

## Board of Directors

## Meeting

## Report

**Subject:** Monthly Quality & Safety Report  
**Date:** Thursday 26<sup>th</sup> June 2014  
**Authors:** Susan Bowler/ Andrew Haynes/ Nicola Crust  
**Lead Director:** Susan Bowler - Director of Nursing & Quality  
 Dr Andrew Haynes – Medical Director

### Executive Summary

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

- Crude mortality is the actual number of deaths occurring in the trust and this time series shows that for this year the rate is lower than in the previous 2 years. The yearly HSMR for April 2013 to Feb 2014 for all acute trusts shows that even with rebasing, we remain within the expected range. Our palliative care coding rate has fallen to a rate that is at the lower end of the range nationally. We are still counting some end of life admissions as unexpected deaths which impacts on our HSMR. We have begun additional work to look this.
- We are seeing good performance in relation to our falls management with the number of fall's resulting in harm below the lower confidence level for the 4th consecutive month. For falls resulting in a fracture we have recorded 3 for April and 3 for May against a trajectory of <25 for 2014/15
- We have identified the need to improve the number of our family and friends responses and have initiated a number of actions to increase our return rate to 50% by October 2014. This includes pursuing an electronic support system as well as offering a project manager position. We still have much work to do in driving this priority.
- Disappointingly our *C. difficile* rates are still outside of our trajectory and we have failed our Q1 target. We have instigated a number of additional actions including requesting a peer review of our strategy and actions
- All NHS healthcare services (with the exception of services commissioned under primary contracts) are now subject to contractual duty of candour under the Standard Contract. The *Being Open – a Duty to be Candid – Communicating care and treatment related harm with patients, their families and carers* policy has been developed and will undergo an extensive consultation phase. This is an important price of work for us; in continuing our drive for complete transparency with our stakeholders, particularly our patients and their carers

### Recommendation

To note the information provided (particularly the changed priorities) and the actions being

taken to mitigate the areas of concern.

**Relevant Strategic Objectives (please mark in bold)**

<b>Achieve the best patient experience</b>	Achieve financial sustainability
<b>Improve patient safety and provide high quality care</b>	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	

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



**TRUST BOARD OF DIRECTORS – MAY 2014**

**MONTHLY QUALITY & SAFETY REPORT**

**1. Introduction**

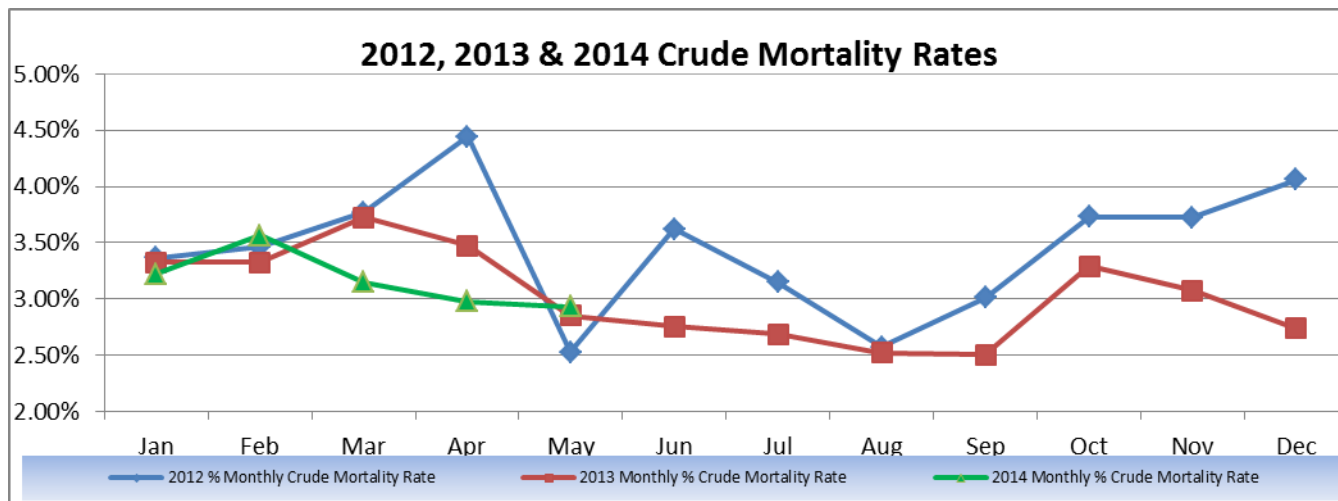
This monthly report highlights to the Board of Directors key areas in relation to quality and safety. It complements the quarterly quality report, which gives a more comprehensive review of progress against the Trust’s quality and safety priorities. The monthly report includes updates on the Trust’s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

