Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors

Meeting Report

Subject: **Monthly Quality & Safety Report**
Date: **Thursday 27th November 2014**
Authors **Andrew Haynes / Lisa Dinsdale / Susan Bowler**
Lead Director: **Susan Bowler – Executive Director of Nursing & Quality**
Dr Andrew Haynes – Executive Medical Director

Executive Summary

This monthly report provides the Board with a summary of important quality and safety items and our key quality priorities. In summary, the paper highlights the following key points:

- Our HSMR position requires further investigation due to a rise in July. The most recent validated data from Dr Foster is to the end of June. The most recent validated quarterly data for SHMI is within the expected range. There was a problem with uncoded episodes in SUS data for April and May. Notes reviews on 30-40 patients a month have not caused any alerts but a review of all deaths in July has been initiated

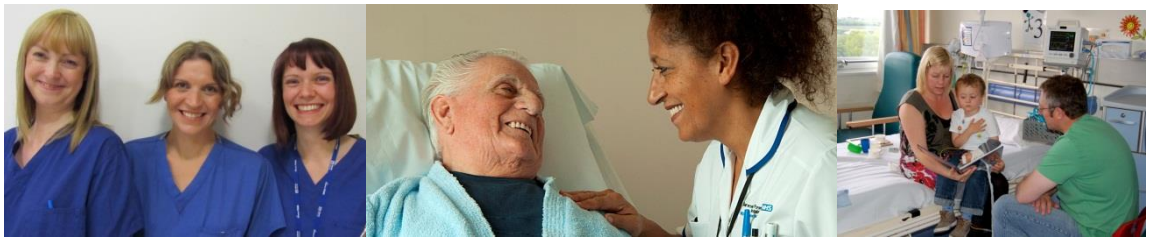
- The total number of patients who have fallen and / or suffered harm has increased in month, however further assurances are being sought from a data quality perspective following the recent transfer to Medway PAS that the data reported is correct. We have strnegthened the falls reduction programme and will monitor these rates closely.

- The Trust reported three post-48 hours Clostridium difficile infection during October 2014. This was in line with the monthly trajectory; however, it has resulted in a breach against the annual target of 37 cases, bringing the trust up to 38 cases at month end. There were no C diff related deaths.
- For family and friends we have seen an increase in response rates across our in patient wards. Further work is on going to raise overall understanding, awareness and uptake of this survey both from a staff and patient stance

Recommendation
To note the information provided and the actions being taken to mitigate the areas of concern.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	Achieve financial sustainability
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	BAF 1.3, 2.1, 2.2 2.3, 5.3, 5.5 Mortality on corporate risk register
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Failure to meet the Monitor regulatory requirements for governance- remain in significant breach. Risk of being assessed as non-compliant against the CQC essential standards of Quality and Safety
Links to NHS Constitution	Principle 2, 3, 4 & 7
Financial Implications/Impact	Potential contractual penalties for failure to deliver the quality schedule
Legal Implications/Impact	Reputational implications of delivering sub-standard safety and care
Partnership working & Public Engagement Implications/Impact	This paper will be shared with the CCG Performance and Quality Group.
Committees/groups where this item has been presented before	A number of specific items have been discussed; Clinical Governance & Quality Committee, Falls Steering Group and Mortality Group
Monitoring and Review	Monitoring via the quality contract, CCG Performance and Quality Committee & internal processes
Is a QIA required/been completed? If yes provide brief details	No



