Sherwood Forest Hospitals NHS
NHS Foundation Trust

Quarterly Patient Safety & Quality Report

Trust Board of Directors Meeting
24th April 2014

Year End Summary 2013/14

Contents – Patient Safety & Quality Report Quarter 4

Introduction & Summary

This report is presented by the Executive Director of Nursing & Quality and has been prepared with the support of the Deputy Director of Nursing & Quality and the relevant clinical and staff leads. This report includes information from Quarter 4 and provides a year end summary of specific quality and safety priorities. It should also be read in conjunction with the Patient Experience report which outlines performance and learning as a result of patient feedback. The report contains information on our 3 top quality priorities, our CQUIN schemes and other key quality and safety indicators.

Quarter 4 has been characterised by working to achieve our year end quality and safety targets and agree our CQUIN schemes and quality schedule for 2014/15. We have also continued to embed and sustain the improvement work to deliver the recommendations following the Keogh and CQC reviews. This has included the launch of our 'Quality for All' initiative to instill our new values and behaviours across the organisation. Sessions are being held throughout April and May to cascade our new values to our staff and these will shape and underpin our future direction. In partnership with our staff, patients and their carers we have developed our values, which are:

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

Quality for all

Key National Developments

New approach to hospital inspection – report published by CQC

In March, 2014 the Care Quality Commission (CQC) published findings from its 18 pilot hospital inspections completed last year, the first step in a radical change to its approach.

The chief inspector of hospitals, Professor Sir Mike Richards, led teams of specialist inspectors and members of the public representing patients, to complete this work between July and December last year. The report concludes that compassionate care is alive and well in the NHS. Inspectors found care and compassion among frontline staff in every hospital visited, as well as a strong commitment to the NHS.

Inspectors found that critical care services were delivering high quality, compassionate care and were able to demonstrate how they monitored quality. Maternity services were also generally providing good quality care, and were good at monitoring their effectiveness. Almost all units were using a performance dashboard that helped them understand their performance. Many of the trusts were found to be making a determined effort to improve care for people with dementia, for example by creating dedicated wards.

However, inspectors found significant variations in quality between trusts and even between services within trusts. Accident and Emergency Departments (A&E) were found to be under greater strain than other hospital services. Outpatient services were poor – they were not responding well to patient needs across most of the hospitals inspected, with patients waiting unacceptably long times to be seen and some clinics being overcrowded as a result.

The report also found that apart from critical care and maternity, most services cannot demonstrate whether they are delivering effective care or not. In all inspections, inspectors asked if services were safe, effective, caring, responsive to people's needs and well-led and CQC is consequently now finding out more about hospital quality than ever before, according to Sir Mike Richards. 'This review shows that inspections with larger, more expert teams work. Our experience so far shows we are moving in the right direction and we have had positive feedback from the hospitals and others.'

The new approach to hospital inspection is a radical change, and much has been learned from this first pilot wave.Three particular areas the CQC have identified for development are:

- Consistency: It is important to have a consistent approach in both how to assess services and how to make judgements about quality. This includes selecting and training the right inspection staff and clinical experts, defining key lines of enquiry, and being clear 'what good looks like'.

- Credibility: Senior expert representation on the inspection teams is vital. The CQC recruited and involved a large number of specialists and experts from the acute sector during Wave 1, who brought a significant amount of credibility to the inspection teams. The CQC recognise the need to recruit more senior managers with 'trust-wide' roles (such as chief operating officers) and to access the right level of expertise in some specific areas, for example A&E. They have also recognised that more high quality training for teams is needed.

- Improving our processes: The CQC have acknowledged that they need to improve the processes being tested in Wave 1. Further work needs to be done to prepare for the main inspection – some areas of assessment are difficult to do in the short space of time available on site, for example looking at complaints handling, looking at clinical information flows, and assessing leadership. There are also issues about the logistics of organising the inspection and making the process sustainable for everyone involved.

  The full report can be found at:

  http://www.cqc.org.uk/sites/default/files/media/documents/20140305_acute_wave_1_report_-_final_for_publishing_2_formatted.pdf

Mortality Summary (Quality Priority 1)

What did we aim to achieve in 2013/14?

To reduce the Hospital Standardised Mortality Ratio (HSMR) by 10%.

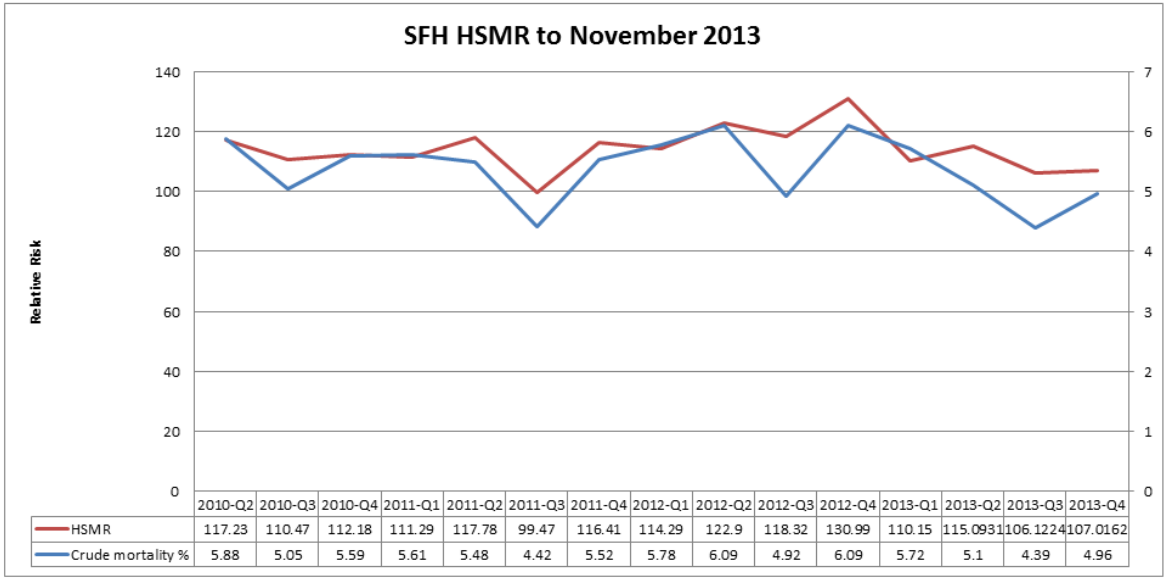
To identify the deteriorating patient quickly. We have committed to invest in the VitalPAC system. VitalPAC is an electronic, wireless point of care system, which enables staff to enter patients' physiological observations using hand held devices, which triggers earlier interventions. We believe this will be a key enabler to achieve our mortality reduction ambition. This cannot be relied upon in isolation and will be implemented in conjunction with other initiatives to drive changes in practice.

What Progress have we made so far?

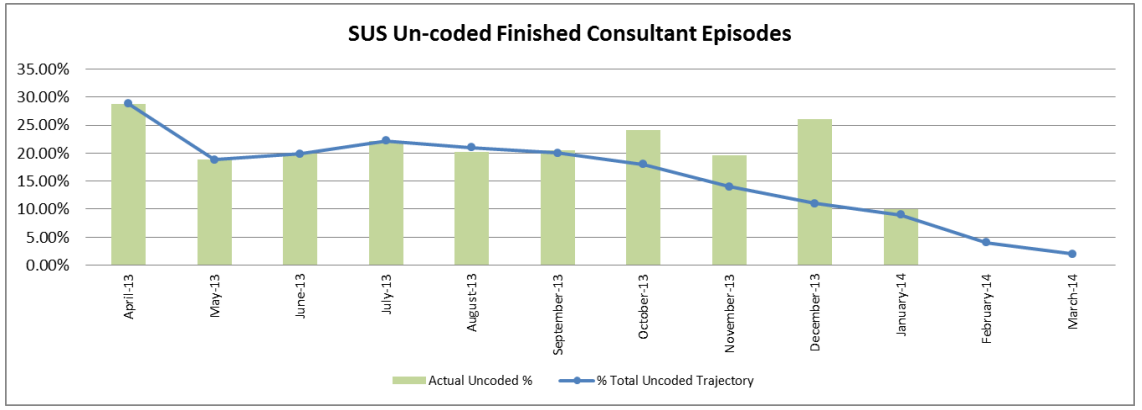
The HSMR position has consistently improved from a peak in Q4 2012 throughout 2013. The crude mortality rate has fallen despite activity levels being unchanged.

The increase in crude mortality in Q4 2013 has not been accompanied by a rise in HSMR suggesting that these deaths were expected end of life events. The repeated pattern of increased crude mortality in Q3/4 reflects the increased deaths seen in winter months. An adjustment is made in the data for uncoded episodes, but is likely to make our monthly HSMR data worse than the true position. Our position on uncoded episodes has improved and this now needs to be sustained.

Our national position has improved. For the year 2012-13 we were at the bottom of the national benchmarking but since then to November 2013 we have moved up 14 places.

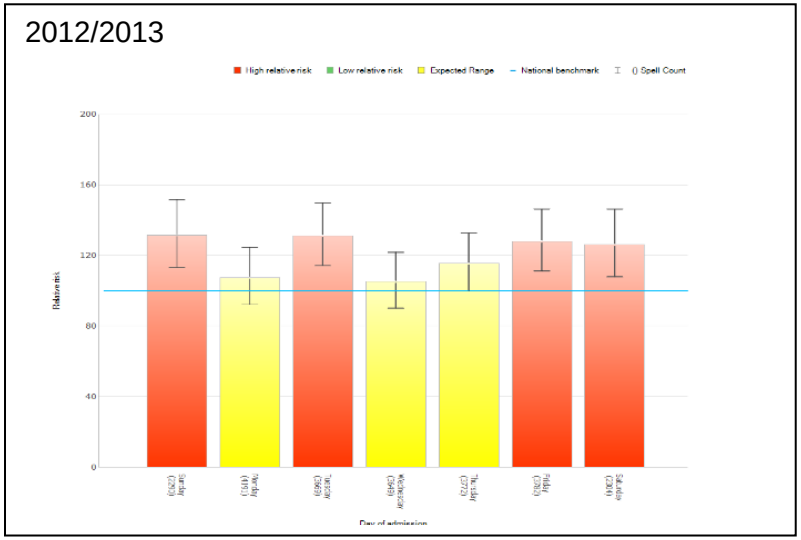


	2010-Q2	2010-Q3	2010-Q4	2011-Q1	2011-Q2	2011-Q3	2011-Q4	2012-Q1	2012-Q2	2012-Q3	2012-Q4	2013-Q1	2013-Q2	2013-Q3	2013-Q4
HSMR	117.23	110.47	112.18	111.29	117.78	99.47	116.41	114.29	122.9	118.32	130.99	110.15	115.0931	106.1224	107.0162
Crude mortality %	5.88	5.05	5.59	5.61	5.48	4.42	5.52	5.78	6.09	4.92	6.09	5.72	5.1	4.39	4.96

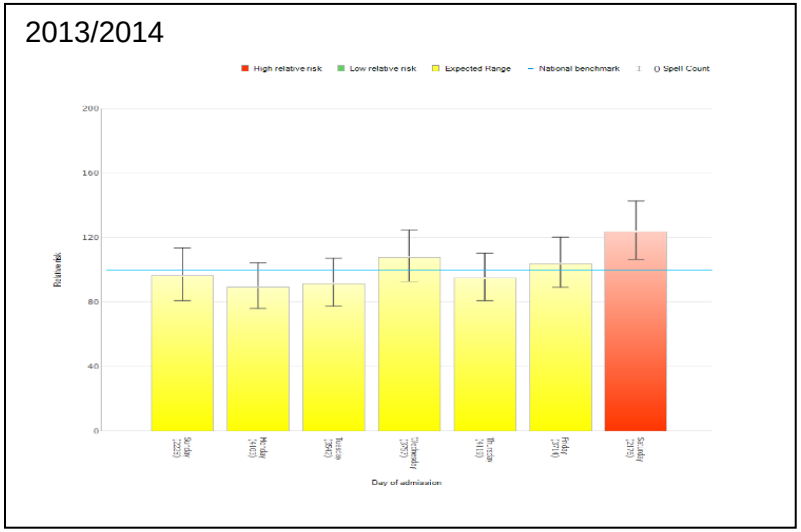


Our weekend mortality remains elevated above weekday but the position continues to improve with a significant reduction in the variation and narrowing of the gap.

2012/2013



2013/2014



What do we aim to achieve in 2014/15?

Our overall HSMR has come down significantly and our aim for mortality is to maintain our position close to the benchmark HSMR and in line with our peers. This whilst sustaining improvement and continuing a robust monitoring process.

What actions will we undertake in 2014/15?

- Continue to identify any areas/issues of concern, for example via Dr Foster mortality alerts, then develop the appropriate workstreams involving multidisciplinary teams
- Monitoring of pathways and services to ensure that improvements are sustained and that any new challenges are identified and dealt with as they arise
- Patient Safety team now comprising both Patient Safety Lead and Patient Safety Fellow will continue to drive forward the Patient Safety programme. Expansion of this team will also take place.
- Continue the liaison between hospital and community teams around issues concerning end of life care in order to offer patients and their families the right options for them
- Build on the improvements that have been made in the area of coding to sustain these and remain consistent
- Develop bed to board reporting system for mortality and train divisional teams to use Dr Foster data to inform this

Pressure Ulcer Summary (Quality Priority 2)

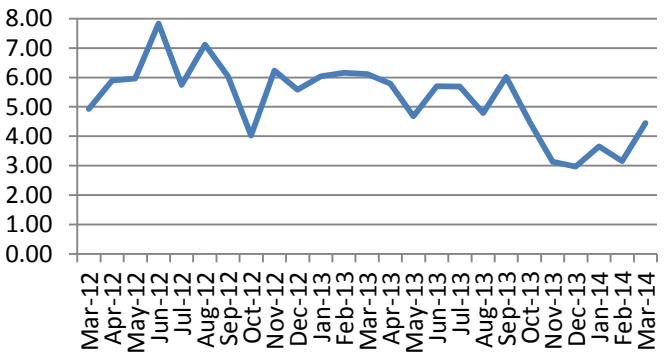
The table below below show all avoidable grade 2 – 4's and grade 1's developed with the Trust in 2012 -13 and 2013-14. (Grades ones are not categorised into avoidable or unavoidable)

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	**Totals**
GRADE 1 - is permanently red skin, but not broken								NB- *No targets set for G1's*					
2012 -13	NA	7	5	9	6	5	4	6	6	2	4	7	**61**
2013-14	5	12	5	5	3	9	3	4	7	1	1	10	**65**
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	5	9	6	7	9	5	7	**106**
Target No.	15	20	10	7	7	6	6	7	7	4	3	3	**95**
GRADE 3 - goes through the whole layer of skin and there is 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	2	1	1	2	0	0	**18**
Target No.	3	3	2	2	2	2	2	1	1	1	1	0	**20**
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**
Target No.	0	0	0	0	0	0	0	0	0	0	0	0	**0**

Achievements for 2013/14

- We had zero avoidable Grade 4 pressure ulcers
- We achieved a 25 % reduction in avoidable Grade 3 PU's from the previous year
- We achieved a 30% reduction in avoidable Grade 2 ulcers by 30% from the previous year
- We did however have 11 grade 2 pressure ulcers above our annual target
- In achieving the above reduction we met all our CQUIN targets for 2013/14

Pressure Ulcers taken from the Safety Thermometer March 2012-March 2014



Our monthly Safety Thermometer audit (point prevalence) demonstrates a reduction in the number of pressure ulcers recorded at the Trust, as per the graph above.

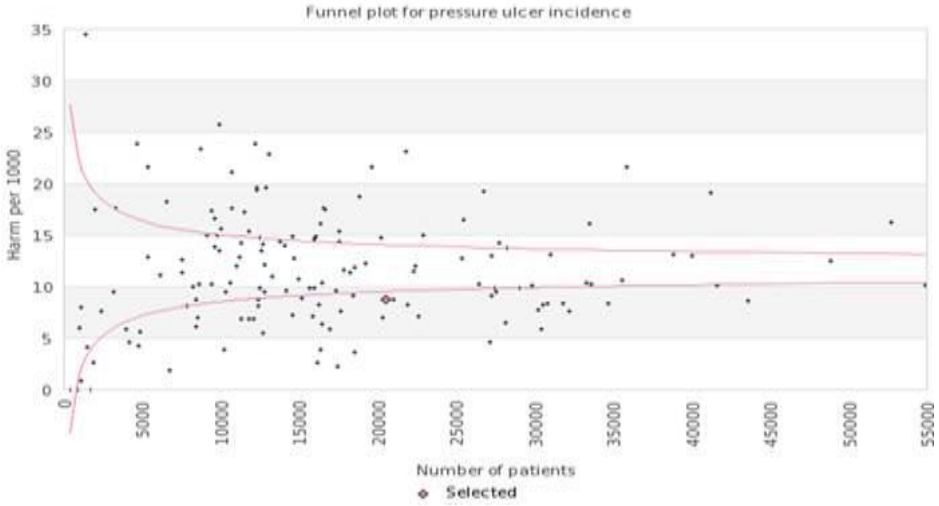
For 2014/15 we plan to:

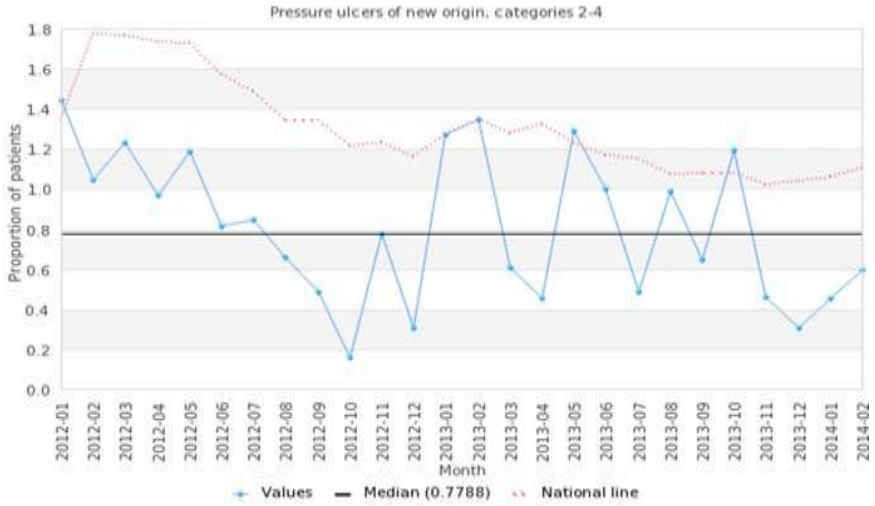
Our ambition is to have zero avoidable grade 3 and 4 pressure ulcers by October 2014. We also aim to reduce grade 2 pressure ulcers by 50% by October 2014 and then zero by March 2015. To achieve this, we will:

- Work collaboratively with the Community, and CCG's to reduce the overall pressure ulcer rates across the region.
- Track pressure ulcers electronically regionally to reduce administrative work and promote accuracy of reporting.
- Provide education in electronic alternatives to complement existing methods.
- Focus on outpatients and waiting areas to
- identify specific tissue viability needs for these patients.

