related HSMR deaths are case reviewed and reported through governance meetings.
- Sepsis education (including screening & escalation) is mandatory element of F1 & F2 curriculum.
- Sepsis education (including screening & escalation) is now included in mandatory training for Nurses, Midwives & HCAs
- Monthly bacteraemia audit for compliance with the sepsis bundle continues & will be reported quarterly through governance meetings.

Sepsis (Quality Priority 2)

Sepsis related HSMR

The mortality data from Dr Foster has been updated for the February 2015 figures.



The February mortality rate is back down to within expected range. The 13 sepsis related deaths for February have all been reviewed and concluded that the deaths were unavoidable.

Falls (Quality Priority 3)

FALLS targets for 2015/16 are:

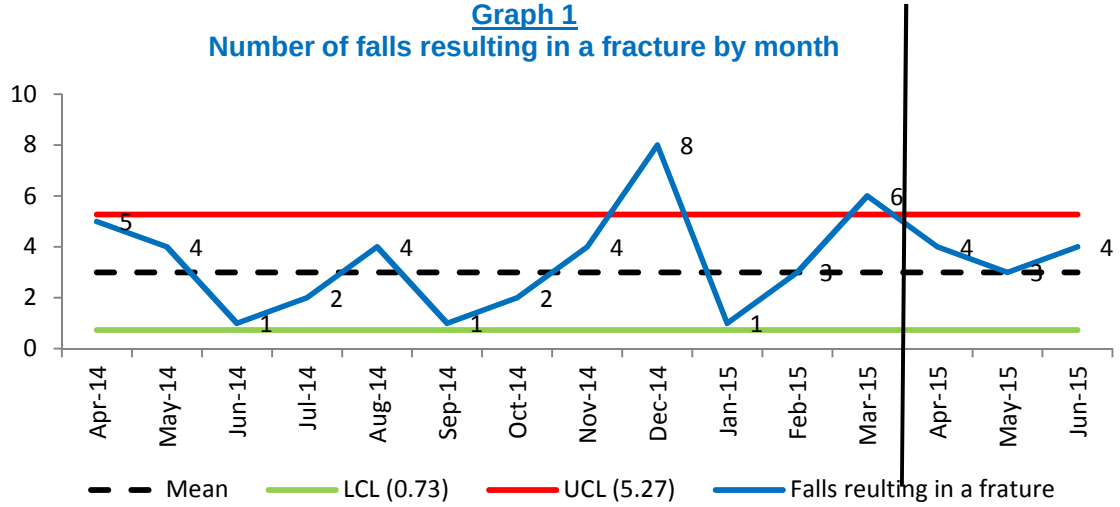
- **CQUIN**

1. Reduce the number of inpatients falling in hospital
2. Reduce the number of inpatients sustaining a fracture as a result of a fall in hospital to <25
3. Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
4. 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.
5. To undertake a review of the Enhanced Patient Care Tool currently in operation

How are we performing against this target

1. Reduce the number of inpatients falling in hospital: The overall falls numbers reported for quarter 1 were; April 150, May 156, June 165. Additional capacity was opened on the Stroke Unit during one month of quarter 1. On analysis this area had the highest number of falls incidents, identified themes include falls in toilets, rolls off ultra-low beds, falls by repeat fallers. The Falls Nurses Specialist are undertaking additional training and support in this area.
2. Reduce the number of inpatients sustaining a fracture as a result of a fall in hospital< **25:** Graph 1 shows falls with factures from April 2014/15 and Quarter 1 for 2015/16. There have been a total of 11 fractures.

Graph 1
Number of falls resulting in a fracture by month

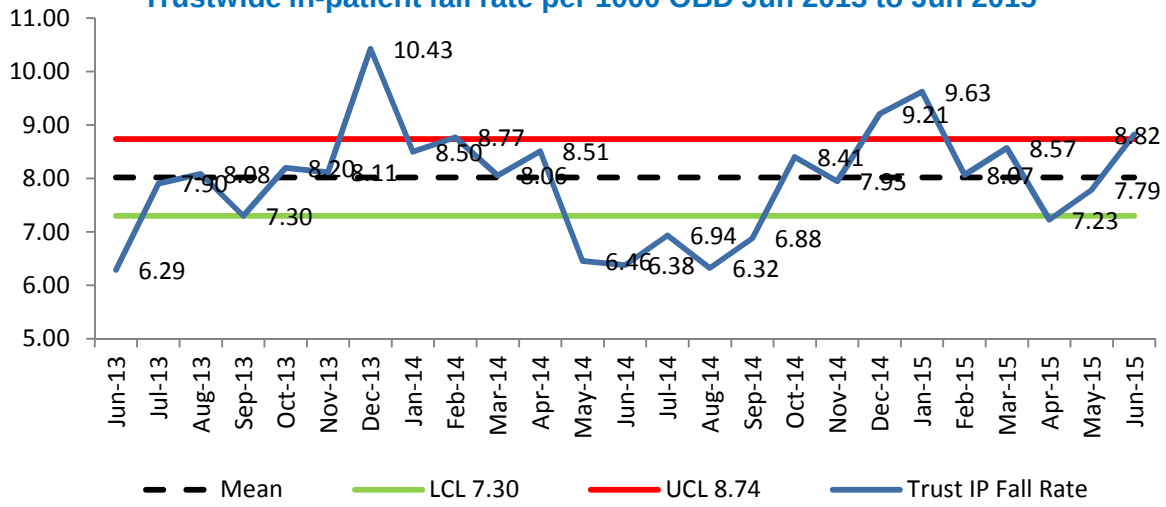


Falls (Quality Priority 3)

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

Graph 2

Trustwide in-patient fall rate per 1000 OBD Jun 2013 to Jun 2015



The average inpatient fall rate for Quarter 1(April-June) is calculated as **7.95%.** This again is slightly above trajectory and continues to be monitored on a daily basis by the falls specialist nurses and matrons.

4.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.

Partnership working has commenced to identify and implement best evidence based practice. A safety improvement programme has been developed through learning from the best and linking with local and national organisations, notable for their innovation /best practice. The Falls and Safety Improvement group is introducing specific training and quality improvement this includes the delivery of E-Learning programmes for Junior Doctors (CareFall) and Registered Nurses (Fall Safe). These awareness packages are endorsed by NHS England, the Royal College of Physicians and NICE. Dates for the Falls Champion meetings have been circulated to all Ward Sisters and Charge Nurses for the 6 weekly meetings are planned to continue until February 2106.

Falls (Priority 3)

5. To undertake a review of the Enhanced Patient Care Tool currently in operation

A review of the appropriate utilization of the Enhanced Care Tool has commenced. The Falls Nurses have continued to work with the Matrons to identify and assess patients identified 'at risk' and ensure appropriate escalation for patients requiring enhanced care including 1:1 support. Falls Specialist nurses are supporting Ward teams to look at accurate assessment of the patient, referral to appropriate support services and consider different ways of working in the ward environment, i.e. ensuring where possible patients are cohorted into bays and that staff delivering enhanced care have a clear understanding about the levels of direct observation and have access to resources that support them with distraction, diversion and de-escalation skills as required. Ward teams are being encouraged to utilise the activity equipment resources in the library.

Mitigation plan (actions to reduce falls/Challenges)

The support of a second falls nurse has enabled the Falls Team to be more proactive than reactive including to:

- provide a 7 day service which will enable wards to be supported /educated out of hours
- provide wider support and visibility to all 3 sites with regard to educational needs and response to patient falls
- continue to develop the work required to achieve the CQUIN target
- provide rapid response to Falls incidents reported on a daily basis and visit the wards/patients to provide support
- provide a wider educational input in various forums in order to develop staffs awareness and knowledge with falls prevention
- forge links and visit patients and relatives to support them after an inpatient fall as identified within the Duty Of Candour

Constructive discussions have been held between the Trust and NHS England resulting in positive advice and feedback specifically related to falls training for staff and in undertaking a self audit in relation to NICE Quality Standard 86 - Post fall actions.

