Sherwood Forest Hospitals NHS
NHS Foundation Trust

Appendix 1

Our improvements since April 2014

Introduction

Since the visit of the Care Quality Commission (CQC), the feedback at the July Quality Summit and the arrival of the Improvement Director, Gill Hooper the Trust has undertaken a significant amount of improvement activity in supporting the delivery of continuous quality improvements and sustainable change. Please find below the detail of our improvement activity. There are a number of significant achievements which I would like to draw your attention to, of which more detail is enclosed within the body of the report:

- The work undertaken to improve Medicine Engagement and the work undertaken to develop and implement a medical engagement strategy (section 4.1).
- The demonstrable improvement in haemodynamic observation recording through the support of VitalPAC (Section 4.2.1)
- The appointment of a Head of Practice Development and eight Practice Development Matrons in driving the delivery of the Quality Improvement Plan (Section 4.3)
- Our progress with governance and in particular risk management through the appointment of a Risk Manager (Section 5.9)
- The evidence of us wishing to learn about ourselves through our Quality Summit, 'Mock CQC Visit and 'Out of Hours Assurance' (Section 6.0)
- The activity undertaken in relation to safer medicine management (Section 8.0)
- The developments to improve end of life care at our Trust.(Section 14.0)

Well Led

1.0 Improvements in Corporate Governance:

1.1 Reporting and Committee Structures

A comprehensive review of corporate governance structures was undertaken and the required actions approved by the Board. Many of those actions have been implemented since April 2014 within a framework which supported:

- Amending governing frameworks defining decision rights and escalation paths
- Detailed design of the corporate governance operating model and its components
- Developing a matrix defining Trust accountabilities across the executives
- Mapped governance requirements to organisational functions and business requirements

The above has culminated in the introduction of new Board Committees and a Trust Management Board and associated committee structure. The design of the structure has helped ensure non-executives are well placed to bring the objectivity that their relative distance from day-to-day matters requires, along with their experience and knowledge acquired elsewhere. The membership of Board committees is such that NEDs draw upon their objectivity and experience as the basis for questioning and challenging the executive.

1.2 Board Development

Whilst board structure, composition and independence condition board effectiveness, we have also began our Board Development Programme recognising that the conduct of the non-executive vis-à-vis the executive is what ultimately determines board effectiveness. Non-executives joined the Trust in 2013 (as did many of the executives) and as their knowledge of the Trust and the NHS has grown, they are now positioned to both support the executives in their leadership of the business and monitor and control executive performance. The key to growing board effectiveness has been the degree to which non-executives acting individually and collectively have been able to create accountability within the board in relation to both strategy and performance.

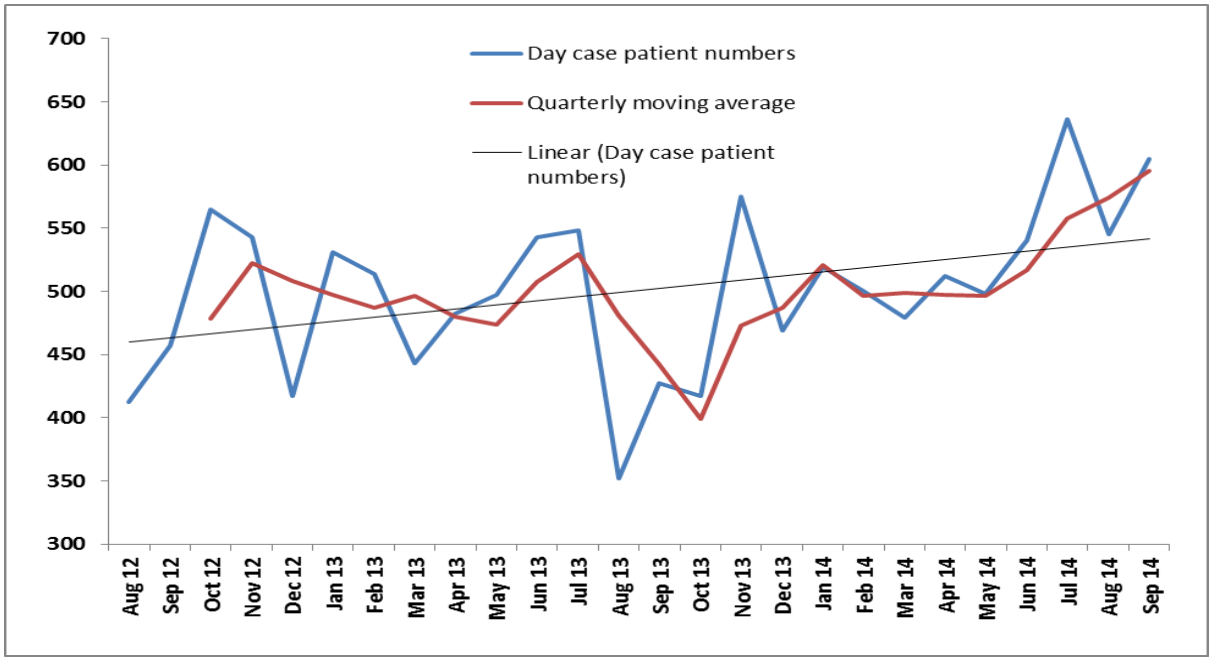
Such accountability has in practice started to be achieved through a wide variety of behaviours – challenging, questioning, probing, discussing, testing, informing, debating, exploring, encouraging – and these are at the very heart of how the non-executives are seeking to be effective. Our corporate governance structure and the behaviours encouraged are to ensure a framework of accountability in terms of three linked sets of behaviours such that non-executives can be 'engaged but non-executive', 'challenging but supportive' and 'independent but involved'. Through such conduct, non-executives are constantly seeking to establish and maintain their own confidence in the conduct of the Trust through the performance and behaviour of the executives; the development of strategy; and the adequacy of financial reporting and risk assessment.