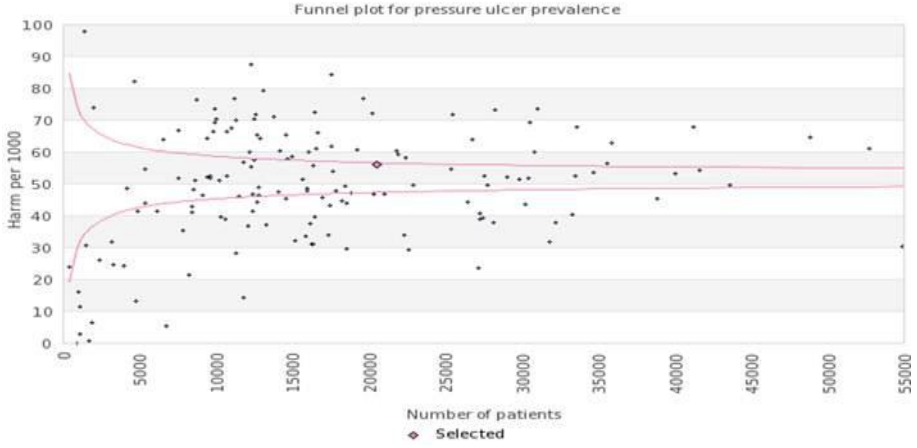
Pressure Ulcer Summary (Quality Priority 2) cont

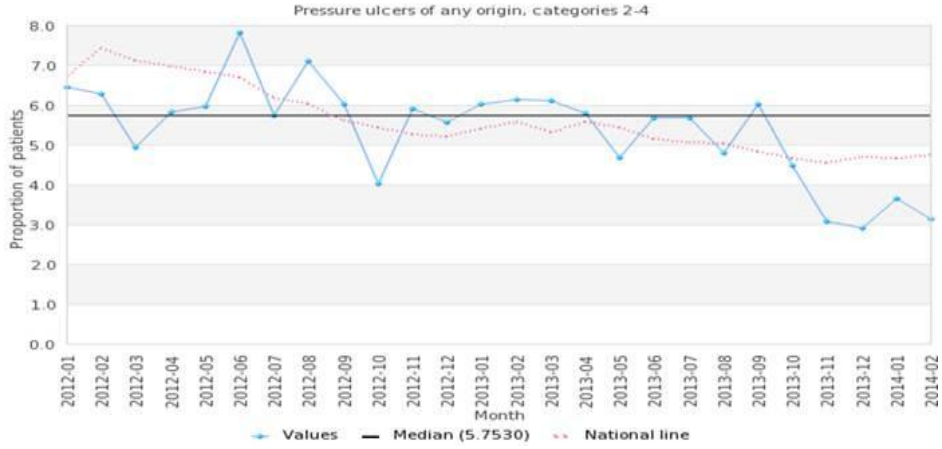
The proportion of our patients with new pressure ulcers (hospital acquired) is below the national average and shows an overall downward trend and is also illustrated in the funnel graphs below.





The prevalence rate of all pressure ulcers of any origin (Hospital acquired and inherited) has mirrored the national prevalence rates over the previous two years; however since October 2013 this is following a downward trend below the national average. The funnel graph below shows our rates are within range compared to other Trusts of differing populations.





Pressure Ulcer Summary (Quality Priority 2) cont

How Did We Achieve this?

Following an audit in April 2013 by the newly appointed Tissue Viability Nurse Consultant the main objectives for the year were:

- Ensuring the right pressure relieving equipment was available for the patient as soon as the need is identified
- To develop documentation to assist nursing staff to assess patients risk and implement the right care at the right time. Also to ingrain the message "REACT TO RED" as soon as it is identified, thus preventing avoidable pressure ulcers
- Thorough and robust investigation process of deep pressure ulcers to ensure lessons learned and sharing to prevent further incidents

We strengthened our documentation – The pressure ulcer prevention plan (PUPP) in line with standards set out by National and European Tissue Viability Standards and providing ward based education and support to nurses has helped to embed the standards we expect Also providing more pressure relieving mattresses with a clear mattress selection guide, as well cushions and 'off-loading' devices for heels . Likewise we provided education on device related pressure ulcers (for example oxygen masks) which continues to affect patients.

We paid particular focus to ED and EAU, developing bespoke documentation and equipment with daily support from the Tissue Viability Team. This meant that patients could be assessed and have appropriate care at the earliest opportunity.

A root cause analysis of all deep pressure ulcers is undertaken. This robust system is finalised with a clear action plan which is monitored until it is completed. Several learning events have taken place as a result of these investigations with monitoring and reporting for sustained improvement.

How do we monitor how we are doing?

- Pressure ulcer prevention is audited monthly using the metrics system, the results of which have shown a gradual improvement throughout the year. This following year the Tissue Viability Team will undertake more in depth auditing with Ward staff.
- The validating of pressure ulcers developed with the Trust is robust but continues to be developed on Datix, to aid information gathering and reporting. This next year we hope to validate all our ulcers from outside the hospital (inherited pressure ulcers) to assist us working collaboratively with community colleagues and commissioners.
- Divisions are also provided with monthly risk rated ward reports which include numbers of pressure ulcers, education/meeting attendance and audit (Metrics) results. This enables Ward leaders to plan for improvements and will assist in monitoring of key performance indicators for 2014 – 15. These are presented at senior nurse forums and ward leader quality groups.
- There is also a collective meeting across the senior nursing teams where we monitor the monthly ward assurance matrix. At this meeting we discuss a range of indicators ward by ward and identify actions for improvement.
- The safety thermometer data will continue to be collated monthly and allows a benchmark (limited) with other surrounding Trusts.
- The Pressure Ulcer Strategy Group continues to monitor and drive the pressure ulcer reduction strategy with monthly reports provided to the Trust Board.

We met our CQUIN targets for pressure ulcers in 2013/14

Patient Flow Summary (Quality Priority 3)

During 2013/14 Sherwood Forest Hospitals NHS Foundation Trust set out to:

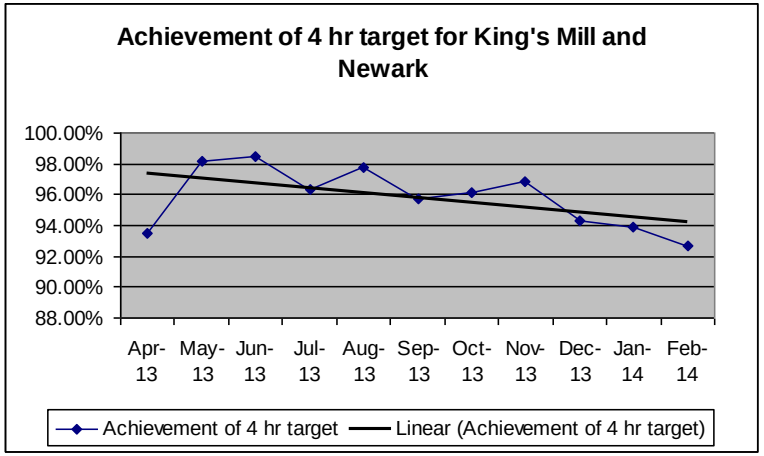
- To reduce length of stay and readmissions by improving patient flows.
- Ensure all patients have access to the right bed in a timely way.
- Ensure we have the right number of beds in the right places
- Ensure our patients are in hospitals only as long as they clinically need to be
- For patients to receive the best care, by right staff with the necessary skills to manage and support their illness

We have made significant progress during the last year in response to increasing demands for our emergency services here at Sherwood Forest Hospitals Trust. However we recognize that further progress is required in the coming months.

Key Achievements during 2013/14

- Recruitment to substantive nursing and medical posts in the Emergency Department
- Dedicated geriatrician time in ED
- Extended front door team for the frail elderly
- Interprofessional standards in ED implemented
- Referral to 24 hour psychiatric nurse support into ED
- Establishment and review of respiratory and gastroenterology hot clinics
- Worked with Social Service to establish 8 Transfer to assess beds in 2 local private homes
- Increased ambulatory pathways available at Kings Mill site
- Streamlined process of patient transfer to Newark hospital
- Integrated Discharge Assessment Team trained and carrying out patient assessments for community rehabilitation schemes
- Ratification of outlier policy
- Newton Europe working closely with the theatre departments looking at scheduling.
- Establishment of Transformation Programme for Emergency Care

Graph: 4 Hour Target



4 Hour Access Target for Patients

The Trust performance level for the four hour target in ED for the last quarter is shown above. The monthly variation for KMH for the last year was 89.51-98.11 % and Newark 97.99-99.29 %. Principle reasons for the variation remain periods of high demand, high occupancy of resus facility, wait for inpatient and psychiatric beds. Ambulance turn around for KMH variation is 19.13- 16.37 minutes and for Newark is 13.42 -10.06 minutes. We remain one of the most consistently well performing Trusts in the East Midlands this measure.

Patient Flow Summary cnt

Ambulatory Attendees

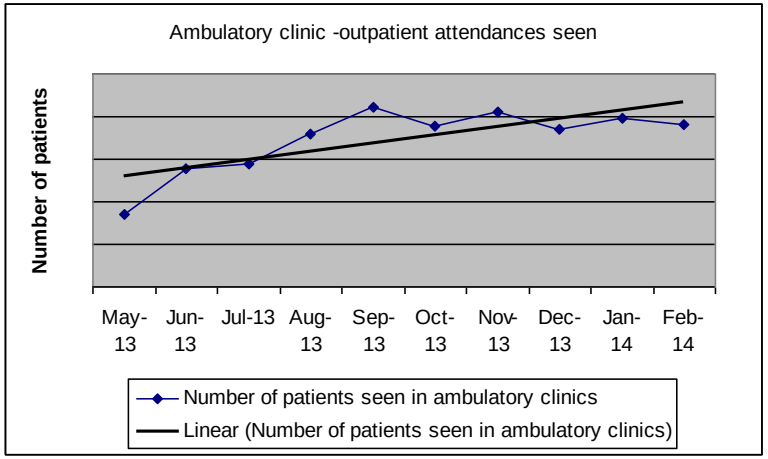
Data is available for this from May 2013 and shows that the number of ambulatory attendees has doubled over these months. This is a very positive move, allowing patients to receive treatments that were in the past only available as an in-patient. CDU has developed the range of treatments offered over the last year and there is further work that can be done to increase the care and treatment. In addition, in July the "hot clinic" initiative was set up, where the respiratory and gastroenterology consultants started to run emergency clinics based within ED. These clinics combined with the "hot phone" which community practitioners can ring for advice, support admission avoidance.

The expansion of ambulatory care pathways is part of a CQUIN scheme in 2014/15.

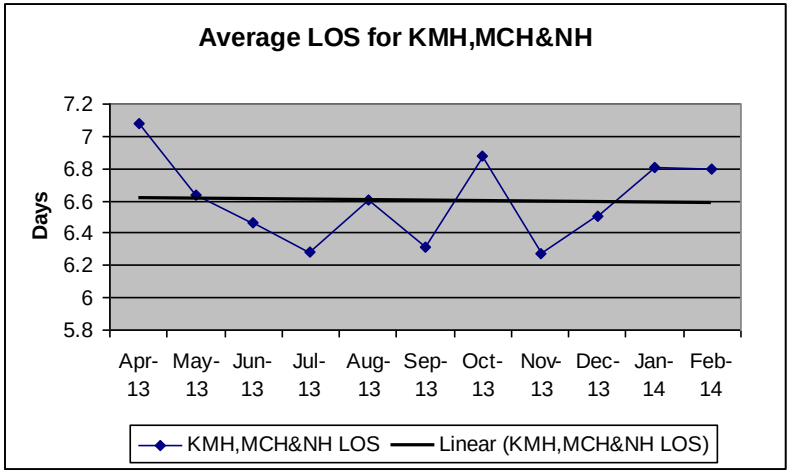
Average Length of stay

There are many ways of representing length of stay and we are investigating this further, however for this year we have been reporting on average length of stay which excludes zero length of stay and well babies. The graph shows no statistical trend.

Graph: Ambulatory Attendees



Graph: Average length of Stay



Patient Flow Summary cnt

Delayed Discharges

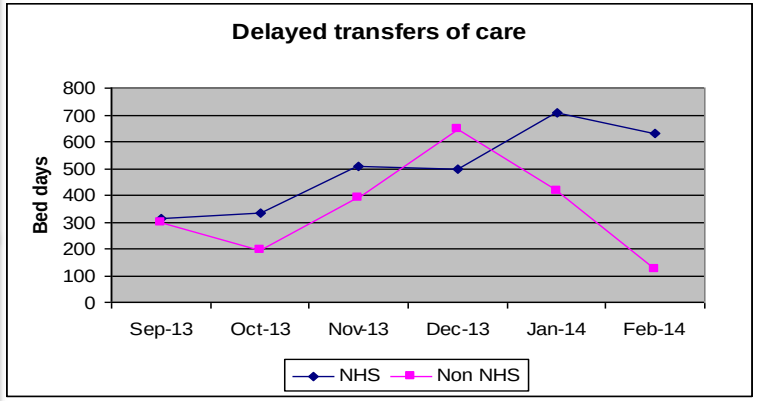
The delayed discharge of care has increased over the last quarter. These are medically fit patients ready for discharge but are waiting for either NHS or Non NHS reasons. The Figure 9 shows the number of days delayed within the month for all patients delayed throughout the month. The reasons include completion of assessment, further non acute NHS care (including intermediate care, rehabilitation etc), waiting for places in care homes, family choice etc. The IDAT team are focusing on managing these patients however there have been particular problems with a few small numbers of patients being made homeless while in hospital. The Difficult to transfer policyis currently being reviewed to ensure staff receive the right level of support to implement. The NHS peak in January was partly due to the need for non acute NHS care, while in Dec for Non- NHS it was patients awaiting packages of care.

However, once home the re-admission rate illustrates that the trend is moving in the right direction in regard to the discharges being more effective, however a further few months data will be needed before we can safely say the trend is downwards.

Further improvements identified to improve patient flow in 2014/15

- Implementation of changes around bed management meetings to ensure accurate information in a timely fashion.
- ECIST review of patient stay over 7days in May
- Further development of CDU activity at Kings Mill site
- Development of Ambulatory pathway at Newark
- Business case development for seated and bedded discharge lounge
- Exploration of new PAS contribution to managing patient beds
- Agreement for referrals to go all electronic by May 2014 for ultrasound
- Review of Transformational programme to review links with commissioners, CQUIN, QUIPP, Better together.
- In recognition that the work required to this requires support to Increased transformation support to the organization to increase the pace and capacity to drive improvement work
- Recognition of need to work closely with health and social care partners, creation of a cross organizational admission and discharge group
- Working with community partners to tag patient records if on a virtual ward or known to a community matron

Graph: Delayed Transfers of Care



2013/14 CQUIN Indicators

A proportion of Sherwood Forest Hospitals NHS Foundation Trust's income in 2013/14 (£4.5m), was conditional upon achieving Commissioning for Quality and Innovation (CQUIN) goals agreed between commissioners (NHS Nottinghamshire County Clinical Commissioning Group) and ourselves through the Commissioning for Quality and Innovation payment framework.

Summary of Acute Schemes for 2013/14		Risk Assessment of Delivery			
CQUIN Scheme	**Requirement**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Actual**
1 VTE assessment	95% of patients screened for venous thromboembolism (VTE) & 100% root cause analyses carried out on cases of hospital associated thrombosis (HAT)	£112,000	£112,000	£112,000	£112,000
2.1 Dementia Screening (Find, Assess, Investigate & Refer)	90% of emergency admission patients aged 75 & over screened, assessed and referred on to specialist services (during 3 consecutive months)				£968,000
2.2 Dementia – clinical leadership	Named lead clinician for dementia and appropriate training for staff	£13.455	£13.455	£13.455	£13.455
2.3 Dementia – supporting carers	Improve the support available for carers	£13,455	£13.455	£13.455	£13.455
3 Friends and Family Test	Phased expansion to ED & maternity, increased response rate & improved performance	£168,187	£168,187	£168,187	£168,187
4.1 Safety Thermometer	Submit monthly harms data for Safety thermometer	£56,063	£56,063	£56,063	£56,063
4.2 Safety Thermometer	Reduction in the prevalence of 'all' pressure ulcers		£112,000		£112,000
5.1 Think Glucose	Maintaining reduced Length of Stay for Patients with Diabetes	£44,850	£44,850	£44,850	£44,850
5.2 Think Glucose	Reduction of errors resulting in harm relating to insulin prescribing and / or administration	£44,850	£44,850	£44,850	£44,850
6.1 Reducing mortality	Implementation of sepsis bundle	£56,063	£56,063	£56,063	£56,063
6.2 Reducing mortality	Failure to Rescue – reduce the number of cardiac arrests	£56,063	£56,063	£56,063	£56,063
7 End of Life	Local action plan to improve care for end of life patients	£100,913	£100,913	£100,913	£100,913
8 Smoking at Time of Delivery	3 year target. 3% reduction in smoking at time of delivery by Q4. 11% reduction by 2015.	£56,063	£56,063	£56,063	£56,063
9 Falls	Reduction in the number of falls resulting in harm (part 1) & 95% patients to be risk assessed for falls (part 2)	£100,913	£100,913	£100,913	£100,913

The Trust achieved 100% of our acute CQUIN schemes for 2013/14

2013/14 Specialist CQUIN Indicators

The Trust also had a number of specialised CQUIN targets, which included:

Summary of Specialist CQUIN Schemes		Q 1 - 3 Actual & Q4 Forecast			
CQUIN Scheme	**Requirement**	**Q1 Actual**	**Q2 Actual**	**Q3 Actual**	**Q4 Forecast**
1 Clinical Dashboards	To embed and demonstrate routine use of specialised services clinical dashboards (Cystic Fibrosis, Cardiology, Trauma, Immunoglobulin, HIV, Neonates)	£18,825	£18,825	£18,825	£18,825
2 Paediatric High Dependency	To prevent and reduce the number of patients re-admitted onto PHDU on an unplanned basis within 48hrs of original discharge	£12,550	£12,550	£12,550	£12,550
3 Neonatal Care	Improved access to breast milk in preterm infants	£12,500	£12,550	£12,550	£12,550
4 Neonatal Care	Timely simple discharge for neonates	£6,275	£6,275	£6,275	£6,275

The Trust is predicting to achieve 100% of our specialist CQUIN schemes for 2013/14

2014/15 CQUIN Indicators

The following schemes have been agreed with our commissioners for delivery during 2014/15. Each scheme has been allocated an executive sponsor and a clinical / project lead and will be monitored via the programme management office. Additional resources have been allocated to support the delivery of several of these quality improvement schemes.