Addressing the themes and trends from Datix and Serious Incident reports:

The action plans in serious incidents is evidencing how we learn as an organisation. Analysis of themes from incident reporting has indicated poor compliance on wards with measurement of lying and standing blood pressure recordings. This has been addressed by:

- incorporating a question in the Nursing Metrics
- educating staff at ward level and in the Falls teaching forums/events
- all wards have information displayed on how to undertake this diagnostic test

Communication between wards and departments regarding patients who have a fall history:

- Introduction of new falls risk signage in all ward areas
- Launch of falls risk stickers for nursing and medical notes

Infection Control

Infection control targets for 2015/16 are :

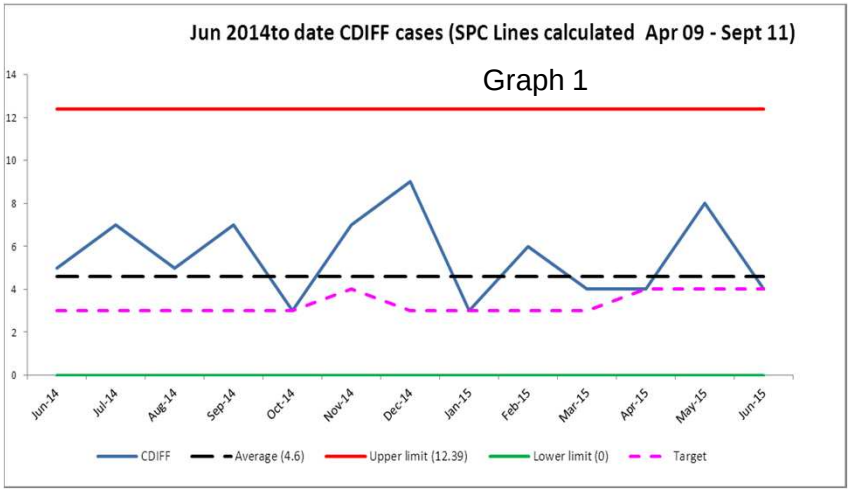
- **Contractual** – 1. Zero tolerance Hospital Acquired MRSA
  2. Minimise rates of Clostridium difficile – No more than 48 cases in the year.
- **Internal** – No more than 5 Urinary Catheter Related bacteraemia

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 16 incidents of *Clostridium difficile i*nfection during Q1 with 8 lapses in care. This breaches our quarterly target of 12 (Graph 1) RCA's have been performed and an outbreak investigation involving 3 cases in May on ward 51 which revealed 2 cases of cross infection related to delayed isolation, delayed testing and inadequate infection control. Rapid action and intense remedial work with the multi disciplinary team was undertaken and audit results show substantial improvement.



Catheter associated bacteraemia:

There have been 4 cases of hospital acquired catheter associated bacteraemia during Quarter 1. The RCA's have been completed and have identified prolonged duration of catheters.

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:

- The health economy *Clostridium difficile* review group; interrogated cross organisational RCA's for commonality's and agreement to target high antibiotic prescribers in the community was reached.
- The mandatory education programme for SFHT contains relevant training managing patients with *Clostridium difficile*
- The sampling proforma introduced last quarter is being used more frequently and compliance with its completion has doubled since the previous quarter.
- Delegates from the Infection Prevention and Control Committee visited Royal United Bath Hospitals in June to review and learn from their systems. The root cause analysis (RCA) process and documentation is being redesigned.

Bacteraemia:

Any bacteraemia are reviewed by an Infection Prevention and Control Nurse (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:

A trial of a integrated catheter management system has been completed and it has evaluated well. The supplier has agreed to include the agreed catheter passport within the sets. The cost benefit analysis is being reviewed and negotiations with the supplier to ensure the product is cost neutral are underway. A session was delivered to the link staff to remind them of the importance of asepsis, documentation of need, on-going need and securing indwelling catheters to reduce rates of infection. The whole health economy Reducing Harm Attributable to Urinary Catheter (RHAUC) group continue to meet monthly, to highlight issues and seek solutions.

Infection Control

Audit

Audit	Total Areas	EC M	PCS	NWK
Hand hygiene	35	90	91	50
PPE	35	100	91	75
Isolation	35	75	66	75
Sharps	35	80	91	100
Linen	35	85	75	88
Catheters	35	75	55	75
Commodes	35	70	66	75

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 taken.
Within Emergency Care and Medicines and Planned care and Surgery Hand Hygiene has shown huge improvements, unfortunately Newark has had some issues, with Bare Below Elbows and poor/inappropriate use of personal protective equipment. The issues have been addressed at the time, and escalated as required either via nursing or medical channels. Sharps non compliance primarily due to poor use of temporary closure, catheter issues related to inadequate securing and positioning, plus inconsistent documentation. Specific Training for link Staff was provided. Commode cleanliness has shown improvements during the past quarter however this is still an area of weakness and ward leaders and link staff are responsible for monitoring the condition daily.
An electronic mobile auditing device was introduced in June, to enable effective collation and dissemination of audit results and implementation of action plans.

Education and Training

Training	% compliance
Infection Control (on Mandatory Update)	88
Hand Hygiene (Total)	86
Hand Hygiene (medical staff)	81
Hand Hygiene (Clinical staff –non medics)	91
Hand Hygiene Non Clinical Staff (New Mandatory Policy)	54

The education and training compliance data is monitored continuously. At the end of Quarter 1 the compliance with infection related training shows improvement on previous quarters. Hand hygiene training for medical staff has shown an increase of 18% on the previous quarter. In non medical clinical staff the compliance with training is over 91%. The IPCT made it a priority to provide additional sessions and with help from link staff assisted with providing increased training sessions to achieve these improvements. Since April it has becoming mandatory that non clinicians are formally trained in hand hygiene every 3 years. There has been a positive response from numerous departments requesting training from the IPCT.
The Link Champions had their own study day in June, with a programme to both develop and disseminate information. The day was very well evaluated.

Decontamination

The importance of maintaining environmental and equipment cleanliness is of paramount importance in limiting the spread of infection. Quarter 1 heralded the introduction of 3 elements to support this process. The R.A.G rated process to assist in identifying type of clean required and streamlining the process, using this system, a report provided to HCAI Group fortnightly to report progress against new schedule. The introduction of a peracetic acid based cleaning product (Sanicol) to provide effective cleaning without degrading equipment was commenced in June and careful monitoring of the products efficacy is being managed and finally the introduction throughout the organisation of a single use spill kit system for blood and bodily fluids.

Surgical Site Infections

Mandatory surveillance of Total Hip (THR) and Total Knee replacements (TKR): During Quarter 1 there have been Zero SSI's to report from that area.

Procedure	Recorded Procedures	Number of SSI cases	Total SSI%
THR	37	0	0
TKR	38	0	0
Total	75	0	0

The trust performs voluntary discharge surveillance on post partum women who have undergone a caesarean section. It is not possible to benchmark against English hospitals, it is not part of the Public Health England identified Surgical Site Infection Surveillance groups. However compared to the whole of Wales(4.8% 2013-2014), the self reported rate of 2.3% is positive.

Procedure	Recorded Procedures	Number of SSI cases	Total SSI%
LSCS	169	4	2.3

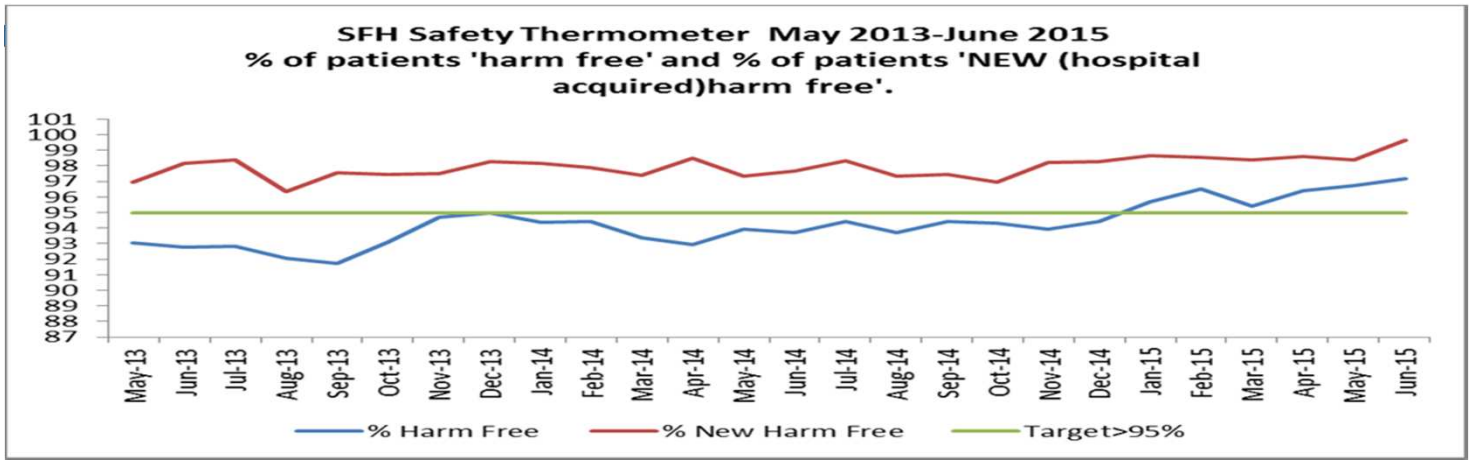
Safety Thermometer

Safety Thermometer targets for 2015/16 are :