Whilst board structure and composition are visible structures they will only ever serve to condition, rather than determine, effectiveness. Actual board effectiveness which depends upon the behavioural dynamics of the board, and how the web of interpersonal and group relationships between executive and non-executives is developed in our particular context have received and will continue to receive much focus. This has included Board members leading the development and roll out of Quality for All, participation in Board and Governor Development programmes, an Executive and Team coaching programme which commenced in October, and site and service visits throughout the year which have all served to ensure strong Board engagement in the Trust to build the new Board's credibility and members' knowledge of the Trust and the Board's role in a review of the Trust's governing documents including a Code of Conduct and an Engagement policy designed with the full support and ownership of the Council of Governors.

2.0 Newark Strategy

The Trust has undertaken significant work in relation to Newark Hospital. At the Keogh revisit in December, the Newark actions were fully assured on the basis that the surgical changes were fully implemented. These changes resulted in elective inpatient surgery ceasing in May 2014 and a full daycase facility coming into place from June 2014. Staff

were fully consulted in relation to these changes and whilst not everyone could participate in the working group to implement the changes, there is evidence of good staff involvement in the Newark changes. The Trust further invested in additional project support from June to increase the pace of changes at Newark and the activity through the daycase facility has increased by over 100 procedures per month since it was established.



Other significant issues at Newark have been concerns related to patients not being offered the Hospital as a choice and therefore the Trust has been working with the gateway operated by commissioners to ensure this is resolved. The Trust now has a theatre schedule for Newark which fully utilises all the available theatre sessions with full clinical engagement which will be fully implemented by the end of the calendar year.

Jacqueline Totterdell has joined the Trust as an interim Director of Newark Hospital for a period of three to six months with effect from27th October 2014.

Almost 40 colleagues from across Newark Hospital attended a listening event on 5 November, hosted by Jacqueline Totterdell, Director for Newark and facilitated by Claire Ward, Non Executive Director. Participants spent time discussing which services worked well at Newark and why. They then looked at ideas for new or expanded services which could be provided at the hospital to further improve patient services and experience at the hospital. Included in the many ideas to be explored further were an increase in endoscopy services; children's radiology; nurse led chemotherapy service and a new service to transport patients, pathology samples and case notes between hospitals. Participants were also keen that all services at Newark Hospital were promoted widely so that healthcare professionals, patients and relatives were aware of the services the hospital provides.

3.0 Quality for All

In Autumn 2013, we launched our Quality for All programme. Our values were developed in genuine partnership with our staff, patients and carers in our Quality for All listening events, feedback events and priority setting events. Throughout these events, patients and carers told us that they want to be treated with care and respect, to be involved in their care and to have confidence that we are being safe and efficient.

Bringing all this together, we have developed four Trust values that will shape our culture and underpin everything we do moving forward. Our Quality for All values are:

- Communicating and working together.
- Aspiring and improving.
- Respectful and caring.
- Efficient and safe.

We have completed significant activities to support our ambition that our culture is focused on delivering 'Quality for All' to everyone we serve. Our Board and Executive development programmes will help us to role-model the behaviours that best demonstrate our Quality for All values.

Work on embedding our values into many of our activities are progressing at pace. Many managers have undertaken 'Team Conversations' to better understand what is important to them as a team and how they enhance patient and staff experience. Teams across the Trust have signed up to actions with identified outcomes to truly live our Quality for All values.

We have commenced work on embedding our values into our recruitment, selection, appraisal and recognition processes and are updating our HR policies on a prioritised basis to align with our Quality for All values.

4.0 Leadership

We know that to achieve our ambitions we will need inspirational leaders to engage, encourage and enable people and teams to do their best and continue to improve.

We also recognize that our staff have experienced variable leadership, and several changes of leadership approach, in recent history. We have now have a stable Board of Directors who recognize the importance of values-led leadership as we move forward and what this means to our staff. We have refreshed our leadership development offering to ensure leaders have the competencies necessary to deliver our strategic priorities and do so in a way that supports our Quality for All values.

4.1 Medical Engagement

The Medical Engagement Scale was run in July with the help of Peter Spurgeon and demonstrated that with a return of over 50% our level of engagement was average in all but two domains; slightly above average in participation in decision making and change whilst

slightly below average in appraisal and reward alignment. Two “In Your Shoes” events were held with consultants in July and open events with senior and junior doctors. One to one interviews with heads of service throughout July and August. This has been used to develop a medical engagement strategy.

The current appraisal rate is 97% and the process has been greatly strengthened with a vibrant and well attended quarterly Appraisers Forum.

An externally supported Radiology transformation has completed a diagnostic phase with excellent attendance from consultant staff at Leadership meetings and discussions with service users. This work is moving into phase two which will develop service improvement projects. Workstream Clinical Leads for the Transformation Programme have been appointed and consultants involved in projects. A new Cancer Lead has been appointed and developed a Cancer Strategy.