	Summary of Schemes Agreed with Commissioners
1. Dementia	Assessment of 95% of patients aged 75 & over for dementia
2. Friends and Family Test	Expansion of friends and family test to outpatients & daycase and undertake staff friends and family
3. Pressure Ulcers	50% reduction in all pressure ulcers
4. Falls	Assess falls history on all ED admissions and reduce no. patients who fall
5. Reducing Emergency attendance (over 65's) – linking with Better Together	Increase primary care presence in ED and ambulatory care pathways. Joint working with partners to reduce emergency admissions
6. Transfer of patients	Use of internal transfer document and a lead doctor overseeing care
7. Patient experience	External review of complaints responses with Patients Association
8. Smoking at time of delivery	5% reduction in smoking rates
9. Information Sharing	Sharing of information and data across organisations
10. Sepsis	95% compliance with sepsis bundle
Specialist 1: HIV – GP communication	HIV: Communication with GP's
Specialist 2: Breast milk in neonates	% pre-term babies receiving some breast milk on discharge
Specialist 3: Clinical dashboards	Data inputting to agreed clinical dashboards

Dementia CQUIN Summary

What did we set out to achieve during 2013/14?

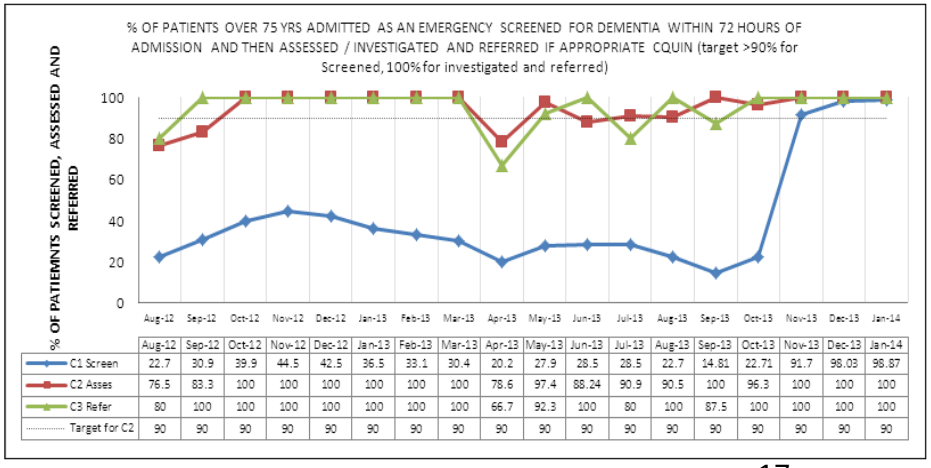
Improving dementia care requires a sustained improvement in finding, assessing, investigating and referring patients and during 2013/14 this continued to be a focus for us. We also wanted to ensure more staff had received dementia training, which will in turn lead to improved patient care, delivered by competent and compassionate staff. The enhanced support of carers and family of people living with dementia was also a key area. Targets were:

- By the end of 2013/14 that 95% of all emergency patients (exclusion criteria in CQUIN) above the age of 75 will be screened for dementia
- To ensure 95% 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 conduct and report a monthly survey of carers, to establish if they felt supported during their relatives stay in hospital.

Progress

- During Quarter 4, we achieved our 95% rate of screening, assessing, investigating and referring of patients aged over 75, admitted as an emergency, so we achieved this objective
- We continue to deliver dementia awareness training to all clinical staff and remain on target to achieve our self-set target of 90%
- The monthly carers survey has enabled a greater insight into the experience of carers at our Trust. This has been invaluable in influencing new projects and initiatives around dementia care.
- We therefore met our CQUIN targets in 2013/14

Outcome



	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
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	96.03	96.87
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
C3 Refer	80	100	100	100	100	100	100	100	66.7	92.3	100	80	100	87.5	100	100	100	100
Target for C2	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Dementia CQUIN Summary cnt

Improvements achieved during 2013/14

2013/14 has been a busy year for improvements in dementia care at Sherwood Forest Hospitals. Below are some of the more significant achievements at our Trust.

- Inside out of mind – The Trust played a role in the development and facilitation of this internationally recognized, theatre based learning event, hosted by Nottingham University.
- Dementia Link – Our 70 strong team of dementia link staff meet quarterly and are key in the roll out and embedding of service improvements in all clinical areas of the Trust. Our dementia link staff represent all specialties and clinical areas, ensuring that dementia care is improved in all areas.
- This is Me – The use of this life history profiling leaflet is becoming embedded across all clinical environments. Its use enables staff to tailor the care they give to individual patients, ensuring a better experience of care.
- Activities to Share Resource – This resource of activity equipment, maintained and administrated by the hospital library team has received national recognition for innovation in care from Health Education England. The resource provides staff with practical equipment to actively engage with patients experiencing confusion.
- Environmental enhancements – We continue to enhance our care environments in order to make them more dementia friendly. Clearer signage, contrasting coloured toilet seats and brightly coloured cups and beakers all go towards improving the experience of care at our hospitals.
- Members events – dementia themed members events have enabled local people to engage and learn from our expert practitioners at the Trust.
- Work showcased at national event in Westminster – In December, we took a stand to the National Dementia Action Alliance event in Westminster to showcase the work that we are doing at Sherwood Forest Hospitals and across Nottinghamshire.
- Cabinet office Review of dementia services improvements – In November we were invited to the Cabinet Office Review into the Prime Ministers Challenge on Dementia. We were singled out for praise by Professor Alistair Burns (National Dementia Lead) for our work to support people with dementia and their carers.
- Dementia befriending volunteers – Our team of dementia befriending volunteers have been hugely popular. The team continues to grow and find new ways of supporting people with dementia on our wards.

Dementia CQUIN Summary cnt

Further improvements identified for 2014/15

- Continue to maintain the good work already achieved and use this to further enhance care delivery and carer/family support.
- Throughout the month of April we are hosting carer support and information sessions (CRiSP) run by Alzheimer's Society at Kings Mill Hospital
- We will continue improvements Trust-wide through dementia link scheme. The next planned major piece of work is to roll out and embed more advanced pain assessment tools for people with dementia.
- We are actively involved in the development and facilitation of an East Midlands dementia conference (Planned for December).
- Delivery of more specialist dementia care training in the form of Stirling University Best Practice courses and commissioned specialist training in Meaningful Activities.
- Make our front door dementia screening process more thorough by integrating it as part of the VitalPac admissions process.
- More engagement with carers and family of people with dementia through more detailed surveys and future engagement events to influence our strategic dementia planning.

We have met the dementia CQUIN targets for 2013/14

Reducing Mortality – Improving the Care of the Deteriorating Patient (including Cardiac Arrest Reduction)

What did we set out to achieve during 2013/14

To improve:

- The monitoring of patients at risk of deterioration,
- The recognition of signs of deterioration
- Access to help from those with clinical skills and expertise to provide appropriate and timely treatment

Key outcome measures included:

- A reduction in cardiac arrest rate
- A reduction in mortality rate

Progress and associated outcomes

Implementation of NEWS

The National Early Warning Score (NEWS) was implemented in February 2013 and use of this highly sensitive risk assessment tool has resulted in a significant increase in calls for assistance to the Critical Care Outreach Team (CCOT). This is good; this is what we wanted to happen, because this means that more deteriorating patients are being identified sooner in the course of their decline and are being escalated to those with specialist critical care skills and expertise. This provides opportunity for delivery of the urgent treatment required. The table below highlights the monthly number of calls made by ward teams to CCOT for assistance with patients triggering on the NEWS.

Table: Number of escalation (NEWS triggered) calls to CCOT per month

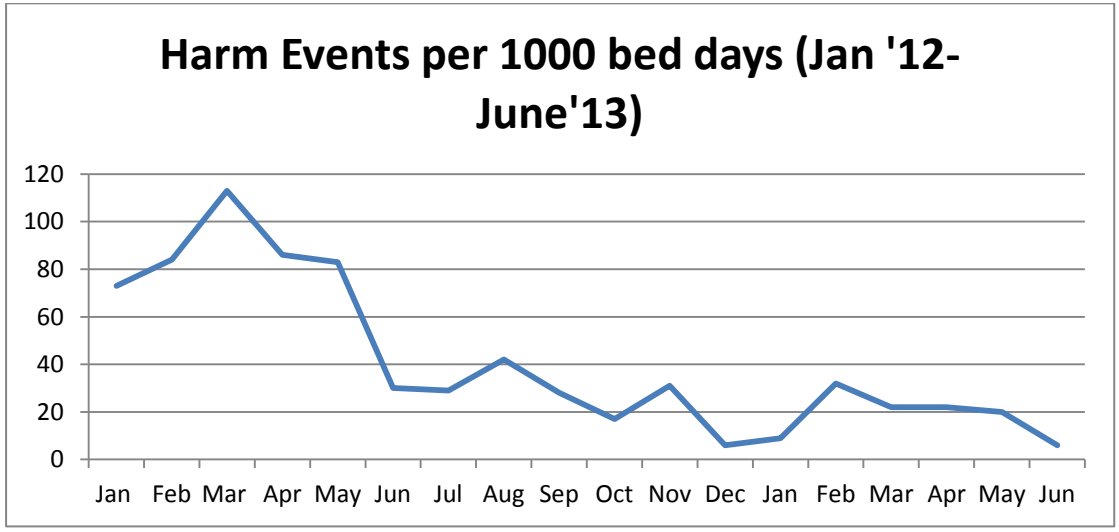
Month	Escalation calls per month
Before NEWS implementation	*150 (average)*
March 2013	230
October 2013	222
November 2013	172
December 2013	243
January 2014	240
February 2014	221

Improved monitoring of vital signs

Compliance with monitoring patients, that is, recording the routine vital signs and NEWS score is now excellent. Data from the nursing care metrics (Focus IT) monthly audits indicates that compliance with recording all six vital signs (respiratory rate, oxygen levels, blood pressure, pulse, temperature and level of consciousness) was 97-100%, and compliance with documentation of the NEWS score was 96-99%. Additional training in the use of a simplified colour-coded observation chart and further involvement of the Healthcare Support Workers who have all been trained to calculate the NEWS score has undoubtedly contributed to this success.

Global trigger tool

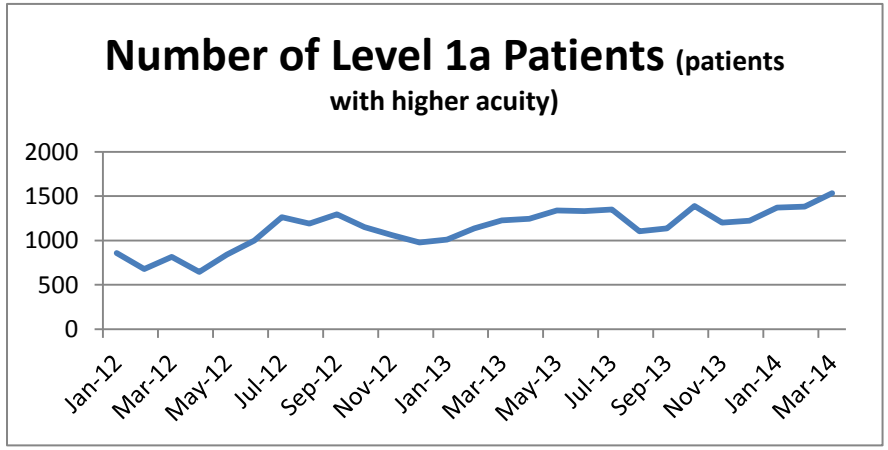
The Global Trigger Tool (GTT) audit involves the retrospective review of randomly selected case notes every month to detect and measure rates of patient harm. Results are presented in standard format (harm events per 1000 bed days) and can be used as an indicator of quality care. Data analysis is currently available from January 2012 to June 2013. Over this period, monthly harm events per 1000 bed days fell from 113 to 6. Further work is currently underway to provide more current data, but the methodology necessitates retrospective review and will therefore always be one quarter behind reporting schedules. The triggers generating the greatest number of harm events were *lack of early warning score* and *shock.* Since October/November 2012 there have been no harm events identified as a result of either triggers. This would indicate that implementation of NEWS and the Sepsis box to augment the sepsis care bundle have been successful.



Increased patient acuity

Data from the Association of UK University Hospitals (AUKUH) acuity and dependency audit, collected daily across the Trust, shows that the proportion of acutely ill adults (those patients needing Level 1a care) has increased gradually throughout the year (see run chart 1 below). An increase in patient acuity provides further rationale for the increased number of calls to the outreach team (CCOT) for assistance.

Run Chart. Proportion of patients identified as requiring Level 1a care (April '13- Mar '14)



Increased support for Level 1a care

The number of visits made by CCOT to patients in ward areas has totalled 2711 to date (12/03/14). In October 2013, the CCOT was increased in size to manage the increased workload experienced as a result of improved monitoring and NEWS. Table 2 below illustrates the number of visits made each quarter

Table: Number of visits made to wards by CCOT

Quarter	No of visits made
Q1 April-June '13	690
Q2 July-Sept '13	707
Q3 Sept-Dec '13	826
Q4 Jan-Feb '14	*488 (March not yet available)*
Total	**2711**

In February 2014, CCOT gathered data for an international multi-centre research study to identify outcomes in the 24 hours following a call for their assistance. Of the 26 calls for urgent help received over a seven-day period, 20 of those patients' problems were resolved within 24 hours. Three patients were admitted to the intensive care unit and three patients needed surgical intervention. Only two patients died, but this was in the presence of an 'allow natural death' decision. This is one of the first studies to examine outcomes related to CCOT interventions and early data analysis indicates positive outcomes at the Kings Mill site.

Implementation of VitalPac

VitalPac, a paperless electronic monitoring device, is being implemented across the Kings Mill site. Nurses and Healthcare Support Workers will input observation data into hand-held devices at the bedside and information will be picked up in real-time by the doctors and CCOT, enabling them to identify the deteriorating patient sooner than ever before. With the recent additions to the CCOT, their ability to respond will be assured. The enhanced team can now provide coverage across the Kings Mill site (0745-2030hrs seven days per week), with two nurses available during the busiest period, 1000 to 1800hrs.

Reduction in unexpected ICCU admissions

Unexpected, unplanned admission to intensive care is a significant event. Avoiding admission is beneficial to the patient on humanistic grounds but also to the Trust, ensuring that finite resources are utilised appropriately. Although only tentative claims can be made at this point, increase in CCOT staffing in October 2013 may have contributed to a reduction in the number of unexpected admissions to the intensive care unit over the last four consecutive months.

Reduction in cardiac arrests

The Trust continues to achieve its targets in respect of cardiac arrest rates with 1.8 arrests per 1000 admissions against a year-end target of 2.21 (data as of 12/03/14). This represents a reduction in in-patient cardiac arrest rates by 53% since 2010. This has been a CQUIN improvement scheme for us over the past 2 years and we have met the required cardiac arrest reduction targets.

We have met the cardiac arrest CQUIN targets for Quarter 4

Reducing Mortality – Improving Sepsis Care

Sepsis is a life-threatening illness caused by the body overreacting to an infection. It is often referred to as either blood poisoning or septicaemia. The incidence of sepsis increases annually and it claims more lives than breast and bowel cancer combined. Survival can be dramatically improved with early diagnosis and timely treatment.

The sepsis care bundle is a collection of clinical interventions for the patient with an overwhelming infection that when delivered promptly within the first hour of diagnosis can significantly improve chances of recovery.

What did we set out to achieve during 2013/14?

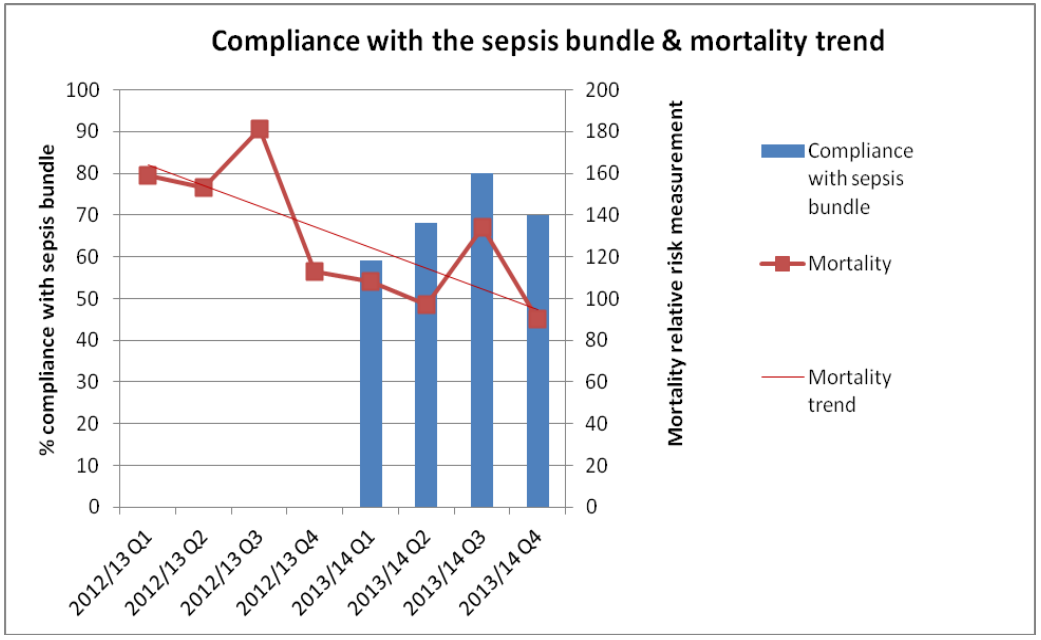
Our aim in 2013/14 was to improve sepsis care for our patients and reduce mortality.

