Quarterly Patient Safety & Quality Report

Trust Board of Directors Meeting
31st July 2014
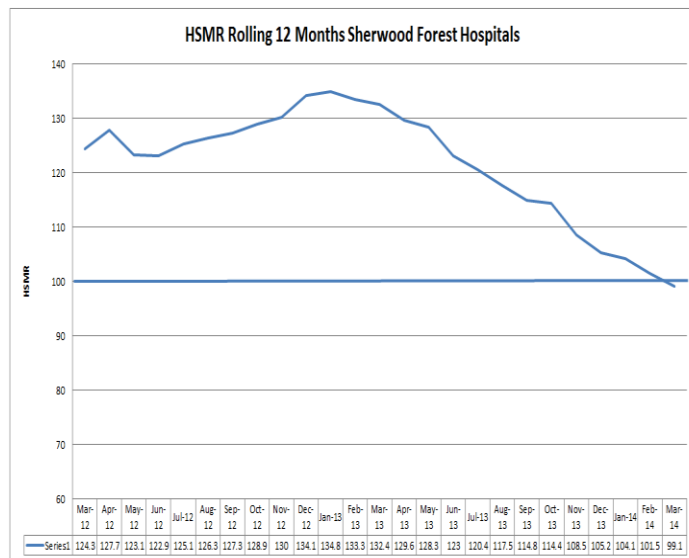
Quarter 1 Summary 2014/15

Contents – Patient Safety & Quality Report Quarter 1

Key Priority One	Reduce mortality as measured by HSMR	Headline & specific **HSMR within the expected range**
		To have an embedded mortality reporting system visible from service to board
		Eliminate the difference in weekend and weekday HSMR

Our HSMR continues to reduce. The following graph shows our rolling HSMR to March 2014 – end of Q4. Please note, the national figures have not yet been rebased, so a 10% recalculation has been applied to give a close approximation to the numbers expected after rebasing.

HSMR Rolling 12 Months Sherwood Forest Hospitals

|	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	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
Series1	124.3	127.7	123.1	122.9	125.1	126.3	127.3	128.9	130	134.1	134.8	133.3	132.4	129.6	128.3	123	120.4	117.5	114.8	114.4	108.5	105.2	104.1	101.5	99.1

This data is taken from Dr Foster Quality Investigator tool with the addition of an estimated 10% reduction in expected Apr 13 - Mar 14 due to rebasing of the data

Legend: ■ High relative risk ■ Low relative risk ■ Expected Range — National benchmark I () Spell Count

Current Position

The data for the year 2013/2014 has not yet rebased so our final benchmark position against the other acute trusts in the UK is not yet confirmed. The graph above shows the current position with regard to our local peers (still pending rebasing).

Crude Mortality - The crude mortality has reduced along with HSMR. This reassures us that the improvements seen in HSMR represent a genuine decrease in mortality rather than simply improvements in our coding.
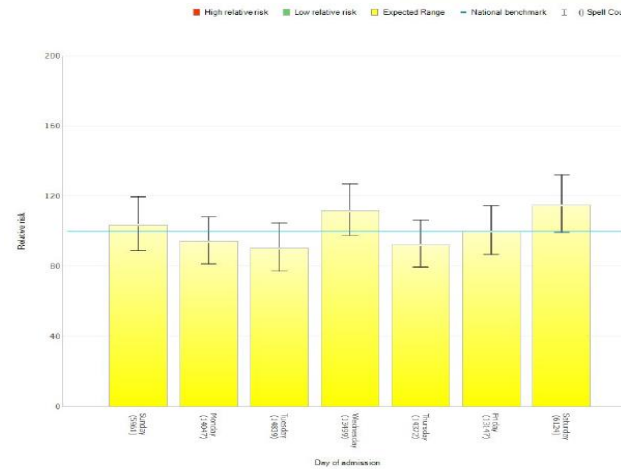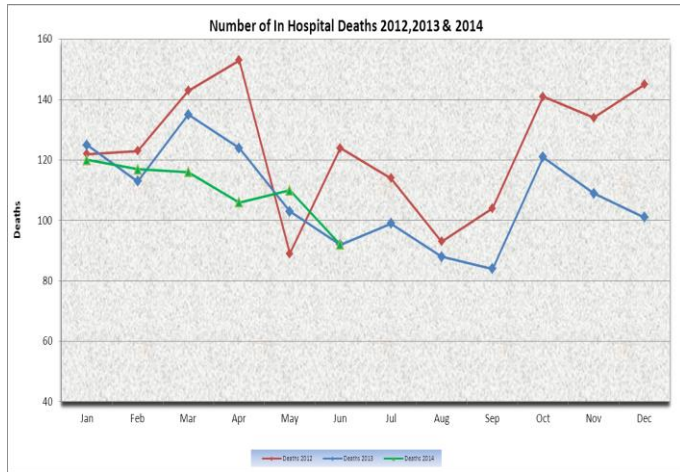
Weekend Mortality

Our weekend mortality remains elevated above weekday but the position continues to improve with a significant reduction in the variation and narrowing of the gap. We continue to monitor this closely. The chart above shows overall mortality by day of admission for the year April 2013 to March 2014.

Coding
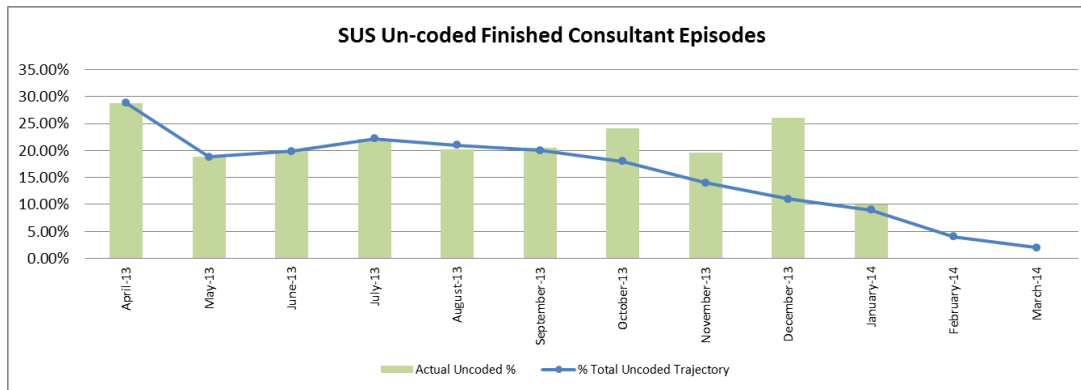
Clinical coding has improved over the last year to less than 5% uncoded episodes at the time the data was given to Dr Foster for March.

Alerts

Alerts show a higher than expected number of deaths in one area (Intestinal obstruction without Hernia). These cases are being reviewed to identify either any areas of concern that need investigation or to provide reassurance that there is no underlying problem

Work has begun with Dr Foster to build a bed to board reporting system for mortality and will be in place by the end of September.

Key Priority 2	Reduce harm from falls	Total falls **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
		Falls resulting in harm **<1.7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
		Reducing the number of patients who fall more than twice in hospital (baseline Q 14/15)
		Reduce the number of fractures from falls to **<25** for 2014/15

Trust wide inpatient falls resulting in harm rate (per 1000 OBD) Apr 2011 to June 2014
SPC set to first 30 data points after Jan 2011
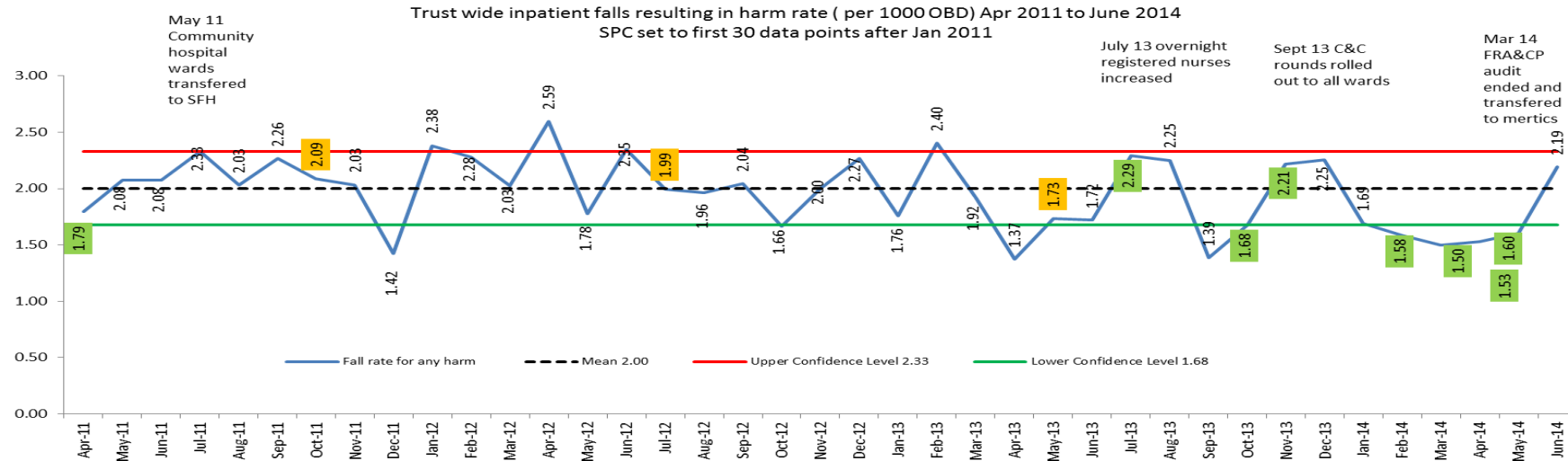
Total falls < 7 per 1000 occupied bed days by quarter 4 (quarter on quarter reduction)

➤ Total falls is 7.46 per 1000 occupied bed days for Q1.

Falls resulting in <1.7 per 1000 occupied bed days by quarter 4 (quarter on quarter reduction)

➤ Falls resulting in Harm for Qtr-1 is 1.93 which represents a slight in increase in this quarter
➤ There is a commitment with the Ward Leaders to ensure patients identified as being at risk are receiving interventions
➤ Earlier referral to the Allied Health care Professional for assessment remains a priority
➤ Wards are prioritised for support in ensuring compliance with the care plans and in action of escalating appropriately for enhanced care support, flowcharts informing all staff of this process have been printed and laminated in all ward areas.
➤ Strong links with the Front Door Geriatric Team remain in place to promote appropriate review of high risk patients

Reducing the number of patients who fall more than twice in hospital (baseline q14/15)

The baseline completed for repeat fallers is 20 for Qtr. 14/15

- Falls data is interrogated as part of the monthly ward assurance matrix with our senior nursing teams.
- The current intelligence received is that repeat falls in the same patient is contributing to our failure to show a marked improvement in fall numbers.
- Repeated falls in the same patient can be considered a failure of assessment and/or intervention (although some falls may be unpreventable without over-intrusive supervision or restriction).
- This is why we have chosen to do focused work to reduce repeat falls during 2014/15.
- Ward teams will be required to demonstrate what positive actions have been taken to reduce the risks of the patient falling again
- Monitoring for repeat falls remains a mandatory field on the Datix reporting system

The number of falls resulting in fracture for Qtr-14/15 is 9

- Ensuring these patients receive a timely review and receive appropriate treatment remains a priority
- The ward Leaders have nominated individuals from their wards to act as Falls Champions being responsible for disseminating information, promoting understanding and influencing change right at the point of care delivery.

Looking ahead

- We will undertake a falls prevention campaign during 2014/15.
- Our campaign has the aim of reducing harm from falls by promoting understanding of and compliance with good practice in falls prevention across the Trust.
- We will be auditing how care plans are actually implemented and acted upon.
- We will continue direct support to the ward teams to promote patient safety and facilitate on ward teaching
- Improvements in how the ward teams communicate about patients at risk from falls is also a priority agenda
- Focusing on the ward teams recognising when escalation is appropriate will also form part of the work the Falls Champions undertake
- Falls management requires a multifactorial approach and partnership working between different specialties is being adopted to influence change. It is therefore imperative that we also work jointly with our community colleagues to put improvements in across the patient pathway. The falls CQUIN for 2014/15 will support this.

Key Priority 3	Improve response rates and scores in the friends and family test	Increase our Friends & Family response rate to **50%** by October 2014To improve the score to **80%** by March 2015

The following table illustrates our current Patient Friends & Family Test (FFT) performance between April 2014 – June 2014 and includes the previous quarter data as a comparison both from a response rate and net promoter score perspective. The overall eligible response rate for acute in patients has improved during quarter 1 to 31.3% in comparison to that of 26.1% during the previous quarter. However the eligible response rate for A&E has deteriorated during quarter 1 to 13.5% in comparison to 15.5% during the preceding quarter. A new plan has been implemented to improve our A&E position through the increased utilisation of volunteers within the department to support patients in the completion of the survey. The Net Promoter Score has steadily improved over Quarter 1 to 70 from 63 during the previous quarter.

	Number of Respondents	Eligible Response Rate Acute In Patients	Eligible Response Rate A&E	Combined Response Rate for Acute In Patients and A&E	Maternity Services Response Rate	Net Promoter Score (+100 to -100)
January 2014	1251	24.8%	18%	20%	10.9%	63
February 2014	1063	27.1%	14.9%	18.1%	11.2%	63
March 2014	1141	26.4%	13.6%	17.1%	12.8%	63
Q4	**3455**	**26.1%**	**15.5%**	**18.4%**	**11.6%**	**n/a**
April 2014	1389	32.8%	16%	20.7%	18.9%	69
May 2014	1358	32.2%	14.9%	19.6%	12.4%	66
June 2014	1021	28.9%	9.6%	15.0%	12.4%	70
Q1	**3768**	**31.3%**	**13.5%**	**18.4%**	**14%**	**n/a**

During 2014/15 we will expand the friends and family test to our staff and across our patients presenting to our day case unit and outpatient departments. We are currently in the final stages of tendering for a provider to facilitate Friends & Family surveys on our behalf and it is therefore envisaged that through this and the use of a variety of data capture mechanisms that our response rates will improve.
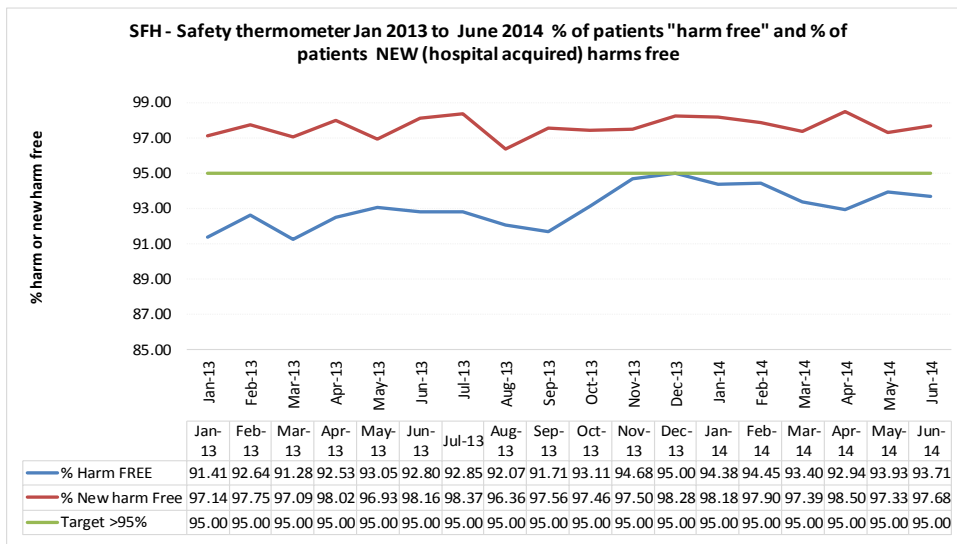
NHS Safety Thermometer Summary Qtr 1 2014/15

Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a '**temperature check'** on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients.