<p><b>Key Priority 1</b></p>	<p><b>Reduce mortality as measured by HSMR</b></p>	<p>Headline &amp; specific <b>HSMR within the expected range</b></p> <p>To have an embedded mortality reporting system visible from service to board</p> <p><b>Eliminate</b> the difference in weekend and weekday HSMR</p>
<p><b>Key Priority 2</b></p>	<p><b>Reduce harm from falls</b></p>	<p>Total falls &lt; <b>7 per 1000 occupied bed days</b> by quarter 4 (quarter on quarter reduction)</p> <p>Falls resulting in harm &lt; <b>1.7 per 1000 occupied bed days</b> by quarter 4 (quarter on quarter reduction)</p> <p>Reducing the number of patients who fall more than twice in hospital (baseline Q1 14/15)</p> <p>Reduce the number of fractures from falls to &lt; <b>25</b> for 2014/15</p>
<p><b>Key Priority 3</b></p>	<p><b>Improve response rates and scores in the patient and staff friends and family test</b></p>	<p>Increase our F&amp;F response rate to <b>50%</b> by October 2014</p> <p>To improve the score to +<b>80</b> by March 2015</p>

## 2. Reducing Mortality (Priority 1)

### Current Position

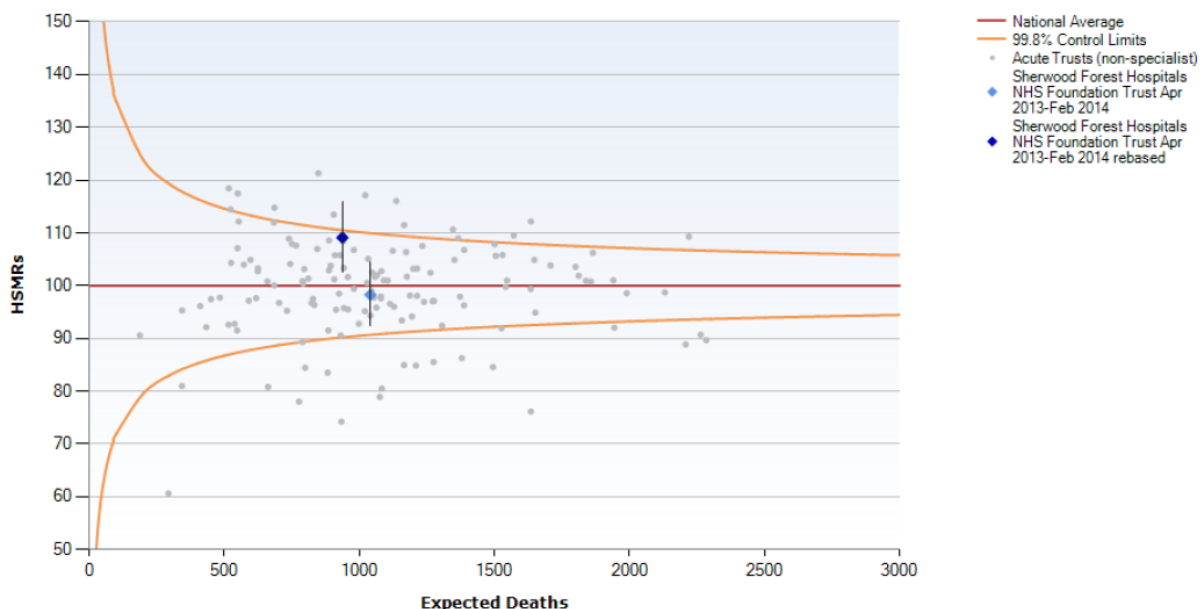
Crude mortality is the actual number of deaths occurring in the trust and this time series shows that for this year the rate is lower than in the previous 2 years. It has fallen more than expected form national data hence represents a real decrease in the number of deaths.



The yearly HSMR for April 2013 to Feb 2014 (most recent data) for all acute trusts shows that even with rebasing, we remain within the expected range. The yearly figure is the method used to compare between trusts and uses validated data, but will always be retrospective.