TRUST BOARD OF DIRECTORS – NOVEMBER 2014

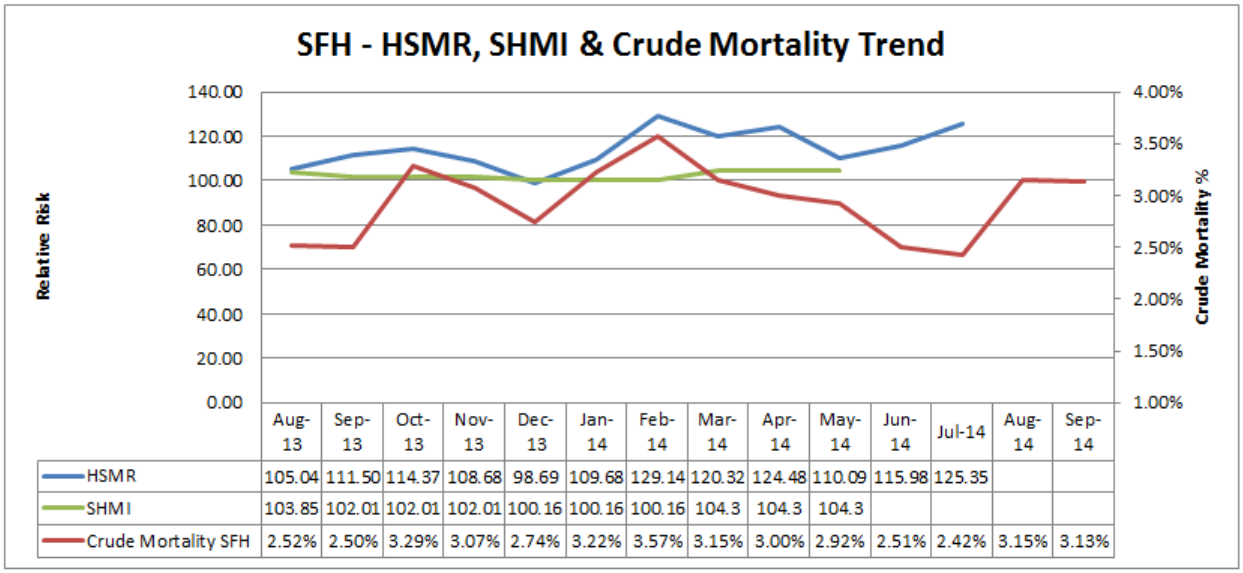
MONTHLY QUALITY & SAFETY REPORT

1. Introduction

This monthly report highlights to the Board of Directors key areas in relation to quality and safety. It complements the quarterly quality report, which gives a more comprehensive review of progress against the Trust's quality and safety priorities. The monthly report includes updates on the Trust's top 3 quality priorities for 2014/15, which are:

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 **Eliminate** the difference in weekend and weekday HSMR
Key Priority 2	**Reduce harm from falls**	Total falls **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction) Falls resulting in harm **<1.7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction) Reducing the number of patients who fall more than twice in hospital (baseline Q1 14/15 – to be reported each quarter) Reduce the number of fractures from falls to **<25** for 2014/15
Key Priority 3	**Improve response rates and scores in the patient and staff friends and family test**	Increase our F&F response rate to **50%** by October 2014

2. Reducing Mortality (Priority 1)

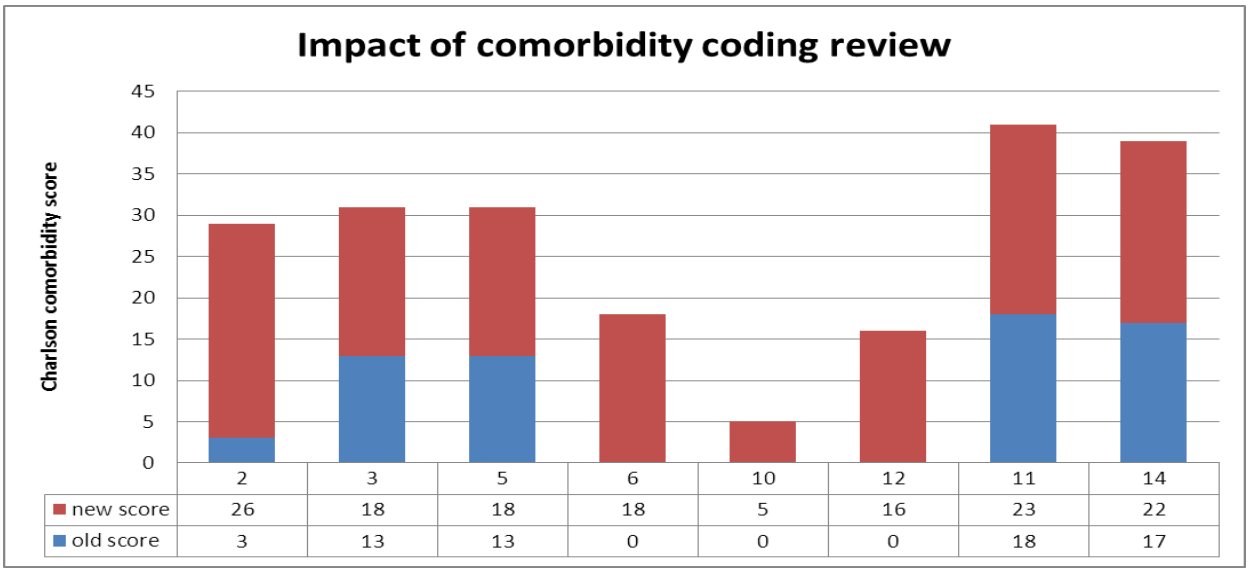


	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
HSMR	105.04	111.50	114.37	108.68	98.69	109.68	129.14	120.32	124.48	110.09	115.98	125.35		
SHMI	103.85	102.01	102.01	102.01	100.16	100.16	100.16	104.3	104.3	104.3				
Crude Mortality SFH	2.52%	2.50%	3.29%	3.07%	2.74%	3.22%	3.57%	3.15%	3.00%	2.92%	2.51%	2.42%	3.15%	3.13%

The crude morality shown is taken from internal SFH data and relates to emergency admissions only

Graph 1

The disparity between the fall in crude mortality rate and rise in HSMR for July is a concern. We were expecting validated data from Dr Foster to inform this but this is now delayed until the end of November. As we discussed last month, we had internal coding issues in April through to June with a large number of uncoded episodes at the SUS return. Internal note reviews on 30-40 patients a month have not caused any alerts but a review of all deaths in July has been initiated. Risk alerts from Dr Foster have been affected by delays in updating risk models due to delays in data supply from HSCIC. Given the uncertainty however we have initiated a review of all deaths in July. A meeting is scheduled with Dr Foster for 28.11.2014 when the updated information is expected.