The NHS Safety Thermometer allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportion of patients that are 'harm free' in relation to
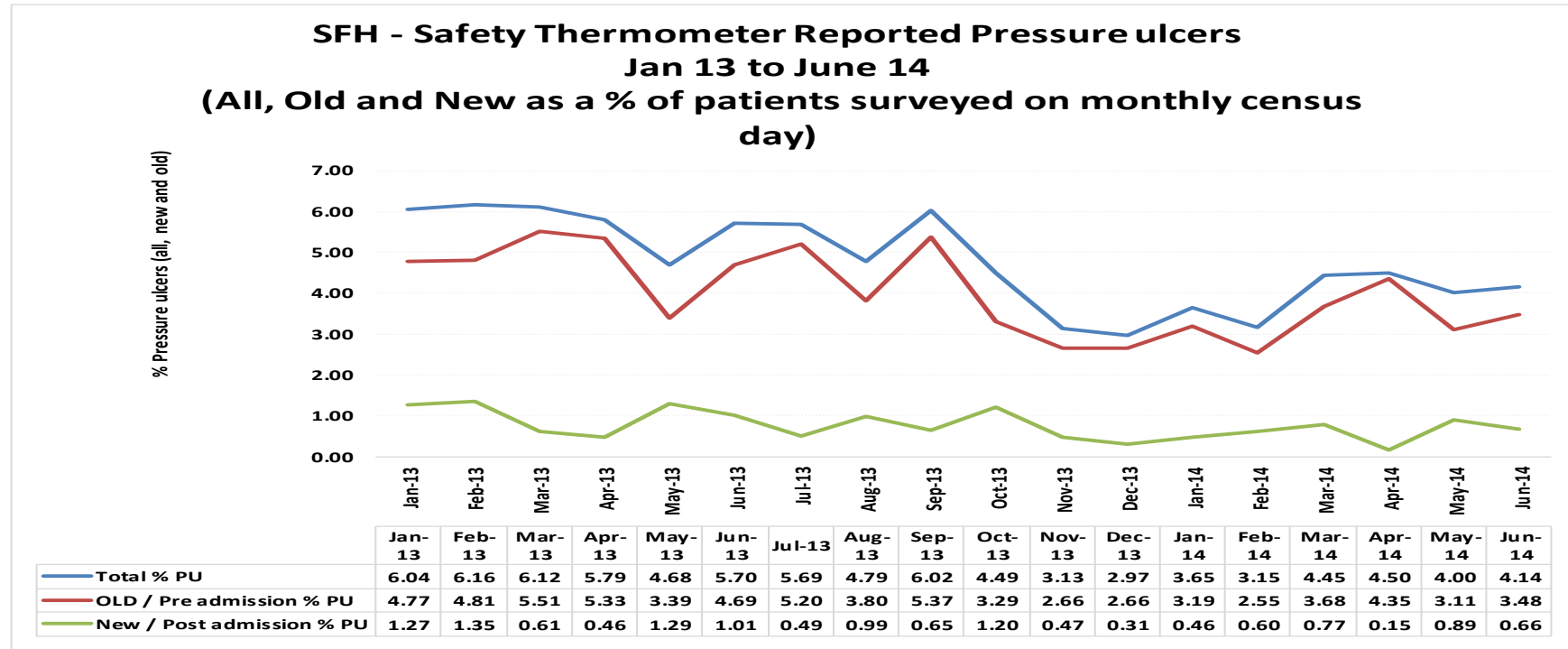
- **pressure ulcers**,
- **falls**,
- **urine infections** (in patients with a catheter) and
- **venous thromboembolism**

This isn't limited to hospitals; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide.

The graph below shows the % patients classified as "harms free" and "NEW (hospital acquired) harms free by month and indicates that for Quarter One we have not achieved the 95% target ,although continue to remain above 95% for patients who have acquired NEW harms.

SFH - Safety thermometer Jan 2013 to June 2014 % of patients "harm free" and % of patients NEW (hospital acquired) harms free

	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
% Harm FREE	91.41	92.64	91.28	92.53	93.05	92.80	92.85	92.07	91.71	93.11	94.68	95.00	94.38	94.45	93.40	92.94	93.93	93.71
% New harm Free	97.14	97.75	97.09	98.02	96.93	98.16	98.37	96.36	97.56	97.46	97.50	98.28	98.18	97.90	97.39	98.50	97.33	97.68
Target >95%	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00

NHS Safety Thermometer

100% Patients

On 1 day
Once a month

Measuring 4 Harms

8

The Graph below illustrates the point prevalence figures i.e. all Pressure ulcers (whether hospital acquired or not) on monthly census day.

SFH – Safety Thermometer Reported Pressure ulcers Jan 13 to June 14
(All, Old and New as a % of patients surveyed on monthly census day)

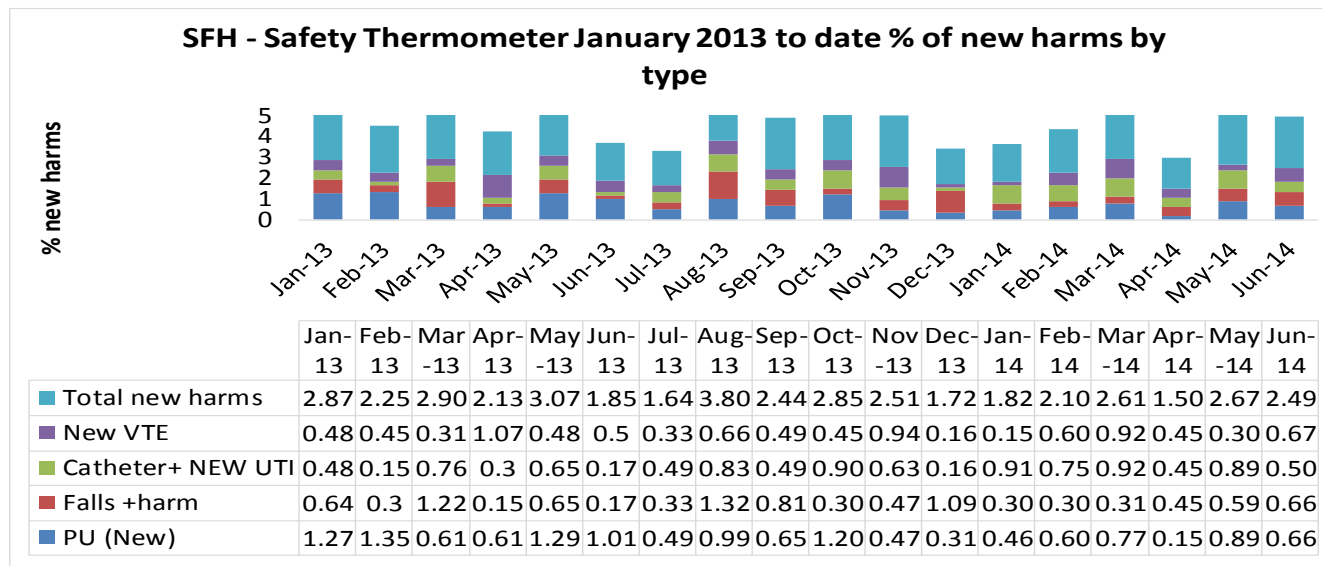|	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Total % PU	6.04	6.16	6.12	5.79	4.68	5.70	5.69	4.79	6.02	4.49	3.13	2.97	3.65	3.15	4.45	4.50	4.00	4.14
OLD / Pre admission % PU	4.77	4.81	5.51	5.33	3.39	4.69	5.20	3.80	5.37	3.29	2.66	2.66	3.19	2.55	3.68	4.35	3.11	3.48
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

2014/15 CQUIN TARGET The focus is on continuing to reduce the prevalence of pressure ulcers.
During 2014/2015 the Trust is expected to achieve a 50% reduction in prevalence of reported pressure ulcers (pre-hospital and hospital acquired) below the Trusts baseline median value as measured using the NHS Safety Thermometer to achieve the CQUIN target.

% Harm Free July 13-Jun 14 National/SFH figs

Legend: National, SFH
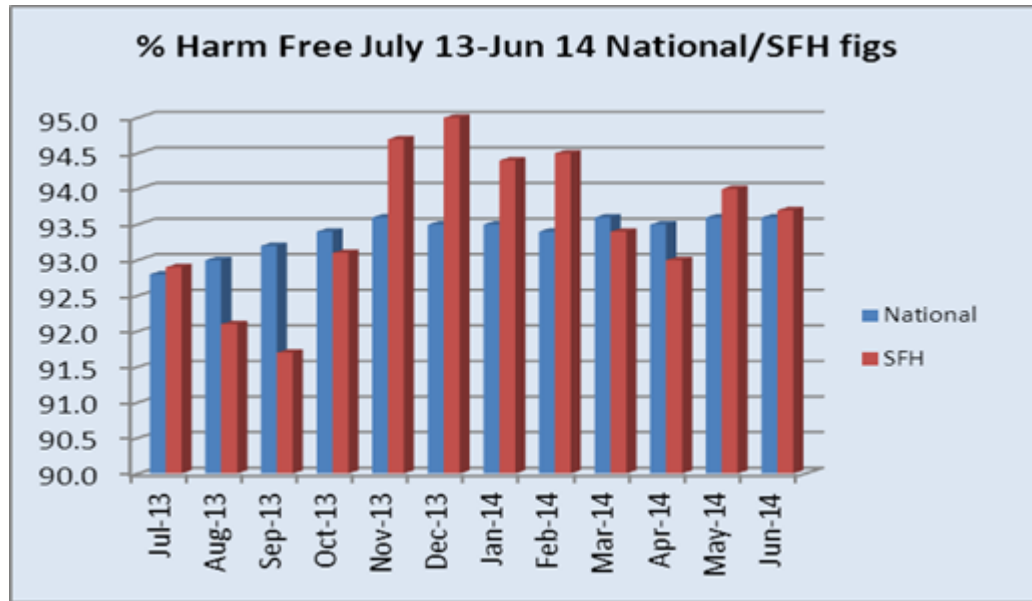
The graph on the left illustrates the Trust position of harm free care alongside the national average performance.

What do the results tell us?

For April-June 2014 SFHFT has had 2 out of 3 months where our reported 'harms' rate was less than the national reported rate - this includes pre-hospital (old) as well as hospital acquired harms

The graph below shows our rate of 'NEW' harms by type per the safety thermometer data.

SFH - Safety Thermometer January 2013 to date % of new harms by type

	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
Total new harms	2.87	2.25	2.90	2.13	3.07	1.85	1.64	3.80	2.44	2.85	2.51	1.72	1.82	2.10	2.61	1.50	2.67	2.49
New VTE	0.48	0.45	0.31	1.07	0.48	0.5	0.33	0.66	0.49	0.45	0.94	0.16	0.15	0.60	0.92	0.45	0.30	0.67
Catheter+ NEW UTI	0.48	0.15	0.76	0.3	0.65	0.17	0.49	0.83	0.49	0.90	0.63	0.16	0.91	0.75	0.92	0.45	0.89	0.50
Falls +harm	0.64	0.3	1.22	0.15	0.65	0.17	0.33	1.32	0.81	0.30	0.47	1.09	0.30	0.30	0.31	0.45	0.59	0.66
PU (New)	1.27	1.35	0.61	0.61	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

Next Steps

After each ward is surveyed and the data entered the Patient Safety lead supported by Tissue Viability team, IPCT and Lead Nurse for falls prevention will attend the ward to validate each harm alongside the clinical teams

These reviews will form a central component of NHS Safety Thermometer Day and will identify valuable learning opportunities.

Pressure Ulcer (PU) Reduction	• **CQUIN** – A 50% reduction in all PU's (both inherited and hospital acquired) using the safety thermometer data. • **Contractual** – A 50% reduction in avoidable PU's • **Internal** – The elimination of grade 3 and 4 avoidable hospital acquired PU's by October 2014 and achieve zero by March 2015

Table 1 below demonstrates actual numbers of avoidable pressure ulcers (by grade) in comparison to the contractual targets.

- A total of twenty seven avoidable grade 2 (superficial ulcers) pressure ulcers developed in quarter one, 12 of which were in June
- Two avoidable grade 3 ulcers developed on Wards 33 and 34 in April, but none since
- There have been no avoidable grade 4 (Deep) pressure ulcers for 18 months

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Totals
GRADE 2 - is superficial and may look like an abrasion or blister													
2012 - 13	12	12	10	4	7	11	8	10	12	16	15	23	**140**
2013 - 14	14	13	16	8	7	3	9	6	7	9	5	7	**104**
2014 - 15	5	10	12										**27**
Target No.	7	4	4	3	4	3	4	4	4	5	5	5	**52**
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	1	3	2	4	1	4	**24**
2013-14	5	4	2	0	1	0	1	1	1	2	0	0	**17**
2014 -15	2	0	0										**2**
Target No.	2	1	0	1	1	0	1	1	0	1	0	0	**8**
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	0	0	1	0	0	0	**2**
2013 - 14	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2014 - 15	0	0	0										**0**
Target No.	0	0	0	0	0	0	0	0	0	0	0	0	**0**

In Quarter 1 2014/15 we have achieve our target for Grade 3 and 4 Pressure Ulcers however we have failed our Grade 2 Pressure ulcer target.