Objectives were:

i. To complete the implementation of the sepsis care bundle and sepsis treatment boxes
ii. By the end 2013/14 there would be 75% compliance with the sepsis care bundle
iii. To evidence a downward trend in sepsis related mortality.

In order to achieve this we set out to:

- Improve education and training of staff about sepsis
- Raise awareness of sepsis both for clinical staff and the wider public
- Implement a robust audit program on sepsis care.
- Through case note reviews, discover “lessons to be learned” and support poorly performing areas.



Reducing Mortality – Improving Sepsis Care cnt

Progress & Outcome

i. The sepsis care bundle and treatment boxes have been implemented across all 3 hospital sites (King's Mill hospital, Newark hospital and Mansfield Community hospital). We therefore met our CQUIN target for sepsis.
ii. Overall annual 70% compliance with the sepsis care bundle by the end of 2014.
iii. This has been a downward trend in sepsis related mortality.

To support this improvement project, we appointed a part-time Sepsis Lead Nurse and a Consultant Lead was identified. They have worked to embed the Sepsis Screening Tool across the Trust & increase compliance with the sepsis care bundle. During 2013/14 we were able to ensure that all relevant clinical areas across all 3 hospital sites have sepsis treatment boxes.

The Trust has demonstrated 70% compliance with the sepsis bundle and this represents an 18% improvement from the beginning of the year.

<u>The Sepsis Treatment Box</u>

- A wide-reaching education program increased knowledge of sepsis across clinical staff.
- A Sepsis Awareness Week raised the profile of sepsis care both for staff and the public. Local media became involved and our campaign came to the attention of and gained support from the UK Sepsis Trust.
- A rigorous case review process and audit tool is in place. Areas of both good and poor practice are fed-back to clinical teams to raise awareness and improve clinical practice.

Further improvements identified for 2014/15

- Compliance with the sepsis care bundle needs to improve. Our CQUIN target for 2014/15 is 95% compliance
- Sepsis education will continue. There will be targeted education for newly qualified staff.
- The governance pathway for action planning against poor care will be strengthened.

We have met the sepsis CQUIN targets for Quarter 4

Safety Thermometer Summary

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Monthly data is collected on pressure ulcers, falls and urinary tract infection (including indwelling urinary catheters) and blood clots (VTE). On a set day each month the nursing teams collect data on all in-patients wards (excluding paediatrics and Special Baby Unit). Collection of safety thermometer data is a national CQUIN and the targets are described in the table below.

2013/14 CQUIN Targets:	Q1 Apr 13-Mar 14	Plans in place to continue to continue work in 2014/15
1. To collect and submit monthly data on the following three elements of the NHS Safety Thermometer : Pressure Ulcers, In-patient Falls and Urinary Tract Infection in patients with a catheter	**Achieved** ☑	Safety Thermometer Co-ordinator in place to collate and validate ward data. Ward leaders & Heads of Nursing aware of monthly deadlines and submission dates and have contingency plans in place to ensure data is collected.
2. Reduction in prevalence of reported pressures ulcers (pre-hospital and hospital acquired) within national median	**Achieved** ☑	Continued implementation of the Pressure Ulcer reduction strategy.

What do the results tell us?

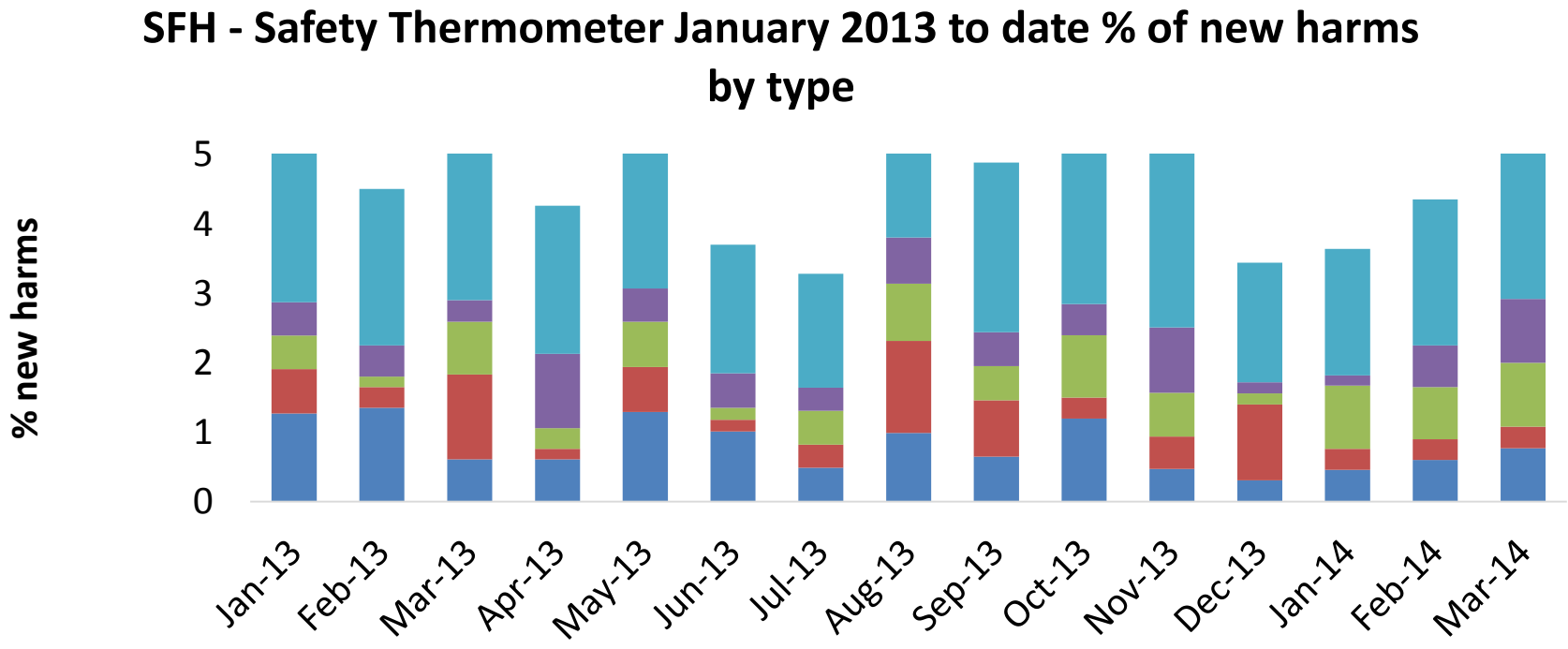
For April-March 2014 we had 7 out of 12 months where our reported 'harms' rate was less than the national reported rate - this includes pre-hospital (old) as well as hospital acquired harms (new). Falls reported in Q4 shows a national average of 0.8% - we have reported 0.3%. When reviewing NEW harms (hospital acquired harms) for 11 out of 12 months we have reported fewer harms when compared to the national results. The National average of NEW pressure ulcers is 1.06% - we have reported fewer at 0.61%.

What will the national requirements be for the Safety Thermometer in 2014/15?

The Safety Thermometer CQUIN for 2014/15 will focus upon the reduction of 'all pressure ulcers'. It is a national CQUIN scheme and Trusts will still be required to submit data monthly.

Safety Thermometer Summary cnt

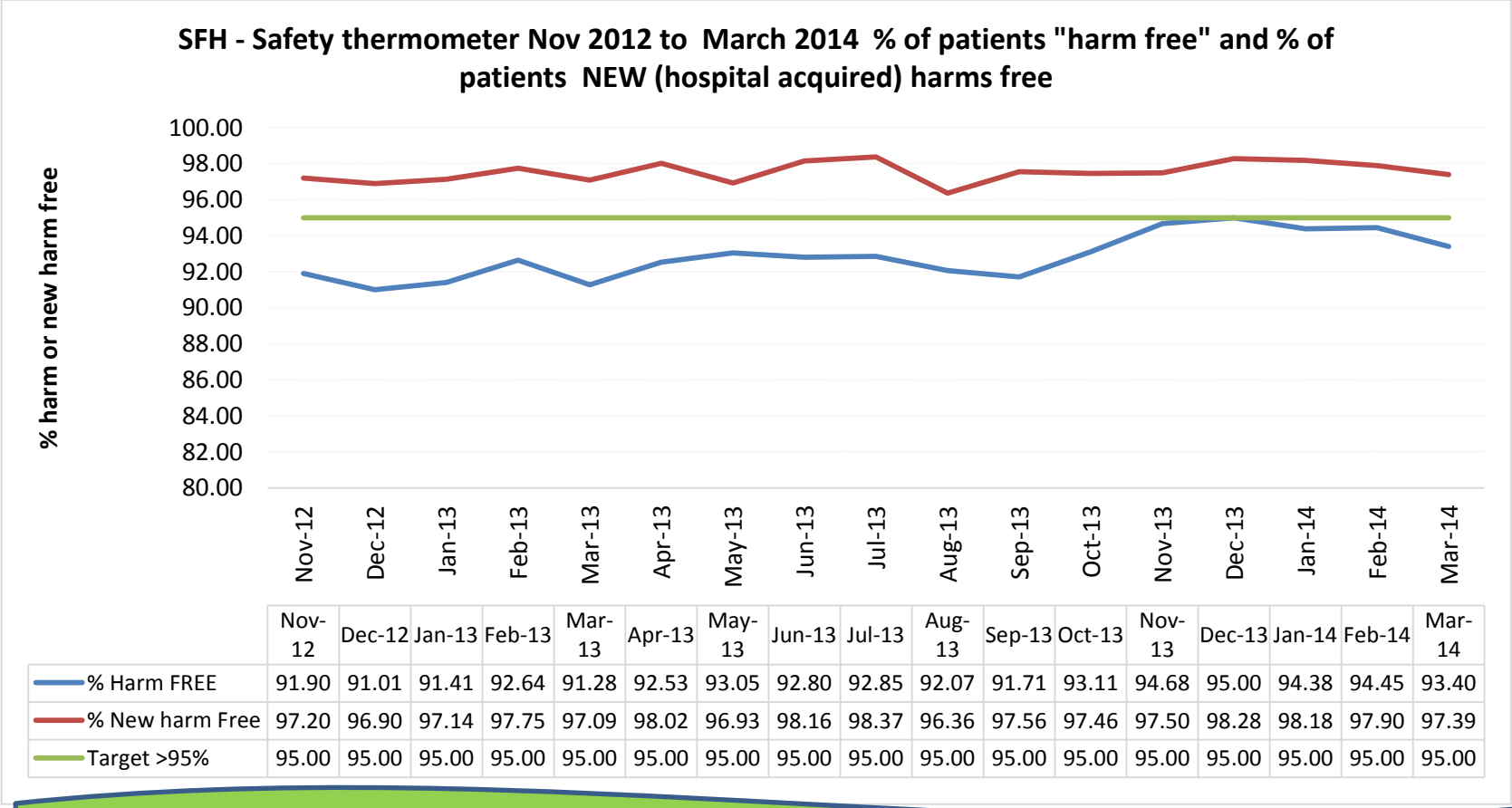
The graph below shows our rate of 'NEW' harms by type per the safety thermometer data.



	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
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
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
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
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
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

Safety Thermometer Summary cnt

The graph below shows the % of patients classified as 'NEW' harms free by month and indicates that throughout 2013/14 our % harm free care from new harms was consistently around 97%. In Quarter 4 we were just below the national average of 95% for all harms. The work we are doing to improve our performance on the individual harms in described in those respective sections within this report.



	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
% Harm FREE	91.90	91.01	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
% New harm Free	97.20	96.90	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
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

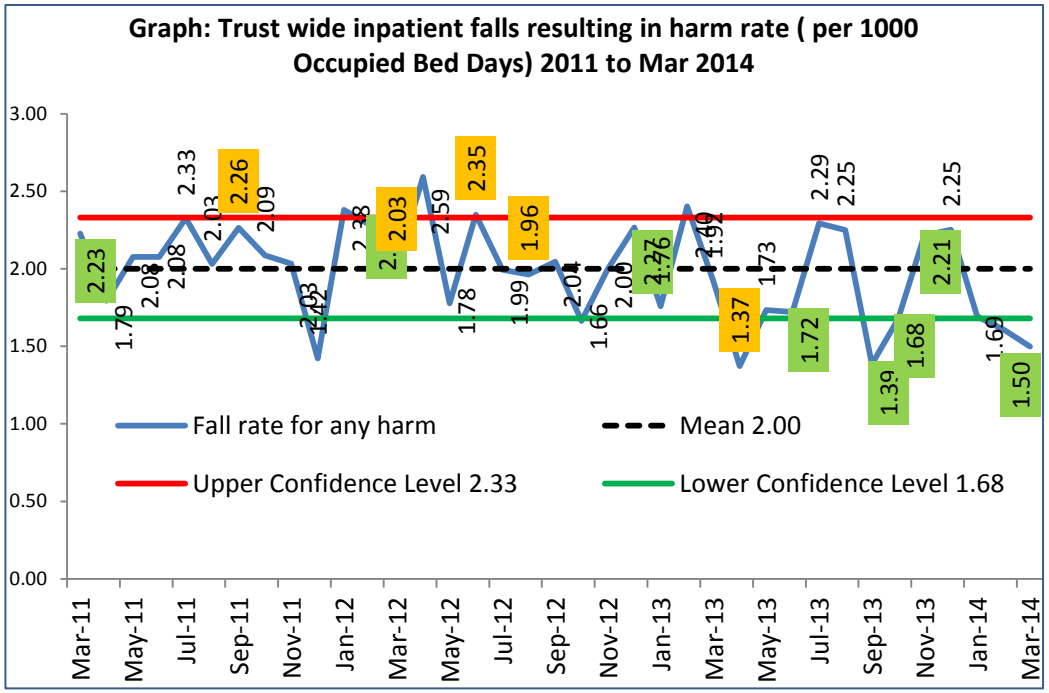
The Trust has achieved the Safety Thermometer CQUIN for 2013/14

Falls CQUIN Summary

What did we achieve in 2013/14?

We measure the number of patients who have fallen daily through our DATIX system and this also provides us with information on whether the patient sustained any harm from the fall.

We agreed locally with our commissioners, as part of our CQUIN work plan, to reduce our falls resulting in harm rate to less that 1.79% by the end of 2013/14. As shown in the graph above, we have therefore achieved our CQUIN targets for falls during 2013/14 and aim to continue this improvement.



There are a number of initiatives we have driven throughout 2013/14.

- We have recruited a lead nurse for falls prevention to help support our staff to drive improvements in care
- We have just received approval through the Medical Records Advisory Group and the Nursing Documentation Group for the complete roll out the post fall protocol to improve post fall care and risk factor mitigation.
- Visual signs for patients to use the Nurse call bell are being displayed in all patient bathrooms.
- Head injury observation guidance has been provided to staff in a credit card size format that can be stored with the ID badge.
- Lessons learnt from investigations into falls is now being used proactively as part of the Falls prevention work by demonstrating to the ward teams how interventions can reduce risk from falls
- Priority areas identified are receiving dedicated support time to review patients identified as being at risk with the aim of treating identified risk factors.
- We also developed an enhanced observation assessment tool that enables us to identify which patients require the additional staffing
- Introduction of the harms team has contributed to reduction in falls by providing 1 to 1's in an environment where we have 50% side rooms.

Our approach has been to target specific training and support into the areas identified as having the greatest risk factors, giving support to those wards that are 'triggering', with evidence of highest falls rates/harms. Improvement projects have been focused in areas identified using the ward assurance data and dedicated teaching and support tailored to the wards needs are in place.

The Trust has achieved the falls CQUIN for Q4 but this will be a top priority in 2014/15

Falls CQUIN Summary cnt

What are we aiming to achieve in 2014/15?

- Capture the number of fallers (non-elective admissions via the Emergency Admissions Unit) in the age group 65 years and over, to enable the whole health community to understand the extent of the work required going forward
- Reduce the number of patients who fall resulting in harm to **<2 per 1000 occupied bed days** by quarter 4
- Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
- Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15)
- Reduce the number of fractures from falls to **<25** for 2014/15
- Reduction in repeat fallers and falls risk assessment is a CQUIN for 2014/15.

How are we aiming to progress our falls reduction work in 2014/15?

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 expressed as the ratio of falls /fallers. This is why we have chosen to do focused work to reduce repeat falls during 2014/15.

We feel we need to revisit our falls prevention strategy and action plan and 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

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.

End of Life CQUIN Summary

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 did we set out to achieve during 2013/14?

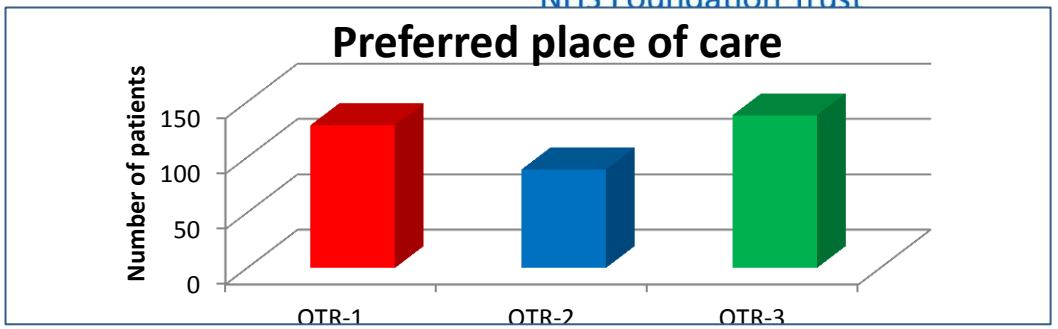
- Commence implementation of the 5 key enablers within the Transforming End of Life Care in Acute Hospitals Programme.
- Commence advance care planning for patients as part of the Gold Standards Framework in Acute Hospitals Programme (GSFAH) on Wards 42 and 51
- Commence the implementation of the AMBER Care Bundle (ACB) on Wards 43 and 44.
- Deliver a minimum of 1 communication skills for end of life and prognosis training course
- Patients 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
- Continue to support staff and monitor the quality of care being delivered to patients in the last days/hours of life.