	2	3	5	6	10	12	11	14
new score	26	18	18	18	5	16	23	22
old score	3	13	13	0	0	0	18	17

Graph 2

Co-morbidities are additional chronic illnesses patients have which are not directly related to their reason for admission. This data is used to describe the risk of a patient dying during an admission and to ensure accurate payment for episodes of care. Coders use information documented in casenotes to inform this; there is a section in the emergency admission booklet to capture co-morbidities in a form that makes it easy and accurate for coders. This is poorly completed. We have analysed a set of notes to compare what the coders were able to record with what should have been recorded if the information was complete. It is clear that significant differences exist and this will result in under recording of "expected" deaths. It will also result in under recovery of income. A project from the Trust Mortality Group run by Dr Harry Wright and our patient Safety Fellow, Dr Jo Richardson, has redesigned the admission booklet and will introduce this into the admission unit practice.

3. Falls Reduction (Priority 2)

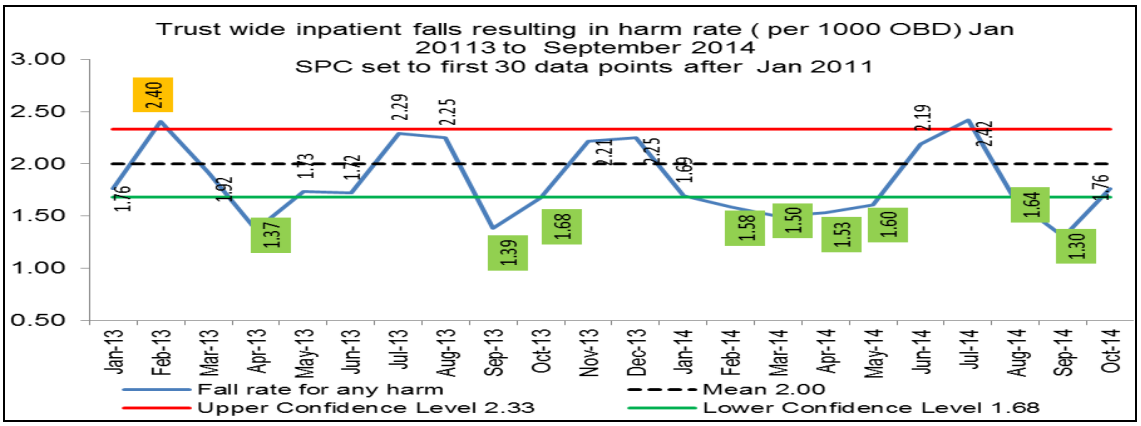
3.1 To capture the number of fallers (non-elective admissions via the Emergency Department & Emergency Admissions Unit) in the age group 65 years and over, to enable the whole health community to understand the extent of the work required going forward

A comprehensive falls history is obtained by clinicians for all non elective admissions aged >65 years within our Emergency Department / Assessment Unit**.**

3.2 To reduce the number of patients who fall resulting in harm to <1.7 per 1000 occupied bed days (OBD) by quarter 4

During October the total number of patients who suffered a fall resulting in harm was recorded as 1.76 per 1000 occupied bed days (Graph 3). This is an increase on the previous month (1.30); further work is being undertaken in relation to the data accuracy following the recent implementation of Medway PAS.

<u>The Total Number of Falls resulting in Harm (per 1000 Occupied Bed Days) January 2013 – October 2014</u>

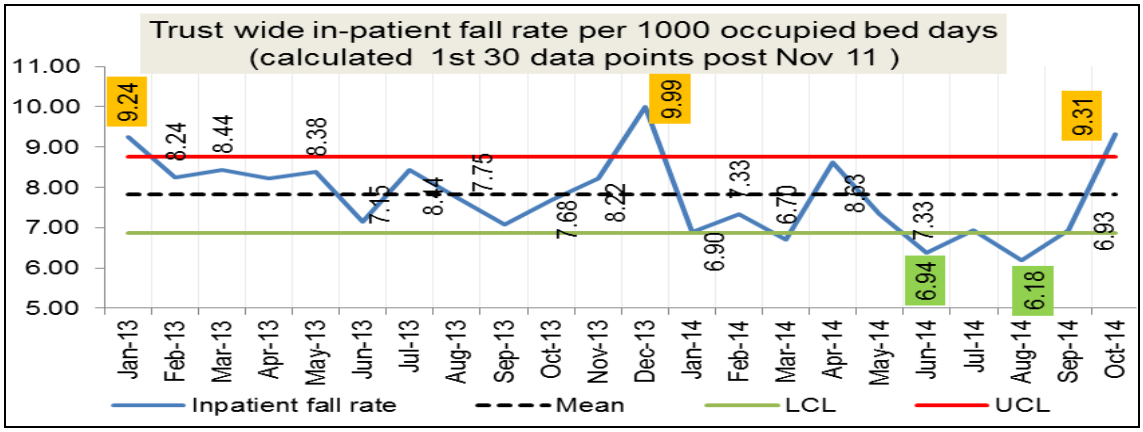


Graph 3

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

During October the total number of patients who suffered a fall was recorded as 9.31 per 1000 occupied bed days and is a significant increase in the number of falls reported (Graph 3). As reported above further work is being undertaken in relation to the accuracy of the data, but despite this the actions in 3.6 are in progress.