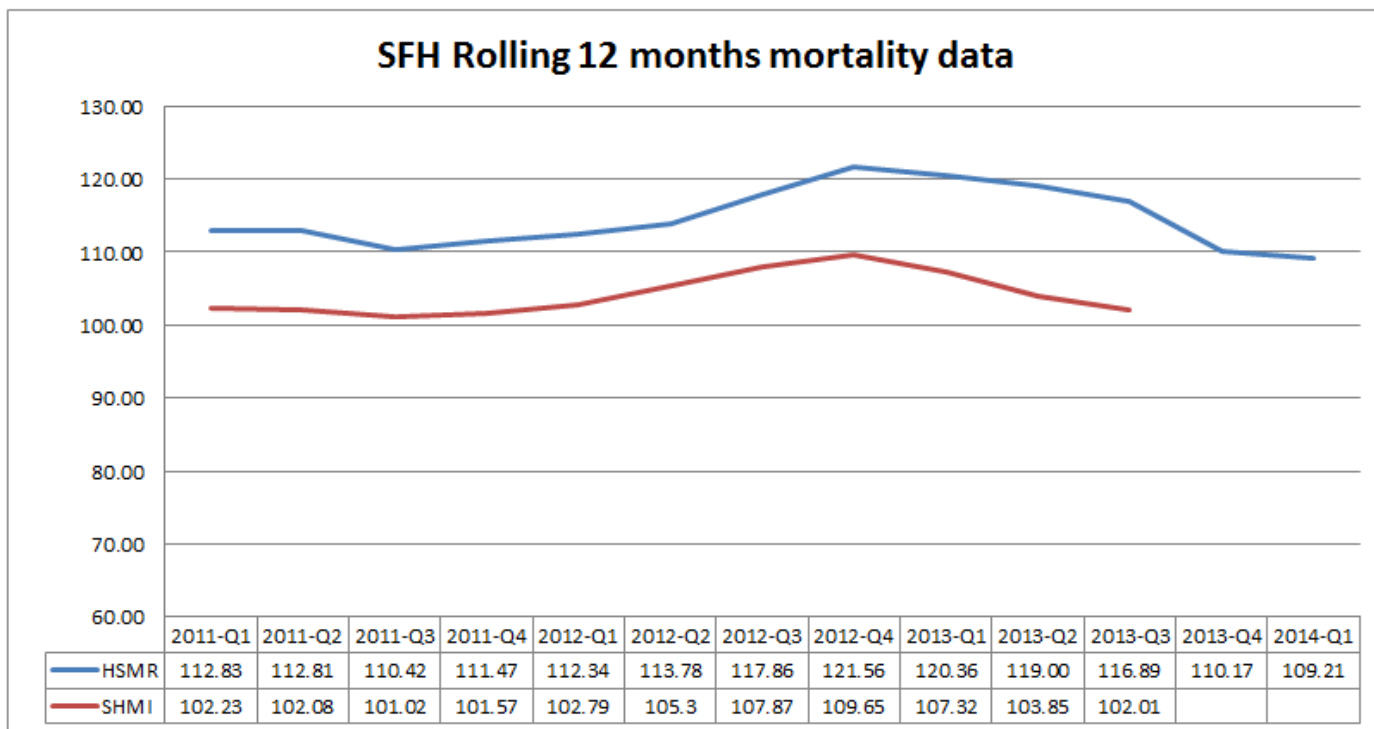
### Acute Trust HSMRs Apr 2013-Feb 2014

The background points show the HSMR for the **current financial year** for each acute non-specialist trust in England. Use the controls below to toggle between the current and rebased values.

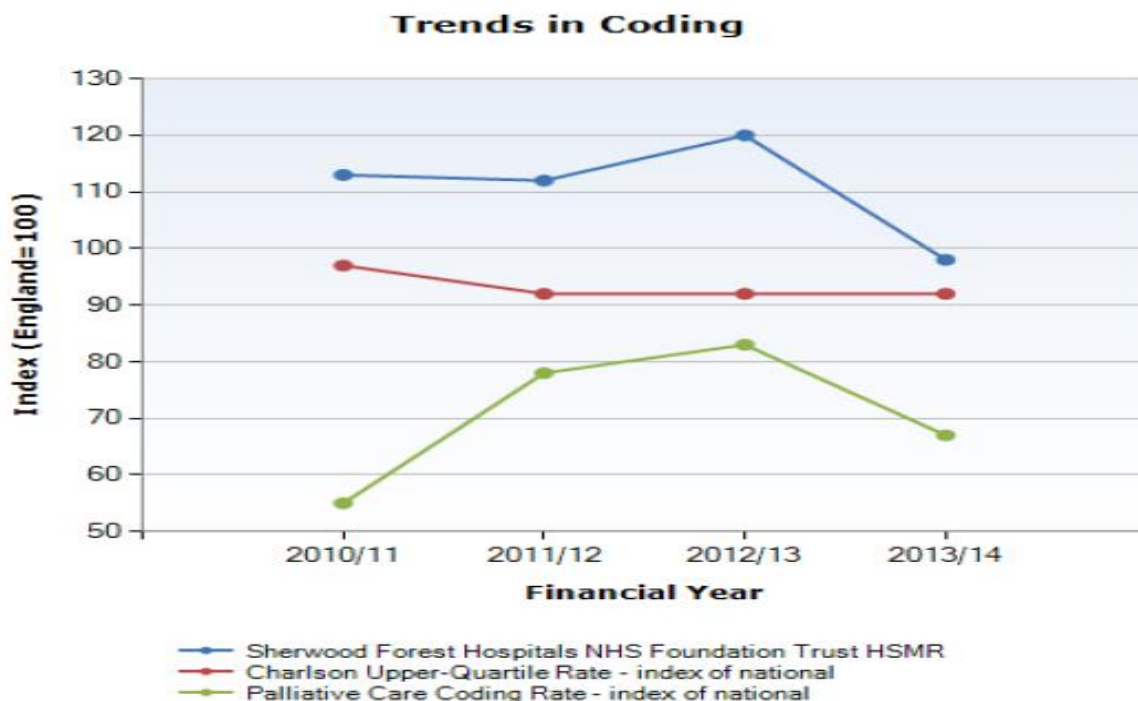


To compare HSMR performance over a more real time, a monthly or quarterly HSMR statistic can be generated. These figures will differ from the yearly figure because of the time lag required to code all deaths but for a given trust the changes in these figures will reflect performance. An alternative measure of mortality, the standardised hospital mortality index (SHMI) includes all deaths in hospital or within 30 days of an admission and is less affected

by the use of palliative care coding. Our HSMR and SHMI are shown below in a time series which demonstrates a consistent fall in both over the last year. The HSMR data is rebased.