Progress and Outcomes

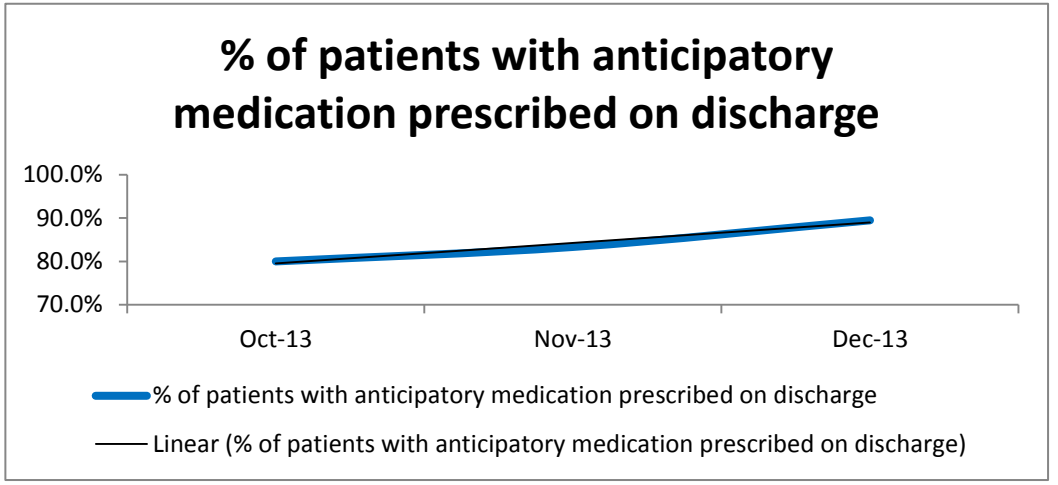
We met out target for Advance Care Planning. Between January and March 2014, 14 patients on Wards 42 and 51 have been identified as being in the last year/months/weeks of life and have been registered on the Gold Standard Framework Register. The data showed advance care planning discussions had taken place in hospital with 7 patients. 2 patients died before discussions could take place;1 patient lacked mental capacity and had no relatives, and no data was 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.

Progress is being made on the implementation of AMBER Care Bundle on Wards 43 and 44. A pilot multi-professional communication skills course was delivered by our End of Life Care Team and Specialist Palliative Care colleagues from John Eastwood Hospice on 19th December 2013. There were 20 participants in attendance, ranging from Consultant level to Housekeeper and Receptionists and it evaluated very positively, generating a number of suggested improvements to End of Life Care.

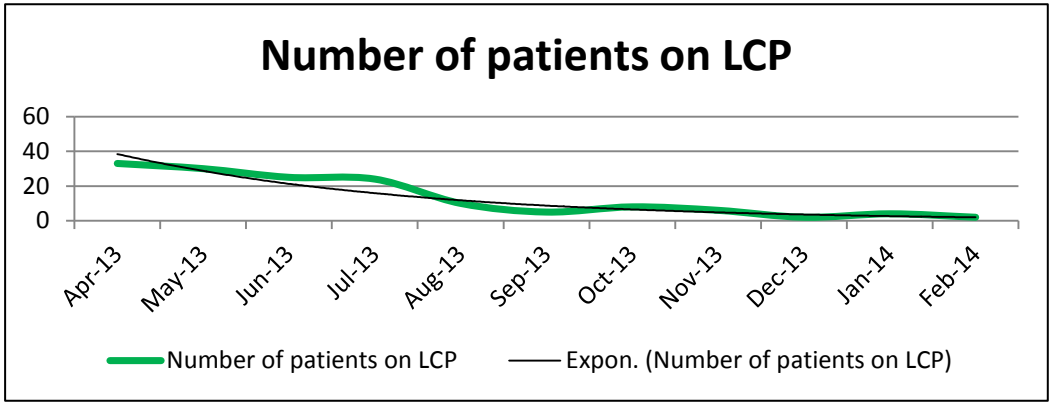
The Integrated Discharge Advisory Team (IDAT) supports the process of enabling those in the last days/hours of life to die in their Preferred Place of Care (PPC) by coordinating and effectively managing the discharge process. PPC data is being captured on a monthly basis as part of the audit data which reports on the number of referrals made to the IDAT.



Currently all patients discharged from hospital to Preferred Place of Care have anticipatory medications prescribed (excluding Derbyshire). This data is collated quarterly and Quarter 4 data is currently being finalised for this indicator and preferred place of care.



Use of the Liverpool Care Pathway (LCP) continues decline since the government announcement that the LCP is to be phased out by 14th July 2014. This has occurred despite the End of Life Care Team encouraging staff to follow the principles of the pathway and use the documentation where appropriate. Therefore while we await further direction and recommendations from the Leadership Alliance for Care of Dying People, the End of Life Care Team have developed Guidance and Care Plans based on the principles of best practice in the last days of life, to support staff reluctant to use the LCP documentation.



End of Life CQUIN Summary cnt

Communication to Staff Regarding Liverpool Care Pathway (LCP)

Communication has been issued to clinical teams in the interim that staff should continue to use the principles of the LCP, which are individualised management and care plans in accordance to their wishes and preferences, good symptom management, having regular communication with patients and their families, and supporting families in meeting their needs. It is also recommended that these principles are built into 'care and comfort rounds' to enhance good last days and hours of life care. And ensuring the care we give is documented clearly in both the medical and nursing notes.

Improvements achieved

- A Lead Nurse for End of Life Care & Cancer (EOLC) who is providing strong visible nursing leadership within end of life care & cancer across the organisation has been appointed. They are driving improvements in outcomes and patient & carer experience and in particular implementation of the Transforming End of Life Care in Acute Hospitals Programme, with the support of members of the Hospital End of Life Care Multi-Disciplinary Team across the Trust.
- We are approaching the end of the first year of implementing Gold Standard Framework on Wards 42 & 51. To date a baseline audit has been completed on both Wards. Key Ward members and the End of Life Care Team have attended a 3rd Workshop and staff training on identification of patients for the register. It is anticipated that staff on both Wards will have received training over the next 4-6 months.
- End of life care awareness training has been integrated into orientation and induction training
- A number of training sessions on end of life care & Communication skills have been delivered with good attendance and evaluation.
- The Sherwood Forest Hospitals General Palliative & End of Life Care Group has been re-invigorated to monitor service developments and support delivery of training.
- The End of Life Care Team have produced interim guidance to replace the Liverpool Care Pathway in response to increasing demand from staff to support practice in the last days of life and in the absence of national guidance being published until summer 2014.
- Work is ongoing to improve effective methods of cross-boundary communication between ourselves and our primary care colleagues. Particularly on flagging patients when admitted to hospital and developing methods of sharing information such as the Electronic Palliative Care Coordination System (EPaCCS) to ensure continuity and co-ordination of care is provided irrespective of which care setting the patient is in.

We have achieved this CQUIN for 2013/14

Q4 - Venous Thromboembolism (VTE) CQUIN Summary

Objectives for 2013/14

- 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
- 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 2012-2014, Against National Average (data from the Health & Social Care Information Centre)

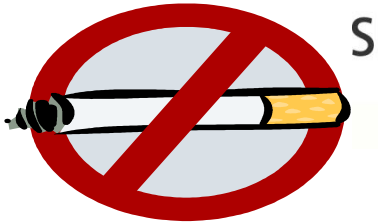
Year	Percentage of Patients Risk Assessed	National Average
2012/2013 (Apr 12 to Dec 12)	94.0%	94.0%
2013/2014 (Apr 13 to Dec 13)	95.0%	TBC

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.

For 2013/14 our average compliance for VTE assessment was 95% and we achieved the CQUIN.



Sherwood Forest Hospitals NHS
NHS Foundation Trust

Smoking in Pregnancy CQUIN Summary

Background

When we embarked upon this CQUIN in April 2013, we started to do considerable work to improve the accuracy of the data we were collecting. We have now completed this and have a robust dataset to underpin the continued work we will do on this during 2014 and 2015. Key initiatives for 2014 are highlighted in pink below.

What is the CQUIN?

- Our baseline smoking at time of delivery rate is 26% (2013/14)
- Our reduction target for 2013/14 is 3% to 23%
- Our reduction target for 2014/15 is 5% to 18%
- Our reduction target for 2015-16 is to reach to 15%

How are we doing with smoking at time of delivery?

- Baseline rate = 26%
- Q2 figures show: SATOD = 25.3%
- Q3 figures show:- SATOD = 22.5%
- Q4 figures show: SATOD = 21.56%

Nicotine Replacement Therapy (NRT)

From April 2014, we have introduced the use of NRT for women when they attend Maternity Services in early labour or are admitted as an antenatal patient. This will support women when attending the Trust and provide them with therapy that will help them to give up smoking.

This will help us to reduce smoking at time of delivery rates.

The Rotherham Model

We have allocated funding to support maternity services being the first maternity service in the east midlands to implement a smoking cessation service that replicates a model developed in Rotherham that provides additional training to midwives enabling them to undertake intense interventions with women to reduce smoking in pregnancy.

Women who disclose that they smoke will receive an intensive, face to face, stop smoking intervention, adopting a prescriptive medical model, which explicitly outlines the dangers to the pregnancy and the fetus of continuing to smoke. This is to be delivered by a Midwife, in uniform, with specialised training, in the hospital setting, at the time of the woman's dating scan.

This evidence based model is currently being implemented.

The Trust has met this CQUIN for 2013/14

Serious Incidents & Never Events Summary

Overview

Figure 1 below indicates the total number of Serious Incidents that were reported in Sherwood Forest Hospitals NHS Foundation Trust for the financial Year 1 April 2013 – 31 March 2014. A total of 104 STEIS reportable Serious Incidents were reported over the year. In the period of Quarter 4, a total of 26 STEIS reportable Serious Incidents forms were reported.

Figure 1

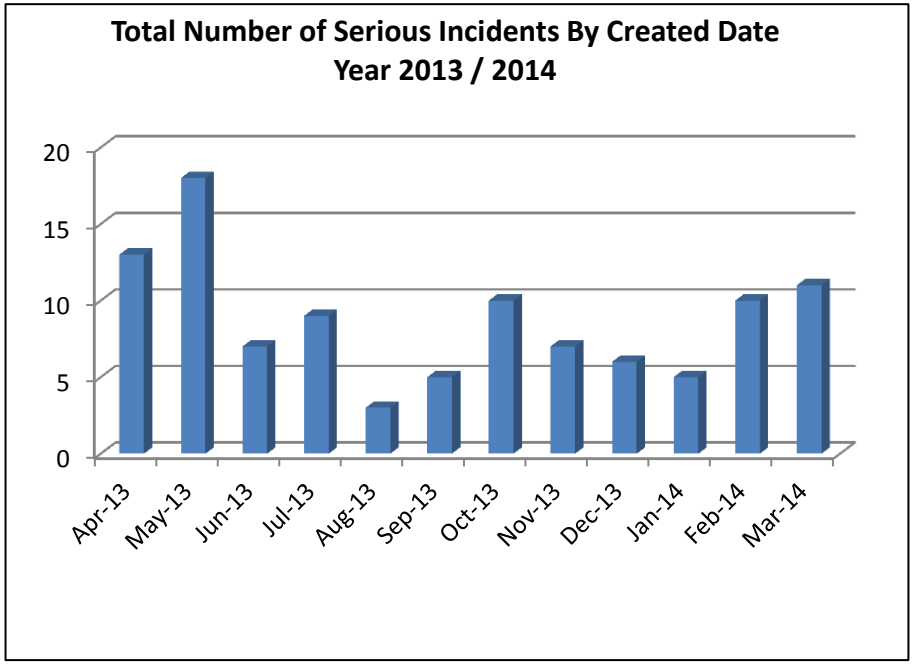
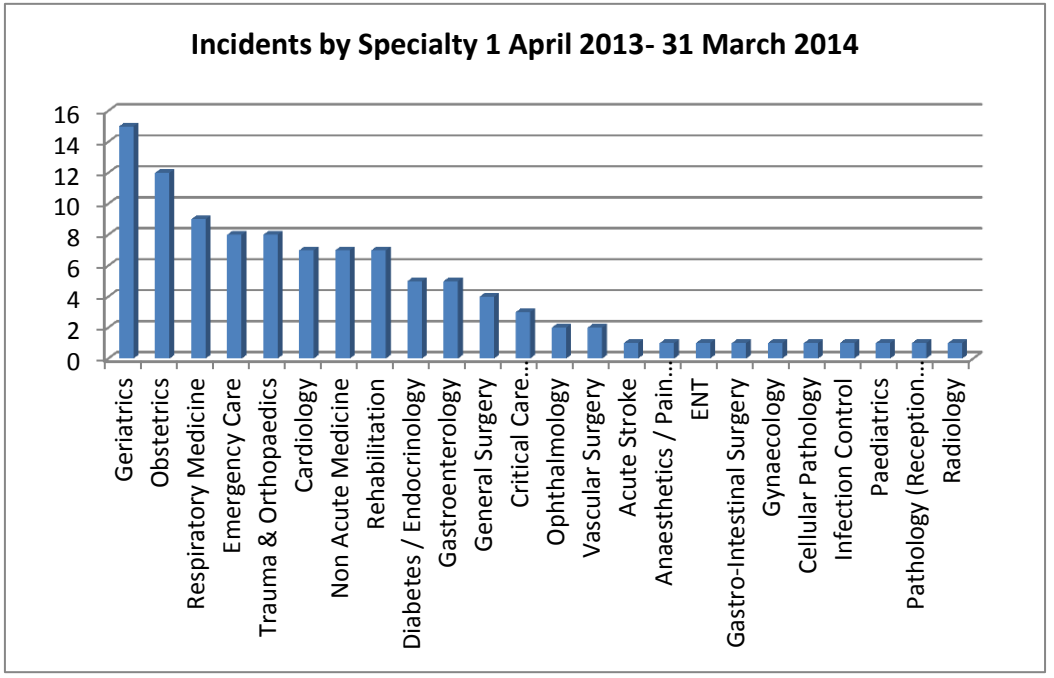
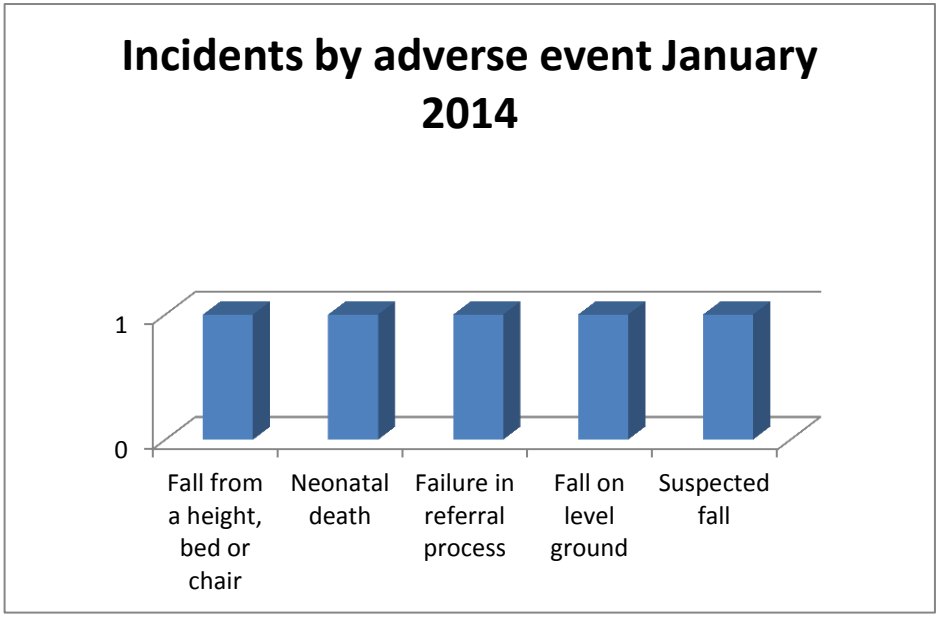


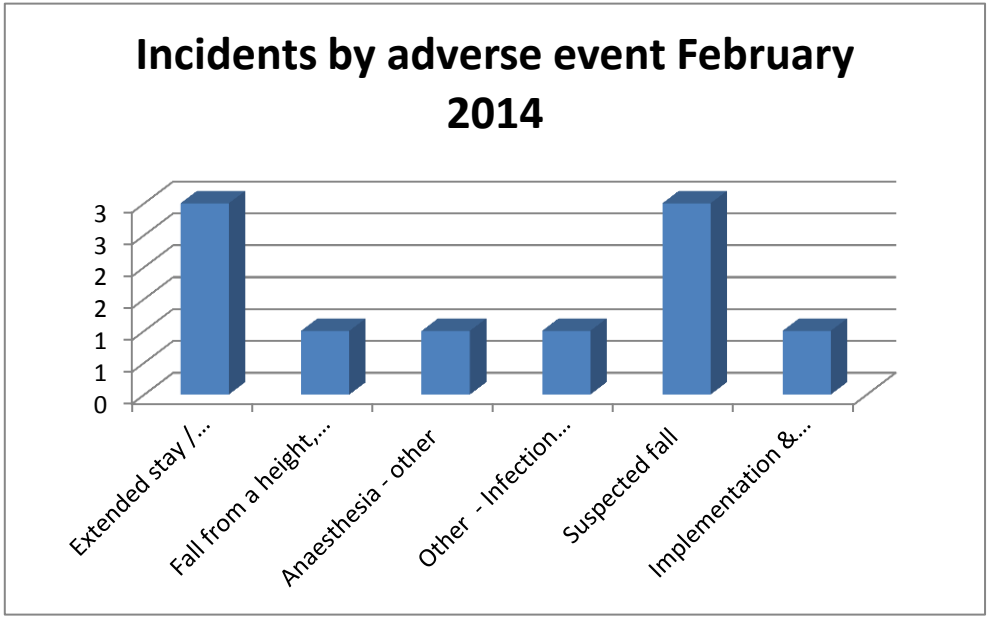
Figure 2

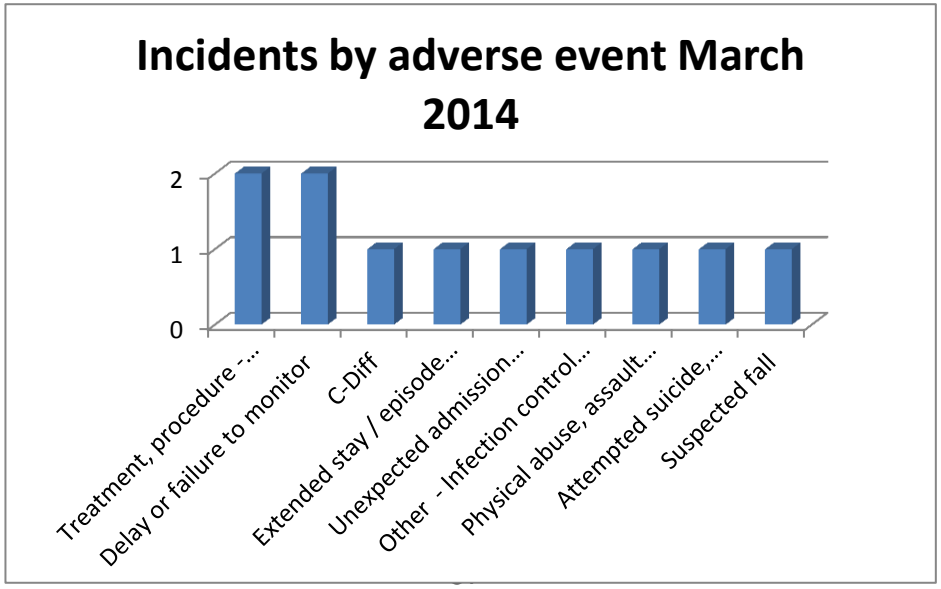


Serious Incident themes and the division whereby the serious incident occurs can be identified below. Falls is the highest reported cause group and a detailed falls report was presented at the April meeting of the Quality Committee.