As part of the communication about our increased C diff infection rate, the completion rate for mandatory training rate was highlighted to be low in the Medical Matters Bulletin. Access to additional training was highlighted in the bulletin and this has seen the in date rate increase from 43 to 77%.

A programme of Medical Director attendance at Service Team meetings has been initiated and drop in sessions at every trust site. A series of informal suppers for consultants with CEO and Medical Director have been scheduled. All newly appointed consultants meet the Medical Director 8 weeks after starting.

4.2 Record Keeping.

External inspections and our serious incident investigations have demonstrated the trust standards of record keeping are poor, a risk to our patients and is unacceptable practice from our professionals. A record keeping audit between October 2013 and March 2014, demonstrated there has been a marked improvement in 10 of the 15 indicators that were measured within nursing documentation but improvement are still required.

To improve record keeping:

- The policy ‘Standards for Record Keeping’ has been reviewed, setting out the expectations of the Trust to ensure our patients are safe.
- A ‘How to Guide’ for record keeping has been developed and launched. Workshops and road shows to educate nurses and midwives about the revised policy have been facilitated.
- A Trust Wide nursing audit has been undertaken– due for completion 14th November 2014. This tool will be used to undertake ‘self audits’ as part of the nursing appraisal process from January 2015.
- A standardised approach to the storage of nursing documentation has been developed, for implementation across all wards by 30th November 2014.
- Accountability handover has been implemented across the trust. This will improve record keeping through the bedside checking of nursing documentation between shifts, whilst also enabling the patients (and their carers) to be part of their handover.

4.2.1 Accurate record keeping with regard to patients observations 'Vital Pac'

The Trust had poor record keeping with regards to patient's observations. This means the Trust did not have an effective system to assess and monitor the hemodynamic status of its patients, which could result in patients becoming acutely unwell. The Trust Board had previously agreed to invest in an electronic tool which would support safer monitoring of our patients. We are the first Trust in the East Midlands to introduce VitalPAC –an innovative software system which enables clinical teams to:

- Capture clinical data on handheld smart devices in real-time at the point of care.
- Analyse and chart the data which can be accessed via the hospital intranet (on PCs) and via hospital Wi-Fi on iPods and iPads.
- Provide real-time analysis, reporting and diagnosis to monitor ward working practices.

- The Trust has rolled out VitalPAC across all of its 23 inpatient wards at Kings Mill site replacing the traditional paper observation chart. Readings are analysed and an Early Warning Score is automatically calculated ensuring accuracy and alerting staff of any patients who may be deteriorating.

- The VitalPAC system supports staff to tailor the patient's monitoring plan in line with the Trust's Observation and Escalation Policy, ensuring that observations are carried out more frequently for those requiring closer monitoring and less often when not required.

- The bedside devices also use smart technology to 'talk to' the other parts of the hospital's network that deal with the individual's diagnostic test results, including pathology, microbiology and radiology, giving a clear and complete picture of the patient's current condition.

- Thanks to the user-friendly design of the device, staff can easily see the prompts when observations are due, helping them ensure they are completed at the right time. The Early Warning Scores are colour coded for easy recognition. Authorised clinical staff can view the observation charts and clinical data for all their patients from any device or PC with access to the hospital network. The Trust now has visibility of activity within hospital related to the deteriorating patient and other assessments.

- The Trust is using this data for assurance and to drive healthcare improvement.

- The Trust has developed a good working relationship with the supplier who have reported that we are doing well in comparison to some other VitalPAC sites.

- To date 1409 staff have been trained in the use of the system and additional training has been delivered to an established network of Ward Superusers.

Results to date have indicated:

- 98% compliance of observations and NEWs completed
- 93% of observations are completed on time
- 22% of observations are recorded during the night (aim 25%)
- Visibility of deteriorating patients across the Trust

4.3 Practice Development Matrons

Since 1St April 2014, the Trust has successfully recruited a new Head of Practice Development and eight Practice Development Matrons. The Practice Development Team work in partnership to encourage and assist the organisation with its continued drive to improve quality of care, enhance patient safety and patient experience. They do this by supporting practice working, alongside Sisters and Matrons to ensure key organisational priorities are implemented and embedded consistently across the organisation, providing resources, education and training;. The following list are the key priorities which the Practice Development Matrons are driving, to support the delivery of the Quality Improvement Plan

- Care & Comfort
- Accountability Handover
- Medicine Management
- Record Keeping
- Documentation review
- Supporting the International workforce support
- Workforce Right skills right place right time
- Education & training

5.0 Clinical Governance

5.1 DATIX

Our incident reporting system was very archaic and did not support intelligent reporting, monitoring or feedback. In January 2014 a project plan was initiated to review the reporting/handling process and reconfigure Datix with the aim to increase reporting and reduce the risks to our patients. The new Datix was launched on the 1st August 2014 and feedback from reporters has been very positive.

- Incidents are now categorised by the reporter. Prior to this the adverse event was determined during a manual coding process; there were no categories or sub-categories. The reconfiguration of Datix has been completed in partnership with the NRLS and all coding is now aligned to the category and signed off by the NRLS.
- Feedback (to incorporate any lessons learned) to the reporter by the handler is now compulsory.
- Automatic feedback will be in place from Monday 17th November 2014.

