Quarterly Patient Safety & Quality Report

Quarter 2 summary 2014/15

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Executive Summary

Within the 2014/15 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.

Our HSMR has over a number of years been elevated, resulting in both an internal and community wide series of actions. Our 12 month rolling HSMR is now within a normal range but we continue to monitor a range of relevant indicators and triangulate incident reporting, alerts and note reviews. During Q2 our falls reduction work has continued to show some good improvements with a comprehensive programme of work in place, led by the Falls nurse. The number of repeat falls and those patients who suffered a fracture as a result of a fall has improved. We are currently reviewing our classification and recording of falls as we do record all slips, trips and falls which is not in line with some large teaching hospitals we have recently visited. The same observation has been noted with the recording of pressure ulcers, e.g. we record peripheral vascular disease ulcers as pressure ulcers, whereas other Trusts classify these as unavoidable ulcers. We are currently asking local Trusts of their definitions.

The Safety Thermometer is demonstrating 100% and of those patients within our care, we are demonstrating that >95% are receiving harm free care. Of those patients that are recording harm, catheter acquired urinary tract infections are an area of increased concern. The newly appointed Nurse Consultant for Infection Control has herself noted that we appear to leave urinary catheters in longer than the Trust she has recently left. She is currently reviewing our practice to implementing new ways of working.

We have failed our C difficile target. We have sought the support of our health community partners to help identify solutions. Our CCG have agreed to facilitate a community wide task and finish group, in which all partners including NUH will be invited to discuss actions and learning across the whole patient pathway.

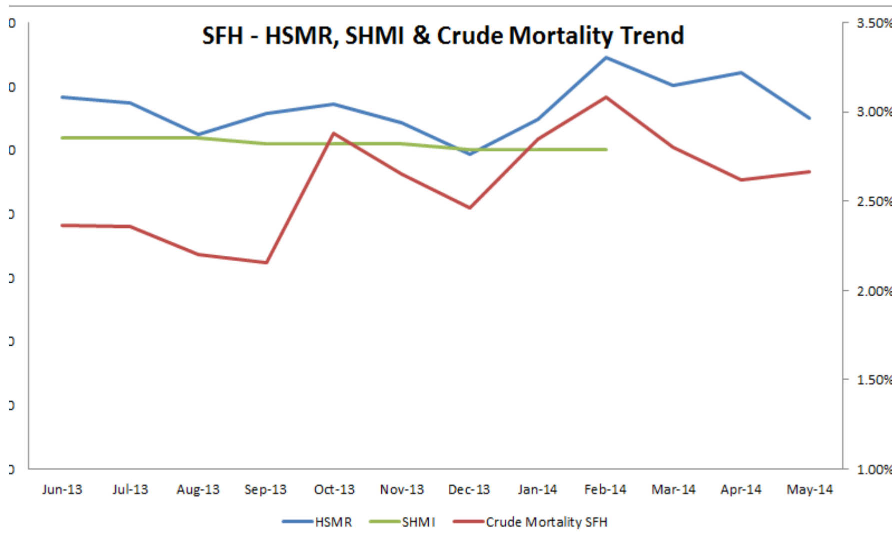
Hydration of our patients is demonstrating that we are supporting our patients with fluid management but we are inconsistent with recording this. Record keeping has been included as part of the accountability handover, but it is proving a challenge to change behaviours. The Lead Nurse for Nutrition and Patient Safety lead are members of a Midlands and East Nutrition and Hydration Strategic Advisory Group that commenced in September, of which hydration is one of the key national priorities being worked on, because the majority of Trusts present were grappling with the same problem of record keeping . Within the forum we have been asked to share our hydration work as it was felt we are further ahead than many of the organisations present.

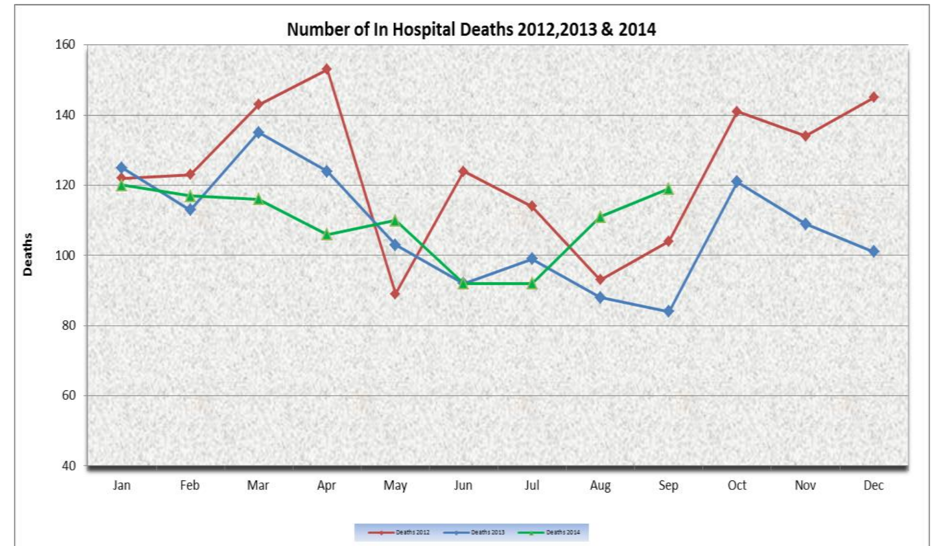
The Trust Board is asked to discuss the contents of this report and note the improvements that are being made in relation to a number of quality priorities, however to be aware there are still areas that are receiving focused attention to ensure improvements are maintained and driven further.

Mortality (Priority 1)

Mortality Targets for 2014/15 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

There is a delay in the data which contributes the quarterly HSMR with 1028 spells and 19 deaths showing in the residual codes category which will affect the HSMR for Jun – 14. These are deaths in un coded spells which make the HSMR calculation inaccurate. This was caused by a problem with coding which can be seen in the graph below. This means that we should be reporting up to and including May. The crude death rate has risen over the last few months. Incident reporting, alerts and note reviews do not suggest problems and we need to see the validated HSMR to see if this has risen suggesting an increase in unexpected deaths. It is possible that the increase is seasonal but earlier than the last 2 years.





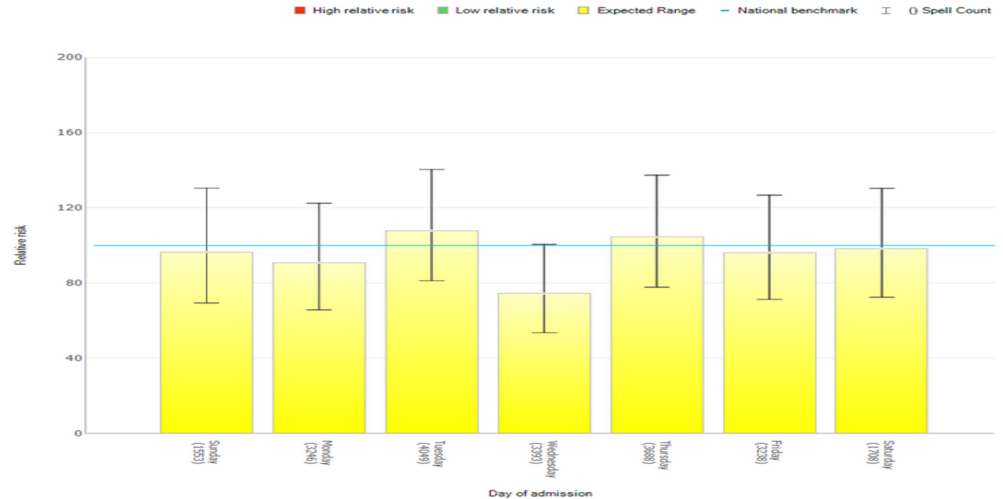
Crude Mortality 2012, 2013, 2014

The SHMI is only reported quarterly – the next figure is due at the end of October. The SHMI remains stable and within expected.

Mortality

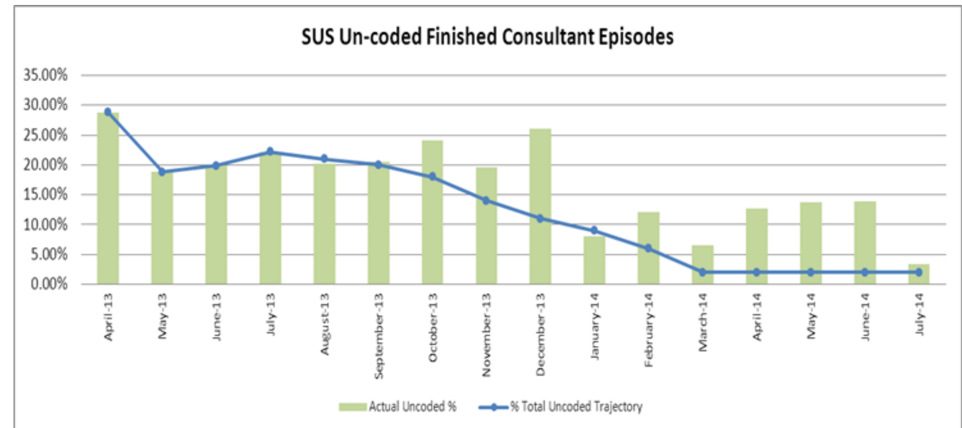
Weekend Mortality

Quarter 1 mortality for patients admitted at weekends has improved when compared to 2013/2014.



Coding

There were issues with vacancies in coding and the time required to train new staff which lead to un coded episodes putting us off planned trajectory in Q1 2014. This has subsequently been corrected and the un coded position for September is 2.1% hence back on track



Above Expected HSMR/Alerts

There were no statistically significant alerts and note reviews have not highlighted any concerns

Falls (Priority 2)

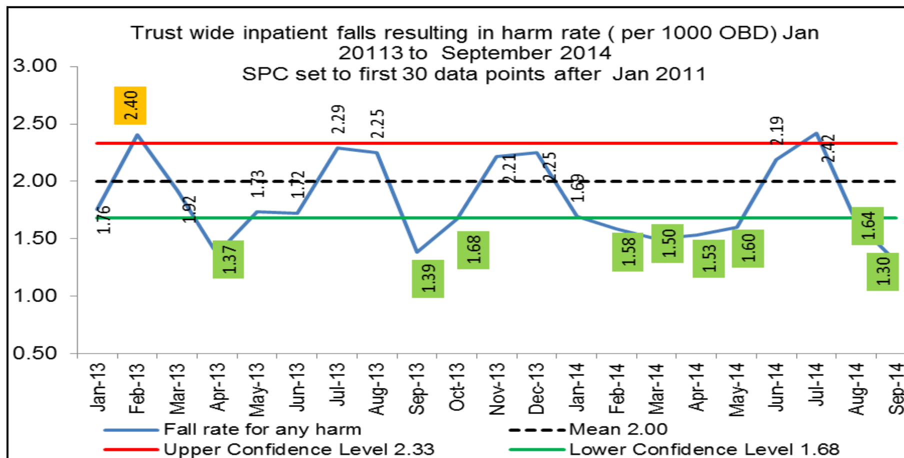
FALLS targets for 2014/15 are to:

1. Capture the number of fallers (non-elective admissions via the 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
2. Reduce the number of patients who fall resulting in harm to **<1.7 per 1000 occupied bed days** by quarter 4
3. Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
4. Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15)
5. Reduce the number of fractures from falls to **<25** for 2014/15
6. Reduction in repeat fallers and undertaking falls assessment is a CQUIN for 2014/15.

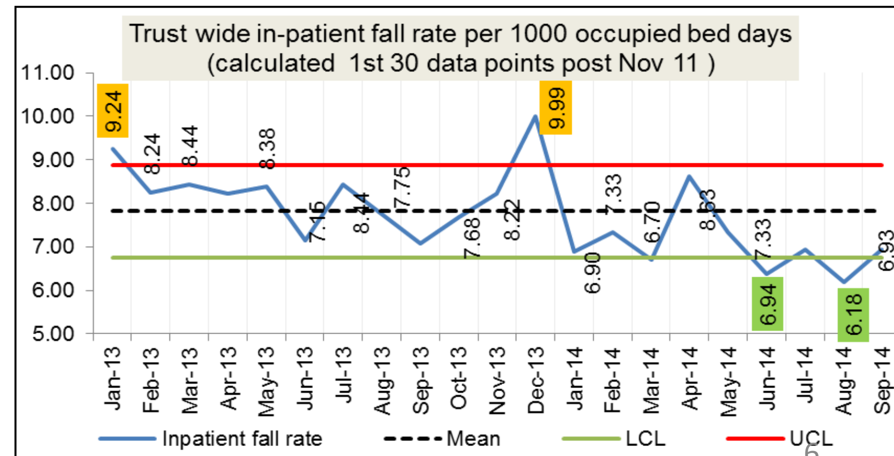
How are we performing against this target

1. A comprehensive falls history is obtained for all non elective admissions aged >65 years within our Emergency Department / Assessment Unit.
2. The total number of patients who suffered a fall resulting in harm was recorded as 1.79 per 1000 occupied bed days during Q2. This is a slight deterioration in performance in comparison to 1.77 recorded in Q1 (Graph 1)
3. The total number of patients who suffered a fall was recorded as 6.69 per 1000 occupied bed days during Q2 This is an improvement on 7.46 recorded during Q1 (Graph 2).
4. During Q2 there were 13 patients who fell more than twice during their inpatient stay. This is a reduction on the baseline target set during Q1 (20)
5. Up until September 2014 we have had 16 Fractures, this remains slightly above trajectory but it should be noted there were less falls with fractures in Quarter 2. Fractures per Quarter, Q 1 = 10, Q2 = 6

Graph 1.