The classification of serious incidents in January, February and March is highlighted in the graphs below. These are individually reviewed and lessons learnt captured.



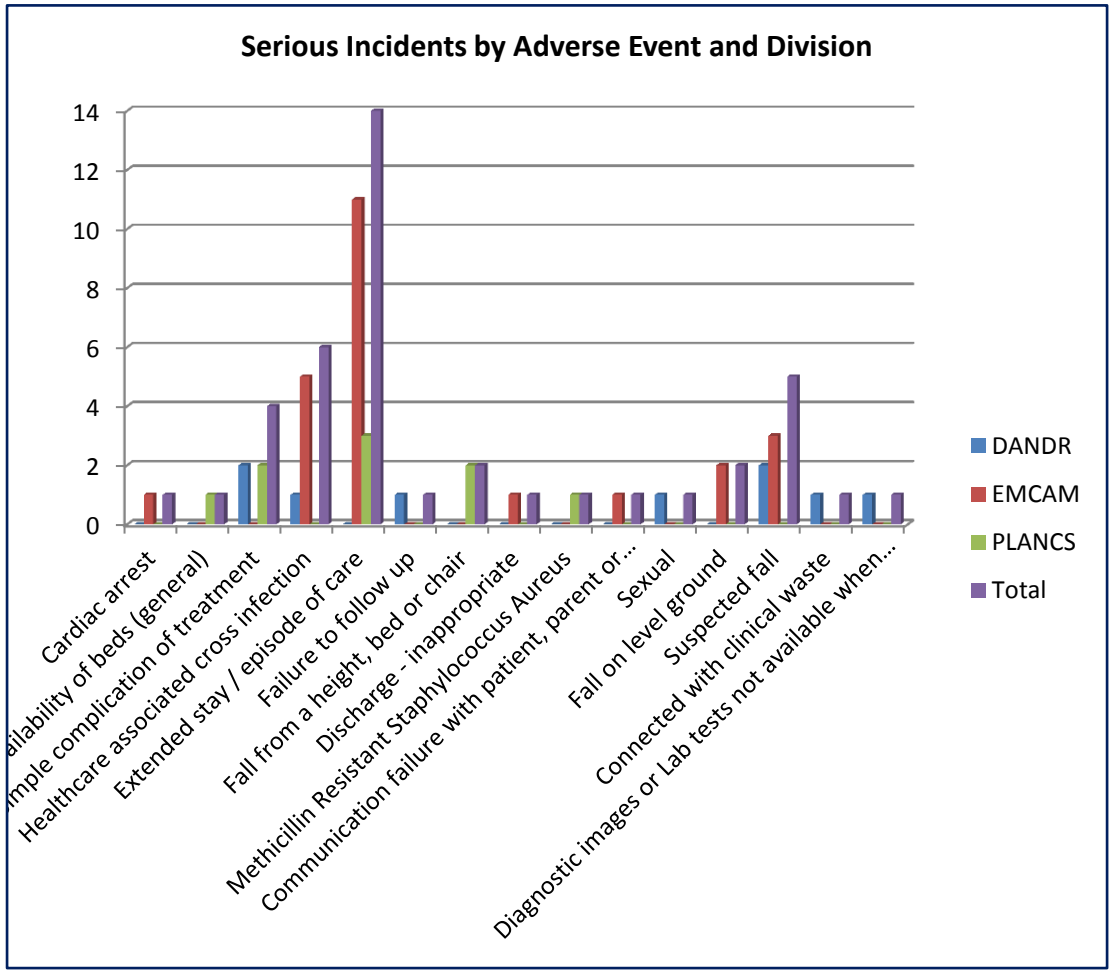




Serious Incidents & Never Events Summary

The Trust reported 3367 incidents to the NRLS (National Reporting and Learning System) for Year 2013/14, this figure includes near misses and patient harms. Of the 3367 incidents 3.09% were reported as a Serious Incident.

Figure 3: Serious Incidents by Adverse Event and Division



NEVER EVENTS

"Never Events", as defined by the National Patient Safety Agency (NPSA), are patient safety incidents that are preventable because:

There is guidance that explains what the care/treatment should be. There is guidance to explain how risks and harm can be prevented. There has been adequate notice and support to put systems in place to prevent them from happening.

It should be noted that "Never Events" and serious incidents (SIs) are not mutually exclusive. It is inevitable by their nature that all "Never Events" are SIs, but not all SI's are "Never Events".

There were no "Never Events" reported in SFHFT between 1 January and 31 March 2014.

The paediatric Never Event Reported in December 2013 investigation is in final draft and highlights a number of learning points in relation to the prescribing, preparing and administration of drugs both in the paediatric unit and wider implications for the organisation. The final report will be approved at the SI Review and Sign Off Group in April and will be shared thereafter to ensure organisational learning.

The Senior Head of Patient Safety for Safe Medication Practice and Medical Devices NHS England has been in contact regarding the Never Event. Incidents of morphine overdose in babies have occurred previously in other NHS organisations and it is anticipated that there is a requirement for more national guidance to further minimise this risk. The purpose of meeting with the investigation panel is to understand more about the identified causes of this incident, and the actions SFHFT have taken locally to minimise the risk of recurrence.

Learning from incidents and resulting action management

The Governance Support Unit will contribute to the strategic development of quality governance, whilst offering professional and operational support across the Trust to strengthen the role of the ward/service area through to the division and ensures there is clear professional accountability and operational management at all levels, from ward to Board. Organisational learning and feedback to staff are continual challenges and this will be facilitated by the introduction of a more robust process for Serious Incident scope and signing off of reports.

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.

Infection, Prevention & Control Summary

What did we set out to achieve during 2013/14?

- For 2013/14 we aimed to reduce the number of C.diffiile cases to below 25, which was an extremely challenging target.
- MRSA: to have zero cases of hospital acquired MRSA bacteraemia
- Urethral catheter associated infections: to reduce the incidence rate of Trust apportioned urethral catheter associated bacteraemia's to less than 2 cases per year

Progress

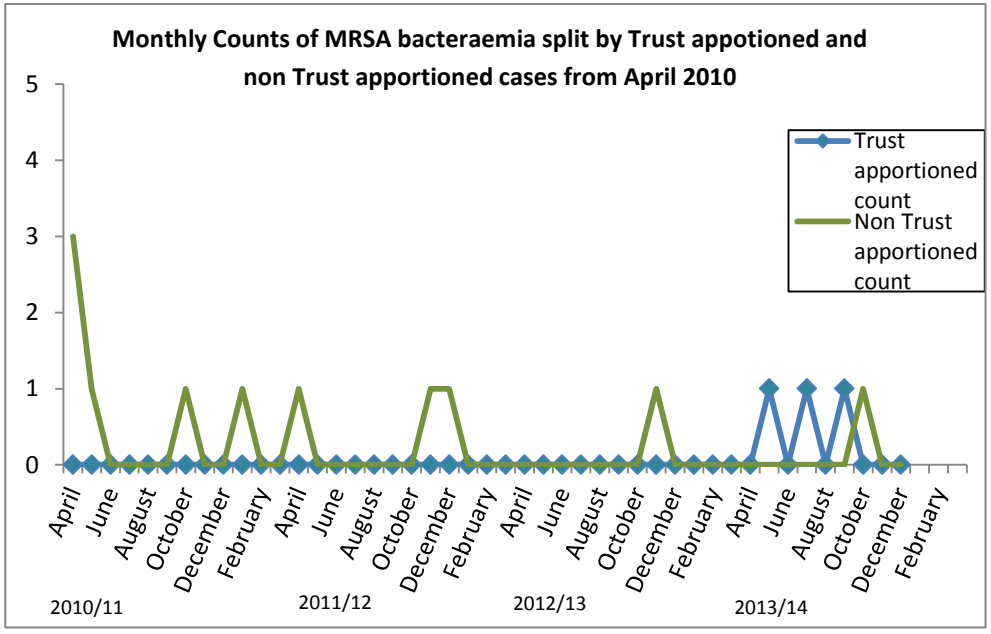
- For C Difficile rates we had 36 cases against a target of 25, so did not achieve this.
- For MRSA we had 3 cases against a target of zero, so we did not achieve this.
- For catheter associated infections we had 14 cases against an internal target of 2, so we did not achieve this.

MRSA

Prior to 2013/14 the Trust had gone 3 years without a Trust acquired MRSA bacteraemia infection.

Unfortunately during 2013/14 the Trust had 3 cases of MRSA bacteraemia infections post 48 hours of admission, the last case being in September 2013.

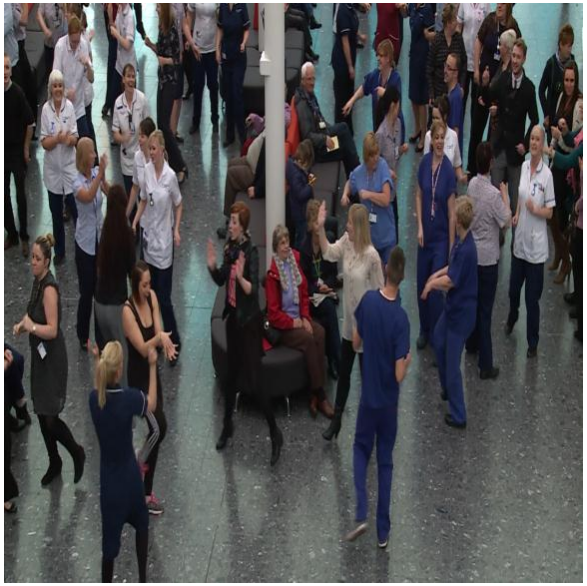
Figure : MRSA trend for Sherwood Forest Hospitals NHS Foundation Trust



Infection, Prevention & Control Summary cnt

A Post Infection Review (PIR) was conducted for each of these MRSA cases, following these reviews the following actions have been implemented in response to the lessons learnt:

- Training and support materials were issued to highlight the screening requirements for MRSA for high risk patients across the Trust
- A program of quarterly audits, which are undertaken by the Infection Prevention and Control Team are conducted quarterly. These include Hand hygiene (against '5 moments'), Personal Protective Equipment, Isolation, Linen, Urinary catheter management, Venous catheter management, and Sharps Management. The audit reports are fed back to clinical staff, the Healthcare Forum and the Infection Prevention and Control Committee
- Following the review of skin preparation prior to the insertion of a venous catheter it has been recommended that ChlorPrep® is used, a business case is in the process of being developed
- Central venous line dressing change reviewed, to minimise the risk of infection at the device insertion sites, cleaning of the insertion site at time of dressing change with ChlorPrep®, letting it dry before applying a new sterile chlorhexidine dressing was implemented across the Trust
- Following the review of the bionector used in the CT department for the administration of contrast, a larger bore bionector was identified and is now implemented
- A Trust global directive for suppression and decolonisation for MRSA positive patients was reviewed and updated. A training pack was developed and has been implemented, with training being provided by the Infection Prevention and Control team at ward level



Our Hand Wash Campaign

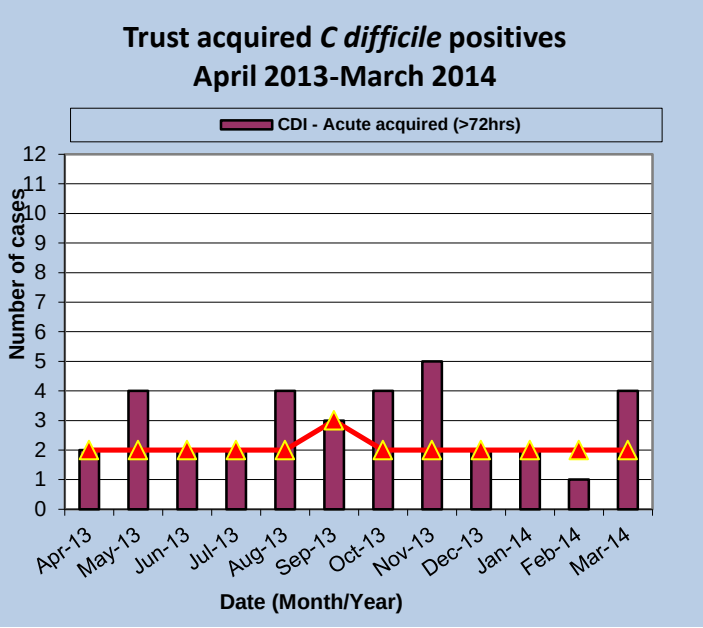
At the end of 2013, our staff oragnised a 'Flash Mob' when a group of people assembled suddenly in a public place to perform the hand wash song and distribute the film widely to raise awareness.

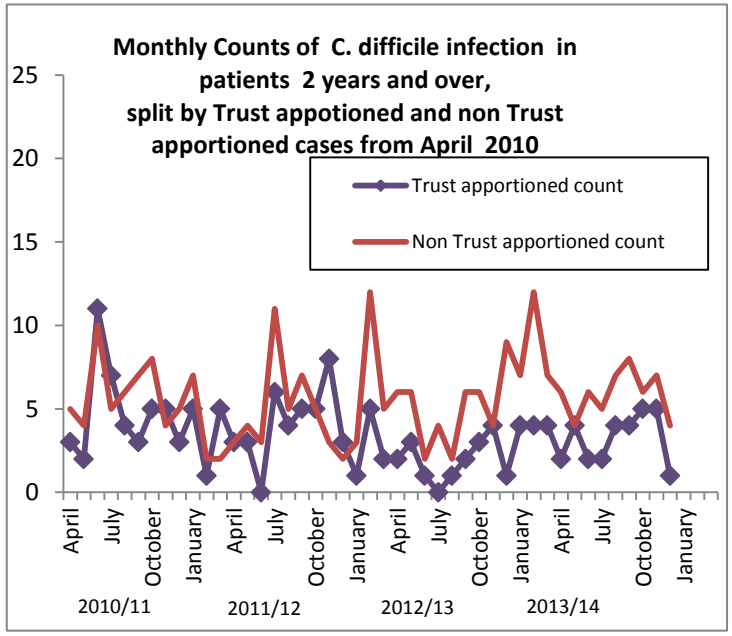
Schülke were so impressed with our song entry for the Hand Hygiene Champion award, they want to professionally record and video our version of 'Hand Wash' to the tune of 'Car Wash'. The photo oppositie shows our 'singers' in action. We have used this film for promotional events and teaching

Q4 – Infection, Prevention & Control Summary

Clostridium difficile

During 2013/14 there were 36 cases of Trust acquired *Clostridium difficile* (*C. diff*) infections against a trajectory of 25. The deterioration in our *C diff* rate from 2012/13 (27 cases) is disconcerting, although the ability of acute trusts to remain under their trajectory has not been achieved either at a local level or national.