- Datix handler training was delivered prior to the change and individual training is supported by the Governance Support Unit on an on-going basis.

- Incident data can now be captured intelligently, broken-down and trend analysis can be conducted in a robust and pro-active manner to protect our patients and staff. More intelligent reports are being provided through the governance structures and forums

5.2 Serious Incident (SI) Process

A more robust process for serious incident management is now in place. A Serious Incident Review and Sign-off group has been established, to provide a forum to oversee and monitor the reporting and review of serious incidents, ensuring that recommendations are implemented and organisational learning has taken place.

- This process has resulted in far greater scrutiny of Serious Incident reports, ensuring there is a consistent approach to the management and that staff at all levels are aware of their roles and responsibilities in the reporting and management of such events.
- When an incident occurs, an initial investigation scoping meeting within 72 hours takes place. This process has ensured that all serious incidents are disclosed to those affected in a timely manner (our patients, their carers and staff), appropriately reported and investigated; findings are shared with families in accordance with the Being Open guidance and the statutory duty of candour requirements.
- A specific focus is to ensure that the final root cause analysis report is comprehensive with action points to address each root cause recommendation(s) and with a named lead and timescale for implementation.

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5.3 Root Cause Analysis (RCA) Training and Methodology

To encourage learning we have increased the categories of investigations that require a RCA investigation. Some staff require training in our new methodology to ensure they feel supported and can achieve the best outcome from the investigation.

- 15 staff have received new training in RCA investigation methodology, tools and techniques.

- In 2015 Root Cause Analysis Investigation Training is planned for the whole year with > 100 staff expected to have attended. The course provides an in depth look at key RCA tools, techniques and methodologies. The course will include Being Open – the statutory duty of candour with patients and families, Incident Decision Tree tools and report writing.

5.4 Clinical Audit

Since 1st April 2014 a new Clinical Audit & Effectiveness Committee (CA&EC) has been established, with new terms of reference, membership and a work plan agreed. This followed a period of approximately one year when the Trust did not have a committee

leading the clinical audit work stream. The new CA&EC is now fully integrated within the Trust's governance structures and has a clear reporting / escalation route to the Clinical Quality & Governance Committee;

- A Clinical Audit forward plan has been developed and is clearly aligned to Trust and National objectives. It has been approved by the Clinical Quality & Governance Committee and the Quality Committee.
- By September 2014, 60% of the planned audits had been commenced with a further 20% due to start in Q3. 20% of the audits will either start in Q4 or will be reported to the CA&EC and a reason established for non-commencement. This demonstrates that the Clinical Audit forward plan is functioning well and is being monitored closely by the CA&EC.
- A new monthly divisional and specialities reporting template has implemented. Early feedback from the divisions has been very positive and although not quantifiable yet there has been a noticeable increase in the number of reported actions / audits back to the Governance Support Unit.

With the above progress the Trust Board and Executive Team can now have assurance that systems and process for clinical audit are now meeting the "Good Governance Institute" and the "Healthcare Quality Improvement Partnership (HQIP)" standards for "best practice in clinical audit. Staff have clear, expert guidance as to what and how to undertake robust and useful clinical audit that will result in positive improvements for patient care.

5.5 Governance Process for the management of in-hospital cardiac arrest and sudden death introduced and approved

In October 2014, the Clinical Quality and Governance Committee approved agreement of the governance process for the management of in-hospital cardiac arrest and sudden death. The purpose is to reduce the number of avoidable cardiac arrest and sudden deaths;

- Each cardiac arrest, with the exception of pre-hospital arrests will be entered onto the Datix system by the ward/department staff.
- All events will be followed up by the Resuscitation Department within 96 hours of its occurrence.
- A case review will be conducted, data elements for the National Cardiac Arrest Audit (NCAA) will be collected and the defibrillator download obtained. Should an event worthy of further serious investigation be revealed by the resuscitation officer's preliminary investigation, a Serious Incident Scoping meeting will be convened to determine if the event meets the criteria of a STEIS reportable event or an internal investigation.

5.6 Early Warning Scoring (EWS) Dashboard Re-design

The early warning scorecard was implemented in April 2013. It was implemented to assess the impact of the Cost Improvement Programme on patient safety indicators. Given the passage of time it was deemed prudent to review the current indicators to establish if they

are still appropriate items to report on and whether there are any gaps in reporting, given the change in Trust priorities. In September 2014, changes were made with the addition of some new indicators;

- Inpatient Falls – Fall rate
- Inpatient Falls resulting in a Fracture
- Dementia screening assessment
- C-Diff performance
- Medical outliers

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5.7 Process for NICE guidance and Baseline Assessment Tools

The trust's processes to support the assessment and monitoring of NICE Guidance has been reviewed and a decision was made to develop a 'new' governance policy to describe the new processes which will supersede the information in the 'Best Practice Policy'. This policy was extensively consulted on and was approved at the Clinical Quality and Governance Committee in September 2014. The new 'NICE Guidance Policy' describes the revised processes and details the supporting tools which will help to evidence progress and closure against compliance for each guidance;.