The Total Number of Falls (per 1000 Occupied Bed Days) January 2013 – October 2014



Graph 4

3.4 To reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded during Q1 2014/15)

During October a total of 7 patients were recorded as falling more than twice during their inpatient stay.

3.5 To reduce the number of fractures sustained following a fall to <25 for 2014/15.

During October 1 patient sustained a fracture following a fall. Year to date there have 17 patients who have sustained a fracture following a fall.

3.6 Progress and outcomes to date.

The CQUIN workers undertake an assessment of a range of fall related factors for example; appropriate footwear and the requirement for a specialist ultra low bed. We have continued to further develop the CQUIN support worker role to ensure all patients admitted to the Emergency Assessment Unit have their lying and standing blood pressure checked prior to onward transfer to a speciality base ward.

We have also implemented a range of falls prevention posters across our in patient wards; the target audience being patients, relatives and staff. Informaton is being displayed regarding the importance of supervising patients, when mobilising and transferring, that are deemed to be at risk of suffering a fall.

The corporate and divisional senior nursing team work in partnership with the falls lead nurse and through analysis and triangulation of data obtained from the Ward Assurance Framework / Nursing Metrics and Datix reports work together to identify clinical areas with a high incidence of falls and provide targeted advice, support and intervention to mitigate identified risks.

The falls lead nurse is currently working in partnership with colleagues at Nottingham University Hospitals (NUH) in order to share evidence based best practice between respective organisations. Work is currently ongoing with NUH colleagues regarding the practice of lowering patients to the floor by staff of which is still currently being reported as a fall within our Trust.

To further supportto the falls agenda, we have recently seconded one of our Ward Sisters to provide advice, training and support to those wards with the highest incidence of falls.

The falls lead nurse is currently working with the Patient Safety Lead to support the development and implementation of organisational learning boards,, thereby providing staff with important information regarding key themes and messages in relation to falls prevention.

We have recently launched our 'Proud To Care' study days, part of which adopts a scenario based learning session of a patient who suffers a fall and sustains a fractured hip; thereby ensuring staff undertake the correct actions and escalations relevant to the scenario.

Over the remainder of this year the falls lead nurse will develop a strategy to support patients who suffer frequent falls through the development of care and escalation plans underpinned by NICE guidance. This will be supported by the Night Team Leaders and Ward Sisters with the aim of ensuring that all patients who fall receive a thorough medical review and have a clear plan of action documented.

4. Improved Response Rates And Scores In The Patient Friends And Family Test (Priority 3)

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Historically the survey was initially implemented across all NHS funded acute services that provided in patient and emergency department (Type 1 & 2) services and latterly across maternity, day case and outpatient services.

We have recently undertaken a procurement process to enlist the support of a partner to:

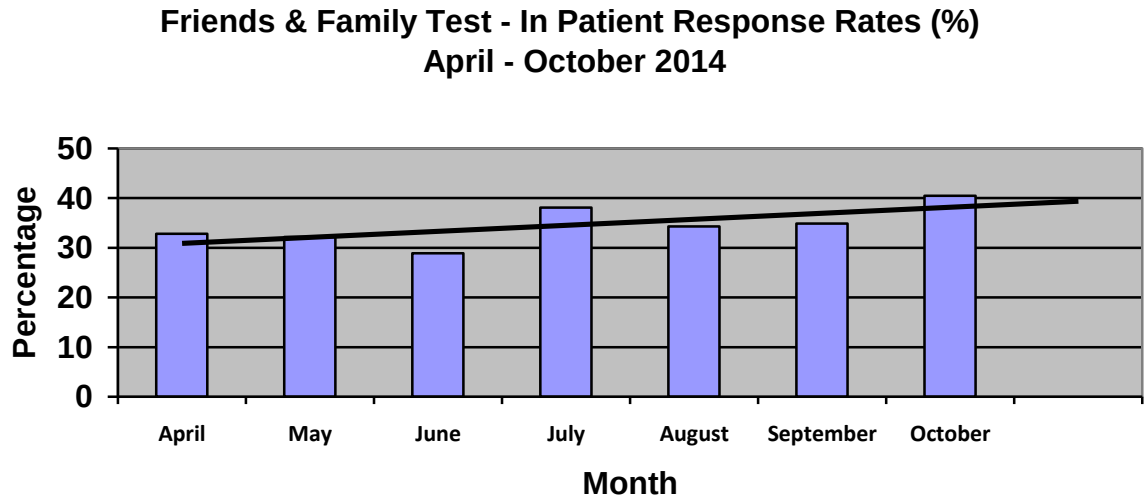
1. Increase our overall response rates

2. Support the expansion of the friends and family test across our outpatient and day case facilities
3. Facilitate real time reporting / analysis and organisational learning

We have been unsuccessful in securing a provider to fulfil these requirements. We will continue to work with our current provider to facilitate the friends and family test across the organisation; however we aim to raise awareness through the use of banners and posters. We are in addition considering whether the use of IPAD technology particularly in high throughput areas (Emergency Department, Day Case and Out Patients) would be a means of encouraging patients to submit their views and opinions thereby increasing our response rates and feedback.