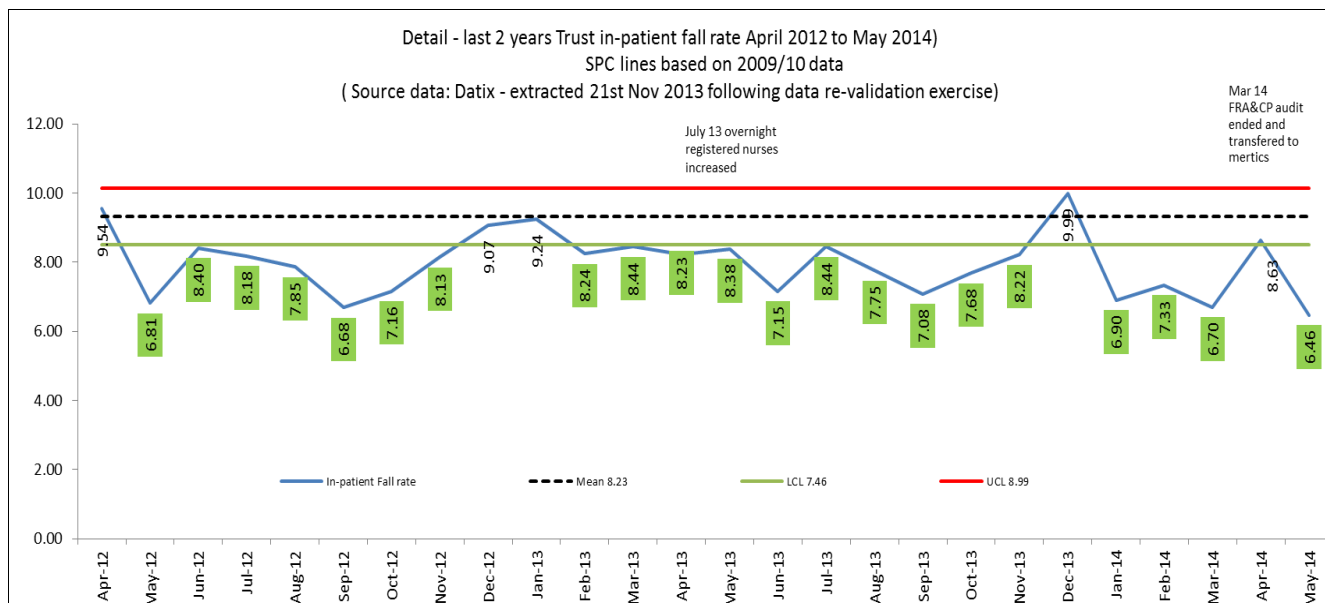
The figure below shows our position with coding.



Effectively we are still below the national average (red line 92 v 100) and our palliative care coding rate has fallen (green line 67 v 100) to a rate of 11% which is at the lower end of the range nationally and we are still counting some end of life admissions as unexpected deaths which impact on our HSMR. We have just begun additional work to look at this with Dr Foster Intelligence, which will also generate bed to board mortality reports.