Aim to : Ensure harm free care for patients (>95%), as measured by the Safety Thermometer, a tool to measure local improvement and reduction in harms over time

We understand that it is essential that the care we provide for our patients is free from harm. The Safety Thermometer allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportion of patients that are 'harm free' in relation to *Grade 2,3 and 4 pressure ulcers, Catheter associated urinary tract infections (CAUTI), Falls, and Venous thrombo-embolism (VTE).*

The Safety Thermometer was fully implemented across our Hospitals in April 2012 and harms data is now collected for every patient on the same day, once a month with the exception of patients in theatres , emergency department and outpatients.



The graph above shows the % patients classified as "harms free" and "NEW (hospital acquired)harms free by month and indicates that for Quarter 1 we have achieved the 95% target and consistently remain above 95% for patients who have acquired new harms

Q1 Safety Thermometer

The Trust continues to successfully collect and upload data to the NHS information centre within the defined period each month.

A total of 1792 patients were assessed using the Safety Thermometer during Q1. In Q1 the result for harm free care is an average of **96.76%**,this is an improvement on the average of **95.85%** in Q4 2014/15 and exceeds the national goal of **95%**.This includes patients who have been admitted with a degree of harm.

Safety Thermometer

Q1 Monthly breakdown of harm free care by %

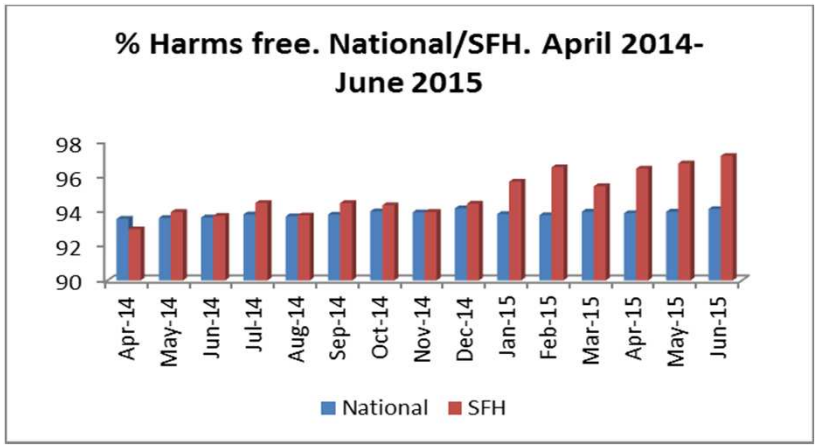
April
96.42%* -harm free care
98.63% - new harm free care
1.37% of our patients suffered a new harm
New CAUTI – 1 New Fall with harm - 3
New Pressure ulcer PU –4

May
96.72%* - harm free care
98.36% - new harm free care
1.64% of our patients suffered a new harm
New CAUTI -2 New Fall with harm- 2
New Pressure ulcer - 5

June
97.15%*- harm free care
99.66% -new harm free care
0.34% of our patients suffered a new harm
New CAUTI-0 New Fall with harm -0
New Pressure ulcer -1

96.76%
Harm Free Care in Q1

98.89%
New Harm Free Care in Q1



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 ?
Since May 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

Each month wards are sent information around the percentage of patients receiving harm free care (new harms) in their area on the Ward Assurance dashboard. Information is also shared with clinical teams through the Clinical Governance forums.
There has been a trial of new catheter packs commenced to support with the care of patients who require the insertion of a catheter .
The Serious Falls Group has recommenced which helps support the understanding of themes and trends in relation to falls and the learning that can be shared across the organisation to further improve harm free care.

Medicine Safety

Medicine safety targets for 2015/16 are :

- **Internal**

1. Zero medication-related 'Never Events' as per NHS England Never Events List 2015/16
2. To increase the number of reported medication-related incidents and near-misses reported on Datix® and improve learning from the incidents.
3. To increase the number of patients whose medicines are reconciled by pharmacy staff within 24 hours of admission to hospital.
4. To ensure all patients have a documented allergy status on prescription.
5. To reduce the number of patients with omitted doses of critical medicines (e.g. antibiotics, insulin etc.).
6. 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 these targets

1. No medication-related 'never events' reported during 2015/15 Q1. Two near-misses based on the OLD methotrexate never-event definition have been followed-up with prescribers and an associated Medicines Safety Bulletin produced.
2. 27.5% fewer incidents reported Q1 2015/16 vs. 2014/15. This is against a reduction in Trust activity (occupied bed days (OBD)) of 9.3% for the same period, equivalent to a reduction of 20% in terms of incidents/100 OBDs. Nursing and pharmacy staff continue to report the vast majority of medicines-related incidents (where reported 'job role' stated (92% of incidents for Q1)); medical staff reported <2%.
3. Data collected monthly for the Medicines Safety Thermometer (MST) indicates an average of 87% of patients for Q1 receiving medicines reconciliation by Pharmacy within 24 hours of admission, compared to 67% for the same period in 2014/15 (an increase of >29%). MST data indicates better performance than the national average.
4. Data collected monthly for the MST indicates >98% of patients have a documented allergy status in Q1. Further assurance is obtained from HAPPI data collected over the same period indicating a rate of 100%, compared to 99.8% from HAPPI in Q1 2014/15 (MST data collection began in Feb 2015). MST data indicates better performance than the national average.

Medicine Safety

5. Data collected monthly for the MST indicate 14% of patients had an omitted dose in Q1 (this includes both valid and invalid reasons for omissions). For critical medicines, the omission rate is <3%. MST data indicates better performance than the national average. Local data collection has a slightly different measure but returns a critical medicine DOSE omission rate of 1.5% and all omissions of 1.9% in Q1.
6. Medicines incidents resulting in ANY harm are down by >20% in Q1 compared to 2014/15. Moderate harm incidents are down by 55% for the same period; there were no incidents in Q1 reported with higher severity. Most reported incidents continue to have no attributable harm (87.5%). High-risk medicines incidents are well reported, with a significant focus on insulin and opioids, reflecting a positive reporting culture.

Mitigation plan (actions to date and future planning)

1. Near-misses relating to never-events are actively followed-up with internal SI investigations. Incident report content is reviewed to avoid the use of 'never-event' as specific terminology for such near-misses, as this would flag on the NRLS despite no such event occurring. Never-events continue to be promoted at new staff induction, mandatory updates etc. to maintain awareness, and are flagged on the 'Be Safe with Medicines' leaflet on the intranet.
2. The importance and value of medicines incident reporting continue to be promoted at new staff induction, mandatory updates, Trust Shared Learning events etc.; increased reporting by medical staff remains a challenge.
3. Medicines reconciliation continues to be a priority for Pharmacy, with significant resources being applied to admissions areas, 7-days/week.
4. Allergy status documentation continues to be a priority for all clinical staff to complete; gaps/omissions are actively challenged and investigated when drug administration has occurred. Revisions to the Trust drug chart has improved space available for such documentation.
5. Medicine omission remains a high priority; significant work continues through the Trust Medicines Safety Task/Finish Group and Medicines Champions in clinical areas. Red 'Do Not Disturb' tabards are now routinely used by nursing staff during periods of medicine administration, and ward-specific missed dose data is now available and fed back to staff in clinical areas. This is to be continued during 2015/16, in addition to monthly MST data collection. A flowchart to help staff minimise missed doses has been designed and is available on the intranet.
6. Medicines-related incident 'harm' measures are closely monitored by the Medicines Safety Officer; those incidents suggesting significant harm, or significant near-misses with no attributable harm (e.g. recent insulin near-misses) are actively investigated, and learning identified where possible. Medicines Safety bulletins continue to be published by the Trust Medicines Safety Group.