- The new allocation proforma supported will now be captured electronically allowing for a more robust system for assurance.
- The new compliance proformas will enable more specific and relevant information to be captured, particularly the compliance measure.
- Use of baseline assessment tools, will also give more robust evidence of reviewing guidance against current practices and auctioning planning to close gaps.
- A 'new' NICE Guidance database is being developed which incorporates improved reporting functionality and will show compliance measures against each guidance – the detail of any recommendations with which we are partially or non-compliant will be recorded in the relevant gap analysis/ baseline assessment tool.
    - It will have improved reporting functionality to enable status reporting by: division; specialty; guidance type
    - It will include information regarding the number of recommendations with which the trust is partially compliant and/or non-compliant
- In addition, the revised policy describes the processes required regarding decisions not to implement NICE Guidance, escalation and using the risk register effectively to evidence non-compliance and actions required to achieve compliance.

Benefit to Organisation:

- This will highlight risks to the organisation enabling relevant decisions and actions to be undertaken.
- Where gaps are identified, action planning to close any gaps can then be addressed and where required escalated appropriately.
- Decisions not to implement NICE Guidance will be recorded.

Benefits to Patients:

- Implementing evidenced based care to our patients is paramount. Through the revised processes, proformas and tools the trust will be able to more closely monitor progression of each guidance to close any gaps in achieving compliance which will in turn ensure promote the delivery of safe, effective care.

5.8 The Being Open – a Duty to be Candid – Communicating care and treatment related harm with patients, their families and carers policy

Since the Francis recommendations, the Trust has embraced the concept 'being open' particularly in relation to reporting incidents and discussing complaints and investigations with our patients. Our staff supported the concept, but were asking a number of questions in relation to the process and the implications. No Trust policy or guidance was available to support them. A new policy was developed and approved by the Clinical Quality and Governance Committee and Trust Management Board in October 2014. It will be approved at the November Trust Board. Communication with staff has commenced through the governance structures, as well as through a poster campaign.

5.9 Risk Management Policy for Consultation

Since the inception of a new Trust Board and stronger governance processes, the Trust Risk Management Policy required a review and update. The Trusts Risk Management Policy has been approved by the Quality Committee (sub board committee chaired by a Non Executive Director) and will be presented at the November Trust Board. The Trust has successfully recruited a substantive Risk Manager who commenced post - 3rd November 2014. Prior to starting formally, the Risk Manager has been supporting the Trust with reviewing both its local, divisional and corporate risk registers.

5.9.1 Risk Management Process Improvements already in place

PLAN	**Policy**
	A revised policy is in the final ratification stage and takes account of strengthened governance processes; locally & Trust-wide.
	Roles and responsibilities have been clarified and clearly defined.
	Escalation of risks & monitoring is improved.
	Risk Treatment and risk levels are described.
	Planning
	A Gap Analysis has been undertaken and an action plan to embed risk management put in place to take RM forward.
	A Risk User Guide has been drafted to assist staff with the identification, analysis and management of risk

	A generic risk assessment form (to take account of non-clinical & clinical risks) has been introduced to replace the various forms in place.
	Risk Profile
	Risks (scoring 15 and above; consequence of 5) have been through a "confirm & challenge" process to agree they are still current, scored appropriately and have action plans in place.
	The significant risk register (scoring 15 and above; consequence of 5) is tabled monthly at Trust Management Board.
	Local Governance Forums are supplied with a monthly Risk Report from the GSU
DO	**Organising**
	Meetings held with key stakeholders to explain the RM process; many more meetings planned
	The past 12 months training has been undertaken:- • Intro to RM = 325 staff • Advanced RM = 168 staff • RM for Doctors = 33 staff A 30 minute Risk Management presentation is delivered to new starters on their Orientation Day
	Communication of the new risk management policy and approach is wide reaching and is underway
	Relevant committees & forums include risk as a standard agenda item
CHECK	**Measuring Performance**
	In addition to checking the quality of risks as more awareness training is delivered along with the at-a-glance Risk User Guide a review of the number of risks is programmed (Currently 7 risks per calendar month are added)
ACT	**Reviewing Performance**
	Review of risks on the risk register including quality of action plans & monitoring of action plans

6.0 Learning

6.1 Divisional Clinical Governance (DCG) Data packs

Final versions of the Divisional Clinical Governance Meetings new documentation has been agreed and disseminated on 6 November 2014. This includes the following templates and papers:

- DCG Agenda
- DCG Minutes of Meeting and Action Log template
- DCG Monthly Report template
- DCG Programme of Work
- DCG Core Terms of Reference

Divisional Governance paperwork will be used as a basis for the Specialty Governance paperwork and the Governance Co-ordinators will support sharing and learning

Consequently the following core documents will be used:

- SCG Agenda
- SCG Minutes of Meeting and Action Log Agenda
- SCG Monthly Report Template (as an option for them to use as prep for their meetings)
- SCG Core Terms of Reference

6.2 Quality Summit and 'Mock CQC' Exercise

During September and October we facilitated sharing and learning events for our staff:

6.2.1 Quality Summit

In September, 50 staff (mainly clinicians) shared with each other the positive outcomes and learning from the April CQC inspection with the aim of promoting cross boundary learning and sharing of good practice. Main points from this event are:

- Areas of excellence (Critical Care, Children's Services and Maternity), shared their approaches and learning with other colleagues.
- The event enabled openness, honest discussion, debate and challenge whilst facilitating elucidation throughout the day.
- Cross profession and divisional sharing and learning was highlighted in feedback as being a strong benefit of the day.
- The day produced practical solutions to address issues raised around how do we own and share learning at a Trust and local level.
- A learning strategy for disseminating information is being developed as a consequence of the summit.