### 3. Falls Reduction (Priority 2) – Dr Schokker and Gerrie Edwards

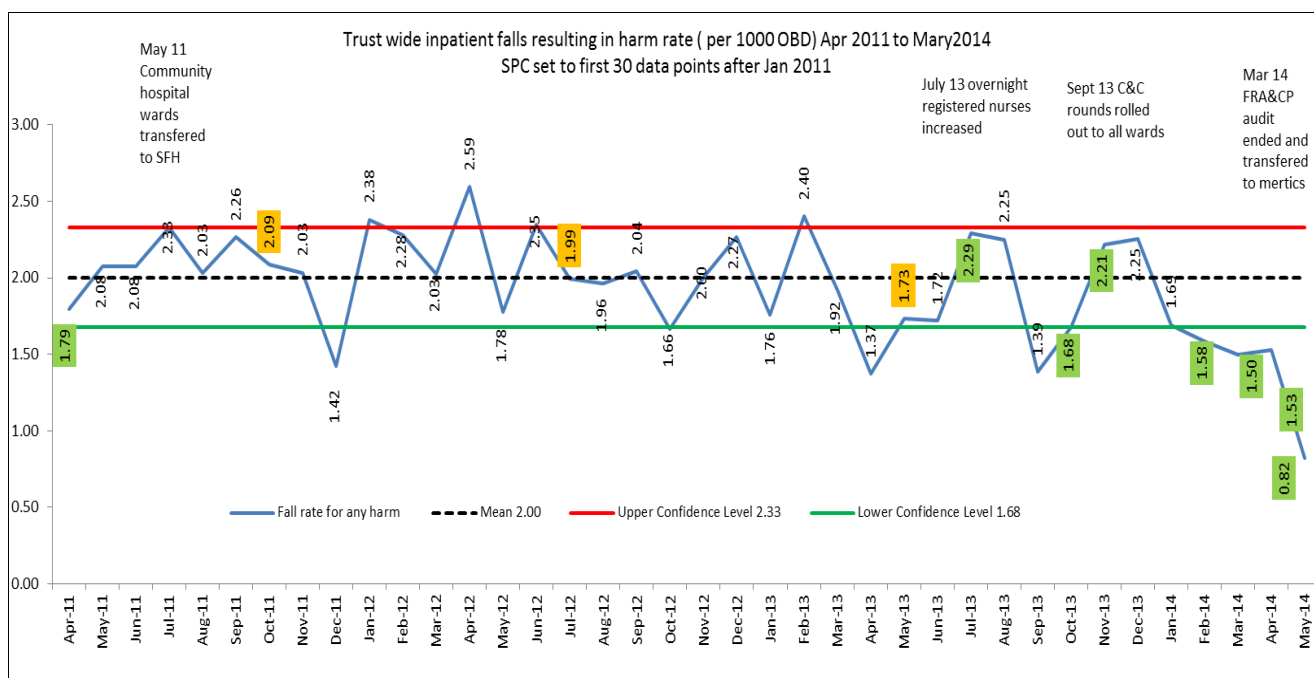
Note – due to the upgrade of the Datix system, some incidents for May have been submitted but are going through a validation exercise. The falls figures for May 2014 may alter as a consequence of the validation exercise.



The graph above shows that the number of falls recorded in May has decreased by 2.2%;

- Continuous focus on using the Ward Assurance information to target specific support and training into any ‘hotspots’ may demonstrate some of the improvements made, in that interventions are being put into place to address the risk factors for individual patients.

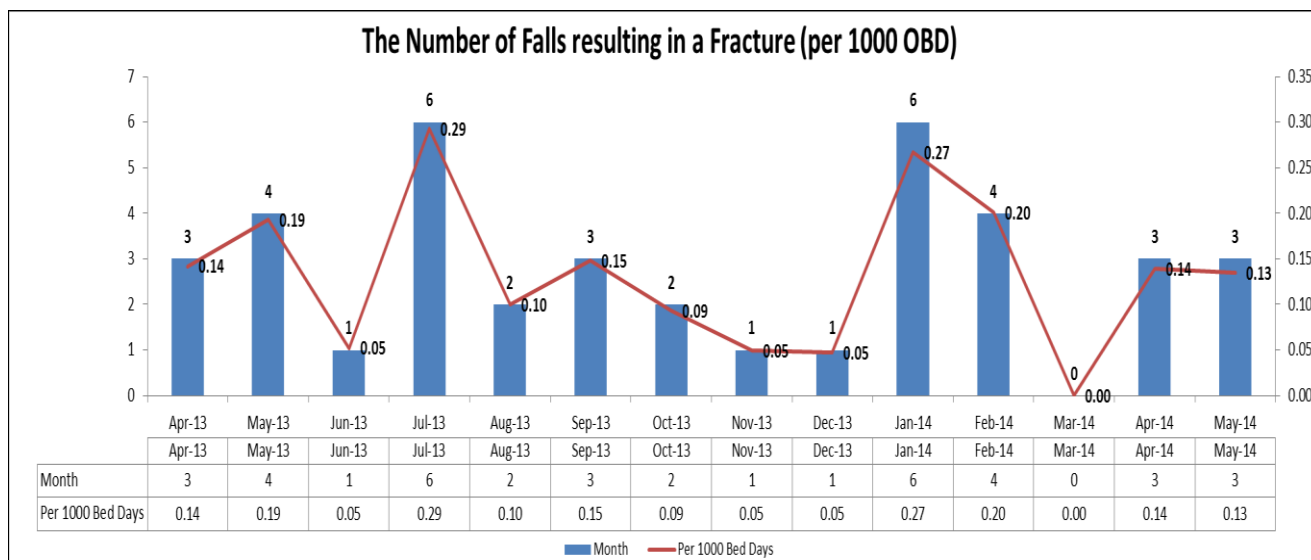
#### 3.1 Falls resulting in harm



The number of fall's resulting in harm is below the lower confidence level for the 4th consecutive month;

- The Ward teams have an increased awareness about earlier interventions and are using the patient enhanced observation more effectively.
- The total number of patients requiring enhanced care is reported on a daily basis during the weekdays
- The Lead Falls Nurse, when possible, undertake s walk around checks on Fridays to support teams in planning for the weekends. This ensures appropriate interventions and requests for additional staffing, if required, is in place.