Pressure Ulcers (PUs)

Avoidable Pressure Ulcer targets for 2015/16 are :

- **Contractual** – Less than 3 grade 2 avoidable pressure ulcers per month with a yearly trajectory of no more than 36.
  – Zero grade 3 and 4 avoidable pressure ulcers.

How are we performing against this target

Contractual

The grade 2 pressure ulcer target has been achieved for the whole quarter with one developing in April, two in May and one in June.

The grade 3 pressure ulcer target was achieved in April and May with none developing, however was not achieved in June with one grade 3 pressure ulcer developing.

A potential grade 4 pressure ulcer developed during June. This patient's care has been initially reviewed by the Tissue Viability Nurse Consultant and a comprehensive investigation is in progress.

Avoidable Hospital Acquired Pressure Ulcers 2015/2016					
		Apr	May	Jun	Total
Grade 2	Target	3	3	3	9
	Actual	1	2	1	4
Grade 3	Target	0	0	0	0
	Actual	0	0	1	1
Grade 4	Target	0	0	0	0
	Actual	0	0	1	1 (to be confirmed)

Pressure Ulcers (PUs)

Mitigation plan (actions to date and future planning)

Themes and trends identified from a review of pressure ulcer development are: Inaccurate Waterlow, not reacting to red skin, concordance issues, and pressure ulcers developing under bandages. Work has been undertaken to address these and includes:

- Teaching and posters for accurate Waterlow and 'React to Red' have been displayed on wards.
- A pilot study is planned for October to introduce a new evidence based pressure ulcer risk assessment tool called PURPOSE-T. This assessment tool will improve independent assessment from individual nurses and identify more accurately patients risk and signpost the level of care required by individual patients.
- Concordance has been discussed with Ward Leaders and Matrons on 10th June 2015, and will be discussed at the Nursing and Midwifery Board on 21st August 2015 where any further action will be agreed. The Tissue Viability Team are working in collaboration with the Practice Development Team and a concordance care plan relating to pressure ulcers, with a Trust Wide role out plan including ward based teaching.
- Teaching about skin inspection under bandages and dressings commenced in June 2015 and will continue with Link Nurses, Registered Nurses and Health Care support Workers. A poster to support this will be developed by the Tissue Viability Team by September 2015.
- A team led by Tissue Viability continues to improve the quick and safe supply of pressure relieving equipment. A pilot of dynamic mattress hire will commence at Mansfield Hospital in August 2015.
- An audit of the safe effective and appropriate of dynamic mattresses is planned to occur in September.
- A root cause analysis template specifically for pressure ulcers is being piloted from 21st July 2015.
- The care of patients who have developed Grade 3 and 4 pressure ulcers are now reviewed at the weekly Serious Incident Scoping Meeting.
- Senior nurses from the Trust are involved in regional work to standardise and improve the serious incident reporting framework.

Venous Thromboembolism (VTE)

VTE targets for 2015/16 are :

- **Contractual** 95% of all patients will undergo a VTE (venous thromboembolism) risk assessment
- **Internal** 100% of cases of Hospital Acquired Thrombosis (HAT) have a root cause analysis performed.

How are we performing against this target

Contractual

Target met every month of the quarter

Internal

The programme to screen the case notes and identify Hospital Acquired Thrombosis continues and all those identified as HAT to date have gone for full RCA by relevant consultant. Not all case notes have been screened within the agreed time frame; the VTE group have set a target screen the outstanding cases by early September 2015.

Mitigation plan (actions to date and future planning)

All potential HAT notes have been made available to the Clinical Lead and future case note will be available as soon as identified.

End of Life Care

Targets for 2015/16 are:

- **CQUINs:**

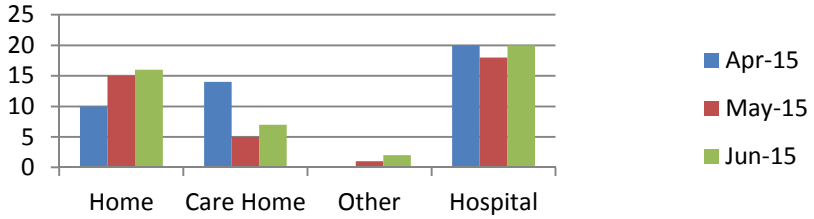
1. Have End of Life (EoL) clinical champion in place.
2. Increase in the number of inpatients who die in their place of preference, as evidenced through audit and a reduction in the number of hospital deaths.
3. Ensuring patients are discharged safely and effectively
4. Evidence of improved rates of staff training in end of life care

How are we performing against this target

The final CQUIN performance requirements for achievement of parts 2-4 were planned to be agreed in year with our CCG colleagues.

1. The Trust appointed Dr Ben Lobo (Locum Consultant Physician / Geriatrician) to this role April 2015.
2. We continue to measure place of preference but our figures are affected due to a higher preference for some patients to remain in hospital care to die. We have discussed this with our commissioners. Our aim is to ensure we allow our patients choice – which our commissioners support. Data presented in this summary is for those accepted onto Fast Track (immediate EoL Care funded by Continuing Health Care).

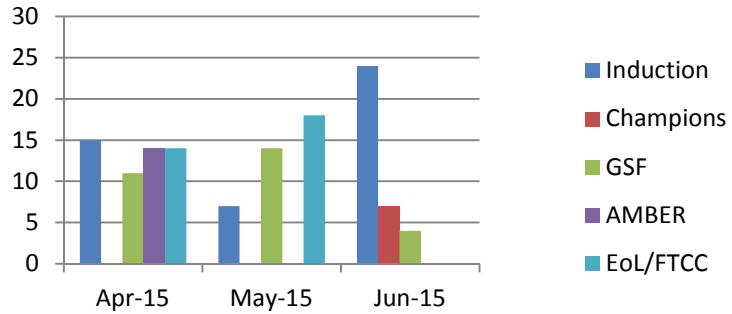
Sample data from patients referred to Fast Track Discharge Q1 2015 Fast Track Discharge



3. We continue to monitor the quality of discharges against the parameters on the CQUiN. Data and performance is ready for discussion with commissioners.

4. Evidence of improved rates of staff training in end of life care: we are reporting increased rates of training in a number of different areas compared to 2014-15 performance.

End of Life Care



516 staff have completed the mandatory workbook in the first quarter.
134 staff attended sessions on the Priorities of Care held during May and June 2015.

Mitigation plan (actions to date and future planning)

Early discussion with lead commissioners are taking place to redefine and clarify expected performance for this CQUiN. Further assessment of risk will be completed in August after negotiations are completed.

Other Clinical and Quality Improvement Priorities:

Care in the Last days if Life: Implementing Priorities for Care

The Trust has implemented guidance and new documentation and continues to support embedding best practice through service support and training schemes. Audits show significant and continued improvement in many areas and opportunities for further development.

Allow a Natural Death Compliance (Do Not Attempt Cardiopulmonary Resuscitation)

Quarter 1 data shows significant improvements in documentation compliance.

Advance Care Planning (ACP)

The End of Life Care Team have been pivotal in designing new clinical resources for use across Nottinghamshire to achieve better planning and documentation of patients' preferences.

Electronic Palliative Care Coordination Systems

The Trust remains actively engaged in the implementation of EPACCS, this is represented in a separate CQUIN for information sharing.

EoL Care Quality Governance and Regulation

The Trust has strengthened many aspects of quality governance and was confident in its engagement with CQC in the recent inspection. A known risk about workforce of the EoL Care Team was explored by CQC. This has been registered on the Trust's risk register. Additional end of life support has been added to the team until December 2015, whilst a review of needs is undertaken. The Trust continues with specialist palliative care support, but the lack of a specific Trust service level agreement has been escalated to the CCG. Further information is being provided and explored with the CCG Lead Nurse. Trust wide end of life risks have been added to the central risk register and are being monitored through the end of life steering group.

Mortality and End of Life Care

Significant work has been achieved throughout this quarter to analyse data that helps us to understand key clinical determinants or risks that will help qualify / reduce crude mortality rates and improve end of life care. This information will be used with commissioners to identify key patients at risks and support business cases for enhanced end of life and palliative care services.