Graph 2.



Mitigation plan (actions to date and future planning)

1. Incident reports are monitored daily with the emphasis on looking for increased risk. Out of hours and at weekends the Hospital at Night)are supporting by ensuring timely reviews of patients who fall and providing a brief update for the Lead Nurse for Falls Prevention.

2. Any areas with a high number of falls or demonstrating an increased risk are prioritised and visited to support an appropriate action plan.

3. Analysis and better understanding of the themes and trends are derived from the new incident reporting system. The highest incidents of falls in relation to time and location has been the shared theme for learning in the Falls Champion meetings.

4. Our 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.

5. An independent audit has been undertaken and the information gathered from this report will be used to address any issues of variability throughout the Trust and adapt our ways of working: to improve the effectiveness based against the challenges we face.

6. The Falls Champion meetings successfully started on the September 16th 2014. 50% of all wards were able to send a representative on that day. All of the meetings for the next 6 months have been sent out to the Ward Leaders this information and will also available on the intranet as part of the staff bulletin.

7. Partnership working with Fernwood Unit at Newark has seen the introduction of the falls proforma: this proforma is designed to improve the standards of review following a fall in hospital. Plans are in place for a full launch following a review of the findings from the audit.

8. All areas have been tasked with making the SAME four key areas the priority for patients identified as being at risk:

- Monitoring of lying and standing blood pressure
- Urinalysis
- Medication review
- Early referral to physiotherapy services

9. As part of the on-going work in identifying the themes and trends in relation to falls,; patient “slips” at the side of the bed is being reviewed : footwear, beds (in particular air mattresses).

Friends & Family Test (FFT) (Priority 3)

FFT targets for 2014/15 are :

CQUIN – 1. Phased Friends & Family Test (FFT) expansion to outpatients and daycase
2. Increase response rate & improve performance
3. Staff F&F

Internal – Increase Inpatient and Accident and Emergency F&F response rate to 50% by October 14.

How are we performing against this target

1. As per the CQUIN requirements the Patient FFT has been introduced into our out patient and day case facilities across the organisation WEF 1st October 2014

2. The response rate for in patients increased to 35.8% during Q2 from 31.3% during the previous quarter. A similar increase was noted from our ED response rate which increased to 18.2% during Q2 from 13.5% during the previous quarter. Our maternity response rate deteriorated in Q2 to 11.4% from 14.6% during the previous quarter.

3. Our staff FFT response rates have deteriorated during Q2 in comparison to that of the previous quarter (Q2 4.6%, Q1 13.2%) and is predominantly due to the method of data collection used within Q2 (online) in comparison to a paper based solution utilised during the previous quarter. Further information regarding our staff FFT can be found in the Workforce Report (Table 1).

Table 1

Month	Response Rate In Patients (%)	Response Rate ED (%)	Response Rate Maternity (%)	Response Rate Staff (%)
April 2014 (Q1)	32.8	16	18.9	NA
May 2014 (Q1)	32.2	14.9	12.4	NA
June 2014 (Q1)	28.9	9.6	12.4	13.2
Q1 Total	**31.3**	**13.5**	**14.6**	**13.2**
July 2014 (Q2)	38.1	12.4	10.5	NA
August 2014 (Q2)	34.3	20.7	12.0	NA
September 2014 (Q2)	34.9	21.6	11.8	4.6
Q2 Total	**35.8**	**18.2**	**11.4**	**4.6**

Friends & Family Test (FFT)

Mitigation plan (actions to date and future planning)

1. We have been in the final stages of aiming to select a provider to facilitate the patient and staff Friends & Family (FFT) surveys on our behalf. The award of this contract was based upon the basis that responses will be sought via a variety of means including paper, electronic and web based solutions.

2. In order to improve our overall response rates we continue to monitor and performance manage our wards and departments. An array of posters and banners have been ordered for display across respective wards and departments in order to raise overall awareness, understanding and uptake of FFT within the organisation

3. We are utilising resources within the CQUIN Team to encourage and improve response rates within EAU and ED of which have historically been low reporters.

4. A dedicated Task & Finish group has been established to support Maternity Services in terms of improving their response rates

5. We have in addition appointed a Project Manager to lead on the continued implementation and expansion of FFT across the organisation and are currently negotiating a start date

National Changes To Patient Friends & Family Test (FFT) Scoring System

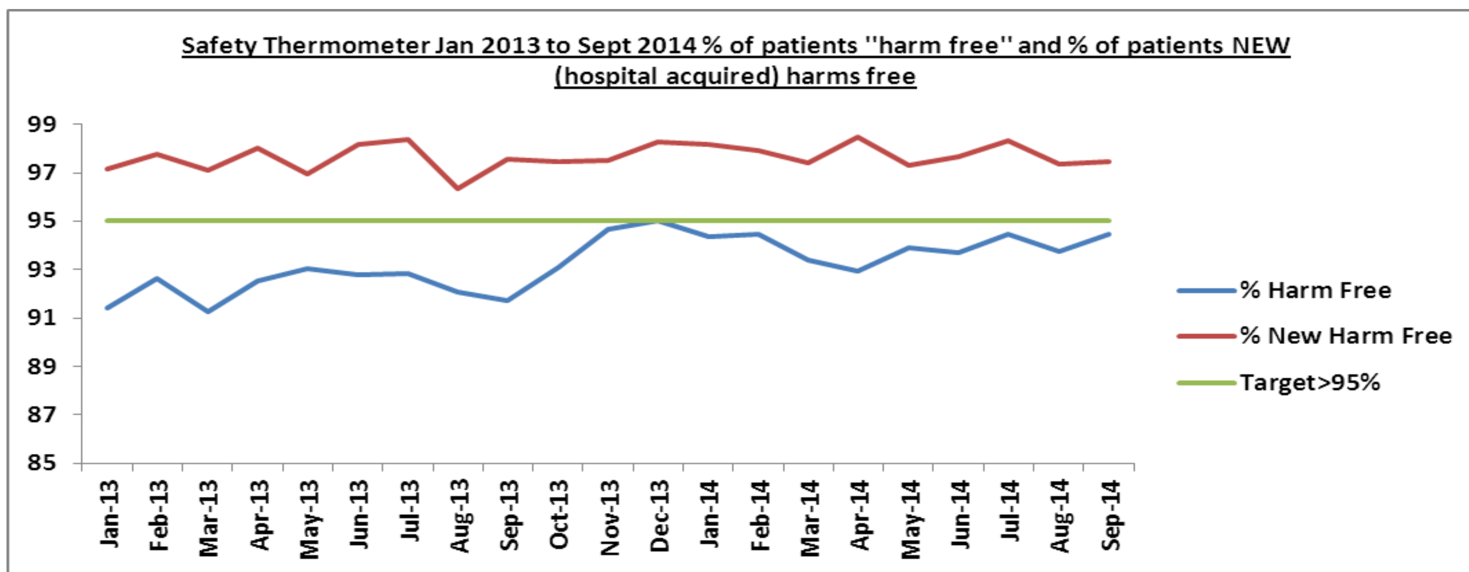
Following on from an NHS England review, a decision was made in July of this year to move away from the **Net Promotor Score** to a simpler scoring system. The changes in the calculation and presentation of FFT results will in the future focus on the percentage of respondents that would and would not recommend a service. For staff this will come in action from September 2014, with the changes to the Patient FFT being introduced a month later.

Safety Thermometer

Safety Thermometer targets for 2014/15 Aim; To ensure harm free care for patients (>95%), as measured by Safety Thermometer .

How are we performing against this target?

The Trust continues to achieve 100% compliance in submitting data to the NHS Safety Thermometer. A total of 1934 patients were assessed using the Safety Thermometer during Q2. The result for harm free care is an average of **94.20%**, just below the national goal of 95%,and an increase on the average of **93.45% i**n Q1.This is an improvement when compared to Q2 in 2013, when **92.19%** patients were reported to receive harm free care and the sample size was smaller.



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	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
% Harm Free	91.41	92.64	91.28	92.53	93.05	92.8	92.85	92.07	91.71	93.11	94.68	95	94.38	94.45	93.4	92.94	93.93	93.71	94.45	93.73	94.44
% New Harm Free	97.14	97.75	97.09	98.02	96.93	98.16	98.37	96.36	97.56	97.46	97.5	98.28	98.18	97.9	97.39	98.5	97.33	97.68	98.35	97.34	97.46
Target>95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

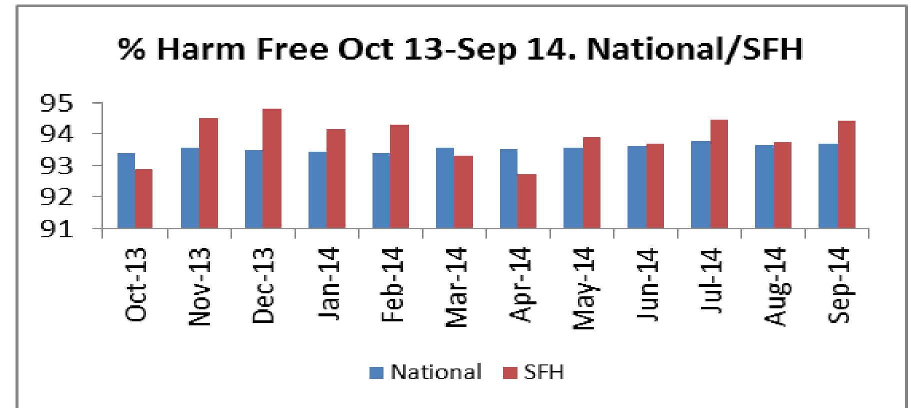
The graph above shows the % patients classified as “harms free” and “NEW (hospital acquired)harms free by month and indicates that for Quarter Two we have not achieved the 95% target although consistently remain above 95% for patients who have acquired new harms

Q2 Monthly breakdown of harm free care by %

July
94.45%* -harm free care
1.65% of our patients suffered a new harm
New CAUTI –4 New Fall -4
New PU – 2 New VTE – 1

August
93.73%*- harm free care
2.66% of our patients suffered a new harm
New CAUTI- 5 New Fall- 5
New PU- 7 New VTE- 0

September
94.44%*- harm free care
2.54% of our patients suffered a new harm
New CAUTI- 7 New Fall- 3
New PU- 4 New VTE- 2



The graph above illustrates the Trust position of harm free care alongside the national average performance

What do the results tell us ?

For each month of Q2 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

As reported in this paper we already have a falls and pressure ulcer reduction plan in place. During Q2, the number of catheter acquired infections has been identified. The Nurse Consultant for Infection Prevention and Control will implement a reduction plan to reduce the overall incidents of catheter acquired UTI's to mitigate further occurrences during this year. This newly appointed Nurse Consultant has herself noted that we appear to leave urinary catheters in longer than the Trust she has recently left. She is currently reviewing our practice with a view to make and implement new ways of working

*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.

Sepsis

Sepsis targets for 2014/15 are :

CQUIN – To achieve 75% compliance against the sepsis bundle by Q2.

How are we performing against this target

September data is not yet available therefore we are unable to report compliance against Q2 target.

The audit data covering the months April-August has demonstrated a compliance rate of 48%

Mitigation plan (actions to date and future planning)

1. A Trust Sepsis Strategy was submitted to the Commissioners in Quarter 1. This had the aim that better sepsis care will be achieved by accomplishing a number of outcomes over the year. These include:
2. Establish the people to lead improvement in sepsis care **:** we have a multidisciplinary working group that will co-ordinate and drive the planned strategy work
3. Establish an audit to evidence good and poor sepsis care **:** the Lead Sepsis Nurse would rigorously monitor patient care.
4. Establish a robust governance system that enables learning and improvement **:** areas where poor care is evident can learn from errors and have support to improve practice. The Lead Sepsis Nurse will ensure governance procedures are followed and that clinical teams have the support needed to share their "lessons learned".
5. Establish a workforce equipped with the knowledge to implement good sepsis care**:** planned education and training programs throughout the year. Poor performing areas will have additional targeted training.
6. The work we had achieved, so far, has been recognised by NHS England who wish to use our Trust as an exemplar site. The Lead Sepsis Nurse has been asked to work with the NHS England sepsis collaborative to improve sepsis care nationally.
7. The Lead Sepsis nurse is also employed as a Resuscitation officer. The work load of the Resuscitation team has meant that the hours for the sepsis work required review. This has impacted on all aspects of the sepsis work including the September's audit. There are now plans to back fill the Resuscitation officer hours resourced through the Education Department. This will allow the sepsis work to progress.