There were no grade 3 pressure ulcers in June, this may be that grade 2's have been identified at an early stage and been prevented from developing into grade 3's.

It has also been highlight that over the weekend period it is very difficult obtaining dynamic mattresses and having mattresses decontaminated in between patient use.

The main themes identified in June were:

- Majority of the pressure ulcers were identified to the buttocks and sacrum. Small number to the heels
- Reaction to red – When skin has been identified as red, staff are not reacting to this with regards to increase repositioning and changes in pressure relieving equipment.
- Gaps in skin inspection, thus missing the opportunity to react to red
- Gaps in repositioning
- Incorrect mattresses/equipment
- Staff not hiring dynamic mattresses when none available in the Trust
- Incorrect waterlow scores
- Delay in reporting and contacting the tissue Viability team
- Some clinical areas are still not ordering Prevlon boots (Heel Offloading Device)

The actions we plan to take

- New Pressure Ulcer Prevention Plan (PUPP) developed for EAU.
- Dynamic mattress audit at the community hospitals - focusing on patients being nursed on the correct mattress.
- Tissue Viability Audit to be undertaken in September 2014. The focus is on pressure ulcer prevention, skin inspection, equipment and documentation.
- Embedding the RCA process for grade 2 pressure ulcers. Themes and trends to be shared with ward/department leaders.
- Band 3 secondment commencing in August 2014. They will have an active role in pressure ulcer prevention.
- Negotiating with training and development with regards to tissue viability being part of the mandatory study days for RN's.
- Pressure Ulcer Prevention study days - Increase number of delegates due to attend in July, September, October, November and December.

Venous Thromboembolism

Objectives for 2014/15

To eliminate unnecessary deaths due to venous thromboembolism (VTE) by ensuring the percentage of patients receiving a VTE risk assessment within 24 hours of admission to hospital is at least 95% - this target has been achieved

- 95% of patients who have been identified as being at risk of venous thromboembolism (VTE) to receive appropriate preventative treatment – this target has been achieved
- 100% of cases of hospital acquired thrombosis (HAT) are subject to a root cause analysis – this target has been achieved for all quarters to date, although Q1 2014/15 data collection is still ongoing.
- An initial review of all potential HAT cases is commissioned at the fortnightly VTE meeting. If the VTE is found to be potentially preventable a full RCA is undertaken by the lead consultant. Preventable VTEs are discussed at departmental governance meetings for actions and learning points.

Sherwood Forest Hospitals NHS Foundation Trust intends to take the following actions to ensure robust assessment and prophylaxis to all patients by

- Although no longer a national CQUIN, this priority will continue to be monitored through the Trust's internal processes (e.g. safety thermometer) and by the CCG via the quality schedule.
- We will continue to work closely with colleagues at the front door to ensure consistent risk assessment of patients and ensure performance is maintained throughout times of increased pressures or changes in medical staff.
- The introduction of VitalPac will help to resolve the challenges in achieving the required patient monitoring targets, VTE being one of these essential fields. While this electronic system becomes embedded the current paper data collection process is being redesigned.

Percentage of Patients Risk Assessed for VTE in 1st quarter of 2014/15 by month	
April	95.25%
May	95.24%
June	95.28%
TOTAL	**95.25%**

Further improvements identified

To ensure compliance with future NICE and contractual targets, a protocol will be implemented for the mandatory investigation of all hospital associated thrombosis (HAT) events. Hospital associated thrombosis is defined as VTE occurring during a hospital admission or within 90 days of discharge.

We are undertaking detailed investigation of hospital associated thrombosis to identify the lessons that can be learned and ways to further improve the care we provide to patients with investigations and reporting at departmental clinical governance meetings.

| Medicine Safety Targets	**Zero** medication-related 'Never Events'. To increase the number of reported medication-related incidents by **20%** (compared to 2013/14 data). 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.

Medicines remain the most common intervention for most patients receiving treatment in the Trust.

- Since 2013/14 Q4, there has been a significant and sustained increase in the number of medicines-related incidents and near-misses reported on Datix® (over 120 reports/month since Feb 2014). This suggests a consistent change in the organisation culture, where the reporting of such problems is considered normal, to support the review and improvement of medicines-related safety systems (Graph 1).
- The 2014/15 Q1 reporting rate is approximately 30% greater than that in 2013/14 Q4, and is accompanied by an improvement in the quality and completeness of incident coding as a result of greater incident scrutiny by Pharmacy, thus improving the quality of Trust data being sent to the National Reporting and Learning System (NRLS).
- A significant component of reports since the start of 2014 is the reporting of incidents relating to service provision by the home healthcare companies, reported by the High Cost Drugs Team in Pharmacy (and coded under 'Pharmacy').
- Most incidents reported in 2014/15 Q1 relate to medicine administration/supply (44.7%,↔), pharmacy (20.2%,↑ - principally homecare), monitoring and follow-up (20%,↑), and prescribing (13.2%,↓) (see Graph 2).
- The most commonly reported adverse event since April 2011 continues to relate to medication non-administration (19.2% overall,↑, but at 22.2% in 2014/15 Q1). Focussed work is underway on 2 pilot wards targeting documentation gaps and 'code 1' (medicine not available), along with pilot data collection relating to dose omissions (and other factors) using the Medicines Safety Thermometer data collection tool.
- Over 90% of patients have their medicines reconciled by clinical pharmacy staff during their hospital stay, resolving a significant number of problems in the process (and now including a pilot study enabling pharmacy staff access to patient Summary Care Records for emergency admissions on to EAU). The 2014/15 target of 95% medicines reconciliation by pharmacy staff within 24 hours of admission (75% achieved in June 2014) is being addressed as part of the 7-day service review project in Pharmacy, with changes to weekend Pharmacy staffing being tested during Sept 2014.
- There have been no medication-related 'never-events' reported on 2014/5 Q1.

Graph 1:

Total Medication Incidents Apr 2011 - Jun 2014
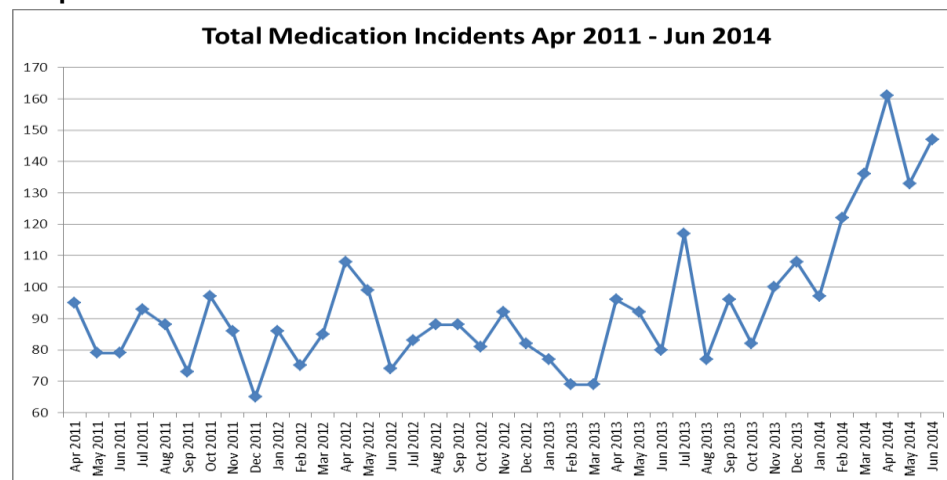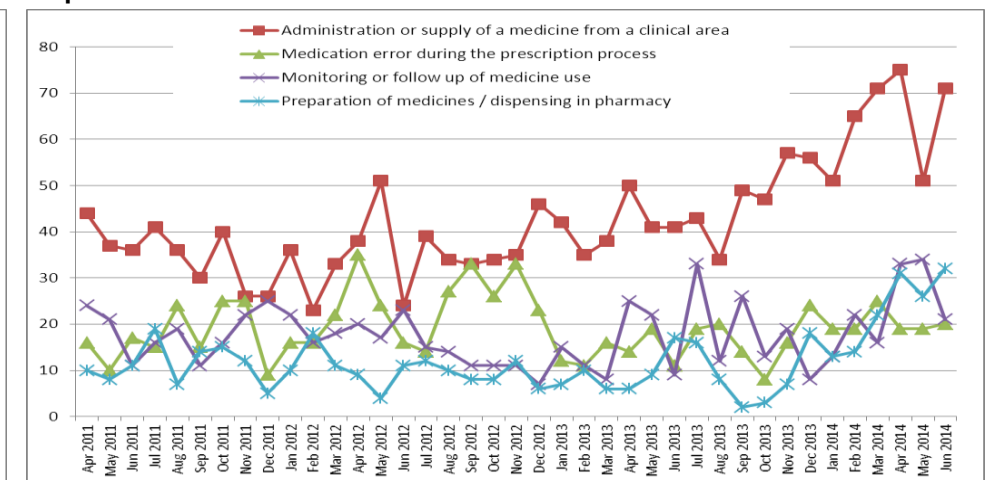
Graph 2:

- Recently updated NRLS data (to Sept 2013), continues to demonstrate a 6-monthly reporting rate at the Trust equivalent to other medium acute Trusts in the region, but a greater proportion of all incidents relating to medicines. Graph 3 indicates the reporting rate per 1000 occupied bed days (again reflecting the recent change in reporting culture).

Medication-related harm events this quarter

- Graph 4 indicates the number of medication incidents resulting in any harm events. 2014/15 Q1 returned over 83% incidents as 'no harm', and approximately 17% as 'low' or 'moderate' harm (none reported as 'serious' or worse).
- 'Harm' rates are increasing since 2013/14 but this is most likely due to a more consistent application of NPSA 'harm' definitions as part of the incident report scrutiny by pharmacy staff.
- The spike in 'harm' activity in June is coincidental with a change to the Datix® system which now requires an allocation of harm by incident handlers on first view of the incident, thus increasing interpretation pressure. 'Harm' incidents relating to high-risk medicines are being monitored by the Medicines Safety Group (MSG).

Graph 3

All Medicine incidents per 1000 OBD

Graph 4

The number of Medicine Incidents - ANY HARM
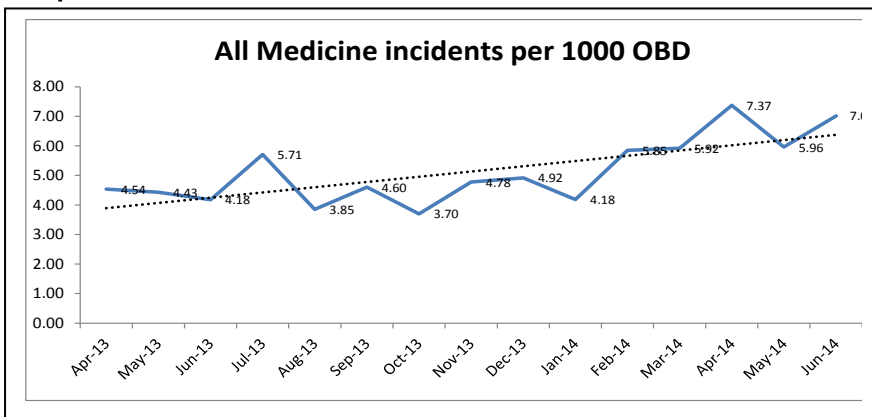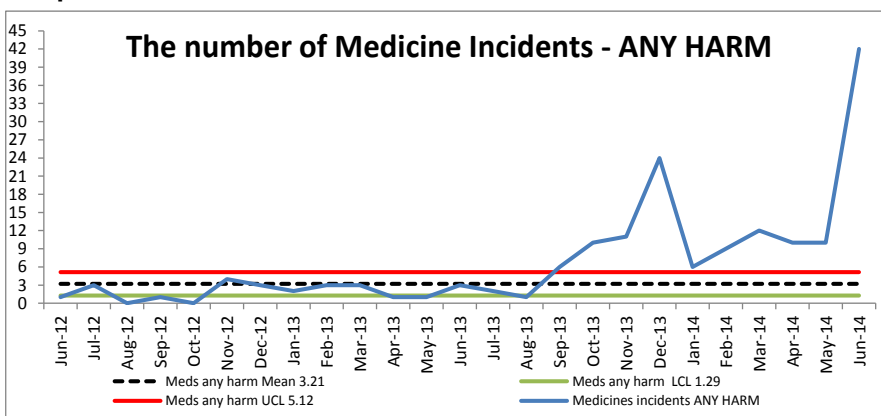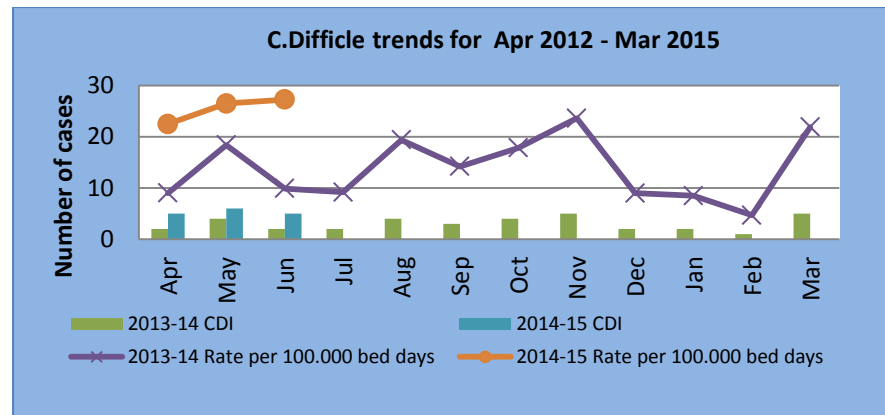
Medicines Safety Messages

- The Trust MSG continues to provide a focal point for the review, analysis and learning from medicines safety incidents and near-misses. Membership and Terms of Reference to be reviewed in light of the NHS England Patient Safety Alert.
- The role of Trust Medication Safety Officer and membership of the National Medication Safety Network is soon to be clarified. This should enable enhanced medicines incident investigation, root cause analysis and learning.
- All Trust staff (including medical staff) need to be encouraged and supported to report medicines-related incidents and near-misses (especially those relating to medication 'Never Events' and other high-risk medicines). This needs to be included in induction and update training of all new Trust and agency/locum clinical staff.
- A key principle of medicines optimisation (helping patients to make the most of medicines) is ensuring that medicines use is as safe as possible. The Trust Medicines Optimisation Strategy 2014-19 is to be launched in July 2014.
- Improving the safe use of medicines and minimising the potential for harm is the responsibility of all Trust staff.
- The Trust is piloting data collection for the Medication Safety Thermometer, providing information on specific risks relating to high-risk medicines such as anticoagulants and opioids.
- Work is planned during late 2014 for pharmacists to transcribe discharge prescriptions (TTOs) in order to improve timeliness of medicine availability and hopefully reduce error rates (28% Trustwide on TTOs in June 2014).