Overview of Achievement of CQUIN Targets 2015/16

Table 1 below shows the agreed national, local and specialist CQUIN's agreed for 2015/16

Table 1

Summary of Acute Schemes for 2015/16				Delivery			
CQUIN Scheme		Requirement	Approx CQUIN Value	Q1 Forecast	Q2 Forecast	Q3 Forecast	Q4 Forecast
1	Acute Kidney Injury (Aki)	Improving the provision of information to GPs at the time of discharge	£459,000				
2a	Sepsis Screening	Screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics	£229,000				
2b	Sepsis Antibiotic Administration	Administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis	£229,000				
3a	Dementia And Delirium (Fair)	Improve care for patients with dementia or delirium during episodes of emergency unplanned care	£183,000				
3b		To ensure that appropriate dementia training is available to staff through a locally determined training programme	£46,000				
3c		Ensure carers of people with dementia and delirium feel adequately supported	£138,000				
4	Reducing The Proportion Of Avoidable Emergency Admissions To Hospital (UEC)	Reducing the proportion of avoidable emergency admissions to hospital	£459,000				
5a	Falls Prevention	Reduce the number of inpatients falling in hospital	£92,000				
5b		Reduce the number of inpatients sustaining a fracture as a result of a fall in hospital	£92,000				
5c		Delivery of safety improvement programme which has been developed through learning from the best and linking with local and national organisations, notable for their innovation/best practice	£92,000				
6a	Information Sharing CQUIN 2015/16	Avoiding unnecessary admissions and in achieving the Gold Standard of Care for End of Life Patients	£294,000				
6b	Record Sharing Refinement	Information will be collected and fed back on the usefulness of the information contained within the GP record	£73,000				

Overview of Achievement of CQUIN Targets 2015/16

Summary of Acute Schemes for 2015/16				Delivery			
CQUIN Scheme		Requirement	Approx CQUIN Value	Q1 Forecast	Q2 Forecast	Q3 Forecast	Q4 Forecast
7	Improving care at end of life	Reduce the proportion of deaths that occur in hospital	£642,000				
8a	Assessment, Care Planning and Communication with GP - Sharing information and improving cancer care planning and delivery	Systematic assessment, care planning and information sharing to provide proactive care for people with cancer	£459,000				
8b	Cancer Pathway Redesign	Review and plan improvement programme for other tumour pathways delivered at SFFHT	£183,000				
9	Better Together: Working in partnership to improve outcomes for our population	To ensure that the population of Mid-Nottinghamshire receives the best possible care	£917,000				
Summary of Specialised Schemes for 2015/16				Delivery			
SFH - B2	HIV - Reducing unneccessary CD4 monitoring	To embed evidence based approach to monitoring CD4 counts for management of HIV treatment	£130,680				
SFH - C6	Eligible patients receiving a NICEG10 compliant test with provision of monitoring data	To help patients, who cannot be categorised as low or high risk by existing clinical practice, make more informed choices about whether to undergo chemotherapy through greater insight into their likelihood to benefit	£27,000				
SFH - WC3	Neonatal Critical Care – Reducing Clinical Variation and Identifying Service Improvement Requirements by ensuring data completeness in the 4 NNAP Audit Questions identified.	Where data are complete for an individual child and for a whole unit for these four questions, clinical quality will be improved through identification of areas for improvement and reduced clinical variation	Value to be agreed by specialist				

Risk rating for CQUIN's

The Trust is currently confirming the risk rating forecast for all CQUIN's for quarter 2, 3 and 4.

The following CQUIN's are risk rated as amber:

Acute kidney injury: the trust has an agreement with Nottingham University Hospitals (NUH) to provide the expert clinical lead for this national CQUIN. They identified consultant resigned from his post during quarter one. The Trust is in negotiation with NUH to identify and appropriately qualified consultant. The CCG have been made aware of the situation.

Sepsis: A notes audit in quarter one has identified poor documentation related to the identification of patients who should be on the sepsis pathway. Additional resources and actions have been put in place to respond to the concerns.

Falls: Reducing falls continues to be a challenge for the Trust. The paper included in this report sets out the identified actions being taken to reduce falls.

Dementia

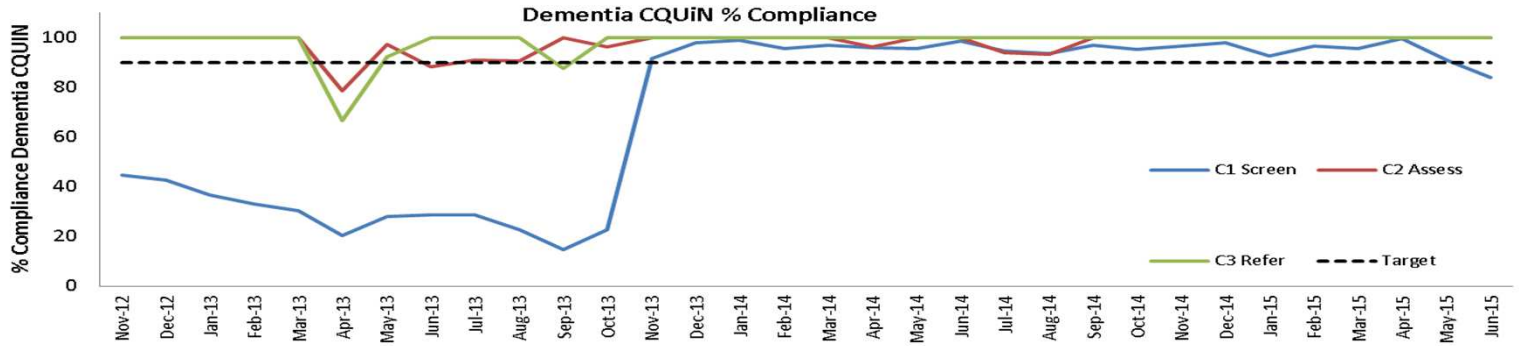
Dementia targets for 2015/16 are :

- **CQUIN** 1. To improve care for patients with dementia or delirium during episodes of emergency unplanned care.
  2. To ensure that appropriate dementia training is available to staff through a locally determined training programme.
  3. Ensure carers of people with dementia and delirium feel adequately supported.

How are we performing against this target

1. To improve care for patients with dementia or delirium during episodes of emergency unplanned care.

For quarter 1, the results for the CQUIN target for finding, assessing, investigating and referring patients is demonstrated in the graph below.



- "This is me" is available in clinical practice to be given to families and carers of patients with dementia to complete. This assists the nursing staff to plan individualised, person centred care
- The Frailty Intervention Team (FIT) based in EAU complete Comprehensive Geriatric Assessments on frail, elderly patients, including those with dementia
- Modifications to the environment across various clinical areas, including; improved signage to toilets, bays & cubicles, and colour coded raised toilet seats & frames
- 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
- The "Forget Me Not" scheme is being implemented across the organisation with the aim of improving dementia care
- Dementia Café has been started once a month at Sconce Ward, Newark Hospital. The dementia café provides a safe, comfortable and supportive environment for people with dementia and their carers to socialise.

*Data for June is currently still being collated. The graph demonstrates 84% compliance, however, this figure will change when all cases have been reviewed.

Dementia

2. To ensure that appropriate dementia training is available to staff through a locally determined training programme.

- During Quarter 1, 796 staff received dementia awareness training as part of their induction to the Trust or as part of the Mandatory Update
- Currently, 87% of staff at Sherwood Forest Hospitals have received Dementia Awareness training
- "Best Practice in Dementia Care" course from Stirling University has been facilitated by the Matron for Geriatrics and the first cohort are due to complete the course in the near future
- 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.

3. Ensure carers of people with dementia and delirium feel adequately supported.

- From a carers audit perspective we have continued to survey carers on a face to face basis. The response rate of this survey has been poor. A more formal survey is being developed for carers to complete post discharge. The feedback from this which will help us to improve the support for patients and carers.