Pressure Ulcers

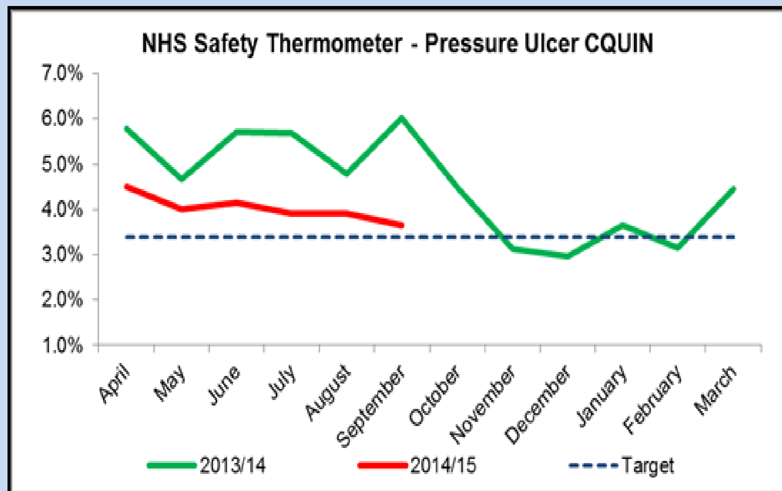
Pressure Ulcer targets for 2014/15 are :

1. **CQUIN** – A 50% reduction in all pressure ulcers (both inherited and hospital acquired) using the safety thermometer data.
   To achieve the above we need to achieve 5 consecutive points below the target line.
2. **Contractual** – A 50% reduction in avoidable pressure ulcers
3. **Internal** – To eliminate all grade 3 and 4 avoidable hospital acquired pressure ulcers October 2014 and achieve zero by March 2015

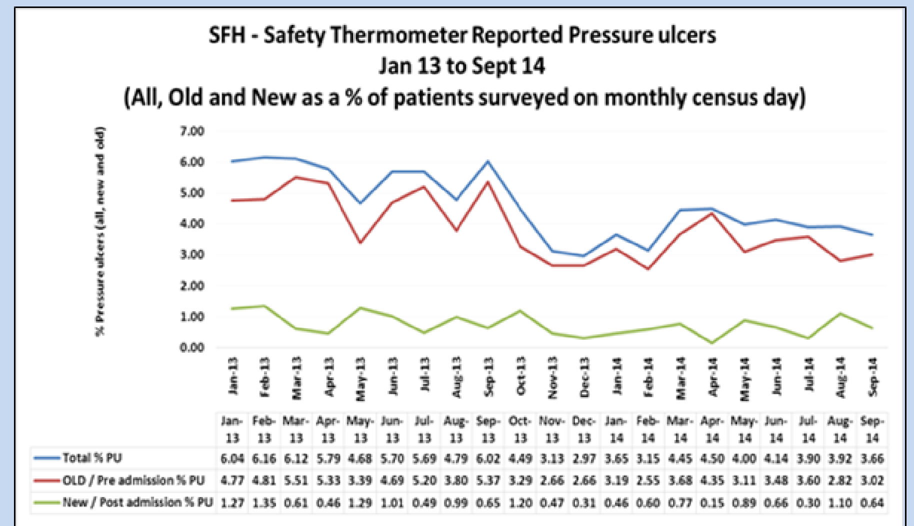
How are we performing against this target

1. **CQUIN** – currently not achieving this target as we have not dropped below the target line.
2. **Contractual** – the target was not achieved this quarter for Grade 2 pressure ulcers although despite this, improvement was noted in September.
3. **Internal** – this target was achieved for Grade 3 and Grade 4 avoidable hospital acquired pressure ulcers.

Graph 1. demonstrates a gradual and sustained reduction in all pressure ulcers in comparison to that of the previous year. It should however be noted that achievement of the CQUIN target is dependant upon our ability to further reduce the number of pressure ulcers below the median



Graph 2 provides further detailed data analysis through the classification of old and new pressure ulcers surveyed on the monthly census day. Whilst the graph clearly illustrates that the vast majority of pressure ulcers surveyed developed prior to admission to hospital it does not differentiate or classify whether avoidable or unavoidable



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	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
Total % PU	6.04	6.16	6.12	5.79	4.68	5.70	5.69	4.79	6.02	4.49	3.13	2.97	3.65	3.15	4.45	4.50	4.00	4.14	3.90	3.92	3.66
OLD / Pre admission % PU	4.77	4.81	5.51	5.33	3.39	4.69	5.20	3.80	5.37	3.29	2.66	2.66	3.19	2.55	3.68	4.35	3.11	3.48	3.60	2.82	3.02
New / Post admission % PU	1.27	1.35	0.61	0.46	1.29	1.01	0.49	0.99	0.65	1.20	0.47	0.31	0.46	0.60	0.77	0.15	0.89	0.66	0.30	1.10	0.64

Pressure Ulcers

Table 1: 2014/15 SFH Avoidable Pressure Ulcer reduction trajectory

Contractual

During Quarter 2 a total of 19 avoidable grade 2 pressure ulcers were reported against a target of 10. However it is important to note that during September a total of 2 pressure ulcers were reported against a target of 3 (Table 1).

Internal

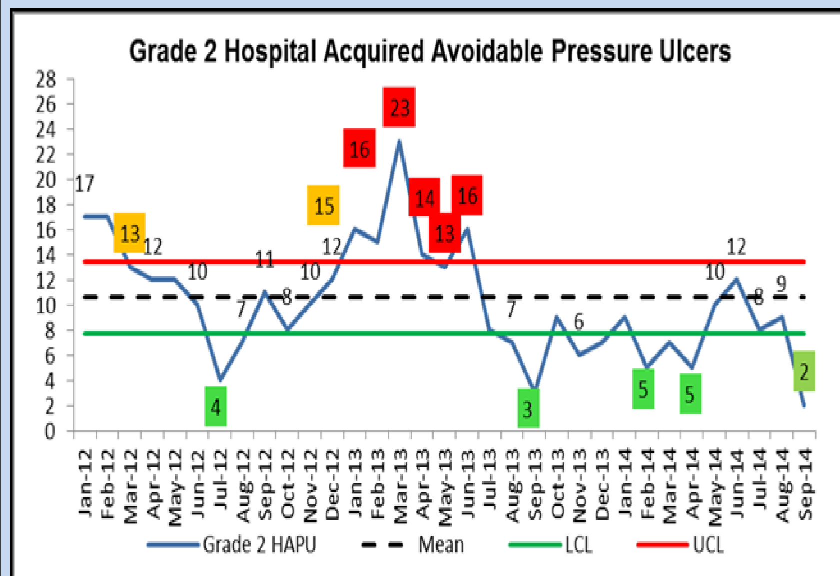
During Quarter 2 there were no grade 3 / 4 Hospital acquired avoidable pressure ulcers reported

The number of Hospital acquired avoidable pressure ulcers in Qtr-2 per 1000 occupied bed days was 0.29 in comparison with 0.44 in Qtr-1

	Qtr-1			Qtr-2			
	Apr	May	Jun	Jul	Aug	Sept	Totals
GRADE 2 - is superficial and may look like an abrasion or blister							
2012 - 13	12	12	10	4	7	11	140
2013 - 14	14	13	16	8	7	3	61
2014 - 15	5	10	12	8	9	2	46
Target No.	7	4	4	3	4	3	25
GRADE 3 - goes through the whole layer of skin with damage to the tissues underneath the skin							
2012 - 13	0	0	0	0	4	5	9
2013-14	5	4	2	0	1	0	12
2014-15	2	0	0	0	0	0	2
Target No.	2	1	0	1	1	0	5
GRADE 4 – is the most severe form, it is deep and there is damage to the muscle / bone underneath							
2012 - 13	0	0	1	0	0	0	1
2013 - 14	0	0	0	0	0	0	0
2014 - 15	0	0	0	0	0	0	0
Target No.	0	0	0	0	0	0	0

Mitigation plan (actions to date and future planning)

1. From an organisational perspective we have instigated a simplified RCA process for all avoidable Grade 2 pressure ulcers that develop within our care. The key themes identified: not reacting to red skin and underscoring of the PU risk assessment tool are now being included into ward posters to back up teaching plans identified in ward action plans
2. The Tissue Viability Team have recently employed a CQUIN Health Care Support Worker to further enhance the provision of care through the early detection and management of pressure ulcers and in data validation
3. Collaborative working with the Practice Development Matrons to ensure consistency within tissue viability care and ward assurance assessments across the Trust



Venous Thromboembolism (VTE)

VTE targets for 2014/15 are :

1. **Contractual** – 95% of all in patients will undergo a VTE risk assessment
2. **Internal –** 100% of hospital acquired thrombosis (HAT) will have a root cause analysis (RCA) performed.

How are we performing against this target

From a contractual perspective we have achieved the 95% target during each calendar month during Q2 (Table 1)

Table 1

Indicator	July 2014	August 2014	September 2014
95% of all in patients service users undergoing risk assessment for VTE.	95.26%	95.20%	95.20%

We remain compliant in respect of all cases of HAT undergoing a RCA.

Mitigation plan (actions to date and future planning)

The VTE Working Group continues to undertake investigations into all cases of HAT and ensure that examples of good practice and lessons learnt are discussed and fed back to our clinical teams to ensure a continuous learning and improvement cycle.

In August we undertook an audit to determine how well our medical staff completed the VTE assessment form. The results highlighted two areas that required improvement; Question 3 - 73% had not indicated where the patient had a mobility risk or thromborophlaxis not relevant. Question 4 - 66% had not indicated if the patient had a bleeding risk.

The findings of this audit have been discussed at the October monthly VTE meeting in order to address the areas that require improvement.

Dementia

Dementia targets for 2014/15 are:

CQUIN

1. 90% of emergency admissions aged 75 years & over are screened, assessed and referred on to specialist services.
2. Identification of a named lead clinician and provision of appropriate training for staff.
3. Provision of carer support audit

How are we performing against this target

1. During Quarter 2 we achieved the target that 90% of emergency admissions aged 75 and over are screened, assessed and referred onto specialist services.
2. The lead clinician for dementia is Dr S Rutter (Consultant Geriatrician). From a training perspective Tier 1 dementia awareness training has been delivered to over 90% of staff via the induction and mandatory programmes. Provision of specialist training has continued during quarter 2 via the Meaningful Activities Programme with a further six sessions planned. Inpatient wards have in addition identified dementia champions within their respective areas in order to share and disseminate knowledge and skills and identify specific training needs.
3. During quarter 2 we received a total of 37 responses to our carers audit, the results of which identified that 81% of carers felt supported / very well supported (Table 1).

A selection of carer's comments include;

- **"The improvement on ward 52 is fantastic! So many smiling, helpful people."**
- **"My Mum was asked the same questions that she couldn't answer 5 times in 2 days. Something needs to be done about it." – EAU**
- **"Dad much prefers the food here from his nursing home. " – Oakham**
- **"The consultant has been amazing, explaining everything to me and my brother." - ward 52**

Graph 1.

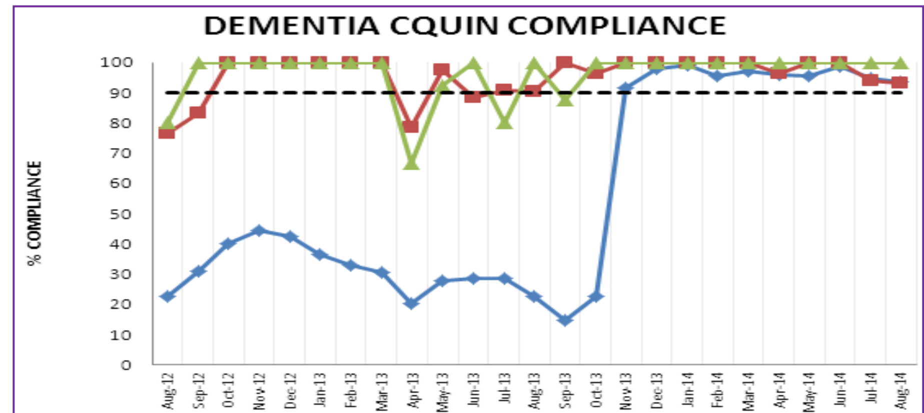


Table 1.

As a carer of someone living with dementia, how supported have you felt during this stay at Sherwood Forest Hospitals NHS Foundation Trust?					
Answer Options	**Very well supported**	**Supported**	**Neither supported or unsupported**	**Unsupported**	**Completely unsupported**
July	8	4	2	0	1
August	5	6	0	1	0
Sept	4	3	1	1	1
Total	**17**	**13**	**3**	**2**	**2**

Mitigation plan (actions to date and future planning)

New Dementia Lead Nurse

Tracey Kurr commenced her role as dementia lead nurse on September 1st. Tracey is passionate about Improving the patient experience at Sherwood Forest Hospitals Trust whilst embedding the Trusts values and behaviours ethos for the staff.