4.1 Inpatient Response Rates

Friends & Family Response Rate – In Patients (April – October 2014)



Graph 5

Table 1 Friends & Family Response Rate – In Patients (%) April – October 2014

April	May	June	July	August	September	October
32.8	32.2	28.9	38.1	34.3	34.9	40.5

As evidenced within the above graph and table, the in-patient response rates has improved during the year, with our best recorded response rate this month. The average star rating for October across the in-patient wards was recorded as 4.8.

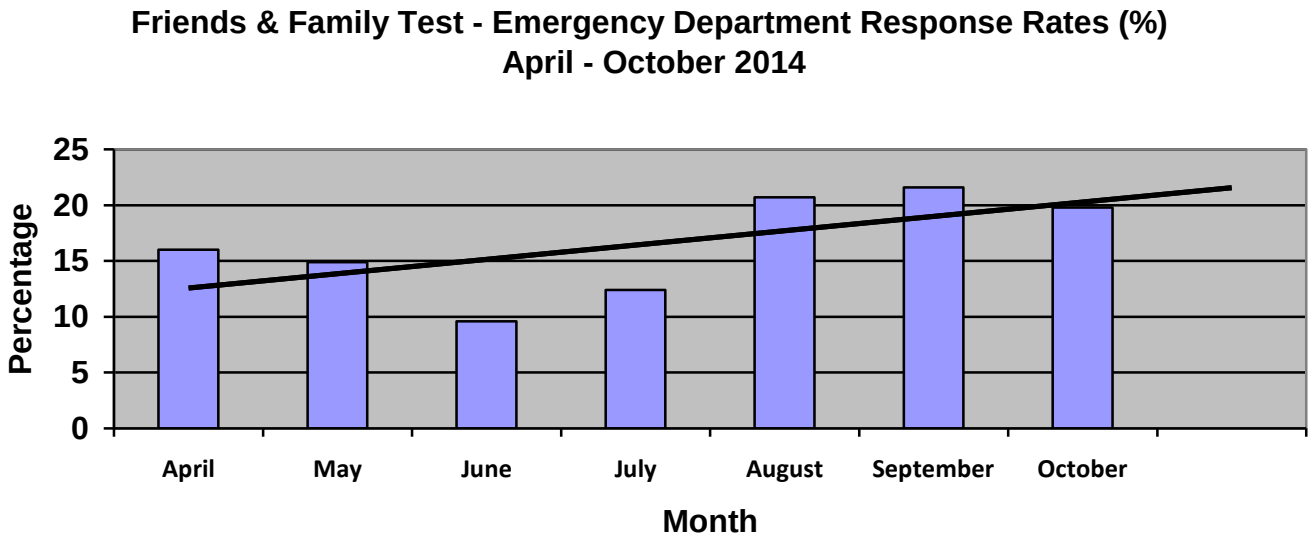
4.2 Emergency Department Response Rates

We are still aiming to improve the Emergency Department Response Rate through the following actions;

- Introduced business type cards that promote the use of the website. These have been made widely available to staff enabling them to direct patients to the feedback opportunities available.

- Displayed additional posters and visual information in the waiting areas and consulting rooms.
- Expanded the role and numbers of volunteers in ED who promote the F & F test.

Friends & Family Emergency Department Response Rates (%) April – October 2014



Graph 6

Table 2 Friends & Family Response Rate – Emergency Department (%) April – October 2014