Mitigation plan (actions to date and future planning)

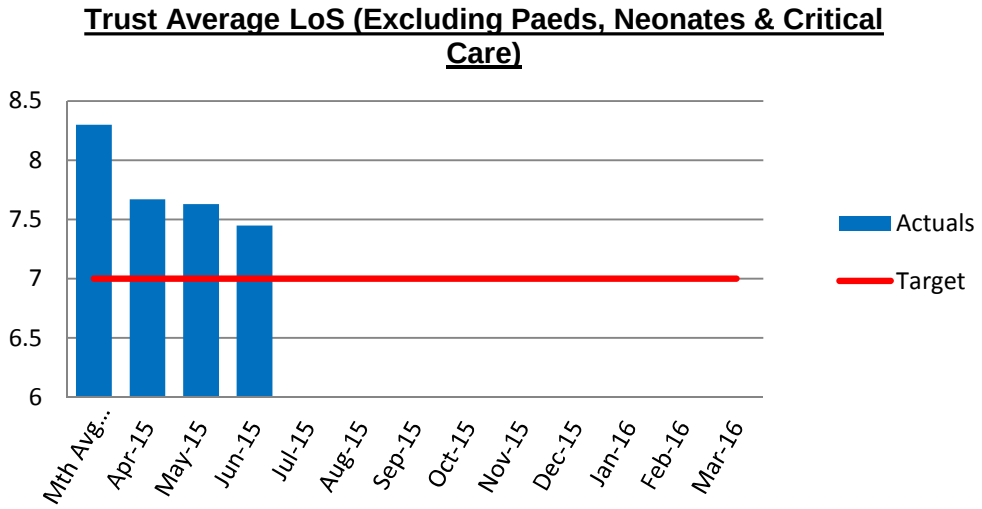
- The Orion discharge summary is to be updated to include information about dementia and/or delirium on discharge.
- Fundraising for the Dementia Care Appeal is to be resumed with our colleagues in voluntary services. This will enable the planned works to continue for the Geriatric Medical and Mental Health Unit.
- New "orientation clocks" (identifying day and night) are being rolled out across our clinical areas.
- Improved signage is to be implemented across the organisation to make the areas more dementia friendly.
- Further colour coded raised toilet seats and frames have been purchased and are being rolled out to more clinical areas.
- The Innovation Group for dementia care have been working together (both SFH staff and Medirest) in order to introduce "Finger Foods" for patients with dementia. The aim is to overcome many of the challenges which patients with dementia often face when eating in hospital.
- Further "Level 3" dementia training for relevant staff is to be sought and staff are to be nominated to attend.
- "Best Practice in Dementia Care" course from Stirling University is to be delivered to more staff at Sherwood Forest Hospitals.
- Meaningful Activities training is to be re-launched and further dates planned throughout the year.

Improving Patient Flow & Discharge Processes

Improving Patient Flow targets for 2014/15 are :

- **Trust Target** - To reduce Length of Stay (LoS) (excluding 0-1 day LOS) to **7 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 which now part of the PMO (Programme Management Office) for Turnaround
- There are several programmes of activity which contribute to reducing the LoS which include
  - Increasing weekend discharge rates, modelling bed state and trend analysis,
  - Effective and timely discharges utilising internal & external teams, Safe & timely pathology
  - Delivering consistent board rounds, Financial savings for ward 33, ensuring effective pathways,
- Ward metrics are communicated on a weekly basis with trajectory for projected & actual discharges, numbers & % discharged before noon which gives timely feedback about the management of discharges.
- A discharge LEAN/ redesign event is planned for the 19th August with the Integrated Discharge Advisory Team and key stakeholders within the hospital

Safeguarding Adults

Safeguarding Adults targets for 2014/15 are :

1. To continue to assess and report to Clinical Commissioning Group (CCG) against the Local Safeguarding Adults Board (LSAB) self-assessment and accountability frameworks
2. Ensure that Mental Capacity Assessment (MCA) and best interest systems and processes are embedded within clinical practice
3. To further embed the recently implemented safeguarding champion model

How are we performing against this target

Target 1: The Safeguarding Adults Self Assessment (SAFF)

- The self assessment is being reviewed for 2015/16 to be submitted to the Trusts Safeguarding Adults Board and the Clinical Governance and Quality Committee, prior to submission to the Clinical Commissioning Group and Nottinghamshire Safeguarding Adults Board (NSAB). The output of the Trusts self assessment, forms the basis of the Trusts safeguarding adult's work plan. Progress against this plan is monitored through the joint Trust and CCG Quality and Performance meeting.
- The Safeguarding Adult's Strategy and work programme for 2015/16 will be shared and discussed at Quarter 2 Safeguarding Board to ensure it reflects the Nottinghamshire Safeguarding Adults Board (NSAB) Strategy and work programme which was agreed at NSAB meeting in July 2015.
- The Safeguarding Adults Annual plan has been written and will be shared and agreed at the July Clinical Governance and Quality Committee.

Target 2: Ensure that Mental Capacity Assessment (MCA) and best interest systems and processes are embedded within clinical practice.

- Training on the Mental Capacity Act takes place on induction and mandatory training for all clinical staff groups.
- A full day's scenario based training is offered to staff which gives them opportunity to practice the application of Mental Capacity Act and Deprivation of Liberty. This course runs monthly.
- 'As required' ward based training takes place on an individual basis.
- Quarter 1 shows that Mandatory and Induction Mental Capacity training at 95% and Mental Capacity study day attendees at 11.

Safeguarding Adults

- All training has been reviewed in line with the changes in law and also considers staff evaluations and the results of MCA audits.
- A recent snap shot audit of MCA reviewing patient records showed that mental capacity assessment are not regularly being documented in medical records. There was evidence however of consent form 4 being completed when required.
- It was evident from the nursing records that nursing staff are considering patients mental capacity as these assessments are documented. But very few individual plans of care have been formulated in the patients best interest.

Target 3:To further embed the recently implemented safeguarding champion model.

- 38 Champions have been trained to date. A further 2 study days are planned for September and January. Support meetings for vulnerable adult champions are scheduled on a monthly basis to date and work is on going to improve attendance. A snap shot audit took place across 9 patient areas of SFHFT to assess if staff were aware they had a ward vulnerable adult champion and if they were aware that they had a vulnerable adults information folder.

Mitigation Plan (actions to date and future planning)

Target 2: There is now a Medical consultant for safeguarding Adults who is to support the safeguarding adults team from a medical perspective.
Mandy Ashton (Director of Mandy Ashton consultants Ltd), has been commissioned by the Trust to review SFHFT Children's and Adults safeguarding. Mandy has many years of working in the NHS and expert skills in managing safeguarding teams and is working with the Trusts safeguarding team to review the Trust safeguarding policies and procedures. These will be evaluated and tested for operational and strategic relevance and appropriateness in safeguarding vulnerable people.

Target 3: Further information has been sent out reminding staff to identify a Vulnerable Adults champion in their area and to book onto the available course dates. Further information providing the monthly support meeting dates has also been circulated. The Vulnerable Adults Team have been supported by the practice development matrons to improve staffs skills to assess patients capacity, individualise care plans and to highlight the Vulnerable Adults Champions and information folders.

Safeguarding Children

Safeguarding Children targets for 2015/16 are :

1. Trust to continue to assess & report to CCGs against the Local Safeguarding Children's Board (LSCB) self-assessment and accountability frameworks (NSCB Markers of Good Practice)
2. Trust to implement **Safeguarding Children & Young People: Roles & Competences for Health Care Staff Intercollegiate Document,** RCPCH (2014)
3. Active participation in **MASH (Multi Agency Safeguarding Hub)**

How are we performing against these targets

The most recent self-assessment against the **NSCB Markers of Good Practice** showed that as a Trust, we are green against 77 of the 79 outcomes. The self-assessment for 15-16 will take place in September. There were no 'red' areas. 2 Amber areas were highlighted, the actions for which are detailed overleaf.

1. 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
2. The organisation adopts a 'think family' approach to care. This considers the impact of any problems (Domestic Violence; Mental Health; Drugs; Alcohol; Learning Disabilities) that mothers, fathers and other key carers are experiencing in the context of the welfare of the children. This assessment includes evidence that children are taken into account during any adult assessment.

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

Training compliance continues to present a significant challenge.

Table 1 show staff compliant with mandatory training in Q1 2015/16 compared to Q4 2014/15

Table 1

Staff	Level 2		Level 3	
	Q4 14-15	Q1 15-16	Q4 14-15	Q1 15-16
Medical	65%	68%	59%	79%
Other	93%	87%	61%	68%

Safeguarding Children

From a minimum staffing standard perspective we now have a Specialist Nurse for Safeguarding Children (1.0 WTE), however we continue to fail to meet the national standard for a Named Nurse, having only 0.5 WTE organisational wide Named Nurse for safeguarding children and young people (the National Standard is 1.0 WTE), which means there is insufficient capacity within the team to meet both strategic and operational demands but we do have a Lead Nurse for Paediatrics and Safeguarding. The Trust Safeguarding Board and Designated Nurse for the CCGs are aware of the shortfall and the risk is on the Trust Risk Register.