6.2.2 Mock CQC Event

In October we staged a mock inspection day. This was designed to develop staff skills and knowledge in the inspection process by mirroring the new CQC model of inspection (how does it feel/what does it mean to me).

- 65 ‘inspectors’ made up of staff from a cross section of departments, professions and roles spent a day inspecting all areas of the Trust using an appreciative, key line of enquiry approach.
- Attendees on the day included clinical staff of all grades, Non-Executive Directors, Directors, Commissioners, Health Watch, Governors, CCG colleagues and patients acting as ‘experts by experience’.
- Clinical leads were asked to observe their own areas with the rest of their teams supporting and providing scrutiny. The day was intended to be a learning experience for those involved as much as an indicative ‘snapshot’ of ‘where we are’
- Prior to the day attendees were given a ‘Key Lines of Enquiry’ information pack and a locally produced performance ‘Data Pack’.
- Concurrent staff ‘listening events’ with professional groups were facilitated throughout the day.
- Sharing, celebrating and action planning was facilitated throughout the afternoon with teams encouraged to develop suggested actions for any concerns they may have raised.
- A summary report has been produced which has been shared across the Trust and is being discussed through our service line Governance Structures to promote local learning and ownership of findings and suggested actions.
- Main learning points and future actions from this day are:
    - To repeat the process; giving assurance, further insight and reaffirm key priorities for all staff
    - Continue to actively listen to staff, share their comments and act on concerns
    - Share findings throughout the Trust to promote awareness, local ownership and action to tackle any issues raised

6.2.3 Out of Hours Assurance Visit

In September a group of 8 senior nurses undertook an unannounced ‘out of hours’ visit (3am onwards) to assess standards and practices during the night. Appreciative enquiry tools were used with over 80 staff being informally interviewed.

- Feedback from night staff was excellent in terms of the interest and support offered to them out of hours.
- Overall, many examples of positive reassurance were observed including; closure of cubicle doors, professionalism of staff, recording of vital signs, record keeping practices and environments that were clean, tidy and conducive to rest and dignity.
- The results from this observation have been shared with Sisters/Charge Nurses
- The main learning taken from this:

- Staff working out of hours felt encouraged by the process and patients were well cared for.
- The huge value of *visible* senior leadership during 'out of hours' periods
- We need to repeat the process to provide further ongoing assurance of improvements being embedded
- Professionalism and high standards continue to be maintained outside of daylight hours and the issues that arise in the day are evident at night e.g. completion of fluid balance charts.
- Staff felt very pressurised in relation to bed management and patient flows until the early hours of the morning

Safe

7.0 Medical Equipment

The management of medical equipment was identified as an area of concern following the Care Quality Commission Visit in April 2014. Key findings identified that the equipment maintenance programme and processes in our Emergency Department (ED) were inadequate.

The Medical Equipment Management Department, (MEMD), have been leading on a series of actions associated with improving the management of medical devices across the Trust, not just ED. These actions are wide ranging, involving proposals for strategic change, policy optimisation and operational practice improvement.

7.1 Strategic

- In addition to the on-going Quality Management System certification to ISO 9001:2008, the department has investigated the use of newly available standards including the asset management standard ISO 55001 and the new publically available specification on supply chain management, PAS 7000, issued on 4th November by the British Standards Institution. The significance of these latter two standards is they potentially broaden the certification to be organisational wide. A scoping paper being drafted for wider organisational discussion
- MEMD are also contributing to the design of the new national service accreditation standard "ICEPSS" – Improving Clinical Engineering and Physical Science Services. This is being developed as part of an NHS England requirement for the accreditation of Healthcare Science services. It is envisaged that the Department will offer to pilot the standard if the opportunity arises.

7.2 Policy

- The medical device management policy has been re-written to incorporate safety alerts and was approved in August.
- From 3rd December a communications strategy around the new policy covering the key elements of equipment management – "Choose it Right, Use it Right, Keep it

Right" will be initiated. Rather than a single message about the policy there will be a campaign around best practice including key life cycle elements, i.e. acquisition, training, cleaning and maintenance. This has led to the development of the "Policy on a Page" document aimed at bringing the policy to life in clinical areas.

- This approach has been tested with MEMD. Two training sessions have been run for MEMD staff, under the "Quality for All" banner, aimed at ensuring staff themselves understand the policy and are consistent in challenging best practice and educating staff. A further session will be held in December. The outcome is that MEMD staff will publicise the policy and capture poor practice which will enable feedback to user areas and Trust Management.
- Engagement sessions are planned on the policy for Nursing forums and Ward housekeepers, who are already well engaged in supporting equipment management
- The revised Medical Device and Equipment Group is now functioning as a forum that will focus on patient safety and medical device risks as well as equipment prioritisation. It has met 4 times on a monthly basis in its revised form and now has the key stakeholders engaged. It will help to identify, address and escalate medical device related safety and risk issues.
- MEMD want to ensure the Trust develops into a learning organisation and a Medical Device Management dashboard is being developed in conjunction with the Governance Support Unit.
- MEMD are additionally contributing members of the recently launched "Improving Organisational Learning" Task Group

7.3 Operational

- 17th September 2014 saw MEMD implement an upgraded Medical Device Information System, Whilst the system is still being fine tuned it has brought immediate benefits – MEMD have gone paperless and the system incorporates a web-based user helpdesk. The helpdesk will enable of electronic reporting of medical device faults and enable users to track progress.
- 6th November 2014 saw the launch of the helpdesk in two pilot sites – Audiology and Ward 23, (Cardiology) to enable some user feedback before a wider programme roll-out during Quarter 4.
- Work is near completion on re-design of the decontamination certificate after consultation with user about how they label faulty medical devices. A multi-disciplinary perspective has been taken via the Medical Device & Equipment Group to ensure the new certificate meets all requirements around infection control as well as maintenance details.
- There is a final data migration stage to the new system MEMD have so that all legacy data can be viewed. This will enable reports to be generated detailing items missing maintenance which will be escalated through the Nursing Management structure.