April	May	June	July	August	September	October
16	14.9	9.6	12.4	20.7	21.6	19.8

The star rating recorded for the emergency department during October was 4.6

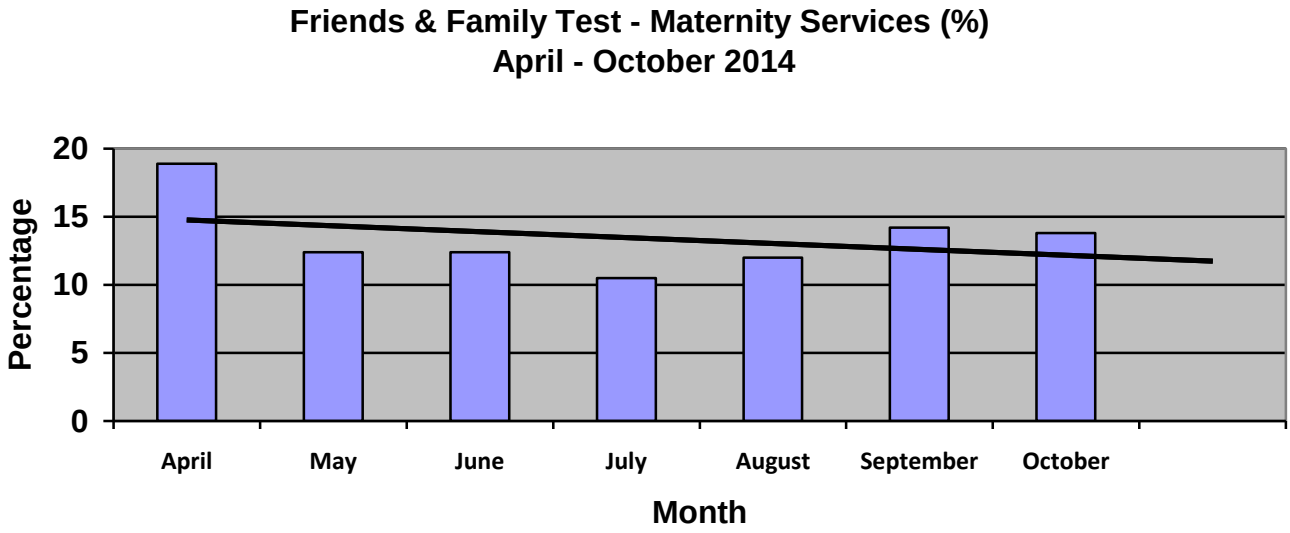
4.3 Maternity Response Rates

We are mandated to report at four separate touch points during the patients antenatal and postnatal pathway. The following table illustrates our performance in month detailing both the star rating and response rate reported. We achieved a score of 4.8 during October but the response rates remains low, most notably during the antenatal, delivery and community postnatal phases of care

Friends & Family Maternity Services Combined Response Rates (%) October 2014

	Antenatal Care at 36 weeks	Sherwood Birthing Unit	Ward Postnatal Care	Community Postnatal Care	Average point Score
Star rating score (max. 5 stars)	4.6	5	4.7	4.8	4.8
Response rate (%)	4.8	10.3	34.1	6	13.8

The following graph shows our maternity services combined monthly response rates from April – October. Our overall response rates for maternity care are of concern, we have therefore taken this to the regional maternity network forum for further advice and support.



Graph 7

During October we extended the friends and family test across our day case and out patient departments whereby we received 452 responses. Further work is currently ongoing to calculate our response rates by speciality.

The Patient Experience Team are currently in the process of developing a promotional re launch of the friends and family test throughout Kings Mill, Newark and Mansfield Community Hospital in order to:

1. Raise overall awareness and understanding
2. Increase our response rates

3. Improve organisational learning

5.0 Emergency Department Survey

We are are mandated as an organisation to undertake a patient satisfaction survey within our Emergency Department on an annual basis. In 2014 this was undertaken during quarter 2 and the following section provides a high level summary of the key headlines reported.

Areas of good practice:

89% of patients felt that they had been afforded enough privacy when discussing their condition with the receptionist

98% of patients were given enough privacy when being examined or treated

91% of patients felt involved in a decision regarding their care

97% of patients felt that the staff explained the test results in a way they could understand

94% felt the environment was clean

98% patients felt that staff explained the purpose of medications prescribed

82% of patients felt that they were treated with respect and dignity

83% of patients rated their experience as 7/10

Areas requiring further improvement

37% of patients were admitted to hospital in 2014, compared to 34% in 2012 and 35% across total number of ED within the survey

51% of staff explained the side effects of medications prescribed

59% of patients were advised when they could resume their normal activities.

45% of patients felt that ED took their home circumstances into account

78% of patients were given analgesia within 30 minutes of requesting it

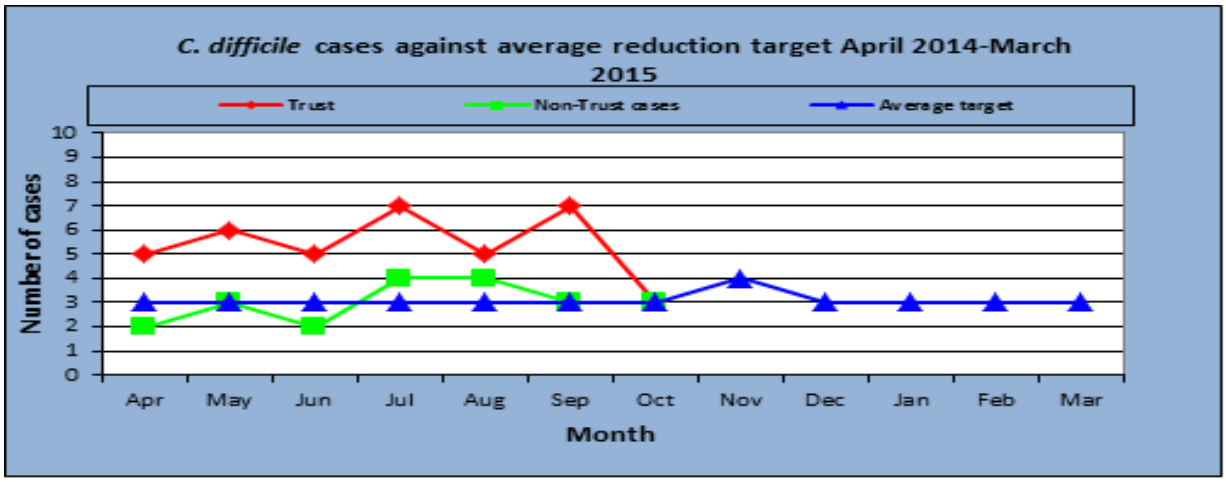
This report provides the organisation with a balanced summary of findings, clearly detailing areas of good practice and those that require further impovement / action. This report has been shared and

discussed with the Emergency Care & Medicine Division whereby an action and mitigation plan will be developed and implemented to address the concerns raised.