MASH (Multi Agency Safeguarding Hub)

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

Initial non-compliance of educational needs is escalated to mangers who are required to follow this up with staff.

The ‘think family’ approach has been built into mandatory training for staff. An audit of the family section of adult nursing documentation is planned to take place in subsequent to ensure training has been embedded.

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

Ensuring staff attend training at an appropriate level remains a challenge. In response to this a new pathway has been developed explaining the range of options for staff. This is being shared with managers and staff across the organisation.

The Safeguarding team is exploring the option of including training compliance in appraisals with Human Resources.

Learning Disability

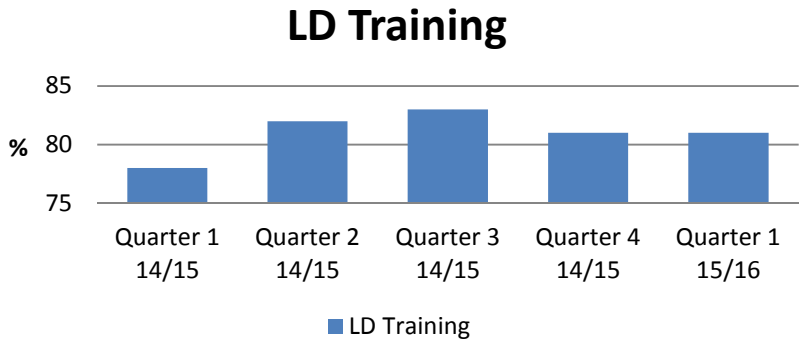
Learning Disability targets for 2015/16 are :

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.
5. The Trust to be compliant in the 6 Learning Disability Standards.

How are we performing against this target

1. To deliver learning disability awareness training on the trust induction and mandatory training programme.

Learning Disabilities training takes place on induction and mandatory
Training is in place for all clinical staff groups.
Training remains at consistent level.
Quarter 4 (2014/15) shows that Mandatory / Induction Learning Disabilities training at 81%.
Quarter 1 (2015/16) shows that Mandatory / Induction Leaning Disabilities at 81%.



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.

The groups main objectives are:

- Raise the profile of Learning Disability
- Formulate and work to yearly work plan, ensuring quarterly update is given to the Safeguarding Board.
- Monitor relevant audit results and give a formal update to the Safeguarding Board.
- Co-ordinating the review of relevant policies and procedures.

During this quarter the group have:

- Advised on the new Autism Awareness poster which is now displayed in every clinical area of the Trust
- The group have advised the Trust on the adult changing places facility (accessible toilet with changing bench and hoisting facility).
- Work has started between childrens services and adult services in the hospital to look at a Transition Pathway, the pathways aim is to plan care for young adults with complex needs to make the move between the different services easier. A project group will be meeting in Quarter 2.

Learning Disability

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.

The Learning Disability Nurse Specialist has received 51 referrals to work with patients during this quarter. Referrals received are split 50% came from community services (GP, specialist LD team, care providers, family members) and 50% from Hospital staff.

Outpatient department have been reviewing the pathway for all patients through Pre Operative assessment. The pre-operative assessment staff (Nurses) have received training on the Learning Disability Risk Assessment so that patients with a LD having a planned procedure will have their needs and risk assessed prior to hospital admission. In complex cases where the risk assessment is high the pre operative department will refer to Learning disability specialist nurse for additional support with planning.

4. To continue to fulfil the requirements of the annual safeguarding adults & learning disability work plan.

The safeguarding adults and Learning Disability joint annual work plan has been written, this plan needs to be reviewed in line with the Nottinghamshire safeguarding adults board plan before sign off by the trust. The work plan will be presented at the Clinical Governance and Quality Committee (CGQC) in august.

5. The Trust to be compliant in the 6 Learning Disability Standards.

The Trust continues to be compliant against the 6 Learning Disabilities Standards.

Mitigation Plan (actions to date and future planning)

- There are now training sessions on Learning Disabilities awareness for Doctors to attend. The doctors can access the training by 30 minute face to face sessions booked via training & Development or they can complete the General Medical Council (GMC) interactive eLearning module.

- Some of the service users involved in our hospital steering group are leading in a joint project with the CCG (Mansfield & Ashfield) to gain patient feedback from their peers about the hospital stay. The ‘Health Champs project’ is a one year pilot the health champs have received training and they will be supported to attend local day services, colleges and service user meetings in care homes so people with a learning disability get a chance to have their say in an environment they are comfortable in. The Health Champs will provide a DVD of the patient feedback and this will inform our joint work plan.

Maternity

Maternity targets for 2015/16 are :

- **Contractual –** Midwife to birth ration of 1:28

How are we performing against this target

Midwifery Staffing

The workforce tool of choice for maternity staffing is Birthrate Plus®. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period, utilising the accepted standard of 1 midwife to 1 woman, in order to determine the total midwife hours, and therefore staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice.

The optimum ratio as described by the tool is 1:28. At the end of quarter 1 the midwife to birth ratio was 1:27 against funded establishment and 1:29 in post. We have several acute unit vacancies and 4 community these are currently being recruited to bring the ratio back down to within optimum levels. There is also a university output of newly qualified midwives which we hope to attract.

On a day to day basis the acute staffing needs take into consideration elective activity and inpatients, with a proxy marker of being able to provide 1:1 care for all women in established labour. Community staffing is predominately based on clinic cover and there are no minimum staffing levels. Acute unit staffing is monitored via the capacity meeting on a daily basis.

We currently have 10 Supervisors of Midwives appointed by the local supervisory authority making us compliant with the 1:13 suggested ratio and welcome Lisa Butler to the team following her recent appointment.

Activity

Our Birth activity is 11% less than quarter one 14/15 having had 825 births in this quarter against 927 last year.

Quality Outcomes

We monitor outcomes in maternity monthly via our quality dashboard and have recently added some new fields in response to our recent quality summits. We continue to perform well with our caesarean section rates both emergency and elective with an overall rate of 23% against a national figure of 26%. Our rate for vaginal birth after caesareans (VBAC) is just under 60% whereas nationally it is 33% (This huge gap is because some maternity services do not offer a VBAC pathway). Our Home birth rate is just under 5% with a national average of 1-2%.

Unplanned admission to ITU requiring level 3 care, Suspension of maternity service and Serious Incidents have all been added to our dashboard. We have had one unplanned transfer to ITU during the quarter and have closed the maternity service twice due to capacity issues.

Maternity

Partnership working

Maternity recently had an Ante Natal and Newborn (ANNB) Quality Assurance visit which was very positive and showed excellent team work across the programmes. The report was received in May following the election contain the following recommendations:-

- A risk assessment of antenatal and new-born screening pathways for women and babies who are subject to “cross border care” arrangements should be completed by SFH maternity to clearly identify risks and mitigations.

- SFH should continue to improve data capture systems for reporting against KPI ST1. In 2014/15 Quarter 2, SFH were able to provide assurance that 81.3% of women booked to birth at SFH had been offered screening and received a result.

- SFH maternity to continue implementation and training for the NIPE SMART system and submit complete KPI NP1 and NP2 data.

- SFH maternity to review and report reasons for non-attainment of the acceptable standard for screening KPI NB2 and develop action plans accordingly so that the avoidable repeat rate is reduced to the acceptable standard. This is a high priority as repeat rates are likely to increase significantly when the Blood Spot Quality Guidelines for Screening Laboratories (2015) are introduced in April 2015.

- SFH maternity and SFH neonatology and paediatrics should ensure babies born to hepatitis B positive women receive first dose of hepatitis B immunisation schedule prior to discharge and complete the schedule.

- SFH to ensure that plans to replace laboratory equipment continue to be progressed.

- In the context of organisational and personnel changes, NHS England North Midlands, Nottinghamshire and Derbyshire should ensure that governance and commissioning functions are maintained. Increasing collaboration between commissioning organisations is an area for development.

The Individual programmes are preparing their individual action plans to address the recommendations.