Carers Audit

We will continue to expand the dementia carers audit across our inpatient wards and will be working with our clinical teams to increase our overall response rates

Dementia Friendly Environment

Coloured Mowbray toilet frames, clocks and signage for all the wards, across all 3 sites, are currently being ordered from the suppliers. Work is on going towards the installation of colour and symbol signage on EAU to make it easier for people with dementia to orientate themselves on the unit.

Dementia Champions

All wards and areas have been asked to identify a dementia champion. A meeting is to be held on December 9th to identify training needs and to facilitate environmental improvements on each ward/area. In addition to this Claire Henley, Learning Disability Nurse Specialist, will be delivering a teaching session on the impact of dementia in learning disability.

Dementia Care Appeal

Donations have been generously received from the general public, the hospital theatre troupe and staff members. Our voluntary services have once again risen to the fund raising challenge and have cheerfully manned stalls in the KTC selling everything from books and plants to bric-a-brac, as well as taking trolleys around the inpatient wards selling sweets, chocolate and drinks. All of the money will be spent on improvements, across the Trust, for people living with dementia.

Celebrating Success

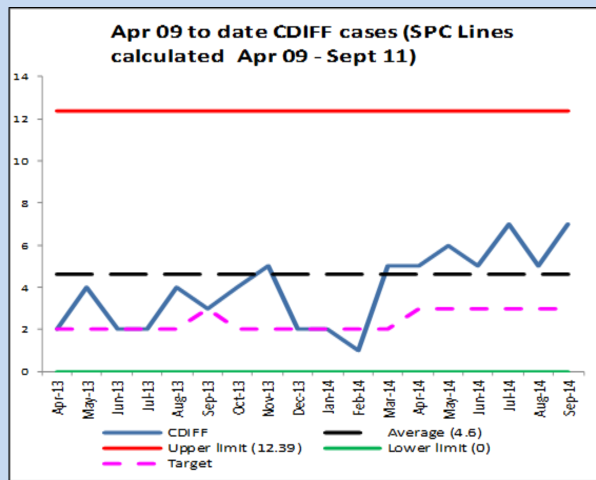
The exciting collaboration between health care of the elderly and the mental health liaison team on Ward 52 has been featured in the local newspaper and on Radio Nottingham.

Infection Control

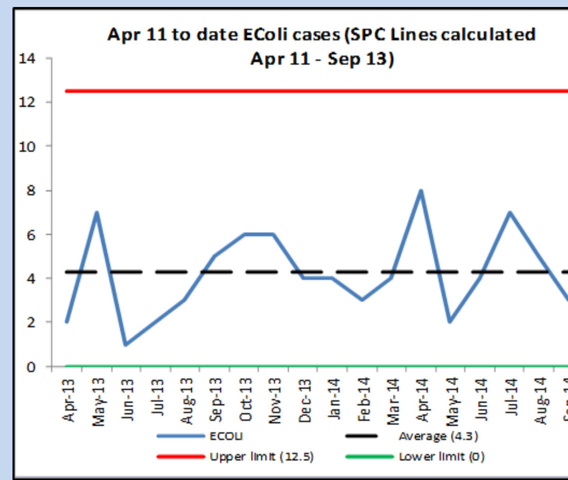
Infection control targets for 2014/15 are:

- Contractual – **1.** Zero tolerance Hospital Acquired MRSA **2.** Minimise rates of Clostridium *difficile* – No more than 37 Hospital Acquired cases.
- Internal – No more than 5 Urinary Catheter Related bacteraemia.

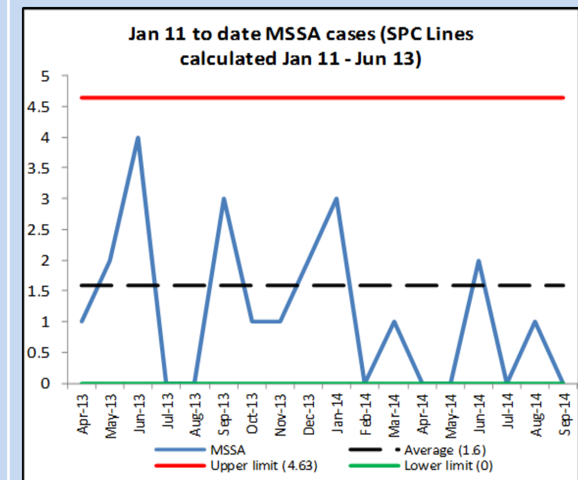
How are we performing against this target and other related issues:



C.difficile: There have been 16 (Quarter 1) and 19 (Quarter 2) cases of hospital acquired C.difficile. This suggests that it is likely that the Trust will breach the target set within the next quarter.



E.Coli bacteraemia: This is part of the trusts mandatory reporting requirements to Public Health England; at present there are no targets set against them. However careful monitoring is required as these organisms are often implicated in the global issue of increasing antimicrobial resistance. There have been 14 (Q1) and 16 (Q2) cases of hospital acquired E.coli bacteraemia.



MSSA bacteraemia: This is part of the trusts mandatory reporting requirements to Public Health England; There has been 2 (Q1) and 1 (Q2) cases of hospital acquired MSSA bacteraemia.

Infection Control

MRSA bacteraemia: There has been zero cases of hospital acquired MRSA bacteraemia in Q1 and Q2 (trajectory 0).

Catheter associated bacteraemia: There have been 3 (Q1) and 2 (Q2) cases of hospital acquired catheter associated bacteraemia.

Surgical site infections: Public Health England require mandatory surveillance of prosthetic joint replacement surgery during one quarter of the year. The trust undergoes continuous surveillance of both Total Hip Replacements and Total Knee Replacements. There was 1 (Q1) and 1 (Q2) Total Hip Replacement infections and 1 (Q1) and 1 (Q2) Total Knee Replacement surgical site infection that have been reported. RCA are being conducted for these. In addition the Trust perform voluntary surveillance of C- Sections and there has been 4 (Q1) and 4 (Q2) post C section surgical site infections reported. This data is subject to change following full reviews annually due to the possibility of readmissions.

Mitigation plan (actions to date and future planning)

- ***C. difficile* and Infection Control:** There continues to be a increase in the number of *C.difficile* infections during Q2. The Trust have implemented a number of proactive and reactive actions, including further education for ward staff, a *C.difficile* ,increased cleaning with Chlor-clean for all ward areas. An external review has also taken place and action plan developed and actions implemented. RCA's have been conducted for all Trust acquired *C.difficile* infections and lessons learnt have influenced the actions. SFH have initiated a dialogue with the CCG with regards to the investigating the increasing levels across the whole health economy. The CCG plan to facilitate a 'task and finish' group to look into this.

- **Bacteraemia:** All bacteraemia are reviewed by the Infection Prevention and Control Nurse and Consultant Microbiologist , they are referred for a full RCA if device or line related. The MSSA bacteraemia in Q2 was a possible contaminant due dermatitis. The Consultant Microbiologist is going to audit our blood culture contamination rate for the Trust and we also plan to work with the Practice Development Matrons to review care of vascular devices.

- **Surgical site infections:** All orthopaedic surgical site infections are referred for a full RCA. The investigations are currently underway for the Q2 infections to enable an action plan to be developed, including the possible change of post operative dressings.

- **Catheter associated bacteraemia:** We conduct quarterly audits of catheter monitoring forms to ensure patients are catheterised for the appropriate reason. We work with our Health partners from neighbouring Trusts and CCG's to help provide the best service across the health economy for our patients. Plans to introduce the use of intermittent catheters across the Trust and commence the use of the urinary catheter passport with the rest of the Health Economy to help improve communication between primary and secondary care

Medicine Safety

Medicine safety targets for 2014/15 are :

Internal – 1. Zero Medication related ‘Never Events’.

2. To increase the number of reported medication-related incidents by **20%** (compared to 2013/14 data).

3. 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. Zero Medication-related ‘Never-Events’

During Quarter 2 there have been no reported medicines-related ‘never-events’.

2. To increase the number of reported medication-related incidents by 20% (compared to 2013/14 data)

Overall there has been a 25% increase in the number of medicines-related incidents being reported. (April to September 2014) however, there has been a decrease of the number of medication incidents during Q2. Further work is on-going to understand this.

Most reported incidents in Q1 and Q2 continue to relate to **medicine administration/supply,** of which medicine **non-administration** (particularly for critical medicines such as antibiotics, antiepileptics etc.) is most reported.

Medicine non-administration is a particular concern locally and nationally, and focussed work is on-going to look to improve practice.

3. To reduce the number of medication-related incidents resulting in moderate/severe harm by 25%, particularly for high-risk medicines.

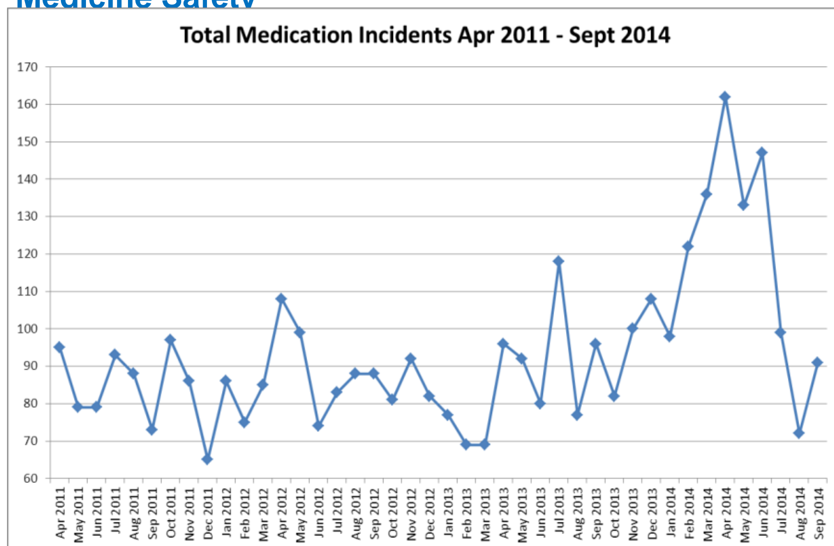
There has been an *increase* in such reporting from April to September 2014 (12 incidents) compared to the same time period 2013/14 (5) for all medicines; further work is required for analysis on harm associated with specified high-risk medicines.

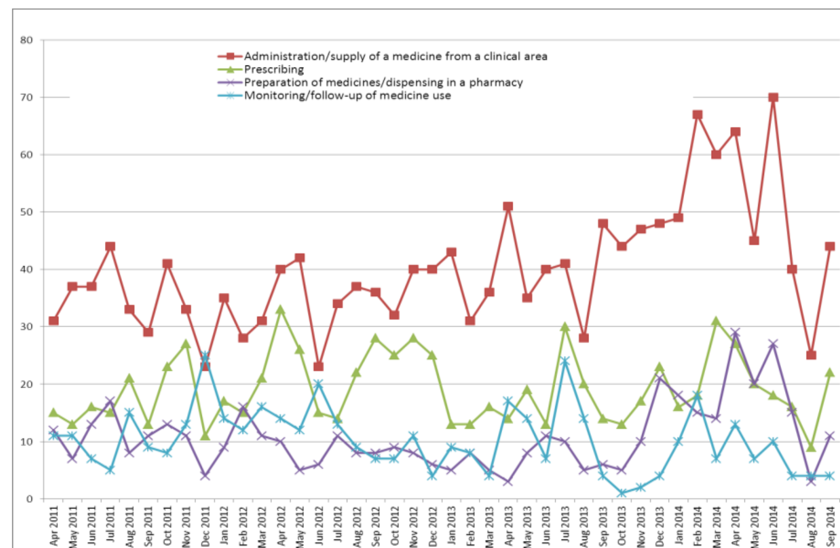
The vast majority of incident reports in Q1 and Q2 of 2014/15 were classified as ‘no harm’ (>80%), and ‘low’ harm (>16%), compared to a total of >99% for the same period in 2013/14.

Any ‘harm’ classification should be viewed with caution as it is often subjective and sensitive to potential bias from either the incident reporter or investigator/handler, with inconsistent interpretation of outcomes against the NPSA standard definitions between individuals. However, the general trend increase in reporting of any harm since September 2013 has been maintained, and is likely to be due to improved completion rates of this field in Datix®, and a more open interpretation of outcome based on standard definitions compared to previous reports, rather than an actual increase in harm severity from incidents. Future reports will be able to provide more insight to this trend.

There were no ‘severe’ or ‘catastrophic’ harm outcomes reported during this period.

Medicine Safety





Analysis of medicines incident reporting rates from recently updated National Reporting and Learning System (NRLS) data (to Mar 2014 – latest update), continues to demonstrate a 6-monthly reporting rate at the Trust equivalent to other medium acute Trusts in the region. This suggests a continued positive culture within the organisation to report incidents and near-misses relating to medicines.