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Infection Control

Infection Control Targets	0 cases of MRSA
	No more than 37 cases of C. difficile
	No more than 5 Urinary Catheter Related bacteraemia (Trust internal target)

There have been 0 cases of MRSA bacteraemia in Q1

During Q1 there have been 16 cases against a trajectory of 9. We have failed the target for this quarter. All 16 cases have completed RCA's and all cases were at a high risk of C difficile. Antibiotic prescribing was appropriate. Ward level education is on-going; a safety bulletin was distributed to all staff, with particular messages to the medical staff within the Medical Directors Bulletin and an external expert review has been completed. Planned actions included weekly HCAI meetings chaired by Medical / Nurse Director with presentation of RCA from the whole clinical team, a reassessment of environmental cleaning products and improved dialogue with CCG and community partners

C.Diffcile trends for Apr 2012 - Mar 2015

Number of cases

- 2013-14 CDI
- 2014-15 CDI
- 2013-14 Rate per 100.000 bed days
- 2014-15 Rate per 100.000 bed days

Catheter associated bacteraemia: there have been 3 cases of catheter associated bacteraemia that were hospital acquired, against an internal target of 1.25 for Q1. Each bacteraemia has been reviewed by the Infection Prevention and Control Team (IPCT) and a RCA has been completed. The definition of a catheter associated bacteraemia has been revised this year from post 7 days of admission to the Trust, to post 48hrs of insertion or removal of catheter. During Quarter 1 we conducted education sessions on all Wards for all staff on the management of catheters. We have also trailed new equipment in the use of catheterisation and are working with procurement to implement this. We continue to conduct quarterly audits of catheter monitoring forms and reason for insertion. We continue to work with our Health partners from neighbouring Trusts and CCG's to help us provide the best service across the health economy for our patients. During Quarter 2 we plan to look at the use of silver catheters and intermittent catheters across the Trust.

Improving Patient flow and discharge processes	To reduce LOS (excluding 0-1 day LOS) to **6 days**

The Emergency Flow Transformation Programme (EFTP)

The EFTP is a new work stream for the Integrated Improvement Plan that was formed in May 2014 to formalise programme management arrangements and refocus efforts to sustain early achievements.

The critical success factors agreed by the programme are to:

- Support development of effective out of hospital services

- Develop effective assessment, decision making, and navigation at the front door to minimise inappropriate hospital admission and expedite appropriate treatment

- Ensure consistent referral to a comprehensive set of high quality ambulatory care pathways

- Move to a culture in which all staff work towards timely treatment and discharge of patients

- Develop right sized, flexible and responsive capacity 24/7 to support real demand for ambulatory care and emergency bed days

- Deliver changes that can be sustained to meet financial and performance targets

- Following a challenging winter, with periods of high demand on services, some early improvements were noted during June. However, more work is required to ensure that these improvements are sustainable.
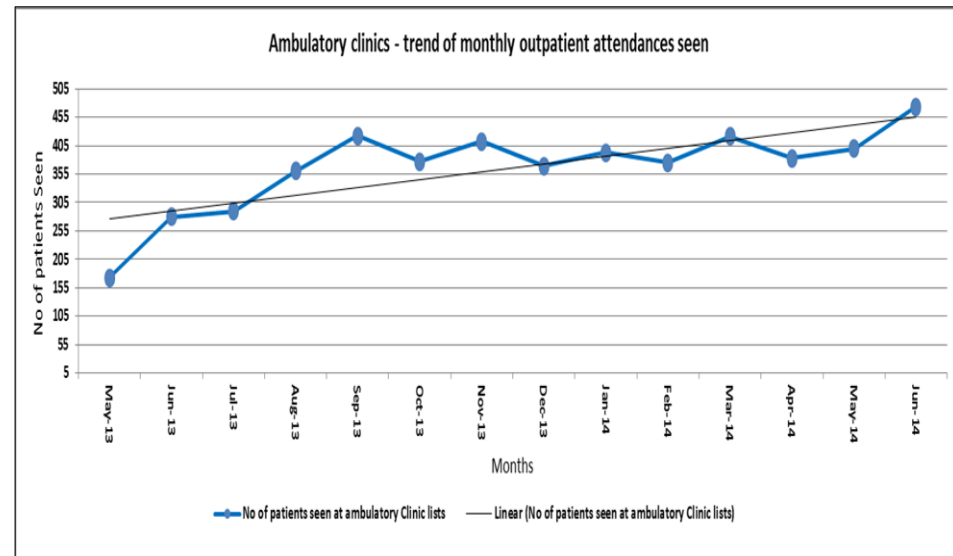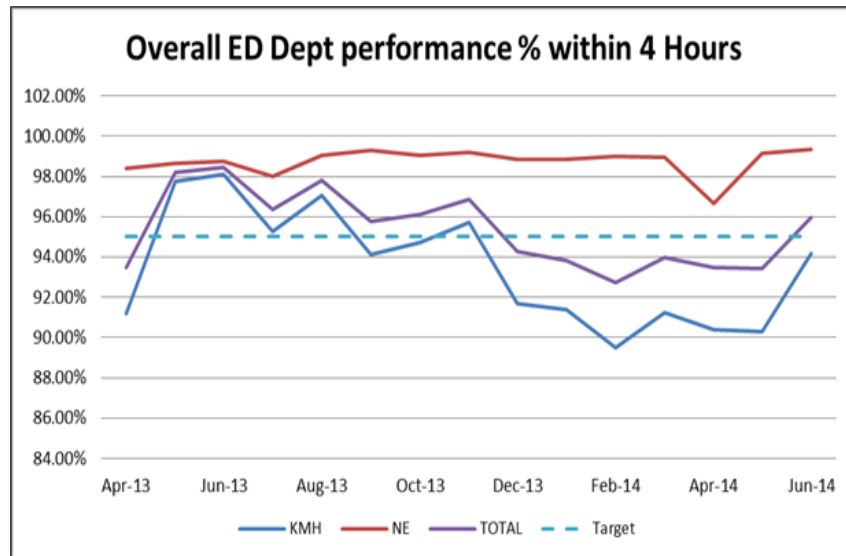
Key Achievements in Q1:

Emergency Flow Transformation Programme now established

- Work streams up and running with agreed milestones and reporting in place

- Ward Based Discharge project complete to timescale

- Streamlined referral and real time progress tracking for rehabilitation

- New Discharge Lounge, well utilised with patients being identified in daily discharge meeting

- Productive Discharge Team and Social Care joint working now in place

- New Discharge Team staff recruited and started in post

- First quarter ambulatory care CQUIN achieved

- Bed reduction programme started in June

4 Hour Access Target for Patients

Performance against the Emergency Department four hour wait target is shown. The Trust did not meet the target in Q1 with performance ranging between a low of 92.72% in February and a high in June of 95.96%. The main reasons for this are periods of high demand (including unexpected late evening spikes of activity which are currently being investigated), delays within ED caused by overcrowding at times and delays caused by waits for beds.

Overall ED Dept performance % within 4 Hours

Ambulatory clinics - trend of monthly outpatient attendances seen

Ambulatory Attendances

The number of ambulatory attendances has continued to rise to a high of 473 in June as shown in the graph. They are being delivered through evidence based pathways of care which were previously only available for inpatients. A programme of new pathways has been agreed for the year which will continue to support development of this model of care. Expansion of ambulatory care is part of a CQUIN scheme in 2014/15. The Q1 target has been met.

Delayed Discharges

Delayed transfers of care (DTOC) are patients medically fit for discharge waiting for NHS or Non NHS reasons. The graph presents delays by month with distinctive changes showing over the last 2 quarters. The reasons for the significant reductions in the non-NHS category over the winter were linked to apportionment changes and improvements to integrated working. Since April 2014 there have been some modest increases in this category. The NHS delays are waits for assessment, insufficient capacity for intermediate care / rehabilitation, delay to care packages in the patient's own home, waits for nursing home placement and for families to choose place of care. These causes are are all attributable to the Trust.

Delayed transfers of care
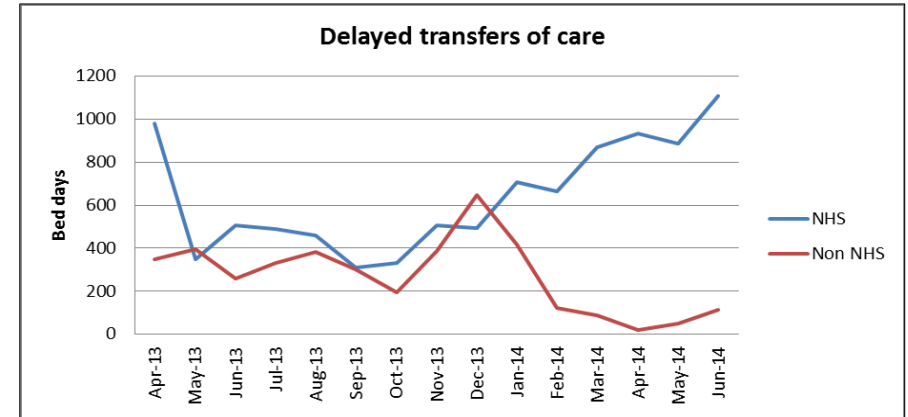
Average Length of stay

The graph shows average length of stay which excludes zero days and well babies. Comparison with previous years shows fluctuation, within an overall increase in length of stay. There is significant complexity around the reasons for increase to length of stay including the impact of increasing patient acuity and changes to the model of care – for example: increases in emergency ambulatory care (which is activity managed through outpatient attendances for cases that would previously be admitted for inpatient care) will impact on the overall numbers. However, the Trust is aware that more work on improving discharge process is required and is currently undertaking a deep dive into the causes of delay to discharge.

Average length of stay - Inpatient trends (exclude zero LoS)
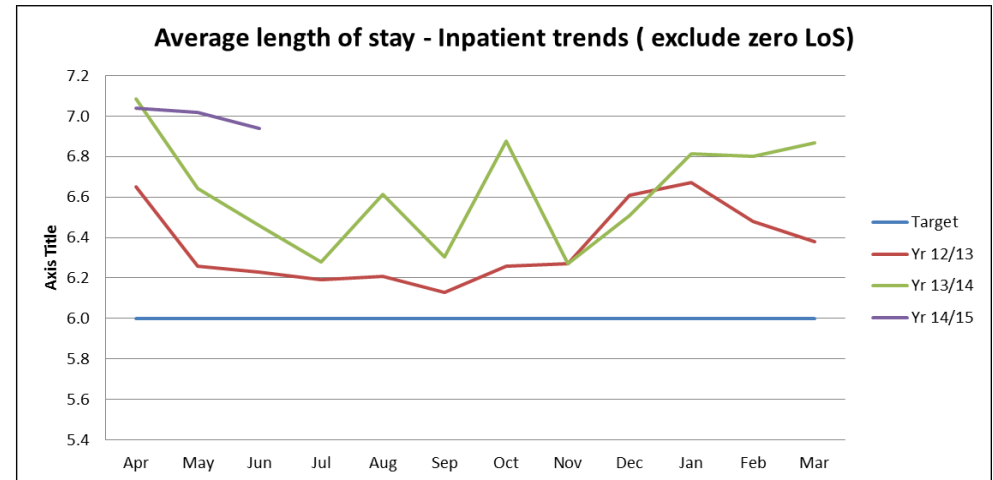
Improving Sepsis Care

Our milestone for Quarter 1 was to have an adult system and an action plan in place. This has been completed.

Sepsis is a life-threatening illness caused when the body's response to an infection injures its own tissues and organs. Many people know it as blood poisoning or septicaemia. The conservative estimate is that sepsis kills 38,000 in the UK, more lives than prostate, breast and bowel cancer combined. The incidence of sepsis increases annually and will continue to do so with an aging population. Sepsis can quickly go from being a mild illness to a very serious one and is very frightening for patients and relatives.

Treatment is time critical. Survival can be dramatically improved with early diagnosis and prompt treatment.

The Sepsis Care Bundle, often referred to as "The Sepsis Six", is a set of clinical interventions which can be delivered by healthcare professionals working as part of a team. When delivered, within the first hour of onset of illness, this treatment can significantly improve chances of recovery.

What have we achieved so far?

We have:

- Implemented a Sepsis Policy and sepsis treatment box
- Increased our compliance with The Sepsis Six
- Evidenced a downward trend in sepsis related mortality.

We have met the sepsis CQUIN targets for Quarter 1

What is our aim for 2014-15?

The goal last year was to improve sepsis care for our patients and reduce mortality. In 2014-15 we will keep improving and reach even higher standards of sepsis care. Our target is to have 95% compliance with the Bundle by the end of the year.