8.0 Medicine Management

Medicine Management was identified as an area of concern from the CQC visit in April 2014 and our own internal assurance process. Our patients were not consistently receiving medicines according to their prescriptions and there was not a secure systems for securing medicines in some ward areas. Medicine Management required a higher profile across the

trust to support rapid improvements in medicine storage, medicine omissions and administration of critical medications. Deciding that urgent actions were required a weekly task group, chaired by the Director of Nursing has taken place since July 2014. Good multidisciplinary attendance and engagement has resulted in:

8.1 Missed & Delayed doses

- Campaign posters developed and printed targeted at 1) Nurses administering medicines, 2) Doctors prescribing medicines, 3) Patients (to involve patients in their care, asking questions, challenging)
- Requirement introduced for Datix incidents to be recorded for missed doses of critical medicines
- Critical medicines list re-emphasised to nursing staff, new laminated lists circulated to all ward areas and included within the nursing risk folder
- Empower nurses and other staff to challenge illegible handwriting – it is not acceptable to administer from a prescription if that prescription is not clear. The Trust Medicines Policy standard is that the medicine should be written clearly in BLOCK CAPITALS.
- Wearing of Red tabards for medicines administration rounds now mandatory to help reduce interruptions
- Fortnightly audits of missed doses introduced to measure improvements in reductions in missed doses
- Accountability handover process includes requirement to check for missed doses and take any appropriate action
- Sister/charge nurse leadership rounds to include a check of prescription charts for missed and delayed doses
- Medicines trollies re-introduced to wards to provide clarity to staff, visitors and patients

8.2 Medicines security

- Ad-hoc spot checks of medicines security continue
- Annual medicines security audit to take place w/c 24-11-2014
- Electronic medicines cabinets procured (April 2014) – to be installed in 5 areas of ED and the admissions ward. Improve security and help improve missed doses, reduce wastage & misappropriation, save nursing time, improve stock management, reduce chance of stock-outs and hence missed doses.
- Trial of hotel style, programmable swipe cards for accessing patient lockers on 1 ward.

8.3 Other improvements

- Medicines Optimisation Strategy ratified and issued to organisation.
- Introduced named ‘medicines champions’ on each clinical ward/department area.
- The use of Patient Group Directives (PDG) reviewed in response to NICE guidance (work started pre-visit). New Policy approved – includes case justifying PGD requirement prior to PGD development, robust competency sign-off process for staff, audit requirements.

- Nurse ‘dispensing’ of pre-packs – process reviewed and additional training identified.
- Pharmacist transcription of TTOs planned to be introduced following a pilot of 2 wards in December 2014
- Policy for managing staff involved in medication errors produced (awaiting approval)
- Medicines safety day targeting staff, patients and visitors taking place on 19th November.
- Pilot work started on the use of the Medicines Safety Thermometer that will help measure and drive improvements on the safe use of medicines.

9.0 Radiology

9.1 Skeletal Surveys for Non-Accidental Injury (NAI)

We have reviewed protocols and imaging to improve quality and radiation dose of skeletal surveys. We have reduced the number of radiographers who undertake skeletal surveys for NAI so that there is just a core of senior radiographers to improve the quality of the imaging. This work has been commended by the Paediatric Radiologists at NUH and they have asked for us to share best practice with the Paediatric Radiology Department at NUH.

9.2 Sonography Project

Commissioners are increasingly required to outsource sonography services and many hospital trusts are reliant on agency staff to provide a responsive timely service, leading to potential quality risks in terms of individual sonographer qualification, experience, skills and competence. The Trust has worked with Health Education East Midlands (HEEM) and other local NHS organisations and education providers to develop the Sonography workforce in the East Midlands. A Lead radiographer was seconded to the project to scope the problem which is that there is a shortage of sonographers in the East Midlands which is higher than the national shortage. The Trust has taken on 2 students to train as sonographers that have been funded by HEEM, other Trusts within the East Midlands have done the same. The traditional route for a sonographer is that they qualify as a radiographer and then go on to train as a sonographer, the universities are developing a sonograpy degree which will take students directly onto the course. Whilst this is being developed the concept of the project was to swell the sonographer numbers from this project. The Lead Sonographer is speaking at a national conference for Sonographers in November where she will share this project with others.

9.3 CT Vetting

All radiology requests have to be vetted to ensure that they are appropriate and that they meet radiation guidelines, this has been done traditionally by Radiologists. The radiographers are now vetting CT head scans that conform to NICE head injury guidelines, this has made the process more efficient.