Mitigation plan (actions to date and future planning)

1. Medicines-related ‘never-events’ categories continue to be included in induction and mandatory update training for nursing staff, related posters are on display for all staff in clinical areas and on the intranet (note ‘never-event’ categories and triggers are likely to be changed in 2015/16).
2. All staff are encouraged to report incidents and ‘near-misses’, but a particular focus is required to encourage reporting by medical staff. Focussed work is continuing within the Medicines Management Task/Finish Group to address on-going issues regarding omission and missed doses. Supplementary data collection on missed doses is also undertaken by nursing staff as part of the metrics data collection. This, along with the imminent launch of a revised Trust drug chart plus new documentation for nursing staff to record actions taken in the event of medicine non-administration should help to reduce inappropriate dose omissions in future. Consideration is being made for the Trust to start collecting data for the Medicines Safety Thermometer, which focuses on omitted/delayed medicines, particularly for named critical medicines (such as opioids, insulin, anticoagulation etc.). This will provide opportunities for benchmarking with other Trusts both locally and nationally.
3. The assessment of ‘harm’ using NPSA definitions is now more open based on details provided in incident reports. Future reports should demonstrate a reduction in actual harm compared to current baseline data rather than historical data, plus greater learning from incident investigations.

Hydration

Hydration targets for 2014/15 are :

➢**Internal – Our focus is to ensure that all patients in our hospitals receive adequate hydration and that their needs are assessed, monitored and optimised correctly .**

Fundamental Standards for Hydration Care

All patients will have immediate access to fresh water at their bedside unless restricted or inhibited by their clinical condition.

This will be within the patients reach

Water will be served from clean ,intact, drinking vessels, suitable for individual patient dependency needs.

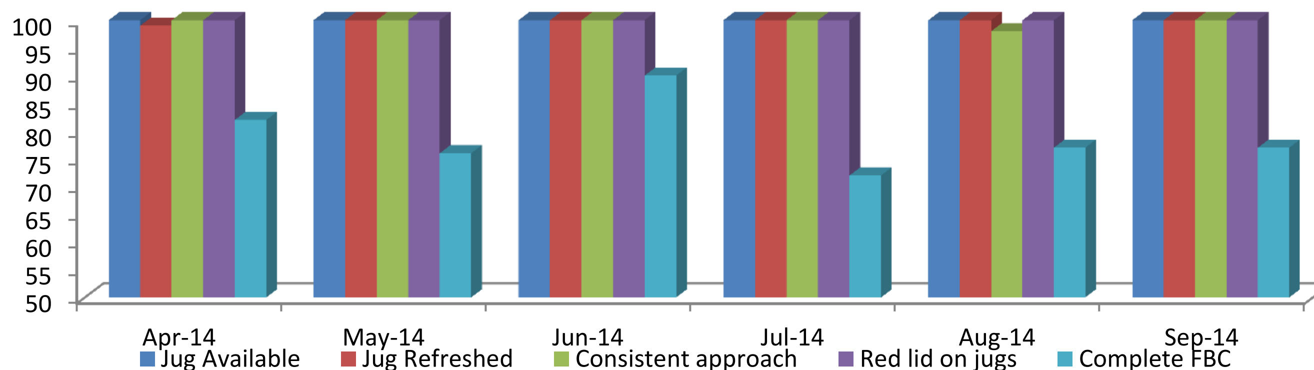
Patients will be provided with a hot/cold drink seven times per day from the beverage trolley, but should feel able to ask for additional drinks at any time of the day or night.

For those patients requiring fluid balance monitoring there will be a consistent approach to the measurement of oral fluids.

Where fluid balance charts are required they will be completed.

How are we performing against this target

The chart below shows compliance with each of the components of the monthly hydration audit across the Trust



The table below shows the % compliance with the components of the monthly hydration audit across the Trust.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Jug Available	100	100	100	100	100	100
Jug Refreshed	99	100	100	100	100	100
Consistent approach	100	100	100	100	98	100
Red lid on jugs	100	100	100	100	100	100
Complete FBC	82	76	90	72	77	77

It is pleasing to see 100% of our patients had drinks available and that there is a consistent approach to measuring fluids and provision of red lidded jugs for those patients requiring additional support with their hydration needs. The results also reassure us that patients feel they can ask for a drink when they require one. However the results tell us that documentation was sometimes observed to be incomplete by which we are demonstrating that the standards and rigour of fluid balancing recording and documentation continue to require improving.

Mitigation plan (actions to date and future planning)

Completion of fluid balance charts has been a focus of accountability handover. Further work is underway to investigate the reasons that staff are not completing documentation appropriately at present. Current investigations are showing that staff are recording hydration near to the completion of other tasks rather than at the time the hydration status changes

Within Phase 2 of VitalPAC we will be implementing a fluid management module to support care of the acutely ill patient and hydration. The outcome of this will be that patients hydration records will be consistently and accurately recorded. This is expected to roll out in January 2014.

The Practice Development Matron for Dementia is presently working with our partners Medirest to implement a rollout of coloured drinking cups. These can help draw patients attention and assist in promoting regular drinks .

The Lead Nurse for Nutrition and Patient Safety lead are members of a Midlands and East Nutrition and Hydration Strategic Advisory Group that commenced in September of which Hydration is one of the key national priorities being worked on.

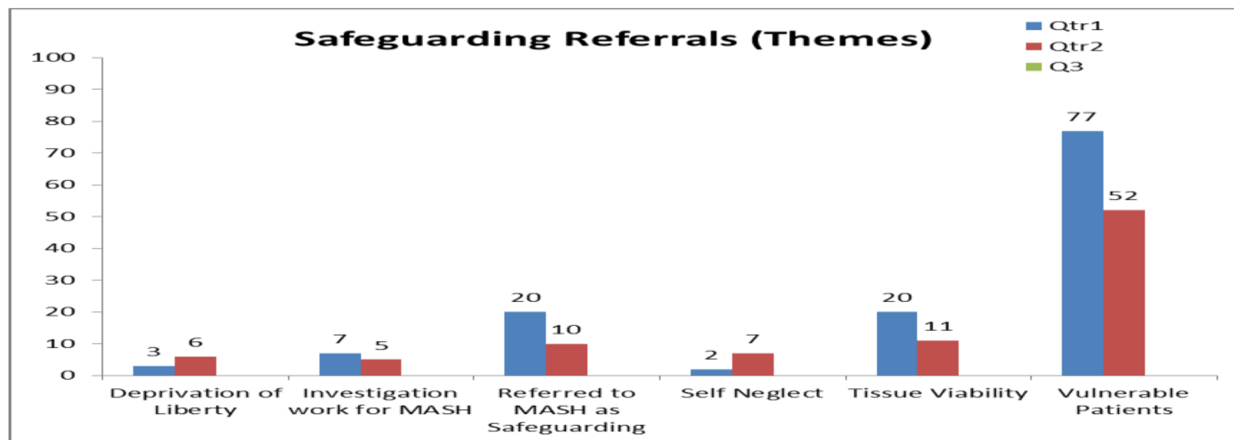
The Matrons are monitoring compliance with regards to the completion of fluid balance charts and addressing issues at the time with staff by providing immediate feed back and training.

Safeguarding Adults

Safeguarding Adults targets for 2014/15 are : No formal targets set for 2014/15

1. During Q2 the trust safeguarding adults team received 123 referrals to the service in comparison to 139 received during the previous quarter.
2. Of the 123 patients referred 10 were subsequently referred onto the Nottinghamshire Multiagency Safeguarding Team (MASH). Graph 1 provides further information regarding emergent safeguarding themes and onward referral patterns
3. The safeguarding adults self assessment has been completed and submitted to the Nottinghamshire Safeguarding Adults Board (SAFF) and local Clinical Commissioning Group, the actions of which will form part of the safeguarding adult's action plan. Progress against this plan will be monitored via the joint SFH / CCG quality and performance committee.

Graph 1



Domestic Violence Update:

1. The Nottingham Multiagency Risk Assessment Conference (MARAC) information sharing agreement has been agreed and formally ratified.
2. The Domestic Abuse Policy has been approved
3. and available on the trust intranet.
4. The Trust Domestic Abuse Specialist Nurse has successfully completed the Coordinated Action Again Domestic Abuse (CAADA) training, this means she is now a qualified Independent Domestic Abuse Advocate.

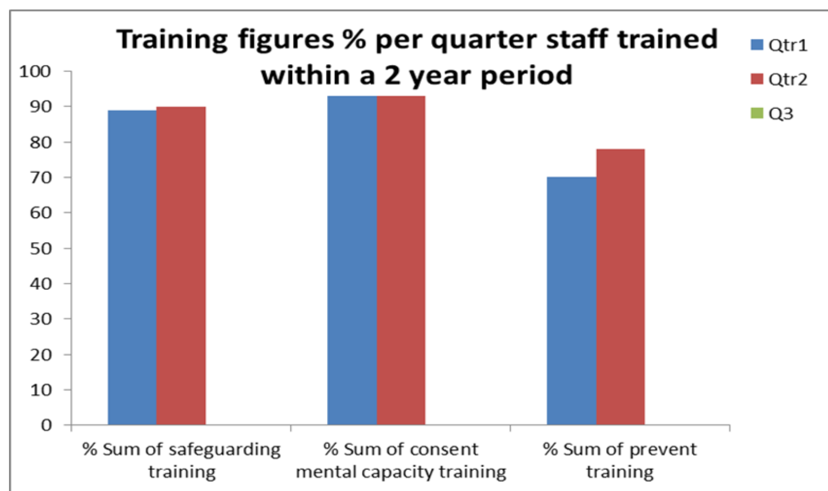
Safeguarding Adults

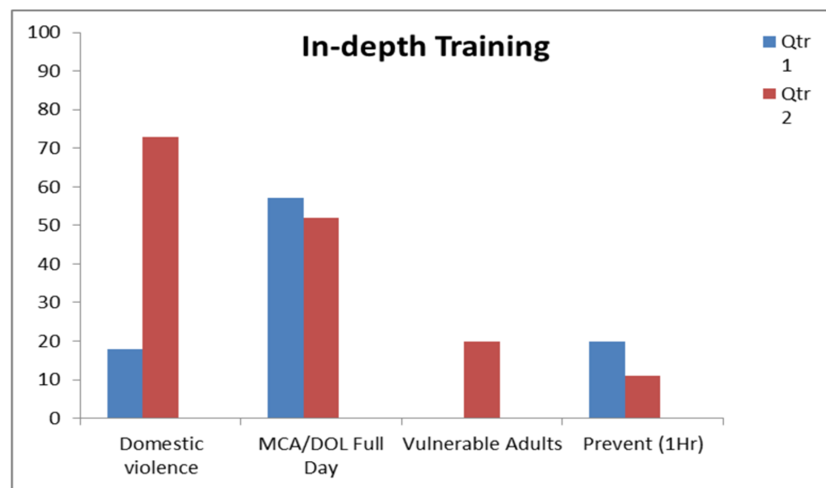
The adult safeguarding team continue to provide generic training through the trust mandatory training programme and in addition facilitate specialist training covering a range of topics including domestic violence, mental capacity act, deprivation of liberty and vulnerable adults training. The following graphs evidence the uptake of respective training opportunities provided.

Training:

Deprivation of Liberty (DOL) Update:

During Q2 we identified and reported 6 patients who were deprived of their liberty during their hospital admission, this represents a slight rise in referrals in comparison to the previous quarter (3 reported). Local intelligence from the regional MCA/DOL forum suggests that our referral rates are consistent with other acute trusts within the area. All deprivation of liberty applications for assessment are managed by the local authority. When a DOL application for assessment is made, the time frame for assessment for the local authority to assess is 7 days this can be extended by a further 7 days. Two of the patients the Trust applied for a DOL for were not seen with in the time frame legal advice was sought. The latter 4 patients have all been seen with in the extended timeframe.





The Safeguarding Adults team have recently implemented weekly audits across our in-patients wards in order to seek assurance that Derivation of Liberty legislation is being appropriately applied particularly to patients who require enhanced care.

The Safeguarding Adults are sourcing specialist domestic violence training to further increase their knowledge and skills.

Safeguarding Children

Safeguarding Children targets for 2014/15 are :

- Trust to continue to assess & report to CCGs against the **NSCB Markers of Good Practice**
- Trust to implement **Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document,** RCPCH (2014)
- Active participation in **MASH**

How are we performing against these targets?