Progress & Outcome

Our aim is that better sepsis care will be achieved by accomplishing a number of outcomes:

1) Establish the people to lead improvement in sepsis care: we have a multidisciplinary working group that is co-ordinating and driving the planned work
2) Establish an audit to evidence good and poor sepsis care: the Lead Sepsis Nurse rigorously monitors patient care.
3) 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.
4) 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

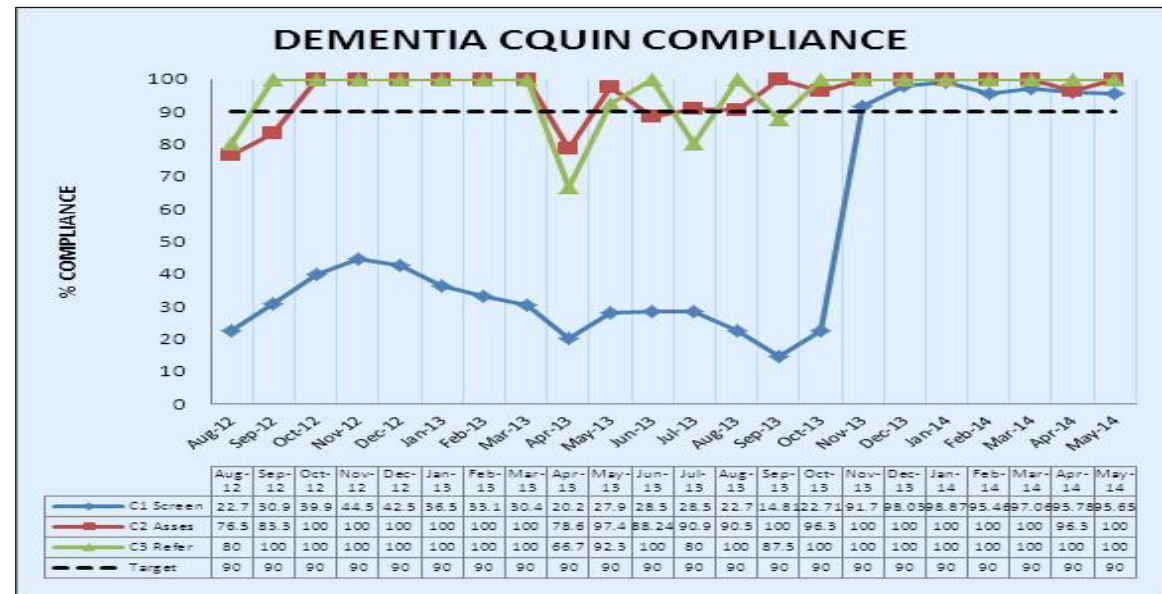| Dementia	Screen 90% of all emergency patients (exclusion criteria in CQUIN) above the age of 75 for early signs of dementia To ensure 90% of those who have been screened as at risk of dementia, have been assessed, investigated and referred as appropriate to specialist services To train 90% of all relevant staff in dementia awareness every 2 years To continue to conduct and report a monthly survey of carers, to establish if they felt supported during their relatives stay in hospital. We also aim to develop this survey further to steer future improvements in the support we offer to carers and families of people living with dementia.

During 2014/15 improvements in dementia care continue to be a key objective for the Trust as well as being an on-going CQUIN. Sustaining our success in finding, assessing, investigating and referring patients and during 2014/15 will be a focus for us with the switch to VitalPac based screening planned for the Autumn 2014. We also want to ensure more staff have received dementia training, which will in turn lead to improved patient care, delivered by competent and compassionate staff. Improving the support of carers and family of people living with dementia also continues to be a key area.

Dementia CQUIN

We are pleased to announce that we have continued to successfully achieve our dementia CQUIN during quarter 1. We have screened, assessed, investigated and referred over 90% of patients aged over 75 admitted as an emergency between November '13 and June '14.

A diagnosis of dementia enables people to access the services that they need in order to live will with dementia in the place of their choice. Case finding such as this plays a vital part in developing dementia services both at SFH and the wider community.

Our challenge is to maintain this excellent work and extend its reach to include and report more detailed assessment and investigatory methods.

DEMENTIA CQUIN COMPLIANCE

	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	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
C1 Screen	22.7	30.9	39.9	44.5	42.5	36.5	33.1	30.4	20.2	27.9	28.5	28.5	22.7	14.81	22.71	91.7	98.03	98.87	95.46	97.06	95.78	95.65
C2 Asses	76.5	83.3	100	100	100	100	100	100	78.6	97.4	88.24	90.9	90.5	100	96.3	100	100	100	100	100	96.3	100
C3 Refer	80	100	100	100	100	100	100	100	66.7	92.3	100	80	100	87.5	100	100	100	100	100	100	100	100
Target	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Training

We continue to be on target to train 90% of our staff in dementia awareness via our mandatory update and orientation programmes.

Ward based dementia, delirium and family interventions training, provided by our colleagues in Liaison Psychiatry continues. Demand is picking up for this invaluable training. 'Away days are booked for Wards 22 and 52.

We have commissioned specialist training in 'meaningful activities'. 250 staff will be trained Trust-wide across 10 months in the importance of being patient centred and therapeutic activity for people with dementia. This is funded by the Local Education and Training Council.

We are working with carers to develop a short training video highlighting the impact that dementia can have on carers and family and the role that our staff can play in supporting carers of people living with dementia. We

Carers Survey

90% of carers surveyed reported feeling either supported or very well supported during the last 3 months, a continued improvement in this feedback. Comments received included:

"They [the ward staff] couldn't have done more for us"

"First class care from start to finish. We're very happy."

"Mum seems worse but, the carers are so patient with her, I wish they had more time"

"The young Doctor was extremely helpful and understanding. They explained everything really well."

"She [Sister] stayed late to explain what is going to happen for going home. It's not an ideal situation but, they [staff] really care about us

Here is a brief sample of some the work being undertaken at Sherwood Forest Hospitals to improve dementia care

Carer Information and Support Programme

Every Tuesday during April we hosted the Alzheimer's Society's Carer Information and Support Programme (CrISP) sessions. With support from our own volunteers and customer services department, these group sessions enable carers to share experiences and identify local services. Feedback has been extremely positive with planning already underway to host more sessions later this year.

RemPod

Lindhurst Ward at Mansfield Community Hospital have been making use of our 1950's themed RemPod. Staff have been using this portable reminiscence room to facilitate activities to improve patients experience during their stay.

In May 2014 the Trust Pain Team formally launched their new pain assessment tool. Developed 'in house' by our pain team, this assessment tool prompts staff to look for non-verbal clues in order to provide a more thorough assessment of a patient's pain. This is especially useful in the care of people with dementia. Our 80 Dementia Link Staff are rolling this out across clinical environments with the support of our Pain Nurse Specialists.

Dementia Members Event

In March we held an evening dementia members event at Lancaster Grange in Newark, in conjunction with Barchester Care Homes. Trust staff were on hand to showcase improvements in dementia care as SFH as well as offering two extremely popular 'Dementia Friends' sessions. Feedback from the event was very positive and we are already planning our next event.

Voluntary services Donations to improve care environments

The first of several planned donations was gratefully received by Dr Steve Rutter in March and since then the money has continued to pour in. At the time of press an amazing £36,000 has already been donated! This money will be used to enhance our care environments making them more dementia friendly. Planning is well under way on EAU to make orientation easier for people with dementia. Bold colours on walls, clearer signage, clocks and other dementia friendly equipment will assist staff to offer the best quality care possible for all.

End of Life Care

Our Aim

We continue to strive to deliver quality and compassionate care to patients nearing the end of their lives, and are making progress in delivering on the five key enablers within the Acute Hospitals Transform Programme below, which aims to enable more people to be supported to live and die in their preferred place.

Our Medical Lead and Lead Nurse for End of Life Care & Cancer continue to drive improvements in outcomes and patient carer experience with the support of members of the Hospital End of Life Care Multi-Disciplinary Team.

What we are setting out to achieve during 2014/15?

- Develop an overarching Trust-wide End of Life Care Strategy
- Continue to implement the 5 key enablers within the Transforming End of Life Care in Acute Hospitals Programme across key wards.
- Continue to support advance care planning for patients as part of the Gold Standards Framework in Acute Hospitals Programme (GSFAH) on Wards 42 and 51. With plans to register a further 2 Wards on the Programme at the end of the summer, which will be Wards 34, and 52
- Continue to implement the AMBER Care Bundle (ACB) on Wards 43, and 44. With plans to commence implementation on Wards 24 and 53 by the end of Quarter 2.
- Continue to refine the Rapid Discharge process, in particular enabling staff to effectively rapidly discharge patients out of normal working hours.
- Continue to audit that patient's discharged on fast track have had their preferred place of care identified.
- Work collaboratively with Primary and Community Care colleagues on the developments of Electronic Palliative Care Coordination System (EPaCCS) and care planning
- Commence the implementation of the Last Days of Life Guidelines and Care Plans that have been developed to replace the Liverpool Care Pathway (LCP) across the Trust.
- Continue to support staff and monitor the quality of care being delivered to patients in the last days/hours of life.
- Continue to deliver education and training on end of life care at induction to all Health Care Professionals new to the Trust. With plans to explore getting additional resources to support embedding the end of life care tools in general.
- Capture patient and relatives experience, in particular in bereavement.

Progress and Outcomes

End of Life Care Strategy

The development of an overarching Trust-wide End of Life Care Strategy is underway. It is envisaged the following key areas will be addressed within this strategy: Person centred/family care, leadership, effective teamwork, safe, effective reliable systems, training & education and measureable outcomes. It is anticipated that this will be completed by the end of August 2014.

Advance Care Planning

We continue to identify patients in the last year/months/weeks of life and have registered 19 patients on Ward 42 & 51 on the Gold Standard Framework Register in Quarter 1. The data showed advance care planning discussions had taken place in hospital with 10 patients. 4 patients died before discussions could take place; 1 patient lacked mental capacity, and no data were available for 4 patients. However the GP's have been informed via discharge letters, in order for them to either begin advance care planning discussions in the community. GSF training for all staff on the 2 Wards is nearing completion. 5 courses have been run since February 2014 with a total of 39 multidisciplinary staff attending. A further course is planned for 4th August where it is anticipated that 5 more staff will have completed the initial training. Full evaluation and training analysis will then follow.

We plan to register a further 2 Wards (34, and 52) on the Gold Standards Framework in Acute Hospitals Programme 2014/16 at the end of the summer, providing funding is available.
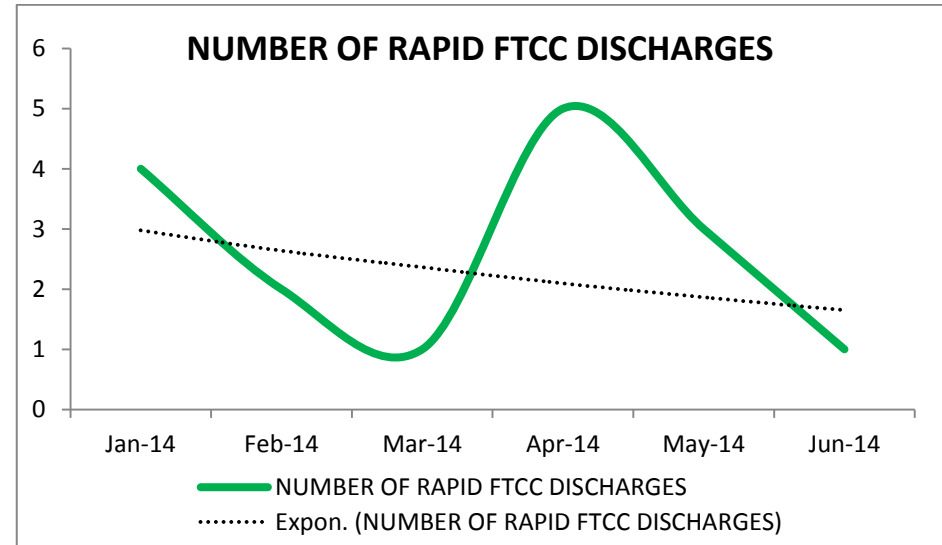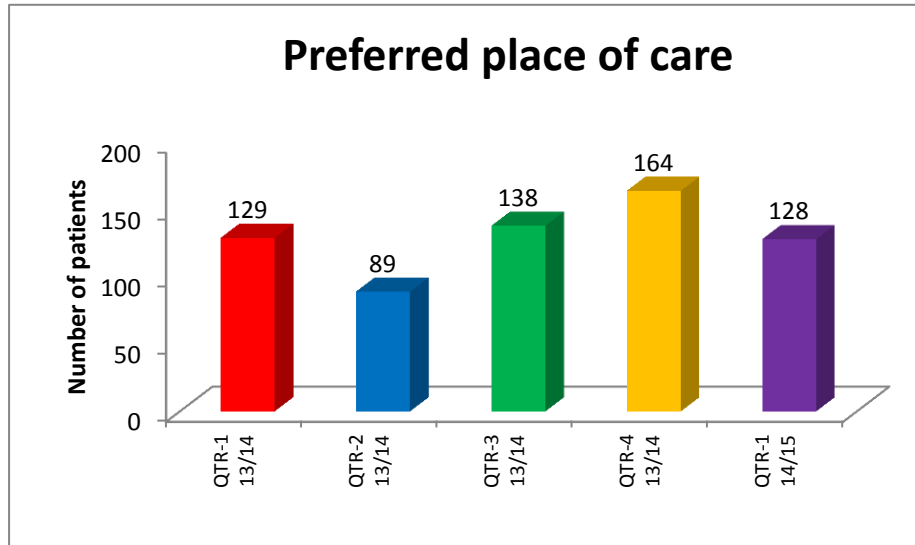
AMBER Care Bundle

Progress is being made on the implementation of AMBER Care Bundle on Wards 43 and 44. A number of patients have been supported on the bundle and staff continue to be engaged with the implementation process. An audit of the impact on patient care and completion of documentation is underway. 8 courses have been run since April 2014 with a total of 24 Registered Nurses in attendance. The courses have consisted of: AMBER Care Bundle in practice; the Fast Track/Rapid Discharge process in particular managing a rapid discharge outside normal working hours; Resuscitation and where this links to the ACB; introduction to communication skills. Evaluation of the training is now underway.
We plan to commence implementation on a further 2 Wards (24 and 53) by the end of Quarter 2.

Preferred Place of Care/Rapid Discharge

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. PPC data is being captured monthly as part of the audit data which reports on the number of referrals made to the IDAT. There were 9 patients discharged from hospital via the Rapid Discharge process in Quarter1. The End of Life Care Team are in the process of working with Ward staff to refine the Rapid Discharge process, in particular to enable staff to effectively rapidly discharge patients out of normal working hours.

Preferred place of care

Number of patients

QTR-1 13/14	QTR-2 13/14	QTR-3 13/14	QTR-4 13/14	QTR-1 14/15
129	89	138	164	128

NUMBER OF RAPID FTCC DISCHARGES

— NUMBER OF RAPID FTCC DISCHARGES

......... Expon. (NUMBER OF RAPID FTCC DISCHARGES)

Anticipatory Medication

Currently all patients discharged from hospital to Preferred Place of Care have anticipatory medications prescribed (excluding Derbyshire). This data is collated quarterly and the table illustrates Quarter 4 and Quarter 1 data.