9.4 MRI

Prior to MRI scans being done, there is a safety questionnaire to check if patients have the chance of metal in their bodies/eyes. If a patient says that they may have a metal object in their eye (e.g. following an accident), then imaging by x-rays has to be done to exclude

metal fragments, so that there is no injury caused during the scan due to the MRI's strong magnetic field. Previously radiologists would request the x-ray of the orbits and then report it. Following training, the radiographers in MRI are now performing this process which reduces time delays for our patients.

9.5 Ultrasound Probe disinfection System

Following an MHRA alert concerning decontamination of ultrasound probes used to scan in body cavities. The department worked with a manufacturer who had procured a high level disinfection fully compliant with cross-infection cleaning requirements. This system was originally used in Australia. We were the first ultrasound department in the country to introduce automated, high level disinfection for the probes we use for trans vaginal scans. The Department has shared practice with other Ultrasound Departments in the country. The Lead Sonographer has spoken at events to share this good practice.

11.0 Patient Movements

The Trust also implemented changes to reduce the number of patient moves and when moves are essential, a standardised risk assessment process to ensure the move is safe. When the CQC visited in April, they positively commented that there was evidence of this process being in operation. The process is audited and the internal improvement group continues work to reduce the number of patient moves. These have reduced since the first Keogh visit and the bed plan for this year will see less opportunity for medicine to outlie into surgery as surgery drives its daycase agenda and changes to the arrangements on the DTOC ward and all rehabilitation areas where patients are listed and therefore fully aware of their planned moves. The Trust has co-located the social care, internal discharge and intermediate care teams to improve working practices and streamline processes. The Trust has also re-energised the daily 'Jonah' (review of barriers to discharge) to ensure daily social care and community presence. Transfer to assess should be in place by early December 2014 and the Trust is more confident that with all these factors in place the need to step down patients from medicine will be minimised.

Caring

13.0 Patient Experience

In September 2014, the Trust integrated the former complaints and PALS service to include all patient experience functions and is now called the Patient Experience Team. The team collectively manage and deal with complaints, concerns and compliments. This integrated approach enables us to triangulate information from a range of sources and is fundamental to improving organisational learning. A newly recruited and established Patient Experience Team are now in post, led by the Patient Experience Manager who is responsible for the leadership of the broad remit of patient experience, including the development of the complaints reporting system and formal and informal feedback mechanisms across the organisation.

A new complaints management system has been implemented throughout the trust,

ensuring all patients and families/carers are contacted verbally initially to discuss their concerns, explain the complaints procedure and agree the next stages of their complaint. A written acknowledgement is provided within 3 working days in accordance with NHS Complaints Regulations.

Although in its infancy, the early results do support this approach is providing a prompt resolution for patients, families and carers. For the period October 2014, the number of concerns received showed a 19% increase from September 2014, however a decrease in the number of escalations to the formal complaints; 0.4% (4 in total) compared to 1.3% on the previous month. Year on year figures show a decrease of 31% on the number of complaints received by the trust in October 2014, in comparison to October 2013 (68 in 2013, 40 in 2014) providing resolutions promptly and capturing the learning as concerns and comments. The complaints policy is being updated to reflect the new system of working developed by the Patient Experience Team. This will be distributed for consultation by the end of November.

A learning/action plan function has been implemented to the complaints management process from October 2014 to ensure learning from complaints and concerns is completed and replicated across the divisions and services via the Clinical Governance Meetings and the newly established Patient Experience Group.

The Datix Web system is currently being developed to be implemented by the Patient Experience team to record and report on all concerns, complaints and compliments throughout the trust. As of the 14^{h} November 2014 there are 130 open complaints within our system, of which 9 are in delay. Of these 9, 2 are undergoing RCA investigations due to their complexities and 7 have been offered or have requested local resolution meetings for which dates have been established. The Patient Experience Manager is in dialogue with all these complainants

Responsive

14.0 End of Life

The CQC identified that the Trust had not implemented guidelines, protocols or documentation to all wards that provided end of life care. It was also felt that there was no trust wide, co-ordinated multidisciplinary training in end of life care.

Since April, 2014 the Trust has:

- Developed an end of Life Strategy which is strongly linked to the six-steps within the National End of Life Care Pathway NEoLCP (2010) describing each step, the enablers and actions needed to achieve the aim of each step. It is also in accordance with the National Transforming End of Life Care in Acute Hospitals Programme (2010) framework, to optimise the use of the five key enablers, which support and follow a person-centred pathway. This is currently being consulted - Elaine Wilson, Macmillan Cancer Support Development Manager has reviewed the strategy to offer an expert opinion.

- Developed a network of Ward Champions and Clinical Leaders within each speciality who will facilitate the processes necessary for good quality care for EOLC patients and their families, and encourage a culture of compassionate care by staff caring for individuals approaching end of life.
- Produced guidelines and care plans to support patients in the Last Days of Life Care. This was launched at the beginning of September and will be fully implemented by the end of December 2014. Implementation is being supported by education, training and clinical support to all wards, to ensure patients receive individualised care that is equitable and documentation is consistent across the Trust.
- Ensured end of life care education and training is either delivered or being developed in a number of ways: Implementation of the Last Days of Life Care guidelines and care plans, Multi-disciplinary Induction Programmes, End of Life Care module within Mandatory Training Workbook, End of Life Care study days and communication skills training for staff who are involved in difficult conversations on end of life care
- Commenced a bereavement survey to capture patient / carers experience during their last days/hours of life has commenced during Quarter 3.

Susan Bowler

Executive Director of Nursing and Quality