The self-assessment against the NSCB Markers of Good Practice showed that as a Trust, we are green against almost all of the outcomes. There were no 'red' areas. 7 Amber areas were highlighted for action as below -

1. SFH representation on NSCB/NCSCB – Limited.
2. A system is in place to review named professionals competencies against the Roles and Competencies of Health Care Staff :Intercollegiate Document 2014 – (compliance 66.6%)
3. Referrals under the LADO procedures are appropriately made
4. 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
5. All staff, including those with specialist roles, are provided with safeguarding children updates appropriate to role and responsibilities
6. Supervisors should be trained in supervision skills and have an up to date knowledge of legislation ,policy and research relevant to safeguarding children – (compliance 89%)
7. Supervision should take place on a minimum of a quarterly basis – we do not fully meet this target

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

1. The training requirements for all levels have staff have increased in the current document and we have increased sessions to meet these but are not yet fully compliant.
2. From a minimum staffing standard perspective we employ an organisational wide dedicated named nurse for safeguarding children and young people and are currently in the process of recruiting a safeguarding nurse specialist to further support the service.

MASH

The safeguarding team actively participate in MASH and are signed up to being an information point for health.

Safeguarding Children

Mitigation plan (actions to date and future planning)

NSCB Markers of Good Practice -

1. Attendance at the NSCB meetings will be shared between the Medical Director, as Lead Director and the Deputy Director of Nursing & Quality in their absence.
2. The Named Nurse is new in post but plans are in place to ensure training is undertaken and competencies are achieved.
3. Policy to be updated to ensure all staff report via safeguarding team so that all referrals are captured.
4. Whilst a report is produced, continued non-compliance needs to be followed up by TED in the longer term and reports produced for action.
5. Training, Education and Development to continue to inform Divisional Directors, Heads of Nursing/Departments of non-attendance and leads to follow up. Safeguarding Children Training is also recorded on the Safeguarding Children Dashboard - compliance rates are escalated to Safeguarding Governance Group (though attendance at this meeting is historically poor). TED report compliance rates to Board on a bi-monthly basis. Additional training sessions have been provided to ensure all staff requiring level 3 training are able to access but compliance remains lower than expected.
6. Mandatory training (Level 2) for Medical staff compliance is currently at 60% previously recorded at 15%
7. Some supervisors require training to be updated. Plans are in place with the CCG Designated Nurse to deliver supervision training in 2015.
8. Compliance rates are 100% for 1:1 supervision, but not all staff attend group supervision. Supervision sessions for ED and MIU staff are to be reviewed.

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

1. Safeguarding CYP training offered at levels 2 & 3 will meet RCPCH standards from April 2015. Compliance of staff in attending training however remains an issue across the trust, and is reflected in item 5 above.
2. Funding has been identified to appoint a safeguarding nurse specialist to work across the Trust, including Newark Hospital, ED, Adult areas where young people are cared for and out-patients.

MASH

No actions at present

Learning Disability

Learning Disability targets for 2014/15 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 – most notably to provide individualised care to vulnerable adults.

How are we performing against this target

1. Training – Induction Programme for Quarter 2, 82% compliance (1839 employees have undergone training). Mandatory Training for Quarter 2, 95% compliance (528 employees have undergone training)
2. Learning Disability Steering Group update:

   The adult changing places facility has now been completed.

   Wheelchair access to the car parking machine at Newark Hospital for disabled users has now been resolved.

   The Learning Disability policy has been updated and will be tabled at the next Safeguarding Adults Board.
3. Referrals to the Learning Disability Nurse Specialist during quarter 2 = 73 patients
4. The Trust maintains compliance against the CQC Learning Disability standards. (Learning Disability Policy was audited February 2014)

Mitigation plan (actions to date and future planning)

1. The Learning Disability & Safeguarding Adults leads have arranged to attend a forthcoming study day hosted by The National Autism Society in order to gain a greater understanding and awareness of this condition. It is envisaged that a trust wide autism strategy will then be developed.

End Of Life Care

End of life care targets for 2014/15 are :

1. **Internal –** To produce an overarching End of Life Care (EOLC) Strategy.
   To continue to deliver EOLC training on the SFHFT induction and mandatory training programme in conjunction with the provision of communication skills training for staff

2. **To facilitate the following EOLC key enablers**

N0:	Indicator	Description
1	Last Days Of Life Care	Launch and embed the LDOL guidelines and care plans into practice. Continue to monitor quality of care being delivered to patients in the last days / hours of life.
2	Gold Standards Framework Register & Advance Care Planning	Continue to implement advanced care planning for patients as part of the Gold Standards framework in Acute hospitals programme (GSFAH) on Wards 42, 51 and 52. By the end of 2014/15 10-15 patients will be identified for the Gold Standards Register and will have had discussions regarding their Advanced Care Planning (ACP).
3	AMBER Care Bundle	Continue to implement AMBER Care Bundle (ACB) on Wards 43 & 44. Commence implementation on Wards 24, and 53 by the end of Quarter 2.
4	EPaCCS	Work collaboratively with Primary & Community Care to develop the system for sharing patient information
5	Patient/Carer Experience	Commence a bereavement survey to capture patient/carers experience in the last days/hours of life

End Of Life Care

How are we performing against this target

Indicator	Progress to Date
End of Life Care (EOLC)Strategy	An overarching EOLC strategy is currently out for consultation. Anticipated that this will be ready for final approval at the end of October
MDT Training & Education	The EOLC Team continue to deliver training regularly to staff new to the Trust at induction; at doctors induction; and on junior doctors palliative care study sessions. EOLC module currently being developed for inclusion to the Mandatory training programme. It is anticipated this will be finalised by the end of December. Currently limited access to communication skills training for staff involved in having difficult conversations with patients/carers who are at the end of life, due to the unavailability of courses. However, funding now available to support Cancer MDT and core members are attending Advanced Communication Skills Training.
Key Enablers 1. Last Days Of Life Care	The Last Days of Life Care Guidelines and documentation to support individualised care plans was launched on the 8th September and are now being embedded into practice across the Trust. A number of presentations at various forums, committees and meetings are being delivered by the end of life care team to support and raise awareness of the guidelines. In order to measure the quality of end of life care being delivered, a baseline audit has been performed prior to the launch of the guidelines and an on-going audit has been commenced.
2. Gold Standards Framework Register & Advance Care Planning	Wards 42 & 51 are now in their 2nd year of the GSFAH Programme. Continuing to identify patients within the last year of life and initiate advance care planning where appropriate and are communicating discussions had with the for patients and carers to the GP via the discharge summary. Wards 34 & 52 recently registered on the GSFAH Programme in Phase 5. Ward Leaders and End of Life Care Champions from both wards attended the 1st Workshop and are currently conducting a baseline audit to establish current practice. It is anticipated that training will commence in Quarter 3.
3. AMBER Care Bundle	Wards 43 & 44 continue to support patients with uncertain recovery using the AMBER Care Bundle (ACB). An audit of the impact on patient care and completion of documentation is underway. Unfortunately the roll out to Wards 24 and 53 has been put on hold due to workload pressures within the EOLC Team.
4. Rapid Discharge Home to Die	The number of Rapid Discharges home to die continues to be monitored. Only 1 patient was discharged via this process in July and August. Refining the Rapid Discharge process is work in progress.

End Of Life Care

How are we performing against this target

Indicator	Progress To Date
Patient/Carer Experience	A bereavement survey to capture patient/carers experience during the last days/hours of life is being planned and will commence in quarter 3. This will be an on-going audit and the findings will be reported on a quarterly basis
Preferred Place of Care	The Integrated Discharge Advisory Team (IDAT) continue to support the process of enabling those in the last days/hours of life to die in their Preferred Place of Care (PPC) by coordinating and effectively managing the discharge process. The PPC data being captured on a monthly basis by the IDAT shows in July and August 79 patients were in their PPC, 16 were discharged home; 18 to a nursing home/residential home; 2 to the hospice; 1 to other and 42 chose to stay in hospital. Unfortunately September data is currently not available for this report.
Anticipatory Medications	The number of patients being discharged with anticipatory medications prescribed continues to be monitored. Data shows that 17 patients in total were discharged with anticipatory medications prescribed during July and August. Unfortunately September data is currently not available for this report.

End Of Life Care

Mitigation plan (actions to date and future planning)

No	Indicator	Description
1	End of Life Care (EOLC) Strategy	Approved and launch in November
2	MDT Training & Education	Continue to deliver EOLC training on new staff induction and junior doctor's palliative care study sessions. An EOLC module to be included in the mandatory training programme by December
3	Last Days of Life Care	Continue to raise awareness and embed the LDOL guidelines and care plans into practice through support and education Continue to measure the impact of the quality of care being delivered to patients in the last days/hours of life through audit. Evaluate the documentation and revise as a result of feedback at the end of December.
4	Gold Standards Framework Register & Advance Care Planning	Continue implement advance care planning for patients as part of the Gold Standards Framework in Acute Hospitals Programme (GSFAH) on Wards 34, 42, 51 and 52 Continue to monitor the number of patients identified for the Gold Standards Framework register and have had discussions regarding their Advance Care Planning (ACP) Commence MDT training on the implementation of the GSFAH on Wards 34 & 52 in December
5	AMBER Care Bundle	Continue to implement AMBER Care Bundle (ACB) on Wards 24, 43, 44, and 53. Commence implementation process on Wards 24 & 53 by the end of Quarter 2 & MDT training in January
6	Rapid Discharge Home To Die	Continue to monitor the number of Rapid Discharges home to die. Audit the timeliness of the discharge and report data quarterly
7	EPaCCS	Continue to support the system development and integration into Secondary Care
8	Patient/Carer Experience	Commence a bereavement survey in Quarter 3 to capture patient/carers experience. Report findings on a quarterly basis.
9	Preferred Place of Care	Continue to audit the number of patients who achieve their preferred place of care.
10	Anticipatory Medications	Continue to audit the number of patients being discharged that have anticipatory medications prescribed

Maternity

Maternity targets for 2014/15 are :

- **CQUIN –** 1. To achieve an 5% reduction in smoking at the time of delivery (SATOD) by March 2015. (Target 21%)
  2. To deliver smoking cessation support via the Rotherham Model by March 2015.
- **Contractual –** To provide a Midwife to birth ratio of 1:28

How are we performing against this target

CQUIN

1. Regular monitoring in place – In Quarter 2, 20.67% of mothers were smoking at the time of delivery. Year to date = 22.5%
   In September 17.98% of women were SATOD this reduction is due to the Rotherham Model being introduced in May and these mothers are starting to give birth from mid September onwards.
2. The Rotherham Model has been implemented to deliver smoking cessation support.

Midwife to Birth Ratio.

During quarter 2 we narrowly missed the midwife to birth ratio recording 1:30 during the quarter.

Mitigation plan (actions to date and future planning)

CQUIN

1. We continue to meet on a regular basis with Public Health colleagues and our smoking cessation programme continues.
2. Discussion has commenced regarding recurrent funding to support the longer term sustainability of The Rotherham Model.

Midwife to Birth Ratio.

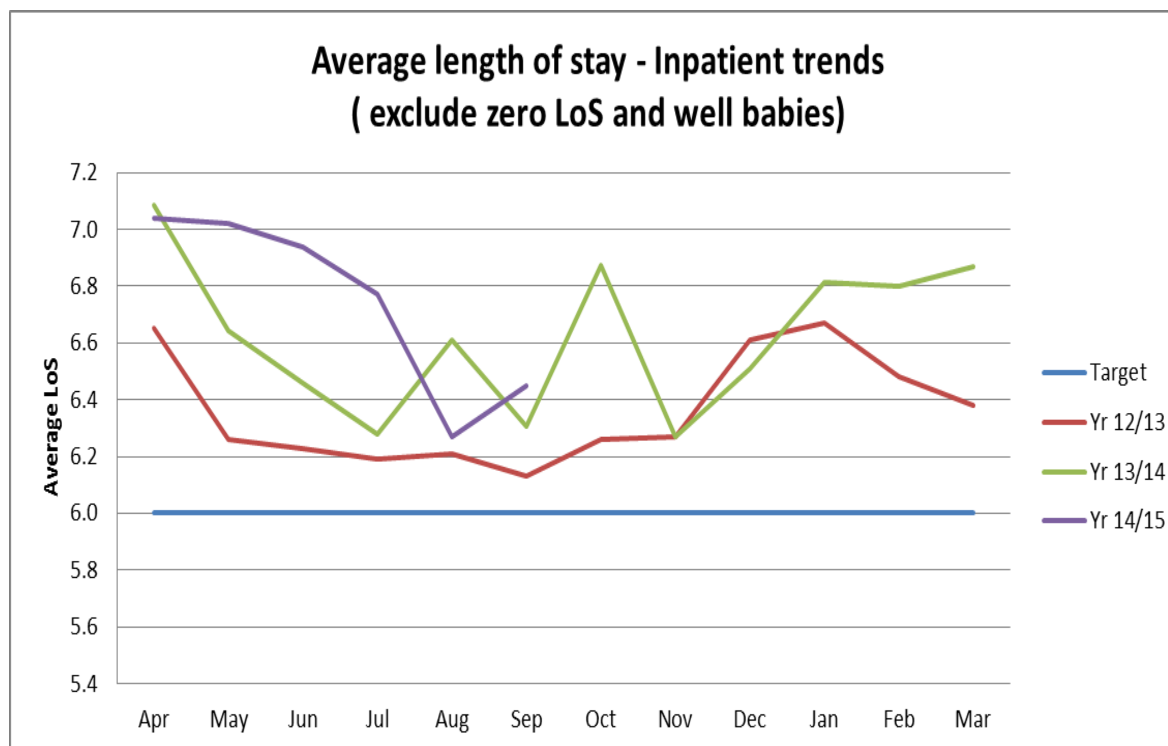
1. We have successfully recruited to a number of midwifery and specialist posts.
2. We are currently in the process of undertaking a midwifery establishment review, the results of which will be formally presented