Last Days of Life

The Liverpool Care Pathway (LCP) has now been phased out and ceases to be used in the Trust. National recommendations from the Leadership Alliance for Care of Dying People *One Chance to get it Right'* has been published in June, and the End of Life Care Team have successfully developed Guidance and Care Plans based on the principles of best practice in the last days of life within this document. These guidelines and care plans have been piloted on 4 Wards and amended in accordance to staff feedback and evaluation. They are currently undergoing internal approval and once this process is complete, the intention is to achieve full roll out across the Trust by the end of Quarter 3.

% of patients with anticipatory medication on discharge
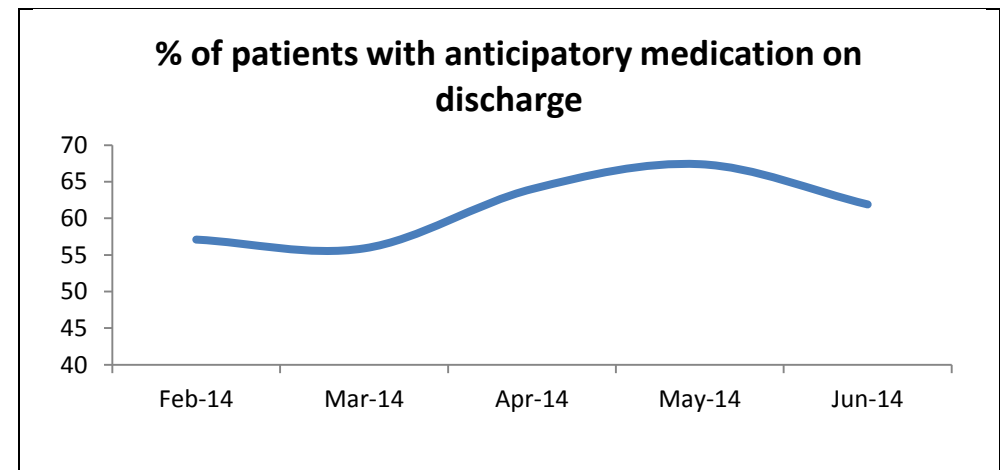
National Care of the Dying Audit for Hospital 2014

The Trust participated in the National Care of the Dying Audit for Hospital 2014 that measured the standard of care based on relevant national policy and describes care provided by the Trust as of 1st May 2013, which precedes the phasing out of the Liverpool Care Pathway.

Key Findings

Out of the 7 organisational KPI's the Trust achieved 3. Out of the 10 clinical KPI's the Trust achieved 9. The following categories were identified as needing actions for improvement:

1. Access to information – overall score - 41%
2. a) Access to face to face palliative care 7 days per week - overall score – 21%
   b) End of Life Care Lead Nurse
3. a) Mandatory Training – 60%
   b) Communication skills training
4. Board Member – overall score - 28%
5. Clinical protocols – overall score – 98%
6. Bereaved relatives survey – overall score – 34%

An action plan has been produced in response to the audit and is being presented at Trust Management Board in July 2014. The key areas of work are as follows:

- Develop patient and relative written information.
- Obtaining funding for: additional Specialist Palliative Care Consultant PA's to support access to face to face palliative care 7 days per week; additional nursing resources to facilitate mandatory training and roll out of the end of life care tools in general; access to communication skills training.
- Roll out of clinical guidelines and care plans.
- Capture patient and relative experience.

Incidents, Serious Incidents & Never Events Summary

NRLS comparative reporting rate, per 100 admissions, for 45 medium acute organisations places Sherwood Forest Hospitals to the top of the middle 50% of reporters according to the latest available report. The Trusts reporting rate = 7.4 incidents reported per 100 admissions. In Quarter 1 2014/15 the Trust reported 857 incidents which resulted in any harm of which 30 were classified as Serious Incidents. The percentage of serious incidents against all harms reported for Quarter 1 is 3.5%. Table 1 shows the top 3 incidents reported during quarter 1. These incidents will include all levels of harm.

The NRLS report that *nationally, 67 per cent of incidents are reported as no harm, and just less than 1 per cent as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult. Organisations should record actual harm to patients rather than potential degree of harm.*
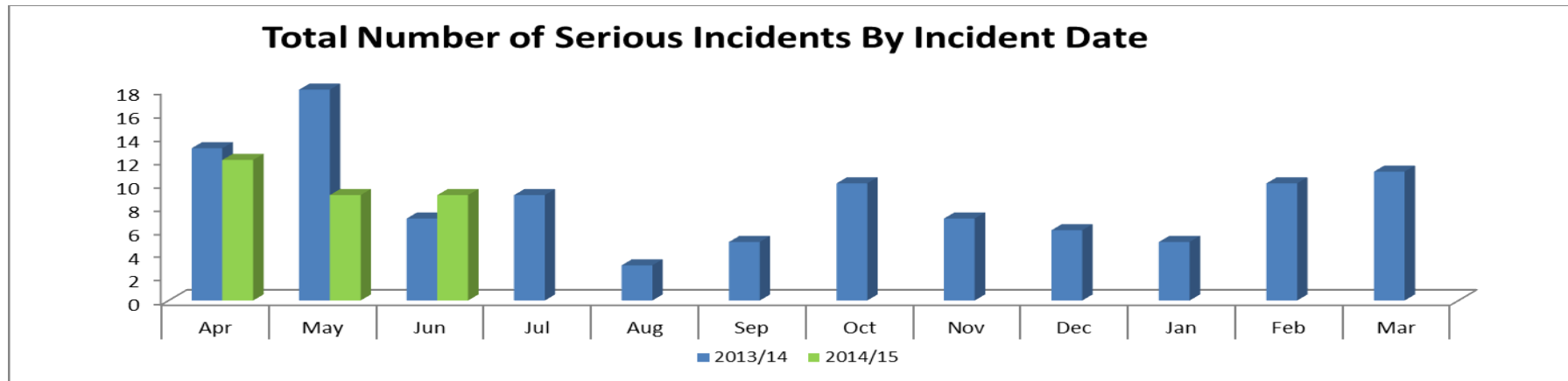
Table 1 = Top 3 Reported Incidents by Adverse event and Division 01/04/14 - 30/06/14

	Central Services Division	Strategic Planning and Commercial Development (SPCD)	Diagnostics & Rehabilitation	Emergency Care and Medicine	Newark Hospital	Planned Care and Surgery	Total
Slips, trips, falls and collisions	2	4	53	389	10	76	534
Pressure sore / decubitus ulcer	0	0	12	276	1	47	336
Implementation of care or on-going monitoring - other	0	0	13	150	3	35	201
Totals:	21	17	377	1624	40	739	2818

The Trust is working with the NRLS to ensure that patient safety harms are captured
correctly and reported at least monthly. Improvements to the Datix database are continuing these include the system re design and planned version upgrade.

Serious Incidents

In the period of Quarter 1, a total of 30 STEIS reportable Serious Incidents forms were reported.

Serious Incidents by adverse event and the division whereby the serious incident occurs can be identified below. Falls is the highest reported cause group and a detailed falls report was presented at the April meeting of the Quality Committee. Diagnostics and Rehabilitation harms also include those reported at Newark hospital.

The number of incidents and the harm figures are captured from the Datix database which is a *live* system. The number of harms may increase or decrease following investigation by the handler/investigator.

Serious Incidents in Qtr-1 by Division April - June 14
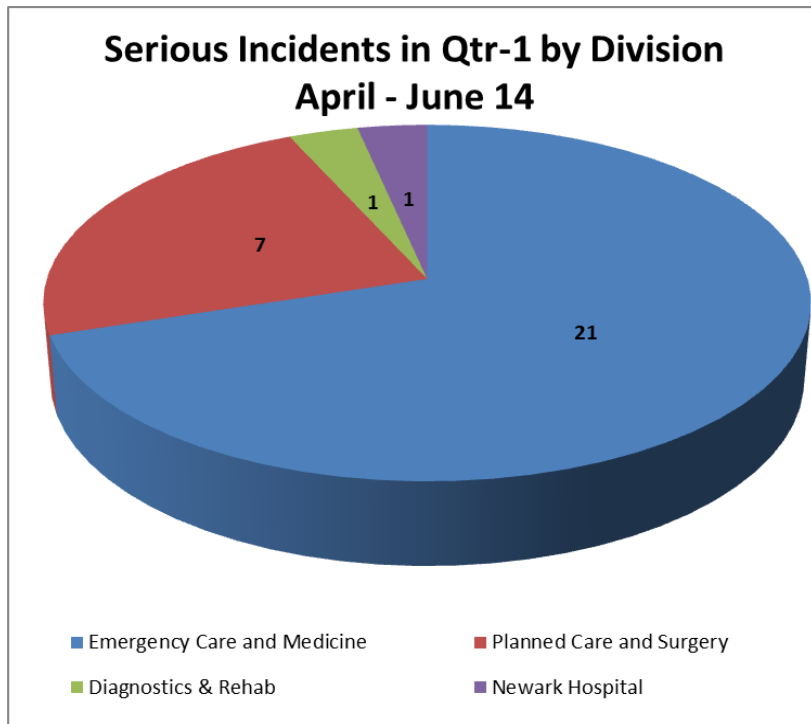
Adverse event	Qtr-1 Total
Fall	7
Breach of patient confidentiality	3
Extended stay / episode of care	3
Cardiac arrest	2
C-Diff	2
Workload exceeds available manpower cover	2
Delayed diagnosis and treatment of sepsis	1
Failure in transfer protocol/handover	1
Failure to act on adverse symptoms	1
Implementation & ongoing monitoring/review - other	1
Lack of clinical or risk assessment	1
Other - Infection control incident	1
Other - please specify in description	1
Other IT malfunction	1
Self harm	1
Stillbirth	1
Unplanned admission / transfer to specialist care unit	1
Grand Total	30

The table to the right shows the Divisional split of Serious Incidents against incidents causing harm.

Never Events

There were no "Never Events" reported in SFHFT between 1st April and 30th June 2014.

Learning from incidents and resulting action management

	Incident Harm	Serious Incidents	Percentage
EC&M	566	21	3.7%
PC&S	198	7	3.5%
D&R	76	2	2.6%

Incidents will continue to be reviewed by the relevant sub-groups of the Trust Management Board and will include the Clinical Quality and Governance Committee, the Patient Safety Group and the divisional governance groups. Weekly Serious Incident Trackers are now sent to Divisional Management Teams and are copied to the Board of Directors to assist in the monitoring of progress with Serious Incident

investigations. It is expected that learning will be identified by service leads and shared
within divisional meetings to ensure the population of actions that can be shared across the Division as appropriate.

	What has changed	Why has it changed	Evidence (when, what, how)
Trust Wide	A review and update of the Policy for Patients Requiring Enhanced Observations to include those patients who express a wish/ are at risk from Deliberate Self Harm. Division	An incident identified that the current assessment needs to be adapted to specifically reflect Acute Behavioural Disturbances.	The Policy is currently under review this needs to be aligned with a clear strategy of communication and embedment.
Trust Wide	A spinal board is now available within the resuscitation back up area. Further training for key on how to manage patients with potential spinal injuries is now planned. Pathway for the management of potential spinal injuries and serious post falls alert is being agreed.	This is in response to 2 serious incidents where the management of these patients post trauma in hospital was inadequate.	The action plan is being led by the Patient Safety Lead with the support of the Resuscitation Officers and Manual Handling Trainer. Discussed within the Trust wide Falls group
	What has changed	**Why has it changed**	**Evidence (when, what, how)**
Trust Wide	A review of the Being Open Policy has been undertaken and arrangements are being made to provide training on the Trusts obligations with the Duty of Candour.	Recognition that Trust wide there is an educational requirement with regards to the Duty of Candour.	Being Open Policy Training dates to be confirmed.
Division	The recognition that the Emergency Department requires to formulate an Emergency Department Policy/Guideline for the safe de-escalation of patients presenting by ambulance in the Majors or Resuscitation Areas so that their safety is ensured and appropriate care given in another area of the department.	The change was required because a patient was transferred from majors to minors without evidence of decision making	Monitoring requirements will be explicit within the policy

Hydration Summary

> **What will we set out to achieve during 2014/15 ?**
> Our focus is to ensure that all patients in our hospitals receive adequate hydration and that their needs are assessed, monitored and optimised correctly.
>
> We will build on our previous year's work on improving how we identify and help those patients who require our assistance to stay hydrated , we aim to continue helping reduce avoidable harm and improve patient outcomes through reliable and sustainable improvements to this aspect of fundamental patient care.

Improvement required

CQC Inspection visit April 2014.	What we are doing
Record keeping in regards to hydration was identified as an area of concern following the CQC inspection undertaken in April 2014. It stated that a review of hydration records identified issues with the majority reviewed including some charts not having daily totals calculated, others had gaps, and others did not specify the amount of fluids taken. The CQC have stated that the Trust must ensure that accurate record keeping is maintained with regards to people's hydration.	We have been focussing on strengthening the understanding and application of Accountability Handover and Care and Comfort rounds processes that we already have in place .This will promote consistent record keeping and support identifying omissions in fluid balance recording and ensuring that appropriate actions are taken to monitor people's condition.

Monitoring & reporting for sustained improvement.

Each month senior nurses have continued to review the performance of each ward against the hydration standards that we have set ourselves. To support improvement the matrons work with nursing teams on occasions that we fall below our standards.