### 3.2 The number of falls resulting in a Fracture



The number of fall's resulting in a fracture for May is 3, a total of 6 for the 2014/15 (our trajectory is <25) and an improvement of 1 on the same period last year;

- Wards are committed to assessing and re-assessing patients if their clinical condition changes or if they are transferred from one care setting to another
- Through supported teaching on the wards, teams are encouraged to ensure patients understand how to use the Nurse Call bell and are able to demonstrate that they can use it.

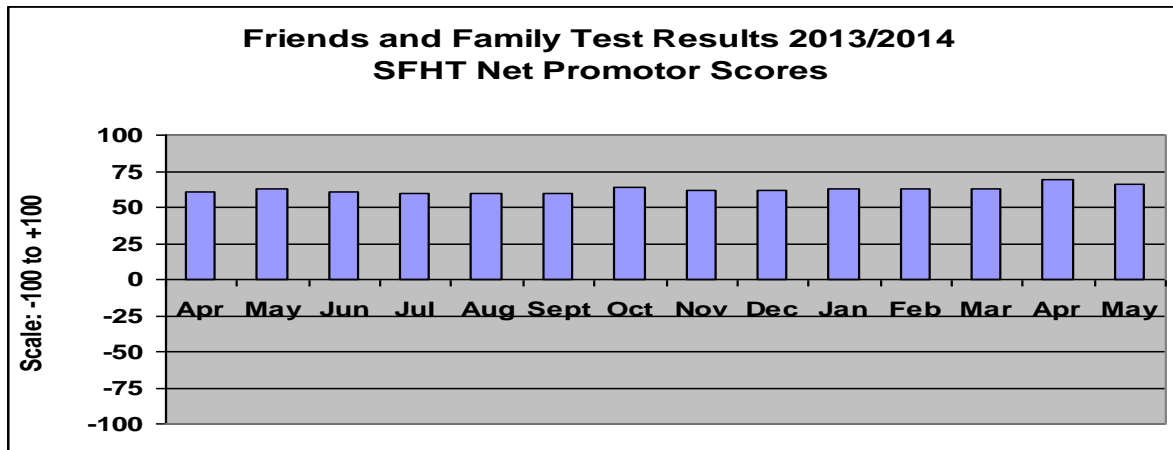
### 3.4 Looking ahead

- The work to engage ward teams with the Falls Champions is on-going and gathering momentum, as each Ward identifies members of staff whom want to be involved directly in falls prevention.
- Information boards that will be centralised on all ward areas in relation to falls is being prepared through clinical illustration
- Information and a response team in relation to patients who fall and have suspected spinal injury is also being finalised and will be communicated and then displayed with the Falls Resource information to promote a culture of safety
- ID badge sized information cards about observations required for an inpatient with a Head Injury or unwitnessed fall will be provided for all new clinical staff.

#### 4. Improved response rates and scores in the patient and staff friends and family test (Priority 3)

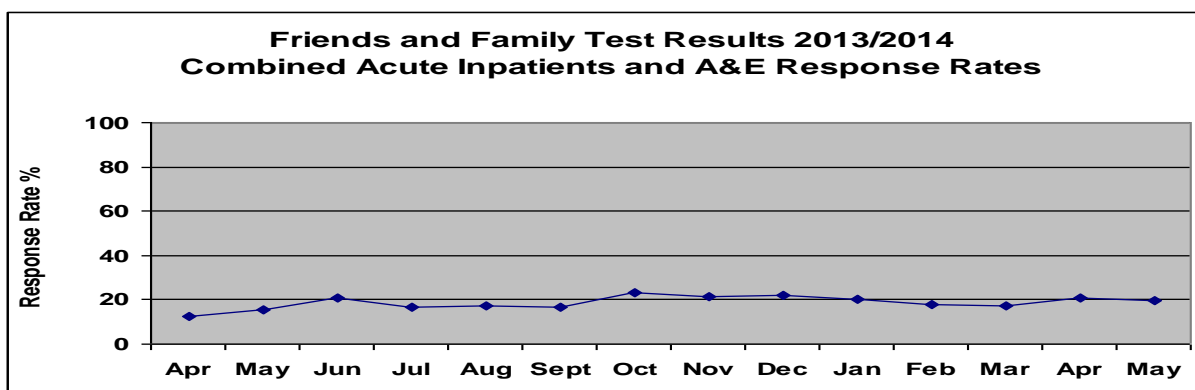
The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received, to friends and family who need similar treatment or care. It was initially for providers of NHS funded acute services for inpatients (including independent sector organisations that provide acute NHS services) and patients discharged from A&E (type 1 & 2). As of 1st October 2013 the survey was extended to include all women of any age who use NHS funded maternity services. For 2014/15, there is a requirement to extend it to day case and outpatients.