Improving Patient Flow and Discharge Processes

Improving Patient Flow targets for 2014/15 are :

CQUIN - To reduce LOS (excluding 0-1 day LOS) to **6 days**

- The target has not been met.
- There were month by month improvements in length of stay over the summer despite some periods of very high pressures in the system followed by a small rise in September
- Previous years show a similar pattern and it is interesting to note that the summer improvement was slower this year



Improving Patient flow and discharge processes

Mitigation plan (actions to date and future planning)

Action to date:

- Board Round Improvement Programme established and Board Round Standards agreed
- Transfer to Assess (T2A) approach agreed by the Urgent Care Network
- Project plan and work streams up and running for T2A
- ‘Perfect Week’ on ward 52 and lessons learned
- Social Care and Discharge Teams now co-located
- Discharge Lounge pilot evaluated as successful and now open in final location on Clinic 9

Future Planning:

- All wards to complete board round training sessions by 30/11/14
- Board round sign off process to be agreed and implemented
- Capacity Planning Group to be established
- Transformation Programme brand and comms to be implemented to support messages re Emergency Flow
- Clinical Congress planned to help embed changes being made
- Ward 52 to work to ‘Perfect Ward’ standards with support from community services and social care
- Team to be formed to reduce backlog of patients in delay
- T2A workstream to deliver non-acute beds; transfer to home where possible and integration of community, hospital and social care services to provide seamless care for patients in line with Better Together
- To deliver a non-weight bearing pathway which will become part of the T2A model
- To maximise impact of discharge lounge including action to expedite TTOs
- To update discharge and escalation policies

Incidents, Serious Incident & Never Events

Overview of Incidents

The National Reporting and Learning System (NRLS) Organisational Patient Safety Incident Report compares Sherwood Forest Hospitals with other medium acute organisations. The medium reporting rate for this cluster of organisations is 7.82 per 100 admissions and SFHFT reporting rate is 7.95 (1/10/13 – 31/3/14) which is average.

In Quarter 2 the reconfiguration of the web based Incident reporting module was launched on the 1st of August 2014. Recording lessons learnt and providing feedback to the reporter of the incident is a key aspect of the changes to the process for managing incidents. Currently this involves manual inputting of information into the communication section within the incident on Datix by the Handler. The process is quality controlled by the Datix Administrator and incidents are not pulled into final approval until lessons learnt have been recorded in the relevant section and feedback is given to the reporter.

The Trust is currently using Datix web Version 12.0 and during the reconfiguration process we were advised to upgrade to Version 14 which was planned to be in place by the end of 2014. We have been recently advised that Version 14 will be delayed for a year. Datix have introduced Version 12.3 which will give automated feedback when the reporter requests this at the time they report an incident. Unfortunately the Trust is unable to upgrade to this Version immediately as a new server is required to support the change. NHIS are facilitating the server upgrade and as soon as this has been completed Version 12.3 can be installed and automated feedback will be available.

Automated feedback will be available as soon as Version 12.3 is installed.

Never Events

There have been no ‘Never Events’ reported since December 2013.

Incidents, Serious Incident & Never Events

Incidents

From the 1st August incidents are categorised by the reporter as they are best placed to determine this. Defining the incident Improves the ability to clearly identify trends and themes.

The data from the 1st August is available immediately by category, prior to this date the information was not precise and relied on a manual system of coding, work is still on-going to add the adverse event to July's incidents. All coding is now aligned to the category and signed off by the NRLS.

Below is a comparison of July's data (the adverse event was determined during the coding process) with data from August and September 2014 this shows the clarity of reporting.

July 2014 - Top 3 Incidents by Adverse Event

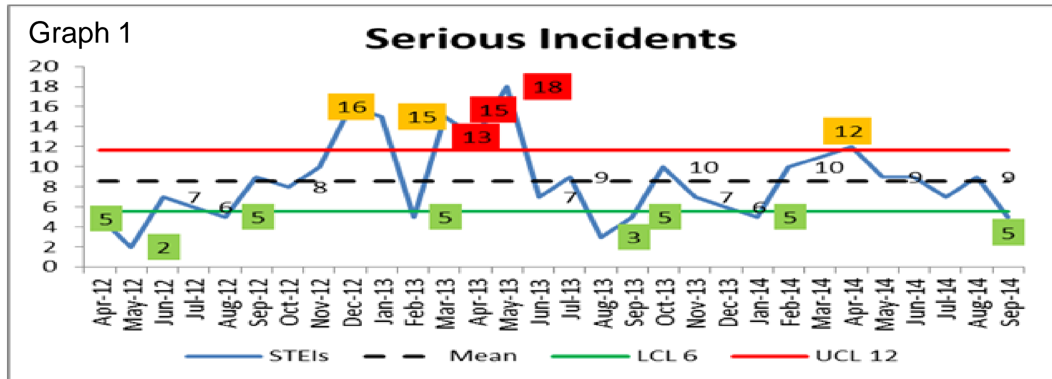
	Strategic Planning and Commercial Development (SPCD)	Emergency Care and Medicine	Planned Care and Surgery	Diagnostics & Rehabilitation	Central Services Division	Newark Hospital
Implementation of care or ongoing monitoring/review - other	0	75	8	1	0	1
Other - please specify in description	2	33	30	7	2	1
Fall on level ground	0	50	6	6	0	0

August and September 2014 - Top 3 Incidents by Category

	Strategic Planning and Commercial Development (SPCD)	Emergency Care and Medicine	Planned Care and Surgery	Diagnostics & Rehabilitation	Central Services Division	Newark Hospital
Falls	1	245	50	17	0	7
Pressure Ulcers	0	233	50	9	0	2
Medication	0	112	43	17	0	5

Incident, Serious Incidents & Never Events

Serious Incident summary



In the period of Quarter 2, there was a total of 21 STEIS reportable Serious Incidents.

The number of Serious Incidents reported during Quarter 2 2014/15 is comparable with Quarter 2 2013/14 - Graph1

Table 1

Number of Serious Incidents by Division and Serious Incident reporting category.

Number of SI's	**Emergency Care and medicine**	Number of SI's	**Planned Care and Surgery**	Number of SI's	**Newark**
5	Slips/Trips/Falls	4	Maternity services- suspension of services	1	Safeguarding
3	Pressure ulcer grade 3	2	Maternity services IUFD	1	Slips/Trips/Falls
1	Delay in diagnosis	1	MRSA colonisation outbreak (not bacteraemia)		
1	Suboptimal care of the deteriorating patient				
1	Information Governance				
1	Clostridium Difficlie				

The number of serious Incidents by Division and STEIS reporting category is detailed in Table 1.

The CCG have shared a draft copy of the revised Guide to NHS Serious Incident Management published by NHS England, this guidance will be reviewed by the Governance Support Unit (GSU) to ensure that Trust Policy will be aligned.

The GSU is also participating in a Never Event consultation process being undertaken by NHS England.

Incidents, Serious Incident & Never Events

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. This table shows examples of lessons learnt from reports submitted during this period.

Examples of some of the actions following incidents are given below:

Trust Wide

•Review of the Head Injury Policy and the need to ensure that the medical teams are aware of monitoring requirements and compliance to NICE guidance. To ensure that the patients are monitored in line with NICE guidance.

•Information Governance team is launching a communication campaign with regards to the security of confidential waste, in response to increased incident reporting .

•A reminder to be shared with all Heads of Nursing and Ward Leaders regarding the importance and necessity to check agency nursing staff induction green card. There is a requirement for Trust Nursing staff to be aware of, monitor and complete the agency induction checklist to ensure that Agency nursing staff are aware of the Trust Policies and Procedures and how to contact the on call Doctor if the need arises.

•The Risk Assessment Tool for Enhanced Support will be considered as being part of the Inpatient Adult Nursing Risk Assessment Booklet within the Documentation Group .A Risk Assessment for Enhanced Patient Support was not conducted on admission to EAU. This led to a failure to provide a level of Enhanced Patient Support. Having within the document would result in this being considered as part of the assessment process .

•The Emergency Department will undertake a review of the care pathway documentation from admission until transfer out of the dept. This is to include recommendations and agreed actions that will be implemented in order to improve the standard of documentation of care for patients admitted to the Emergency Department.

Learning from Serious Incidents

Divisional

- Improved understanding of the the Trust wide Guideline for Enhanced Patient Support. There is a requirement for nursing staff to be updated with regard to the Risk Assessment and use of the Trust wide Guideline for Enhanced Patient Support particularly for patients who are at risk from falls.

Speciality

- The process for cross checking the type and power of an intraocular lens prior to insertion. There were no cross checks with the biometry results/theatre list and the WHO check list.

- NHIS and Trust pathology department are reviewing the ownership and knowledge of the different components of the Electronic requesting and reporting software processes. There is a requirement to establish clarity of system ownership and responsibility

- Nursing staff to understand the importance of patient assessment and appropriate movement and handling equipment to be used when a fall has occurred. Hover jack not used to move the patient. All staff to be re- trained in the use of specialist aids by the link nurse for moving and handling to improve staff knowledge.

- Investigation findings to be shared with the Physiotherapy Team, and request that new signs and symptoms are verbally communicated to ward team in addition to written documentation of findings. Reliance on written communication from the physiotherapist to the ward team in respect of new patient signs/symptoms. No documented evidence of verbally communicating findings to ward team to alert them to new information.

- Medical teams are advised that when a review is required for a specified date and time that this is clearly articulated and documented. To allow the referring team to schedule this into the required time frame for the patient to help prevent delays in surgery. Patient review by the Urology Team was not undertaken nor advice to Trauma team by required date to inform decision to operate.

CQC Compliance & Quality Assurance

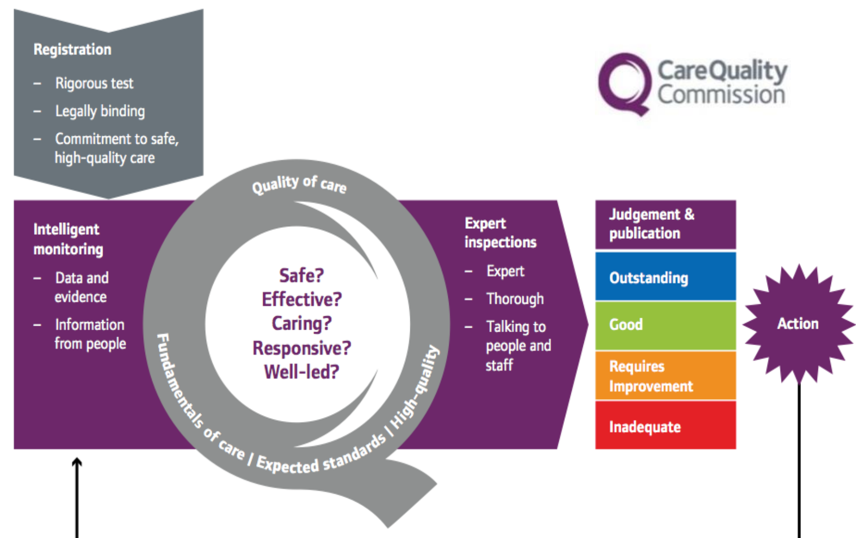
As with all health care providers, Sherwood Forest Hospitals is required to be registered with the CQC and inspection of services is an integral part of this. Inspection of our services by the CQC took place in April 2014 with the results of this influencing the decision of Monitor to maintain our special measures status for a further six months. We have made significant progress and improvements since our last inspection and we continue to work with our 'buddy Trust' (Newcastle upon Tyne Hospitals) and our Improvement Director (Gillian Hooper) to make further advances. We aim to be removed from 'special measures' following our next inspection (expected in early 2015).

CQC Model Finalised

In late September the CQC finalised their new approach to acute hospital inspections and internally we are adapting our own assurance processes to reflect this new approach.

The new model of inspection assesses services across five domains, asking if services are **Safe, Effective, Caring, Responsive and Well-Led** and applying the four ratings of **Outstanding, Good, Requires Improvement or Inadequate** to each. Aggregated scoring is used to indicate an overall rating as well as providing ratings for divisions.

There has been a fundamental change in the methodology of looking at services provided. Inspectors follow a 'key line of enquiry' (KLOE) approach to look for good practice, concentrating on the needs of complex patients who use a service.