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

Nursing Metrics Scores for Hydration Standards (% appropriate patients)
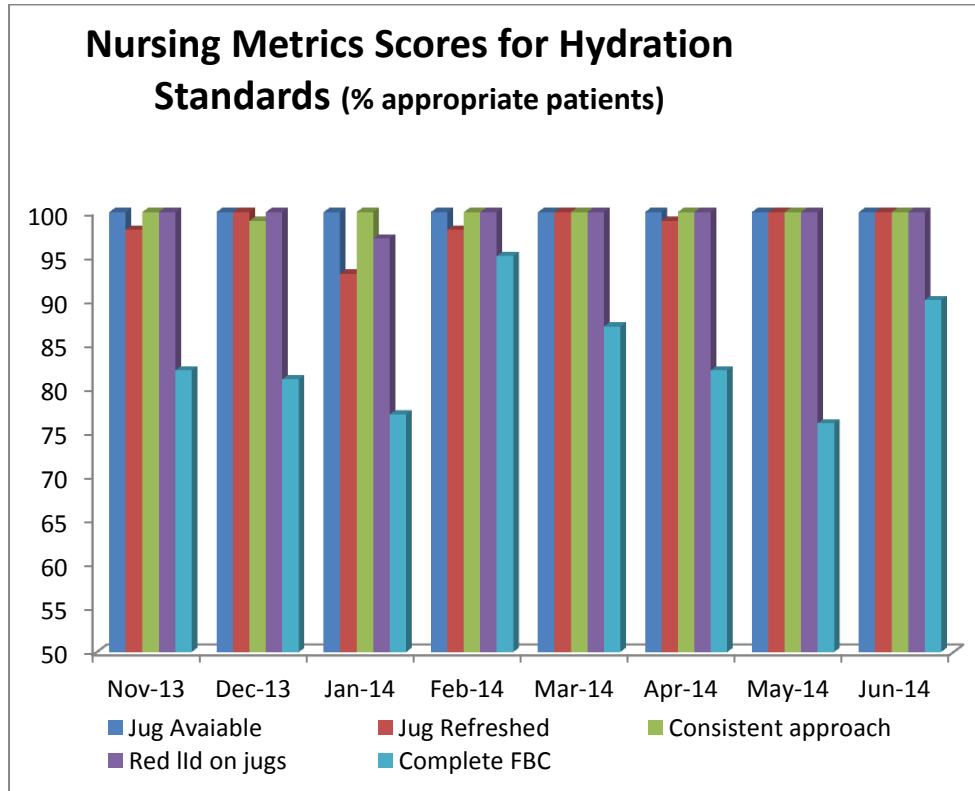
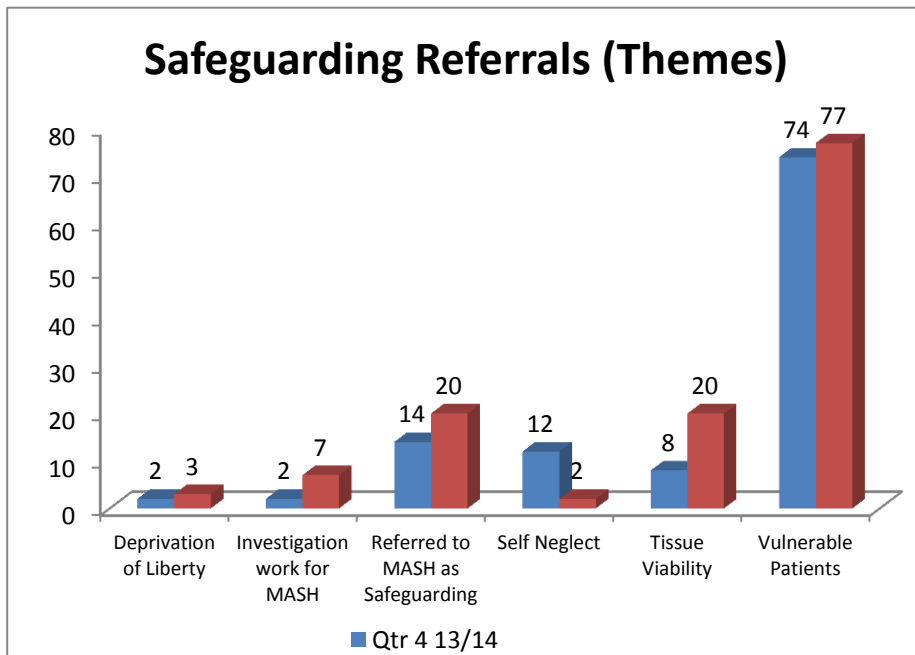|	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Jug Available	100	100	100	100	100	100	100	100
Jug Refreshed	98	100	93	98	100	99	100	100
Consistent approach	100	99	100	100	100	100	100	**100**
Red lid on jugs	100	100	97	100	100	100	100	100
Complete Fluid balance chart	82	81	77	95	87	82	76	90

Next Steps

• A review of the supportive equipment available for patients so they are able to drink independently.

• A further service evaluation to measure compliance with the hydration risk assessment tool and fluid balance monitoring will be scheduled so we can see how we are doing.

• Develop new ways of assisting Patient Participation

• Consider new innovative measures to raise the awareness of this basic but complex aspect of care

Safeguarding Adults Summary

There have been 139 referrals to the Trust's Safeguarding adult's team during Q1. This is the same as Q4. In Q1 19 of the 139 patients referred necessitated a referral to the Nottinghamshire Multiagency Safeguarding Team (MASH), 18 referrals were with suspected neglect, 8 of these because of tissue damage and 1 referral with financial abuse. This is an increase in the amount of referrals made to MASH from Q4 when 14 referrals were made; there is no identified reason for the increase.

During Q1 a Domestic Homicide Review (DHR) independent management review has been written and submitted to the Domestic Homicide Review panel. Information for a further two DHR's has been requested and preliminary information submitted.

The safeguarding Adults annual report has been written and will be submitted to the Quality Committee in September. We continue to see the same themes from safeguarding concerns in respect of the trust which are; nursing staff transfer/discharge letters not being completed or not containing detailed information therefore community colleagues unsure of patient needs, not following the Mental Capacity Act process for patients lacking capacity and incorrect documentation and Allow Natural Death (AND) forms that do not follow the Mental Capacity Act process when applying AND across all care settings. These themes are part of the work plan 2014/15.
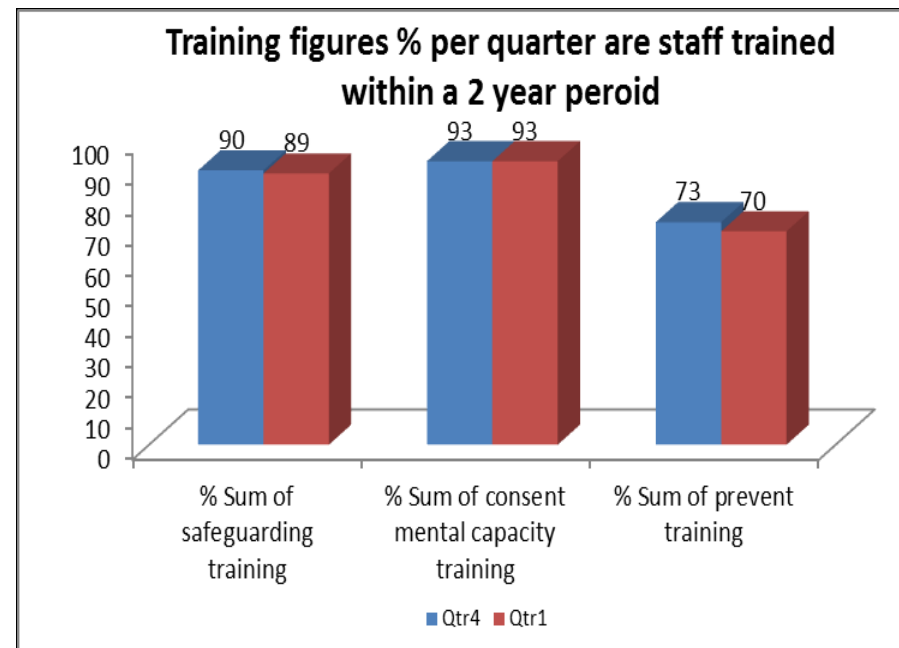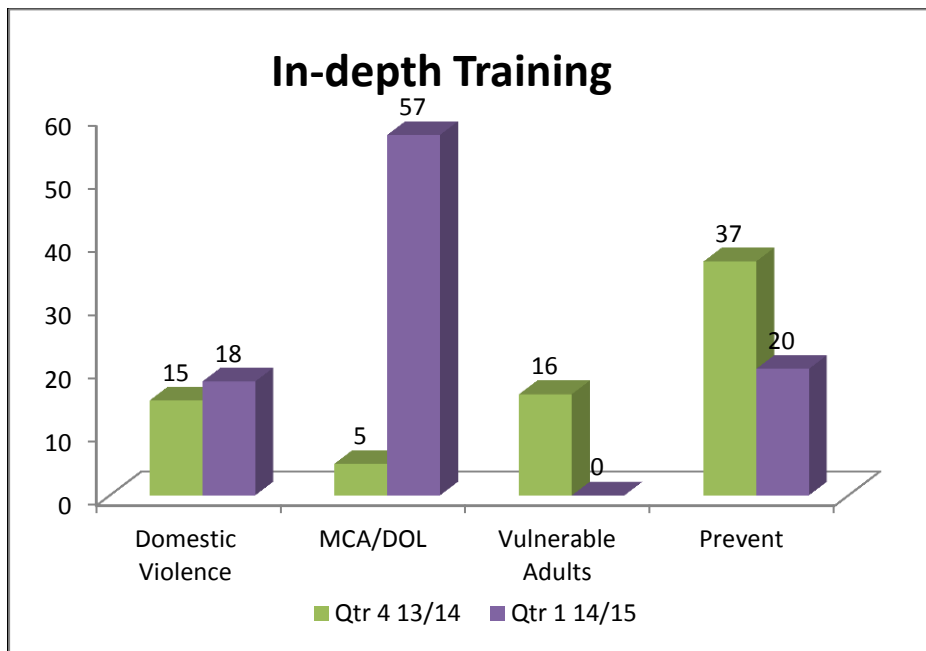

Safeguarding Referrals (Themes)

Qtr 4 13/14

Theme	Qtr 4	
Deprivation of Liberty	2	3
Investigation work for MASH	2	7
Referred to MASH as Safeguarding	14	20
Self Neglect	12	2
Tissue Viability	8	20
Vulnerable Patients	74	77

Deprivation of Liberty (DOL)

On March 19th 2014 the Supreme Court has clarified the "acid test" to define a DOL as the person is:

"Under continuous supervision and control and are not free to leave" and lacks capacity to consent to the care and residence arrangements.

What has happened so far with in the Trust regarding DOL:

- The safeguarding team met with the Trusts solicitors.
- A paper has been considered at Trust Board outlining these concerns.
- All wards in the Trust were scoped to give an estimate of how many patients may be at risk of being deprived of their liberty in one day. (39 patients)
- Trust Training has been reviewed.
- The DOL policy is to be revised following recent case law
- A policy for the use of Restrictive Practices for Adult patients is out for consultation.
- Information for Trust healthcare professionals is being developed to improve compliance with MCA where patients may be subject to restraint and restriction.
- Contact with other acute Trusts is maintained regarding current best practice.

In-depth Training

Qtr 4 13/14: Domestic Violence 15, MCA/DOL 5, Vulnerable Adults 16, Prevent 37
Qtr 1 14/15: Domestic Violence 18, MCA/DOL 57, Vulnerable Adults 0, Prevent 20

Training figures % per quarter are staff trained within a 2 year peroid

% Sum of safeguarding training: Qtr4 90, Qtr1 89
% Sum of consent mental capacity training: Qtr4 93, Qtr1 93
% Sum of prevent training: Qtr4 73, Qtr1 70

In-depth Training

Mental Capacity Act (MCA)

This training which takes place at both KMH and Newark hospitals is evaluating very well. Staff comments include: - *learnt different ways of approaching patients: e.g. encouraging familiar surroundings, how to complete mental capacity assessments and individualised care plans.*   I have gained extra knowledge around restraint, restriction and deprivation of liberty.

Vulnerable Adults

No VA study days have taken place in Q1 but one planned for Q2 and Q3.

Prevent

As it was risk assessed that midwives needed to receive prevent training, extra sessions had been put on for midwives in Q4. This is why there is a decrease in the Q1 numbers.

Maternity

Midwife to Birth Ratios

We have seen a busy start to the year in maternity services at Sherwood Forest Hospitals with births increased by 14.4% in quarter 1. In 2013/14 we had 793 which have risen to 927 this year. June was especially popular in which we had 358 births. This has affected our midwife to birth ratio which is 1:30.5 for the quarter against funded establishment. We will continue to monitor this trend. We are actively recruiting at the moment and by the end of September should have filled most of our current vacancies with a mixture of experienced and newly qualified midwives and we are looking forward to welcoming them to the team at Sherwood Forest.

Smoking in Pregnancy – Quarter 1 2014/15

CQUIN TARGET 2014 – 2016 - 8% Reduction in Smoking at the Time of Delivery (SATOD) to 15%

Data Capture - Recording of smoking at the time of delivery is a mandatory item on the electronic Maternity Pathway, completion remains @ 100%.

Q1 figures show:- SATOD = **24.5%** (April = 17.9%, May = 29.4% & June 26.2%)

Risk Perception Intervention (Rotherham Model) –Commenced in April 14, this intervention occurs at the 12 week gestation dating scan. We are getting positive feedback from New-leaf re the quit rates amongst these pregnant women, these women will begin to give birth September/ October 2014, we wait to see the impact on the SATOD figures at that time.

CO Monitoring at 34 - 36 weeks gestation –Routine CO monitoring has been moved from the 34 to the 36 week antenatal appointment in readiness for the national change in collection of Smoking in Pregnancy data, from SATOD to data collected @ 36 week gestation, verified by a CO reading. This is planned to happen at the end of 2015 early 2016.

Nicotine Replacement Therapy (NRT) - Training for Midwives commenced early July 14, we plan to commence this offer of NRT to pregnant women when admitted into Maternity services from Sept 2014. Women will be offered between 4 & 7 days of NRT & will receive a follow up phone call from New-leaf to offer further support re continued NRT or quitting.

MIQUIT 2 –Recruitment to the trail is underway; the Research Midwife is recruiting to meet target set by University of Nottingham.
MIQUIT 2 uses a motivational texting service that pregnant women opt into.

Q1 Learning Disability Summary

- **65 referrals have been made to the Learning Disability Nurse Specialist in Q1.**
- **Training figures for quarter 1 are: induction training 79% (1656 staff members trained), Mandatory training 95% (589 staff).**
- **Learning disability steering group meeting postponed from June and rescheduled for July 2014.**

Supporting people with LD at end of life: During Dying Matters week the Learning Disability Nurse Specialist had a stand at a local event to remind professionals in the local area about 'My End Of Life Plan' the document is 'easier read' and its aim is to document a person's wishes and choices. The document was developed to support patients with learning disabilities but this could be used for any patient requiring an easier read plan.
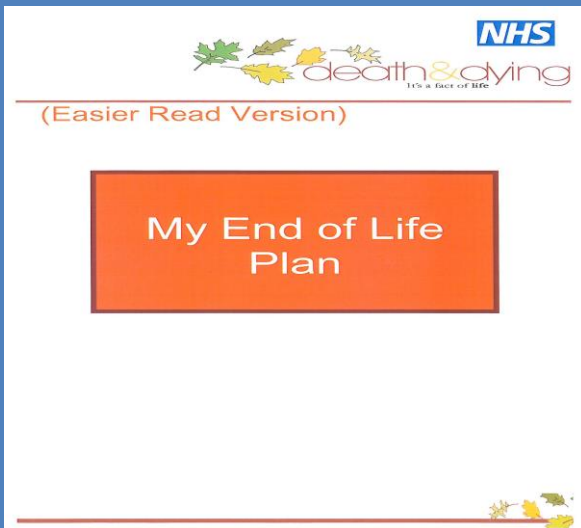
Documentation: Learning Disability Documentation has been reviewed and some changes have been made.