The graph below shows current feedback scores have been in the upper quartile.



The graph below shows the response rates from our patients in inpatient areas and A & E.

We are only performing adequately when compared to the national target for our patient’s friends and family response rates, but still requirement a marked improvement to reach our internal target.



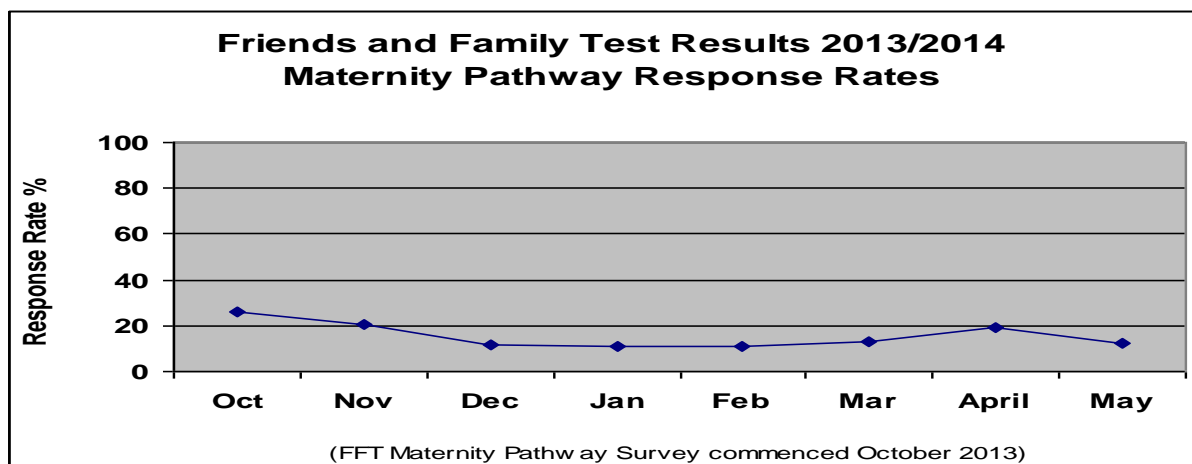
A&E have formulated an action plan to support an improved response rate. The actions are:

- Introduce business type cards that will promote the use of the website. These are to be made widely available to staff enabling them to sign post patients to the feedback oppoportunities.
- Display additional posters and visual information in the waiting areas and consulting rooms
- To expand the role and numbers of volunteers in ED who will promote the F & F test

The graph below shows response rates from our maternity areas. We ask our maternity patients the friends and family test at 4 separate parts of their patient journey (during their pregnancy and post birth phase) and we continue



to actively encourage women to provide us with this feedback. We are introducing additional ways for our patients to provide feedback to try and make this as easy as possible for them to give us this valuable information. Our response rates for May have deteriorated so like A&E a proposal to improve the response rate has been requested.



We are currently seeking expressions of interest from external providers for an electronic system to support us in collecting and reporting the data. The electronic system will support the delivery of the patient friends and family test, the staff friends and family test and medical and nurse re-validation. It will provide our patients with expanded opportunities to give us their feedback through electronic means, as well as a paper system. We are aiming to make a decision on a preferred supplier early July.

We are currently securing a project manager to support us in driving F & F's harder. A 6 month contract has recently been offered to a candidate

## 5.0 Infection Control Update

### 5.1 C.difficile Infection

As of 31st May 2014, the Trust has identified 11 cases (5 cases in April and 6 cases in May) of Trust acquired C. difficile infection against a trajectory of 6 cases (3 cases for April and May each). Detailed Root Cause Analysis (RCA) of 10 cases has been completed. Most of the cases were deemed to be unavoidable. (9/10)

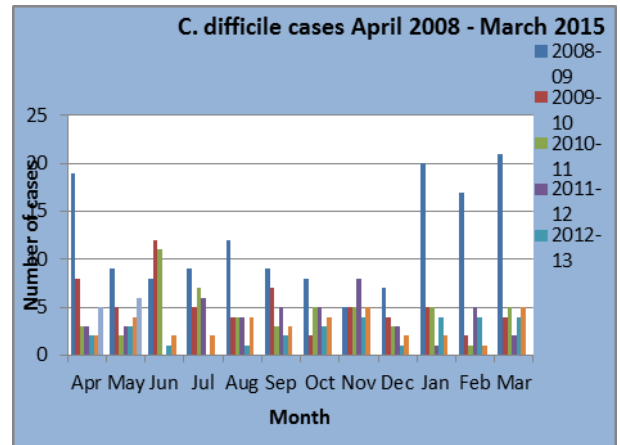
Findings from the root cause analysis-

- All patients were prescribed appropriate antibiotics in accordance with trust guidelines.
- There were few issues regarding delayed sampling and isolation in two cases.
- There has been one case of probable cross infection identified by typing results on Oakham ward. There was a 17 day gap between the two patient episodes, with the cross infection being identified through ribotyping. An outbreak has been declared and an investigation been carried out. Audits have not identified any poor practice on this ward. Although it is possible cross infection could have occurred because of lapses in hand hygiene.