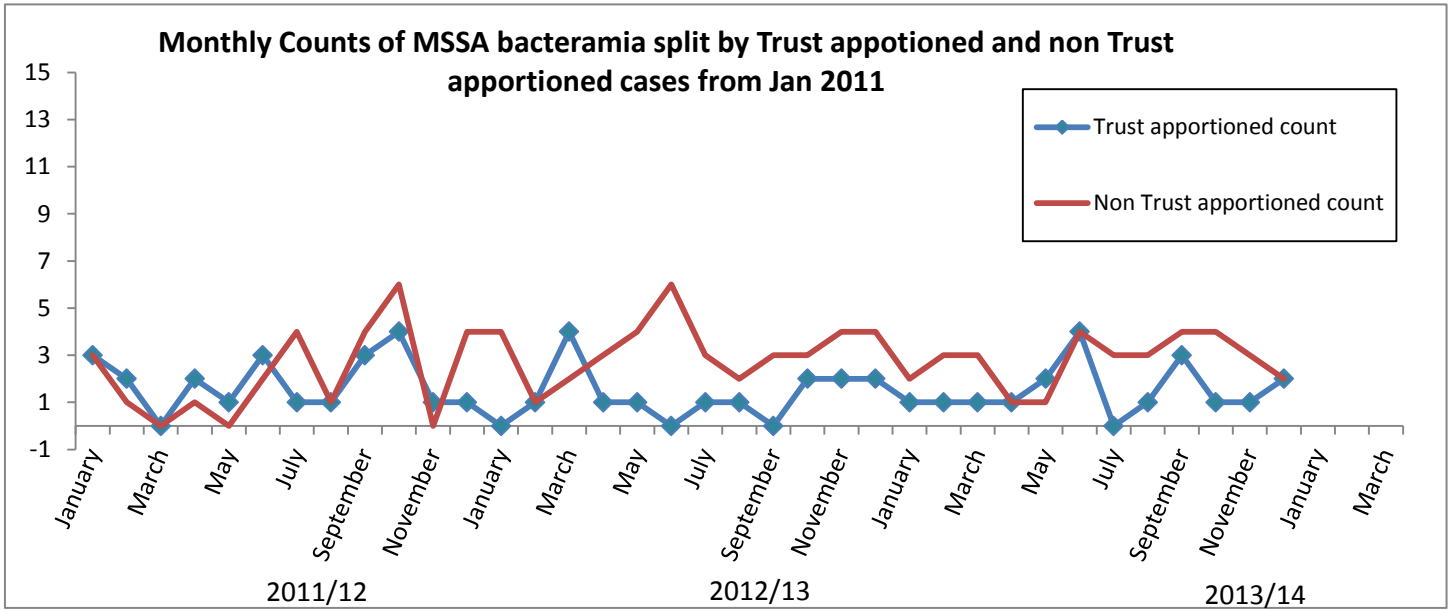
A Root Cause Analysis (RCA) was conducted for each of these cases, following these reviews the following have been implemented in response to the lessons learnt:

- Early recognition of loose stools and the need to isolate promptly. SIGHT poster designed, printed, issued and displayed in clinical areas by the Infection Prevention and Control Team
- Samples sent promptly for ribotyping in the event of a period of increased incident by the Infection Prevention and Control Team
- Implementation and completion of bowel chart for suspected cases by ward staff
- Prompt review of patients drug prescriptions and amend as required by medical staff
- Prompt discussion between medical staff caring for the patient and the Consultant Microbiologist
- Increase the multi-disciplinary team round to twice a week implemented by the Infection Prevention and Control Team
- During 2013/14 there were 3 separate periods of increased incidents, involving 6 cases; there remaining 28 cases were sporadic (unlinked). The infection prevention and control team are confident that it identifies all outbreaks and outbreak cases, including ribotyping and epidemiological tracking is undertaken for each case. The vast majority of these cases were clinically mild, although they frequently occurred in patients who were seriously ill from other causes.

Q4 – Infection, Prevention & Control Summary

MSSA

There is no external trajectory for MSSA bacteraemia infections post 48 hospital admissions. During 2013/14 we had 20 cases of MSSA bacteraemia infections post 48 hours of admission.



A Root Cause Analysis (RCA) was conducted for each of these cases, following these reviews the following have been implemented in response to the lessons learnt:

- A program of quarterly audits, which are undertaken by the Infection Prevention and Control Team are conducted quarterly. These include Hand hygiene (against '5 moments'), Personal Protective Equipment, Isolation, Linen, Urinary catheter management, Venous catheter management, and Sharps Management. The audit reports are fed back to clinical staff, the Healthcare Forum and the Infection Prevention and Control Committee
- When a patient has several drains insitu for staff to take samples from all drain sites
- VIP score documentation was reviewed and updated to reduce the inconsistency in recording on VIP score documentation, this will eventually be part of Vital Pak which is being introduced into the Trust
- Hand over sheet is being developed to ensure correct information is transferred with the patient for internal transfers

Medicines Safety Summary

Medicines remain one of the principle treatment interventions for all patients receiving care in hospital and on discharge. Whilst the vast majority of this use is safe and effective, the potential for direct and indirect harm from medicines remains, and the Trust is committed to ensuring that effective, multidisciplinary medicines management will provide safe, harm free care that will bring significant benefits in terms of patient care and the management of risk.

What did we set out to achieve (this is from 2013/14)

We aimed to deliver harm-free care, by promoting the safe use of medicines. We aimed to improve our medicines to take out (TTO) error rates, medicines reconciliation rates and ensure appropriate prescribing of anti-microbial medicine The aim of medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission.

To achieve this we identified that we needed to prioritise EAU as the focal point for ward pharmacy service delivery in order to ensure that medicines reconciliation and other issues are resolved as early as possible during the patient stay.

We also set out to identify prescribers in relation to TTO prescribing errors and antibiotic prescribing standard omissions, in order to enable targeted feedback and learning via the divisional clinical governance structures.

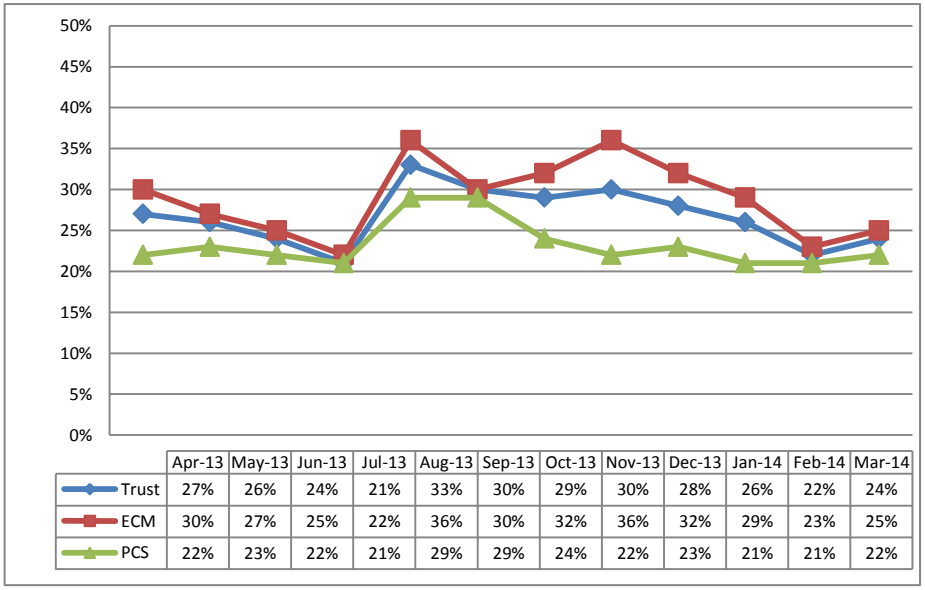
In order to achieve this we planned to:

- Support the safe use of medicines for patients with the introduction of weekend clinical pharmacy services
- Reduce the number of delayed and missed doses of critical medicines
- Improve the quality and safety of prescribing to minimise risk and improve patient outcomes
- Maximise safety gains achieved with the introduction of e-prescribing (an electronic prescribing system)
- Achieve 95% reconciliation of medicines within 24 hours of admission
- Minimise risk to patients by ensuring medicines are stored securely throughout the Trust

How did we perform in 2013/14?

The graph below shows our 2013/14 TTO error rate across the Trust and also by division (Emergency Care & Medicine and Planned care and Surgery). It indicates that there is further work to do to reduce errors on discharge medication, which will be part of the medicines safety programme during 2014/15..

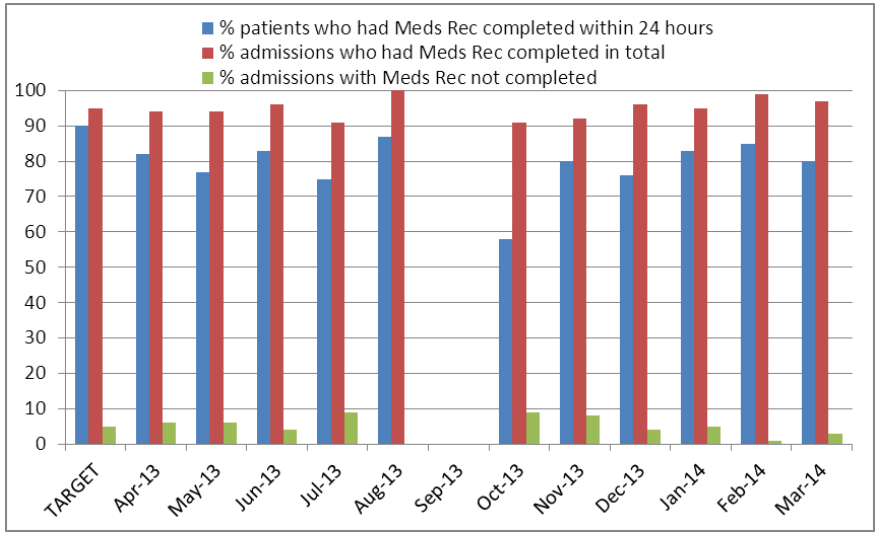
Graph: To Take Out (TTO) Error Rate in 2013-14

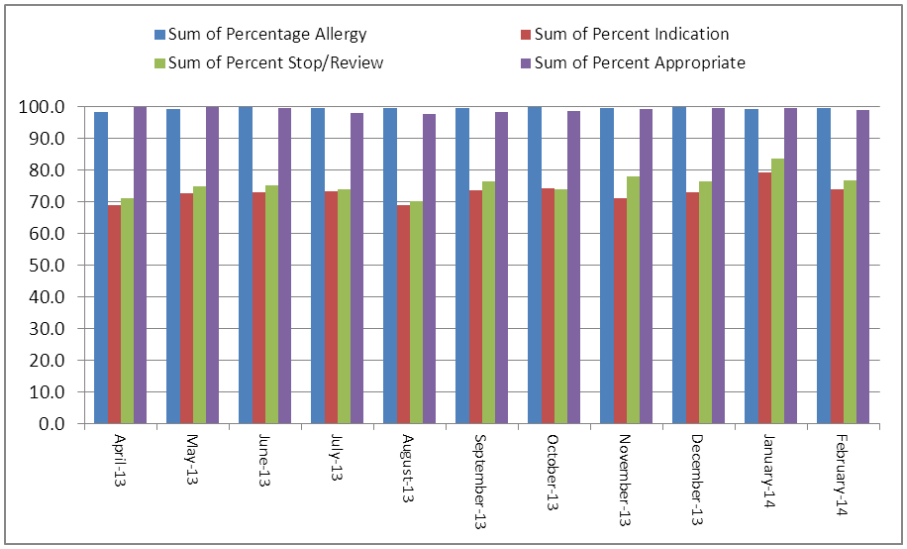


	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Trust	27%	26%	24%	21%	33%	30%	29%	30%	28%	26%	22%	24%
ECM	30%	27%	25%	22%	36%	30%	32%	36%	32%	29%	23%	25%
PCS	22%	23%	22%	21%	29%	29%	24%	22%	23%	21%	21%	22%

Medicines Safety Summary cnt

In terms of how well we are doing in reconciling medications when a patient is admitted, we consistently ensure that over 90% of our patients have their medicines reconciled, as shown in the graph below. However we are only able to do this within 24 hours for 80% of patients. This is an area for improvement.





We continue to ensure that nearly 100% of our patients are prescribed appropriate antimicrobial medication, as shown in the graph below.

Improvements achieved

- The safe and cost-effective use of medicines is essential and, for example following the visit by Professor Dearden (National Infection Control Expert) the Trust prescription chart is being substantially redesigned to ensure (amongst other changes) that antibiotics are now prescribed on a dedicated section of the chart to facilitate adherence to best practice.
- Focused medication reviews by pharmacists for patients identified as having Acute Kidney Injury (AKI).
- An electronic medicines ordering process has been developed for pharmacy staff to reduce turnaround times for getting medicines to our patients.
- Remote dispensing out-of-hours via the pharmacy robot by the on-call pharmacist can minimise missed doses of critical medicines due to non-availability.
- Various medicines safety issues including omission/delay of critical medicines and medication ‘never-events’ are now routinely included in Mandatory Update training for nursing staff, and in the staff questionnaires completed as part of the CQC Outcome 9 Guardian work.

- Ongoing promotion of the need to report medicines incidents (errors and near-misses), with effective feedback and learning from identified trends and 'hotspots'.
- Identifying and learning from other potential sources of medicines-safety related information such as calls made to the Hospital at Night team, and the on-call pharmacist.
- Building on learning from Trust staff attending the medicines safety (in older persons) course, being run in conjunction with staff from Nottingham University Hospitals NHS Trust.
- The e-prescribing project continues in pilot phase on Ward 14, providing valuable data on the further development and planned rollout of e-prescribing benefits.
- Medicines security and general medicines management spot-checks have continued during 2013/14 as part of the CQC Outcome Guardian project work.

Further improvements identified for 2014/15

We are aiming to deliver safe, harm-free use of medicines. A well-recognised source of medicines-related risk is the omission or delay of medicine doses, particularly of critical medicines (e.g. IV antibiotics). We are undertaking a project designed to reduce the number of such omissions/delays by at least 50% in 2014/15 and by 95% by April 2016. We will be looking at ways of introducing similar processes to those adopted by other Trusts who do continual snapshot audits of missed doses.

Other medicines safety-related goals:

- Improve the quality and safety of prescribing to minimise risk and improve patient outcomes (through ongoing input to undergraduate medical education, and strong multidisciplinary working at ward level)
- Maximise potential safety gains with the introduction of a Trustwide e-prescribing (an electronic prescribing and medicines administration) system (EPMA)
- Achieve 95% reconciliation of medicines within 24 hours by end-2014
- Optimise the response to and concordance with the requirements of medicines-related patient safety alerts from NHS England (the requirement for all Trusts to identify a nominated Medicines Safety Officer (who will be a member of a proposed National Medication Safety Network) is likely during 2014).

To help achieve these work is planned for pharmacists to transcribe discharge prescriptions in order to enable medicines to be prepared and ready 1 – 2 days in advance of the expected date of discharge.

Compliance with the NHS England Patient Safety Alert on improving medicines incident reporting and learning, by mid-September 2014, and developing the role, profile and output of the Trust Medicines Safety Group.

Nutrition Summary

What did we set out to achieve during 2013/14 (include specific goal)?

Meeting our patient's nutritional and hydration needs is a fundamental priority at the Trust and an area that is carefully monitored through monthly nursing metrics and observational visits.

Through the Trust's own internal quality monitoring processes we have acknowledged the need to strengthen and reenergise the importance that these elements of care play in the overall wellbeing of patients

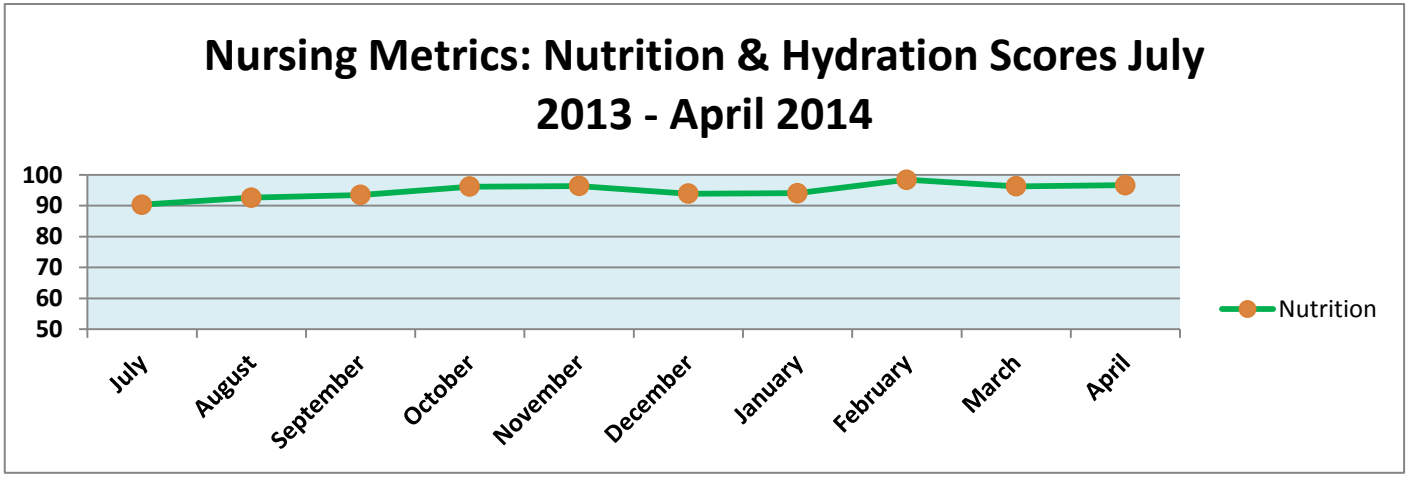
Following their visit to the Trust last July, the Care Quality Commission identified that actions were needed to embed the principles of nutrition and hydration and improve the mealtime experience for patients.

Progress

'Making Mealtimes Matter' was developed and launched across the Trust to support the national 'protected mealtime's initiative' and drive up standards with clear expectations. There have been 2 peer review audits undertaken in order to review progress. The results are being used in conjunction with nursing metrics, PLACE audit findings and outcome guardian visits to identify areas of good practice and highlight areas requiring further support.

Outcome

The graph here shows the nursing care metrics scores for nutrition in March 2014. Each month senior nurses visit our clinical areas to assess care across a range of indicators and questions. We expect all areas to achieve 95% in their nutrition metrics and if they don't we discuss the reasons for this and actions are instigated to address it.



How did we achieve this?

- Development of an e –learning nutrition screening module
- The nutrition steering group has been re-energised and will take place on a monthly basis. This will ensure plans for the future are sustained
- Nutrition screening training for medical staff
- Quarterly peer review audit plan established
- Red tray and red lid jug guidance has been strengthened for staff.
- Redesigned resources that inform both patients, their carer's/relatives and staff of the support available to them in ensuring individual needs of patients are met have been distributed to all areas.
- A comprehensive nutrition training plan for all staff groups has been commenced.
- The Nutrition and Hydration Policy has been revised and implemented.

Nutrition & Hydration week – March 17th 2014

We were proud to support national Nutrition & Hydration week from 17th March 2014.