Maternity

Maternity's LSA audit report received in April was also complimentary about the service. We were fully compliant with 17 of the 23 criteria being assessed an action plan has been developed the six areas that required improvement:-

- Supervisors need to formalise the process for reviewing concerns in midwifery practice locally and provide the evidence.
- The Trust should continue to work towards a 1:13 ratio in order to ensure that there is adequate succession planning.
- Supervisors must ensure all their annual reviews are up to date and entered on the LSA database.
- The Supervisors should ensure that they continue to seek administrative support whilst managing the current lack of support within the team.
- The supervisors should develop and maintain a spread sheet to demonstrate equity in allocation of the investigation workload.
- Supervisors should recruit service users to increase the numbers on the user forums.

We welcome the opportunity for visitors and have been a research site for one of the Midwifery Lecturers looking at Midwifery Decision making during labour and Birth, and welcomed Students from Australia for an overseas placement as well as hosting elective placements from around the country.

We are actively engaged with the East Midlands Clinical Network for Maternity and Children's and have engaged with work on Escalation, Management of the raised BMI and are currently working on a regional approach to Feto – Maternal Medicine.

Quality Summits

We held three quality Summits during May and June which has resulted in a Maternity Improvement action plan being monitored by the improvement group. We are currently finalising the terms of reference of this group but in the interim have established a working group to progress this work.

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 1. There has been a fall in incidents when compared to 2014 – 2015 Quarter 4.

Falls remain the highest reported incident with either low or minimal harm.

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

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	381	96	11	0	0	488
Medication	288	37	3	0	0	328
Skin Damage	159	45	2	0	0	206
Pressure Ulcers	169	31	2	0	0	202
Security or unacceptable behaviour	135	16	0	0	0	151
Delays in Care	109	16	5	1	0	131
Treatment	78	21	3	0	0	102
Staffing Issues	81	2	0	0	0	83
Pathology / Specimen related	70	7	4	0	0	81
Staff injuries / illness at work	41	35	2	0	0	78
Totals:	1511	306	32	1	0	1850

Incidents – Datix

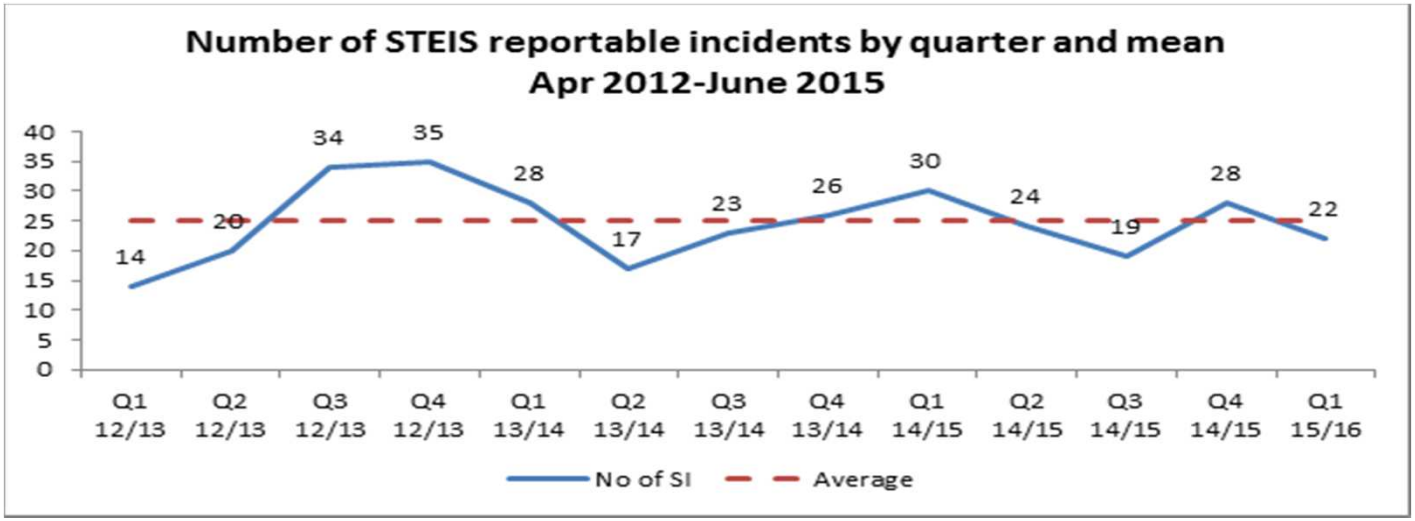
To further improve our systems and processes we are in the process of upgrading Datix to Version 14. The test environment was successfully installed and upgraded to version 14 on 16th July 2015 . Testing has now begun. The upgrade to the live system will more than likely take place towards the end of August. Datix have not yet confirmed the availability of their Technicians.

Never Events, Incidents and Serious Incidents

Serious Incidents

Graph 1 shows quarterly the number of serious incidents raised on the Strategic Executive Information System (STEIS) Quarter 1 2015/16 shows a slightly reduced number compared to Quarter 4 2014/15.
Following the publication of the NHS England framework for the reporting and management of Serious Incidents the Trust Incident Reporting Policy has been update and is due for ratification at Trust Management Board in July.
The update also includes a strengthening of our Duty of Candour in response to communicating with patients or their representative if they are affected by an incident that it graded moderate or above. A standard operating procedure is also being developed to support staff in the delivery of this requirement.

Graph 1



Learning from serious incidents

Once the investigation report has been submitted to the CCG, the Clinical Governance Co-ordinators are ensuring that the report is presented at speciality & divisional governance meetings to help close the loop for shared learning across the Division.

During Quarter 1 the Governance Support Unit have worked closely with the Mid Nottinghamshire CCG Governance team to help facilitate the closure of Serious Incident on STEIS. This work has also included the development of robust processes for dealing with incidents that have been raised by GP's and other community Multidisciplinary team members, in particular incidents that relate to discharge.

Examples of Learning from Serious Incidents

- Reinforce with all staff the importance of record keeping in evidencing actions taken.
- Ensure that staff are aware of the escalation process if specific equipment is not available when needed.
- The ward leader, in conjunction with the Tissue Viability Team, will raise tissue viability awareness on the ward by delivering extra training. A bi-monthly risk assessment day will be facilitated, whereby, tissue viability are included on the agenda. There will be specific learning boards displayed on the ward and the ward leader will monitor practice during leadership rounds.
- Develop Standard Operating Procedure for Administration Staff to include management of patient correspondence and complaints handling.
- All patients who are at risk of falling are to have their lying and standing blood pressure monitored as part of the falls prevention care plan (unless rationale documented for not monitoring). A monitoring chart for recording lying and standing blood pressure has been developed and shared across the Trust to be used in all areas

Organisational Learning Boards

- During June the new themed packs for the Learning Boards have been rolled out to all areas. 105 boards have now been distributed to Wards and Departments and include the following organisational learning.
- Patient Story –Safeguarding
- Serious Incident –Recognition of a deteriorating patient incident summary
- Safety Briefing –Record Keeping
- Lessons of the month –Safeguarding Vulnerable people.
- What are the themes for vulnerable people in the Trust? and What should we do to prevent them ?
- Safe use of Bair Huggers (Warm air devices) learning identified following a number of reported concerns /incidents
- Learning from Patient Experience-A serious fall incident that has been shared by the Ward 12 team. Highlights learning around the use the Enhanced observation risk assessment tool and escalation if additional support required
- Timely review and consideration of removal of urinary catheters

Legal Services Report – Quarter 1 2015/16)

This report provides details of Claims made under the Clinical Negligence Scheme for Trusts (CNST) and feedback on Inquests held in Quarter 1 of 2015/16.

1. Clinical Negligence Scheme for Trusts (CNST) Claims received in Quarter 1 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 1	6 (1 incident)	10 (1 incidents)	0 (0 incidents)	2	1	7	16

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

2. Coroner's Inquests held during Quarter 1

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 1	2	1	0	3	3	3

The above table shows all three of the Inquests held in Quarter 1 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. She has also requested that statements prepared by staff for the purposes of the SI investigation are shared with her.

No Prevention of Future Death (PFD) Reports were issued by the Coroner during the Quarter. All three Inquests held were subject to a narrative conclusion. One case, where the patient he had an un-witnessed fall, was highlighted as a potential for a PFD report to be issued. However, having heard evidence relating to the SI investigation, the Coroner specifically noted that she did not think that the fall could have been prevented and she was content that there had been improvements in terms of the management of elderly care patients.