Actions –

- Appropriate feedback was given to the clinical and nursing staff highlighting the importance of prompt sampling and isolation.
- Education and training sessions on various aspects of infection control were organised for the health care professionals.
- Enhanced cleaning is in place on Oakham ward.
- All the RCA's is being fed back to the respective divisional clinical governance meetings by the clinical area to share the lessons learnt.

Year on year data							
Month	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Apr	19	8	3	3	2	2	5
May	9	5	2	3	3	4	6
Jun	8	12	11	0	1	2	
Jul	9	5	7	6	0	2	
Aug	12	4	4	4	1	4	
Sep	9	7	3	5	2	3	
Oct	8	2	5	5	3	4	
Nov	5	5	5	8	4	5	
Dec	7	4	3	3	1	2	
Jan	20	5	5	1	4	2	
Feb	17	2	1	5	4	1	
Mar	21	4	5	2	4	5	



It is clear from the above data that trust had increase of C.difficile cases in April and May 2014 compared to last year. Although most of these cases seem to be unavoidable we are taking it seriously and putting in extra effort to prevent all avoidable cases. A detail action plan has been developed and a peer review has been requested.

Actions include:

- Reducing the rate of *C difficile* disease relapse by considering the use of fidaxomicin in selected patients with C difficile disease (e.g. those who are required to remain on antibiotic treatment)
- Reducing the likelihood of successful transit of spores through the stomach by ensuring all proton pump inhibitor (PPI) is justified
- Minimising environmental contamination by *C difficile* spores by reinforcing; a) Prompt isolation and sampling, b) Appropriate use of PPEs, c) Appropriate cleaning (Hydrogen peroxide vapor) and d) Ward level training sessions in this regards ( facilitated by ICNs) & developing simple flow charts .

## 6. The Duty of Candour

### 6.1 Background

All NHS healthcare services (with the exception of services commissioned under primary contracts) are now subject to contractual duty of candour under the Standard Contract.

Under the contractual duty of candour, the Trust is required to comply with obligations regarding candour if a reportable patient safety incident (i.e. a patient safety incident involving moderate or severe harm or death) occurs or is suspected to have occurred. However this only relates to patient safety incidents arising in the course of services delivered under the contract. As such the contractual duty of candour is not applicable to any incidents, which took place prior to April 2013.

### 6.2 Current Position

A policy has been drafted which addresses Sherwood Forest Hospitals NHS Foundation Trust's (SFHFT's) response to the ethical responsibility and duty of candour when a patient safety incident occurs, using the 10 principles underpinning 'Being Open' as supported by the National Patient Safety Agency (NPSA). These are:

- Acknowledgement
- Truthfulness, timeliness and clarity of communication
- Apology
- Recognising patient and carer expectation

- Professional support
- Patient Safety, Risk Management and systems improvement
- Multidisciplinary responsibility
- Clinical governance
- Confidentiality
- Continuity of care

At present there is just the contractual Duty of Candour. The Government is committed to going further and implementing a statutory Duty of Candour across a much wider range of providers. The Care Bill will place a specific duty on the Government to include a Duty of Candour on providers registered with the Care Quality Commission. This means that, subject to the passage of the Bill, a statutory duty of candour must always be one of the registration requirements placed on CQC registered providers. The Duty of Candour itself will be set out in secondary legislation in regulations.

The draft regulations require all providers registered with CQC, both healthcare and adult social care providers, to be open and transparent with service users about their care and treatment. The regulations also impose a more specific and detailed Duty of Candour on all providers where any harm to a service user from their care or treatment is above a certain harm-threshold. A consultation document was published in March 2014, regarding Introducing the Statutory Duty of Candour and is a consultation on proposals to introduce a new CQC registration regulation.

### 6.3 Next Steps

The *Being Open – a Duty to be Candid – Communicating care and treatment related harm with patients, their families and carers policy* will undergo an extensive consultation phase once initial feedback has been received from members of the Clinical Quality and Governance Committee and TMB.

The training requirements to ensure appropriate implementation of the policy are significant and resources will be required to support a training awareness programme. It is anticipated that the training programme would be co-ordinated by the Patient Safety Team within the Governance Support Unit. It is proposed that:

- ‘Being Open- a Duty to be Candid’ forms part of the syllabus for all Trust RCA courses
- ‘Being Open- a Duty to be Candid’ is included in Trust induction for all staff
- ‘Being Open- a Duty to be Candid’ is a mandatory component of the junior doctor’s education programme

It is recommended this policy receives approval at the Trust Board given the importance of the policy but the consultation is led through the Quality Committee, who in turn recommends approval to the Trust Board.

Susan Bowler  
Director of Nursing

Dr. Andrew Haynes  
Medical Director