Out of Hours Visit

During September a team of 9 senior nurses undertook an out of hours assurance visit on the main Kings Mill site whereby they visited a number of inpatient wards unannounced at 03:00. A total of 15 wards were visited and over 85 staff were interviewed generating more than 350 responses of which were subsequently inputted into an electronic survey tool.

Findings were predominately positive with staff indicating that they felt supported during night shifts, they equally demonstrated fantastic levels of professionalism and care. Areas for improvement included record keeping, personalisation of some care and the distribution of temporary staffing across the site.

Further out of hours visits are being planned for later in the year. One of the key findings from this is that reports from future assurance visits need to be shared efficiently and effectively with a wider audience.

CQC Compliance & Quality Assurance

Executive Walk Rounds
During September a number of Trust Executives and Non-Executives undertook a series of 'walk-rounds' across a number of clinical areas across the Trust. Whilst observations made during these visits were reported back for assurance, the visits enabled clinically based staff to meet with the Trust Board and have their questions answered.

Nursing Metrics
A more advanced system for assessing nursing care at Sherwood Forest Hospitals is being devised through a project group. Our existing 'Focus IT' metrics system requires updating to keep pace with the many improvements already made and to better suit our future needs. The tendering process has commenced with a view to us being able to shape and influence a future system.

Intelligent Monitoring Reports
Intelligent Monitoring Reports (IMR) present findings from statistical analysis indicators that look at a range of information including patient experience, staff experience and performance. Data is analysed from a range of sources, including:

- Hospital Episode Statistics.
- Incidents reported to National Reporting and Learning System.
- Never Events reported to the Strategic Executive Information System (STEIS).
- National Inpatient Surveys.
- Experience information reported on NHS Choices, Patient Opinion, and to CQC.
- NHS Staff Survey.
- Junior Doctor Survey.
- Electronic Staff Record.
- Staff concerns reported to CQC (whistleblowing information).

They are produced by the CQC and are used to influence the need for inspection as well as give Trust's a reliable indicator of potential areas of concern by highlighting areas of 'risk' or 'elevated risk', as appropriate. IMR's replaced the older style Quality and Risk Profiles (QRP) in July this year. IMR's are provided four times a year and we are anticipating our next IMR any time now.

Links
You can view the latest full CQC report, as well as our latest CQC inpatient survey by following the links below.
Inpatient survey > http://www.cqc.org.uk/provider/RK5/survey/3
Latest IMR > http://www.cqc.org.uk/sites/default/files/RK5_103v3_WV.pdf
CQC report in full > http://www.cqc.org.uk/sites/default/files/new_reports/AAAA1772.pdf

Feedback from Quality Committee

HIGHLIGHT REPORT – Quality Committee 18 September 2014

Incidents, Serious Incidents & Never Events

Serious Incident Report

The July and August SI position statement papers were summarised. There was discussion regarding Root Cause Analysis (RCA) review and sign off processes and NEDs were provided with assurance around the RCA methodology, process and outcomes, in particular that Serious Incident RCA reports are confirmed and challenged at the sign off group which meets every two weeks and has Executive Director attendance. The review and sign off process includes a review of the action plan to ensure it adequately reflects the findings of the RCA and that actions are SMART. The action plan is also not closed until evidence is received that all the actions have been completed. Committee members were advised that the Clinical Quality & Governance Committee (CQGC) look at trends and themes. It was noted that there will be some slippage in timeframes given the more robust scrutiny of RCA's.

There was specific discussion regarding the Healthcare Association Outbreak referred to in the August SI report. The impact of increased activity was discussed and it is well recognised that increased utilisation increases the chance of infection control issues particularly when operating at above 85% capacity. SFH are operating at above 90% capacity. It was however confirmed by the Infection Control Nurse Specialist that whilst a full ward decant clean has not been possible, they are deep cleaning bays and side rooms. It was confirmed that in 2012/13 six areas were deep cleaned and to date in 2013/14 the same has been accomplished. The clean team responsible for deep cleaning are on standby and respond rapidly to any opportunities to deep clean an area. In addition, a case of need for new equipment has been submitted which will reduce time taken to decontaminate and is more effective.

CQC Assurance and open debate

Adam Haywood, Assistant Director of Nursing attended to apprise the committee regarding his role. He stated that his role is to get the internal assurance process up and running and identify what has been done previously and what the potential gaps to fill are. A model is being worked on to ensure a route of assurance from ward to board. Members were advised regarding survey monkey for data collection and that survey monkey is being used to get the data collected and analysed and any issues will be fed back to the clinical lead to ensure issues are identified, escalated and leads are supported in improvement actions. It was confirmed that whilst the CQC are working on the five domains (Safe, Effective, Caring, Well-led and Responsive), they continue to use the judgement frameworks and therefore SFH will continue to use the outcome frameworks using a key line of enquiry approach to support self assessment. A mock CQC visit is planned to include an overnight visit and a full visit across SFH on 17 October 2014. This full day event will seek to assess our Trust's position by replicating the CQC inspection process. In order to do this, an invitation was extended to internal and external stakeholders to attend on the day. Representatives included a number of disciplines as well as commissioners and former patients acting as 'expert by experience'. This opportunity will be used to scrutinise the Trust, discovering how the many recent improvements are working for our patients, their families and carers and where further efforts can be made. The results will go into survey monkey and a forum for the concerns raised will be identified. Given the importance of external objectivity, it was agreed that the Executive Director of Nursing & Quality would engage key stakeholders involved to include non-execs in a workshop.

Feedback from Quality Committee

CQC Intelligent Monitoring Report

The CQC Intelligent Monitoring Report is intended to be a quarterly report and to date the first was released on October 2013 and the latest report is dated July 2014. The CQC has developed a model for monitoring of acute and specialist NHS Trusts. The intelligent Monitoring Report looks at more than 150 different sets of data (indicators) to help the CQC to decide when, where and what to inspect. The data the CQC looks at includes information from staff, patient surveys, mortality rates and hospital performance information such as waiting times and infection rates. The purpose of the Intelligent Monitoring is that the CQC, together with local information from their partners and the public, use the results to help them decide when, where and what to inspect. The CQC last updated their reports on 24 July 2014 and the specified report for Sherwood Forest Hospitals NHS Trust was shared.

The new reports included changes to the indicators they use as a result of comments they have received. The indicators have also been refreshed with more up-to-date data where it was available to them. In the July 2014 report Sherwood Forest Hospitals have 3 'elevated risks' in the red category and 5 'risks' in the amber category.

Elevated risks (Red)

- Dr Foster intelligence: Composite of Hospital Standardised Mortality Ratio Indicators. It is recognised in the report that HSMR data at SFH remains at 'elevated risk'. The data they have reported from is 1/10/2012 – 30/9/2013 and at that time our HSMR was in the 'elevated' category. However, since November, we have been in their 'no evidence of risk' category. Dr Foster has factored in 10% rebasing, but we still show an on-going improvement.
- Monitor governance risk rating subject to enforcement action therefore elevated risk
- Monitor – Continuity of service rating 1: significant risk therefore elevated risk. This is a new indicator and did not feature in the March report presented to Quality Committee.

Risks (Amber)

- Composite of Central Alerting System (CAS) safety alert indicators. The information is based on data from 1 April 2013 – 30 April 2014. There was one open at the time however this has since been closed. None remain open beyond timescales. This is a new indicator and did not feature in the March report presented to Quality Committee. A later paper highlights the current position.
- Composite indicator: In-hospital mortality: gastroenterological and hepatological conditions and procedures.
- Composite of hip related PROMS indicators – Data of 1 April 2013 - 31 December 2013 suggests PROMS oxford score: Hip replacement primary is in the lower 95% - hence amber risk. This is a new indicator and did not feature in the March report presented to Quality Committee. The Divisional matron is reviewing this indicator.
- Audit SSNAP Domain 2: overall team-centre rating score for key stroke unit indicator is level D. Data for this was 1/10/13 – 31/12/13. This is a new indicator and did not feature in the March report presented to the Quality Committee. The Divisional matron is reviewing this indicator.

Feedback from Quality Committee

- Composite risk rating of ESR items relating to staff sickness rates. Page 11 of report 2 amber risks around staffing proportion of days sick in last 12 months for both ‘other’ clinical and non-clinical staff. These did not feature as an amber risk in the March report. The revised management of sickness policy has been implemented with positive feedback and is considered will have a significant impact on reducing sickness absence.
- Ratio of nursing staff to occupied bed days amber risk observed 3>05 and expected 2.18.

It was also noted that there are three indicators in this ESR category that were a risk in the March 2014 report and show no evidence of risk in the July report. These include:

- ESRSIC01 Proportion of sick days due to back problems
- ESPRSUP03 Proportion of ward staff who are registered nurses
- ESRSTAFF01 Ratio of all medical staff and dental staff to occupied beds.

Never event incidence in March 2014 was a risk and in July is coded as no evidence of risk. The purpose of the paper (and other similar ones going forwards) was to ensure the Quality Committee get a deeper understanding of how SFHFT looked to, or is perceived by the public/stakeholders/regulators and inspection/accreditation teams.

Deep Dives

There were two deep dive presentations which included the Patient Experience in Emergency Department and Discharge.

Both were detailed presentations and provided assurance to the Quality Committee regarding actions being taken. It was confirmed by those presenting that undertaking deep dives had been an incredibly useful experience. The guest presented for the discharge confirmed that the work was being undertaken as part of the transformation agenda anyway and the request for this level of detail had helped focus the minds. On-going work of the transformational programme projects will be monitored as they all have KPI’s. Both presenters were requested to provide an update in 6 month’s time regarding progress made.

C-Diff External Report and C-Diff Performance Report

The Committee confirmed that they had received and read the report by Tim Boswell whom had been invited in to undertake a review of SFH. The review had been helpful and flagged some environmental issues which have been implemented. It was reported that the action plan has been implemented and is monitored and updated weekly. The anti-microbial guidelines have been changed i.e the criteria for using Fidaxomicin, and this has been incorporated into the anti-microbial guidelines. The cleaning programme has been amended to include Chlorclean. All the actions within the action plan are now complete apart from the fogging equipment which will enable a much quicker effective service. It was confirmed that the report has been shared with the CCG.

Feedback from Quality Committee

There was discussion regarding the Trust target of 37 for the year and the consequences of breaching this target. Committee members were assured that RCA's are completed and the above external review was part of on-going work to fully understand if anything further can be done to improve our compliance against target.

It was noted that there is a strong strain of Norovirus being report which was affecting regional hospitals.

Annual reports

Infection Control Annual Report and Annual Work Programme – The 2013/14 annual report was received and approved by the Quality Committee. The work programme for 2014/15 was noted.

Safeguarding Annual Report – The 2013/14 annual report was received and approved by the Quality Committee.

Complaints Annual Report – The Committee confirmed that they had received and read the report. It was considered that it would be helpful to have an understanding of the demographic profile i.e it would be useful to have a demographic profile of who is living in each area against who is putting in the complaints and also useful to have a comparison of age ranges. It was noted that the top five categories of complaints appear to be the same year on year. Committee members were advised that with the introduction of Datix Web there will be improved category and sub-category recording which will enable improved detail and consequently greater understanding of themes and trends. In addition, it is anticipated that the Quality For All values work and the Nursing and Midwifery focussed work on quality attributes will improve complaints related to attitude and communication.

There was discussion regarding timeliness of responding to complaints within the 40 day deadline as the reporting year included a period in time whereby there was a significant backlog of complaints. Committee members were informed that current performance in August for ECM, Newark and D&R is 100% and it is anticipated that within 2 weeks PCS will also achieve a 100% target. In terms of learning, the appraisal system will include complaints involving individuals and will form part of the data and appraisal output for medical staff.

The chair thanked the Infection Control team, the Safeguarding Leads and the Patient Experience team for their comprehensive annual reports.

Feedback from Quality Committee

NICE policy and Assurance around process
The Committee received and approved the revised NICE policy which had been amended to give more assurance of compliance of NICE and escalation for non-compliance. Committee members were assured around the implementation of the new processes and noted that going forwards non-compliance. Committee members were assured around the implementation of the new processes and noted that going forwards non-compliance will be recorded on the risk register. It was confirmed that implementation and compliance with the policy will be closely monitored.

Early Warning Scorecard and Assurance Dashboard
Paper received and no specific highlights. It was noted that medication incident reporting was increasing due to changes in the process and improved reporting and changes in pharmacy reporting however level of harm is still none or low. Training compliance was still noted by the non-execs to be low.

Compliance with CAS alerts
There was confidence that there were no concerns regarding pending deadlines and that it was expected there would be n delay in closing CAS alerts before deadline.

Quarterly Claims and Inquests Report
The report was received and there was discussion about how we pull together learning from claims and a coroners inquest as it is often out of date. It was agreed that in 2014 the claims and inquests data will form part of an integrated quarterly learning report.

Quality Committee Annual Work Programme
The outcome of the meeting held in August was agreed that the cervical screening paper would come to the September meeting, however in line with the deep dive in December on screening; a decision was taken to include this item as part of the deep dive.