1. The **Hospital Traffic Light Assessment** has been changed in our region. The new document can be found on our intranet page.

2. The **Learning Disability Risk Assessment** has been changed after audit showed usage very poor. The new risk assessment has been streamlined; it now contains a colour coded scoring guide to help support staff make a clinical decision on if a patient requires support from familiar workers to have an equitable health service from our trust.

3. A resource file will be available to wards with copies of the new documents.

Big Health Check Day – 25th June 2014 – The summit Centre.

SFHFT took part in the 'big health check day' where people with Learning disabilities, family carers and professionals input on how they have found using health services in the past year. Using a red, amber, green scoring chart to grade the service.

KMH received very positive comments, 80 people attended the day. Most comments were green, one amber comment and no red comments. The full report will be made available from quarter 2.

CQC Assurance – External Inspection

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. Following the Trust's review from Sir Bruce Keogh in 2013 we were placed in 'special measures' by Monitor. The planned follow-up inspection of our services by the CQC happened in April 2014 with the results of this influencing the decision of Monitor to maintain our special measures status for a further six months. The CQC's new model of inspection is outlined in the following diagram:

Judgement of the quality of care are based on a combination of what was found during the 2 days of announced inspection and follow-up unannounced out of hours inspections, information from the CQC's 'Intelligent monitoring' system, and information from patients, the public and other organisations.

"Working for a Trust in special measures is challenging, but it is a challenge that our talented and committed staff have risen to. Their passion and dedication are admirable and I am delighted that the CQC recognised this in their report, highlighting the care and compassion shown to our patients." – Paul O'Connor, Chief

The Report

An outline summary of the findings shows that whilst progress has been made, there are areas that require improvement. An overall judgement was made that the Trust requires improvement.

	Safe	Effective	Caring	Responsive	Well-led		Overall
Overall trust	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement

Looking Forward

A key area is to build on for 2014/15 is the celebrating, sharing and Trust wide learning from good practice. Outstanding practice was identified in the recent CQC report in Maternity, Emergency department, Children and young people's services and Surgery at Newark Hospital. All services across the Trust were rated as Good in the caring domain. Nursing staff were found to be compassionate kind and patients expressed that staff respected their wishes.

By identifying and learning from what we do well, we can influence positive change in areas that require improvement. Areas for improvement identified from our most recent CQC inspection include: Staff mandatory training and appraisals being completed to meet Trust targets, Ensuring there are appropriate numbers of staff in place for the care required in Newark Hospital, accurate record keeping with regard to patients' observations and hydration and ensuring that there are secure systems in place for storing medicines and that people are given medicines according to their prescription. Robust, sustainable action plans are being formalised to address these areas, whilst maintaining an overall drive to achieve the Trusts longer term strategic objectives.

Internal Assurance Visits

Reinvigoration of our internal assurance processes in order to reflect the new model of inspection, as well as understanding how we can better use data to influence a 'key lines of enquiry' approach of assessment for our patients with complex needs, will help us to give more insightful assurance across the Trust. We have a newly appointed Assistant Director of Nursing for Quality and Assurance who is looking at how we can incorporate these improvements to include out of hours visits, in order to further strengthen this part of our assurance model.

We plan to continue to develop our Internal Assurance Team (IAT) visits, with adjustment being made to the guidance tool used enabling the Trust to keep pace with improvements being made. These visits have been a big success with both inspection teams and ward staff reporting their usefulness.

Nursing Metrics

Planning is underway to develop a more advanced system for assessing nursing care at Sherwood Forest Hospitals. Our existing 'Focus IT' metrics system requires updating to keep pace with the many improvements already made and to better suit our future needs. A list of the requirements for a new system are being drawn together as well as learning from other Trust's that have successfully integrated their own nursing metrics. We plan to have a new bespoke system in place by the end of 2014.

Sherwood Forest's Intelligent Monitoring Report

The CQC's intelligent monitoring report looks at key indicators (Tier 1) in order to influence the regularity and specificity of inspections by analysing and reporting areas of potential risk. This useful tool also enables us to identify areas that may require further improvement in order to mitigate potential risks.

Sherwood Forest Hospitals NHS Foundation Trust	

Trust Summary

Priority banding for inspection	Recently inspected
Number of 'Risks'	5
Number of 'Elevated risks'	3
Overall Risk Score	11
Number of Applicable Indicators	96
Percentage Score	5.73%
Maximum Possible Risk Score	192

Elevated risk	Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators (01-Oct-12 to 30-Sep-13)
Elevated risk	Monitor - Governance risk rating (27-May-14 to 27-May-14)
Elevated risk	Monitor - Continuity of service rating (27-May-14 to 27-May-14)
Risk	Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 30-Apr-14)
Risk	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures (01-Apr-12 to 18-Jun-14)
Risk	Composite of hip related PROMS indicators (01-Apr-13 to 31-Dec-13)
Risk	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13)
Risk	Composite risk rating of ESR items relating to staff sickness rates (01-Apr-13 to 31-Mar-14)

Many of the areas of highlighted risk on this report have been addressed in recent months and we expect the next report to reflect this move towards a reduction in the number of risks highlighted.

Two new areas of risk have been highlighted by the latest report. They are the 'SSNAP Domain 2 indicator' and the 'Composite of hip related PROMS indicator'. SSNAP is the Sentinel Stroke National Audit Programme into which all stroke units submit data on all of their stroke patients on a monthly basis. This particular report reflects the need to ensure that patients with a diagnosed stroke spend as much of their inpatient stay within a specific stroke unit setting. We are currently working to improve flow of patients through the hospital whilst experiencing exceptional pressures on beds. The Stroke team are looking further into how we can improve this indicator report.

The composite of hip related PROMS indicator analyses feedback from patients following hip surgery at the Trust. Our Orthopaedic team are looking into the detail of this indicator to ascertain how this can be improved. We will continue to actively review this monitoring framework to ensure we fully understand the reasons behind our identified areas of risk, enabling us to mitigate risks and improve services as quickly as possible. 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

CQC report in full > http://www.cqc.org.uk/sites/default/files/new_reports/AAAA1772.pdf

Feedback from Quality Committee

HIGHLIGHT REPORT – Quality Committee 17 July 2014

Members

Peter Marks	-	Non-Executive Director (Chair)
Claire Ward	-	Non-Executive Director
Gerry McSorley	-	Non-Executive Director
Tim Reddish	-	Non- Executive Director
Andrew Haynes	-	Executive Medical Director* item 7 only
Jacqui Tuffnell	-	Director of Operations
Kerry Rogers	-	Director of Corporate Services
Nigel Nice	-	Public Governor

Attendees

Nichola Crust	-	Head of Governance
Denise Berry	-	Clinical Governance Lead
Joanne Loughton	-	Secretary
Dr Colin Dunkley	-	Consultant Paediatrician (*item 6 only)
Julie Siddons	-	Team Leader (*agenda item 6 only)
Patrick Keady	-	Interim Risk Manager (*item 10 only)
Lynn Smart	-	Clinical Lead Diagnostics and Rehabilitation (*item 9 only)
Julie Fottles	-	Pathology Quality Manger (*item 11 only)
Elaine Dower	-	Assurance and Development Specialist

Apologies

Susan Bowler	-	Executive Director of Nursing & Quality

This report summarises the discussions and decisions made, and the assurances received at the Quality Committee held on July 17 2014.

Agenda item

- **Serious Incident Report**

DB summarised the quarter one 2014/15 Serious Incident Report. The report was discussed and going forwards it was agreed that more emphasis is required on triangulation of the learning. It was agreed that the Quality Committee would discuss outside of the meeting specifically what in addition they want from the quarterly SI report. Trends and themes and assurances around the actions taken were agreed as essential and recognition was made that the SI report had significantly improved from a year ago. There was non-executive discussion regarding use of the NPSA Incident Decision Tree (IDT) as part of Root Cause Analysis (RCA) investigations involving individuals. It was confirmed by NC this is always used and completion invariably highlights system and process failings.

- **Serious Incident Never Event**

This was presented by the lead investigator and discussed in detail

- **Out of area clinical transfers (ICCU and neonatal)**

Out of area clinical transfers (ICCU and neonatal) were discussed and the two options for clinical transfers was described.
- Clinical need – this is the most common where babies are transferred to a tertiary specialist area e.g. neurological unit
- Non-clinical – these transfers are those whereby there are no beds and transfer is essential

The Quality Committee were assured that as the SFH neonatal unit has more beds then funded, there is the flexibility to increase staffing and open if required for only a short time. It is acknowledged this takes the unit above funded capacity however from a patient and family experience perspective as well as safety, this is often the most favourable option. In 2013 there were ten non-clinical transfers and to date for 2014 there have been none. Costs are collected on the bed report. Where possible, non-clinical transfers are kept within the mid-Trent network and it is always the fittest baby that is transferred.

The intensive care society has published new guidelines in relation to non-clinical transfers and these are being discussed at the Mid Trent neonatal network.

- **CQC Report and Quality Summit**

AH attended and provided a brief summary of the recent CQC visit and their draft findings.

- **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 March 2014. The CQC Intelligent Monitoring Report enables members to see how the CQC view us and what they are currently

measuring. It was recognised by the Quality Committee members that some of the data used is out of date however it does support the committee going forwards on influencing the agenda as knowing what the CQC look at, helps the Committee decide what it too might want to get a deeper understanding of. The elevated risk composite of Hospital Standardised Mortality Ratio Indicators is based on old data and covered the period from 1 July 2013 – 30 June 2013 and at that point SFH were in the elevated risk category. The Quality Committee was assured that since November, we have been in their "no evidence of risk" category. There was some discussion regarding the methodology for calculating when an area becomes a risk. NC confirmed that the website does have a numerical methodology paper to support how they achieved the data of what is expected, what is observed and whether there is a risk. Some anomalies in the "evidence of risk" and "no evidence of risk" were discussed and challenged; accepting this was an external report. The Quality Committee agreed that this report should form a standing agenda item when it is released and that further consideration is required about how we use this information and how it cascades. It was agreed this would be defined by the NEDs. 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. This will in include feedback on the views of complaints, PALS, surveys and through the new External Recommendations Policy implementation.

- **360 Assurance CQC standard 16 (Assessing and Monitoring Quality Departmental Compliance)**

Following the CQC inspection in October 2012 it was agreed that a 360 assurance audit would be undertaken by internal audit in September 2013 within Diagnostics & Rehabilitation. The Internal audit team met with Departmental managers at the end of October with a retrospective review of data Aug –Sept 2013. The first draft report was shared in April and was challenged by the Division as it was felt that this report did not reflect the vast array of work that had been undertaken since August 2013. For example a trust wide quality template had been implemented for Departmental and Divisional Governance meeting agendas and reporting in December 2013 but was not accepted as evidence. Issues were identified in relation to the evidence supplied by pharmacy, this has been addressed with the service leads and an action plan completed. LS provided assurance of actions taken to date and the Quality Committee were assured actions were being taken within agreed timeframes.

- **Board Assurance Framework and Corporate Risk Register**

PK attended and provided a verbal summary to supplement the paper and summarised the findings and actions following the 360 audit of risk management. PK advised that the purpose of the paper was to focus on eliminating risk and having a plan rather than reliance "doing the right thing" i.e. human factors for example following policy. The Quality Committee acknowledged there remain gaps in risk management however were assured that actions would continue with the appointment of a permanent risk manager and TMB receiving a monthly risk register update. KR advised the BAF had only recently been to the Audit Committee and was therefore not required to come to Quality Committee.

- **The Human Tissue Authority Inspection Visit**

JT attended and provided a verbal summary of the visit and the status to supplement the paper. The HTA found that the Designated Individual (DI), the Licence Holder, the premises and the practices were suitable in accordance with applicable HTA standards and the requirements of the legislation. All applicable HTA standards were assessed as being fully met and no shortfalls were identified. Advice has been provided to the DI where the HTA identified opportunities for improvement to existing systems and procedures. An action plan to implement the improvements suggested by the HTA has been prepared and will be presented at the next Trust HTA Group meeting. Work to complete these actions has

begun and progress against the actions will be monitored by the Trust HTA Group. The Quality Committee were assured by the report, the findings and the actions being taken as a consequence of the visit.

- **The Clinical Microbiology CPA Surveillance Assessment Visit**

JT attended and provided a verbal summary of the visit and the status to supplement the paper. During the course of the assessment, the Regional Assessor found evidence to demonstrate overall confidence in the competence of the Clinical Microbiology Service, adequacy of the quality management system and conformity with the required CPA standards. The Regional Assessor also commented on the many areas of good practice, especially the positive feedback from the service users that had been received as part of the Pathology Service User Survey and that it was clear that quality was embedded in the culture of the department. Six mandatory findings (formerly known as non-critical non-conformities) were identified during the course of the assessment. The improvement actions needed to close each finding were agreed with the Regional Assessor during the course of the visit. JT confirmed that work to complete these actions has begun. The Quality Committee were assured by the report, the findings and the actions being taken as a consequence of the visit.

- **Draft External Recommendations Policy**

KR summarised the purpose of introducing a new policy for external agency visits. The Quality Committee approved the role of the Quality Committee and for onward circulation of the proposed policy for consultation and eventual adoption. The committee were supportive of the self-assessment approach and thanked KR for her work to date.

- **Early Warning Scoring and Ward Assurance Dashboard**

Paper received and no specific highlights. NC alerted members to the fact that the business analyst will be reviewing the EWS dashboard to ensure the indicators are still appropriate and whether there are additional indicators to be considered for example outliers. It was confirmed that the Mike Davidge presentation had been shared with the Governance Support Unit (GSU) to ascertain if there are indicators we can measure and report on more meaningfully.

- **Infection Control Annual Report and C-Diff figures**

PM expressed concern regarding D-Diff rates. It was confirmed that an external expert will be attending the Trust to ascertain if there is any additional action to be taken to improve C-Diff given compliance is below target.