6.0 Infection Control Update

6.1 Clostridium Difficile Infections

The Trust reported three post-48 hours *Clostridium difficile* infection during October 2014. This was in line with the monthly trajectory, however it has resulted in a breach against the annual target of 37 cases, bringing the trust up to 38 cases at month end. There were no C diff related deaths.



Graph 8

The RCA's of all three cases have been completed. All three had underlying infections reported and treated in accordance with the trust anti-microbial policy. One individual was on the 'fast-track discharge package' in preparation for end of life care, but passed away prior to CDT infection being identified. There was some evidence of poor management of samples, poor labeling and timeliness of them and this has been addressed within the ward areas.

Trust wide cleaning using chlorclean is demonstrated in all clinical areas. Trials into alternative disinfectants are underway. The rolling program for partial 'deep cleaning' wards has continued. An upgraded machine for sterilising rooms is expected for December which will enhance this programme. This will complete the actions recommended in the external review.

The IPCN for EAU has commenced attending their monthly clinical governance meeting; providing full breakdown of patients identified with infections during their admission to the department and increasing awareness of potential issues and the importance of prompt isolation, effective precautions and communication pathways.

The Infection Prevention and Control have continued with their regular program of audit which during October includes monitoring of Hand Hygiene, Personal Protective Equipment and catheter management.

A Rapid Action Audit Tool (RAAT) has been developed for use following a CDT HCAI on the wards. The intention is for this to be used as a process for identifying any immediate issues that require rectifying and will support the RCA.

More than 80% of our senior medical staff have now completed infection control mandatory training compared to less than 30% last year.

Benchmarking data for the East Midlands is currently not available from PHE but our new Infection Control nurse consultant, Rosie Dixon, is investigating a suitable peer group.

7.0 Incident & Serious Incident Update

7.1 Datix upgrade

Datix web is being updated to Version 12.3; this will enable automatic feedback to reporters. Feedback will include lessons learnt from the incident. A new server has been installed by NHIS and the appropriate files for the new install of Datix (guides and installation files) have been obtained.

7.2 Uploading to the National Reporting Learning System (NRLS)

The Trust is required to upload Patient Safety Incidents to the NRLS at least monthly and in the case of Serious Incidents within 48hours. The reconfiguration of Datix has been achieved with the support from the NRLS and they were notified at the start of the Quarter 2 2014/15 that our reporting would be delayed. This is due to the work that was required to manage the changes to the new version of Datix web and deal with the legacy incidents. The aim of the Governance Support Unit is to upload all Patient Safety Incidents for reporting cycle (April –September 2014) by the 28th November 2014.

7.3 Top ten incidents reported

Falls, Pressure Ulcers and Medication related incidents continue to be the highest number of incidents reported.

October 2014 - Top 10 Incidents

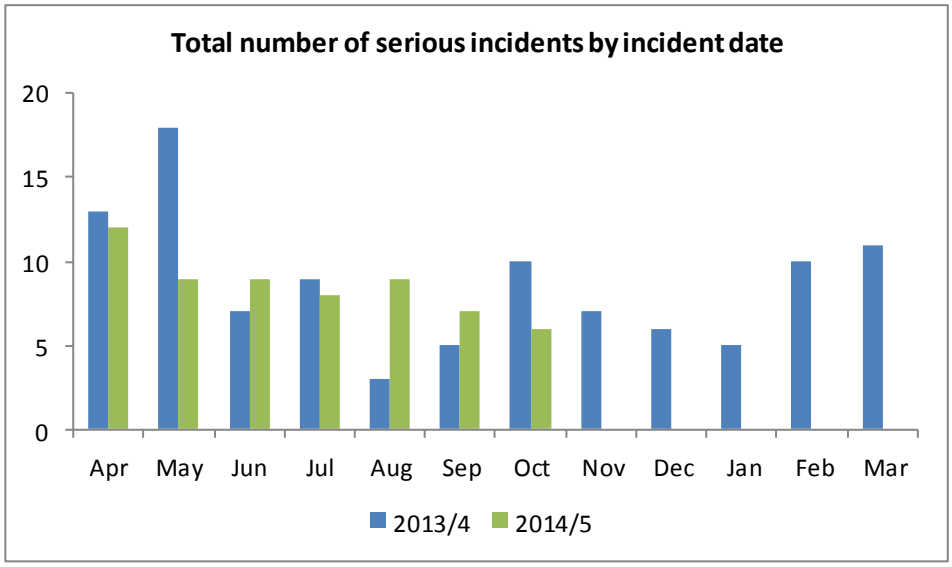
Category	Total
Falls	185
Pressure Ulcers	170
Medication	106
Delays in Care	76
Treatment	46
Pathology / Specimen related	39
Health and Safety	37
Security or unacceptable behaviour	31
Staff injuries / illness at work	26
Appointments and clinics	24

A review of the harms rates is planned for incidents raised between 1st August – 31st October 2014. Severity coding the incident is now undertaken by the Handler and the incidents will have to be sent through to Awaiting Final Approval before October incidents can be included within the review. The aim of the review is to assess the quality of the severity coding and ensure this is in line with the NRLS requirements. A report will be submitted to the December Clinical Quality and Governance Committee.

Since the introduction of the new DatixWeb, medication incidents have been flagged as an area of concern with variability in reporting rates and quality of severity coding; a review is planned with Pharmacy and the Clinical Governance lead to explore the reason/s for this.

7.4 Serious Incidents

Graph 9 below illustrates the number of incidents reported by incident date in the month compared to the previous year. There were 6 incidents that occurred during October.



Graph 9

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2013/14	13	18	7	9	3	5	10	7	6	5	10	11	104
2014/15	12	9	9	8	9	7	6						60

Breakdown of incidents by incident date for October by Hospital and Division is shown below;

Hospital	Emergency Care and Medicine	Planned Care and Surgery	Diagnostics & Rehab	Newark Hospital	Total
King's Mill Main Hospital	**3**	**3**	**0**	**0**	**6**
Mansfield Community Hospital	**0**	**0**	**0**	**0**	**0**
Newark Hospital	**0**	**0**	**0**	**0**	**0**
Totals:	**3**	**3**	**0**	**0**	**6**

This report looks specifically at STEIS reportable incidents for October 2014

The table below describes the 8 serious incidents as reported during October by Category and Sub Category as recorded in Datix (2 occurred in September but were reported in October).

Category	**Sub category**	**Oct-14**
Pressure Ulcer	PU Grade 3- Acquired during admission (2 of the 3 have been confirmed as unavoidable to date)	3
Falls	Fall not witnessed-whilst walking/standing	1
Treatment	Treatment-known side effect/risk of treatment	1
Antenatal	IUFD>37 weeks	1
Treatment	General- Incorrect diagnosis	1
Health & Safety	Another kind of accident	1
Grand Total	**8**	

7.5 Shared learning

It is evident from the findings outlined in the CQC report that our goal of improving as a learning organisation must be prioritised and we must evidence that we deliver on the actions in the improvement plan associated with learning. To this end it was agreed that an organisational learning strategy (and the various elements of underpinning work that will ensure we are a learning organisation) is an absolute priority for the next three months. This goes beyond the learning board which has been widely discussed although obviously this is a very important element of it. Use of IT and flash screens like we see for the flu jab but used for patient safety message of the week are important elements and consideration how we can really evidence learning at a local and organisational level need to be considered and implemented. The Patient Safety Lead within the Governance Support Unit is taking a lead on this project and this will include networking and learning from other organisations.

The organisation is making improvements following investigations of claims, complaints and incidents;

- From a falls perspective all Datix reports submitted are reviewed daily, with the emphasis on increased risk. During out of hours and the weekend period, the Hospital at Night Team are supporting this by ensuring timely reviews of patients who fall and providing a brief update for the Lead Nurse for Falls Prevention. The Executive Director Nursing and Quality is now the chair of the Falls and Safety Group to further support the importance of the Falls Agenda across the organisation.
- Whilst it is acknowledged we are above the trust trajectory for Grade 2 Hospital Acquired Pressure Ulcers, there has been a sustained reduction in avoidable pressure ulcers across the Trust over the last 6 months. Collaborative working with the Practice Development Matrons is on-going to ensure consistency within tissue viability care and ward assurance assessments across the Trust.
- The recent annual SHOT report has been widely shared across the organisation and at divisional and specialty governance meetings and the medical managers' meetings to raise awareness of the implications of wrong blood in tube incidents. A task and finish group has been convened which is actively looking at positive patient identification and various initiatives are being considered and implemented. The outputs of the group will include organisational and local actions and will be shared in a future report. A communication campaign will be launched raising awareness of the importance of positive patient identification to ensure "right patient, right treatment". An example being considered is #hello my name is....what is yours?
- Identification and discussion of opportunities for shared learning will now be a standing agenda item for SI sign off group commencing 11th November 2014.
- Two day Root Cause Analysis training will commence in 2015 and will run eight times over the year.
- Once the completed RCA investigation reports have been submitted to the CCG following Serious Incidents Requiring Investigation, the Clinical Governance coordinators are ensuring that

the recommendations and actions are presented at Speciality and Divisional Governance meetings to help close the loop for shared learning across the division.

- Improving organisational learning and engagement task group held its first meeting on the 3rd November, the main aim of the group is to develop a consistent approach to shared learning across the Trust.

Susan Bowler	Dr. Andrew Haynes
Executive Director of Nursing	**Executive Medical Director**