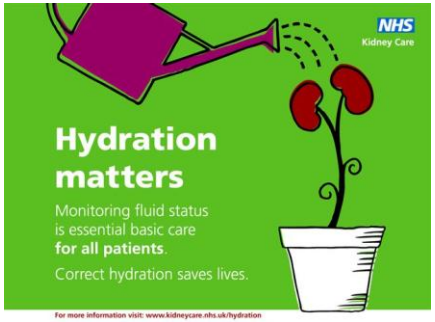
We organised a range of events to involve staff, patients and their families, which included Afternoon tea for all inpatients across the Trust and activities to promote good nutritional care. Our wards also made pledges about nutritional care.

Following the success of the afternoon tea initiative we are exploring possibilities of providing this more routinely with our Medirest colleagues.

As part of her project for the RCN leadership course, one of our ward sisters, Adele Bonsall has devised an information pack and set of objectives for our nutrition link nurses.During 2014, we will be reviewing and strengthening our nutrition link nurse roles and audit activity to capture Adele's excellent work.

This photos shows our chairman, Sean Lyons, with Angela Hill, our Nutrition Nurse Specialist, one of our hostesses and patient's, about to enjoy her 'afternoon tea' on Lyndhurst ward.

Hydration Summary



What did we set out to achieve during 2013/14?

We know that keeping patients appropriately nourished and hydrated is essential. During 2013/14 we said we would improve how we identify and help those patients who require our assistance to stay hydrated. We alo wanted to ensure our patients would be risk assessed to ensure they are appropriately hydrated and that appropriate steps taken to help our patients meet their hydration requirements. Fluid management was identified as an area of concern following the 'Keogh' review undertaken in June 2013. It stated that a review of fluid charts identified issues with the majority reviewed including no records for patients for over a day; fluid records not completed; patients not being risk assessed for fluid on arrival; and fluid balance charts not being totalled. In addition, the team also highlighted that the 'Red Jug' initiative being used for patients with a need for assistance with fluid was not observed to be effective.

Progress

An accurate intake and output record provides valuable information for assessing and evaluating a patient's condition. Fluid balance assessment and documentation had been identified as an area of care that we needed to improve in. In August 2013 a hydration workshop was held; attended by a multi-professional group of staff who contributed ideas, which were developed into a plan to improve the way we support patients with their hydration needs and from this a multi-professional Hydration Improvement Group was established.

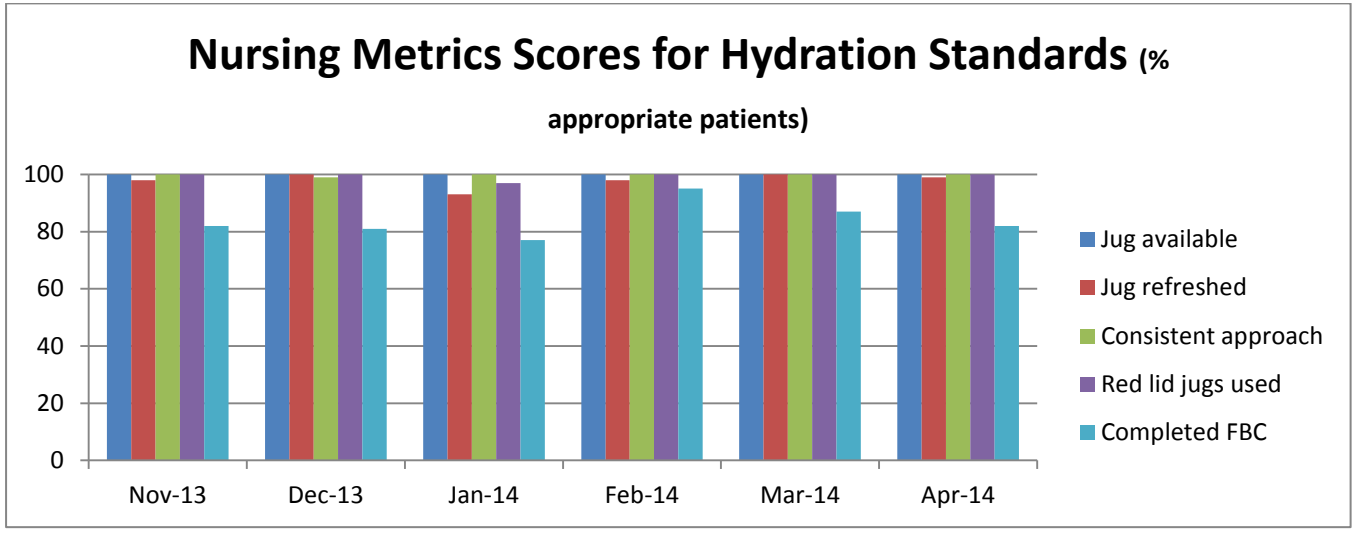
In September 2013, a trust-wide mandatory joint training programme for all registered nurses and healthcare support workers commenced, providing an update on all patients' hydration needs and some of the service improvement projects currently underway. Nursing staff who have attended training were valuable in contributing to the development of a new hydration risk assessment tool. Trials of the tool proved to be a success and have since been rolled out to all inpatient wards. Hydration training is now included during induction for new clinical staff.

For patients who require help with drinking, we now provide their water in a red lidded jug. This highlights to staff that assistance is required with drinking, ensuring that the patients ongoing needs are reassessed.

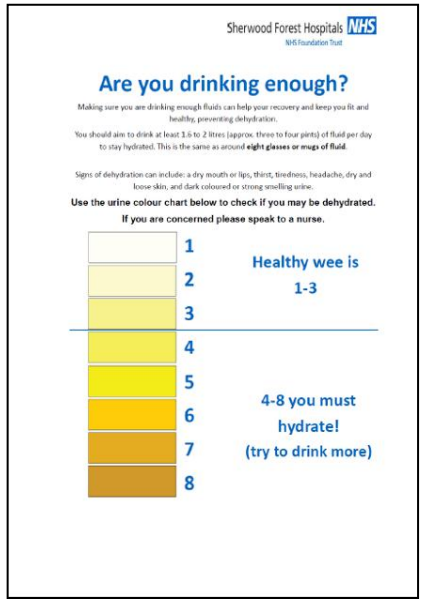
Outcome

In October 2013 we were pleased to note that 100% of our patients felt that they are able to ask for a drink when required and where appropriate 100% patients had a jug of water near that they could reach. Red-lidded jugs were in use for 100% of those patients who required them. We

undertake monthly nursing metrics scores which show good performance around hydration care over the past 6 months. We continue to do work to educate our teams to ensure they understand when to use a fluid balance charts and when a hydration chart is more approporiate.



NB – FBC = fluid balance chart



In order to achieve this, a hydration work stream was established and a group formed to oversee this work. Its focus was to ensure that all patients at our hospitals receive adequate hydration and that their needs are assessed, monitored and optimised correctly to reduce the risk of fluid imbalance.

Improvements achieved

The development of a new hydration risk assessment tool to identify when patients require more support to maintain their hydration and to direct health professionals on the appropriate care actions to be undertaken.

- Development of a new Hydration chart in addition to existing Fluid Balance chart
- “Are you drinking enough?” poster in wards and departments providing information for both patients and staff

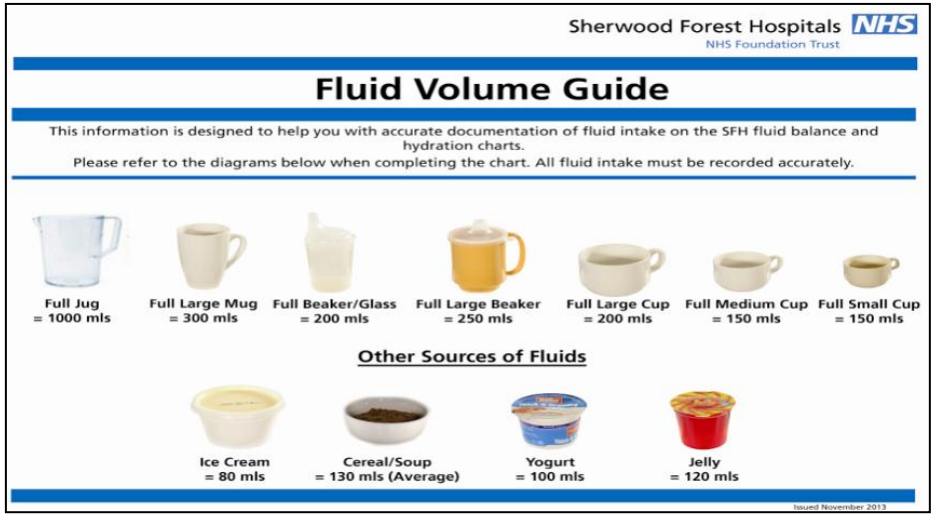
- Development of a “Fluid Volume Guide” which was designed to help staff with accurate documentation of a patient’s fluid intake.

- In order to raise awareness of the assessment tool more widely `and reinforce the messages from the mandatory training a pocket sized card has been designed.

- A simplified list of instructions has been devised and circulated to ward sisters

- Red lidded jugs and process of when to use made available on all wards

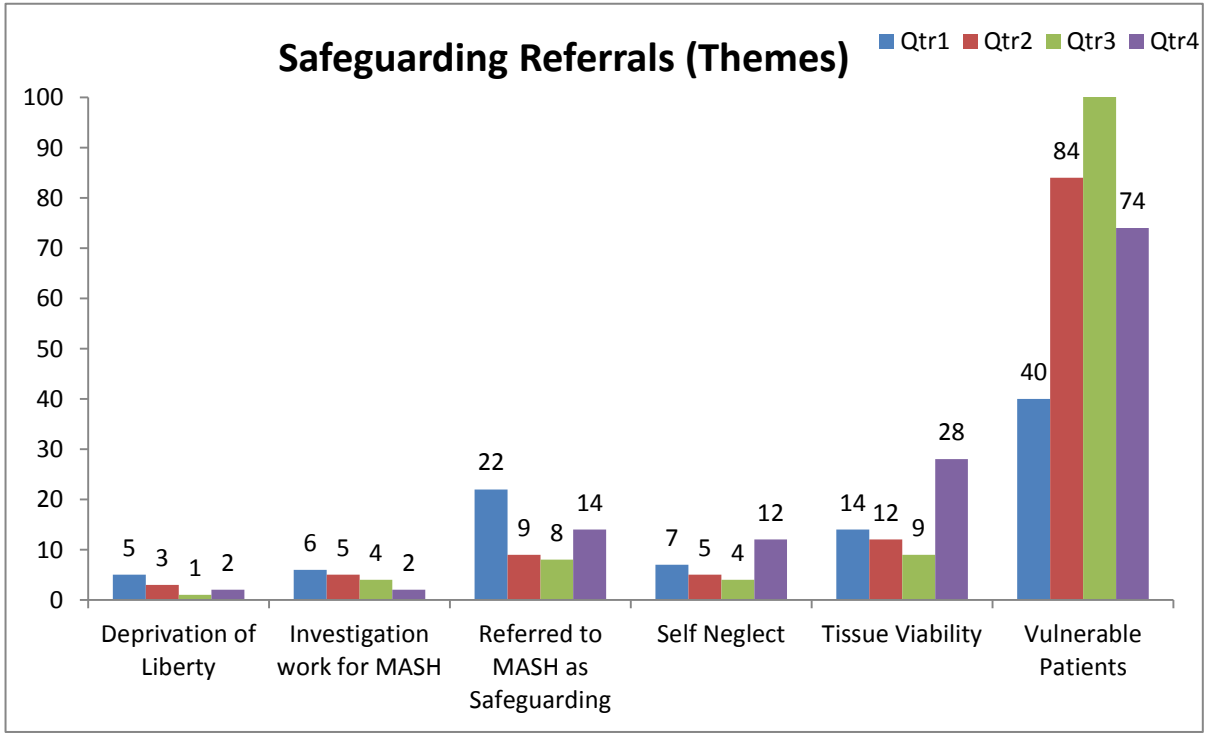
- We hosted a National Outreach Study day incorporating principles of good fluid management and Nutrition and Hydration week was held to raise the profile and showcase our work



Safeguarding Adults Summary

There have been 140 referrals to the Trust's Safeguarding adult's team which is a slight decrease from Q3 when 165 referrals were made. In Q4 14 of the 140 patients referred necessitated a referral to the Nottinghamshire Multiagency Safeguarding Team (MASH). This is a slight increase in the amount of referrals made in Q4 to MASH – 14 referrals made, 8 were made Q3. In Q4 there has been significant rise in the number of patients in the tissue viability category from 9 in Q3 to 28 in Q4. When looking at the tissue viability data there has been an increase in the amount of patients with grade 4 pressure ulcers being admitted into the Trust and 8 of the 14 referrals to MASH have been for patients who have tissue damage, so can account for the increased referrals to MASH. In Q4 there has been a rise in patients who have self neglected referred to the Trusts safeguarding team. See graph below.

During Q4 Information regarding a Domestic Homicide Review (DHR) has been requested and preliminary information submitted to the DHR review panel.



Safeguarding Adults

The executive trust lead for safeguarding adults is now the Medical Director who chairs the Safeguarding Adults steering group.

During Q4 all the training has been reviewed. Consent form 4 has been revised.

The main aims for the next quarter are:

- To review flagging of vulnerable patients with in the Trust.
- To review the restraint policy.
- To audit the use of the mental capacity act across the Trust

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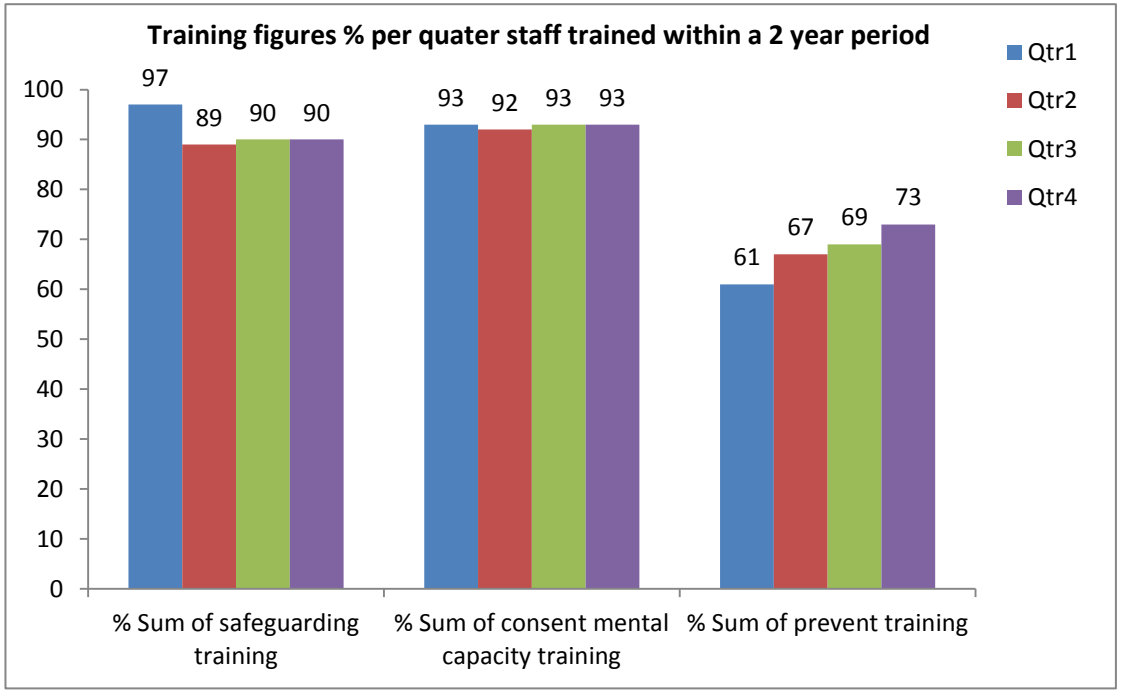
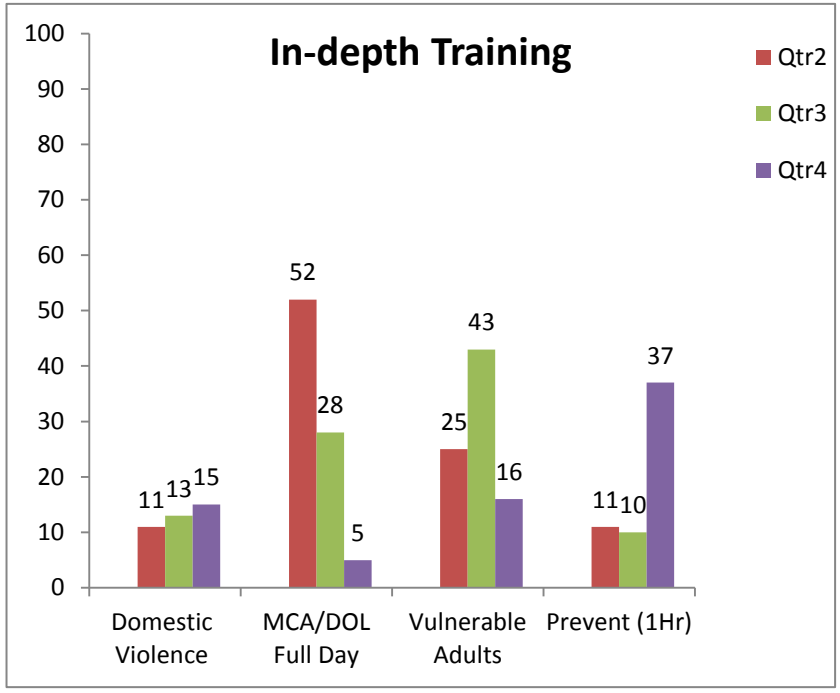
Safeguarding Adults Summary cont





Training

Mental Capacity Act (MCA)

The revised programme of Mental Capacity Act and Deprivation of Liberty Training has been commenced with the 1st session taking place at Newark hospital and although the there was a small number of staff attended the training evaluated very well.

There has been new case law around Deprivation of Liberty this will have some impact on practice and will involve a revision of training.

Vulnerable Adults

The 1st day of the revised vulnerable Study day which has been opened up outside organisations in Nottinghamshire commenced this evaluated very well.

Prevent

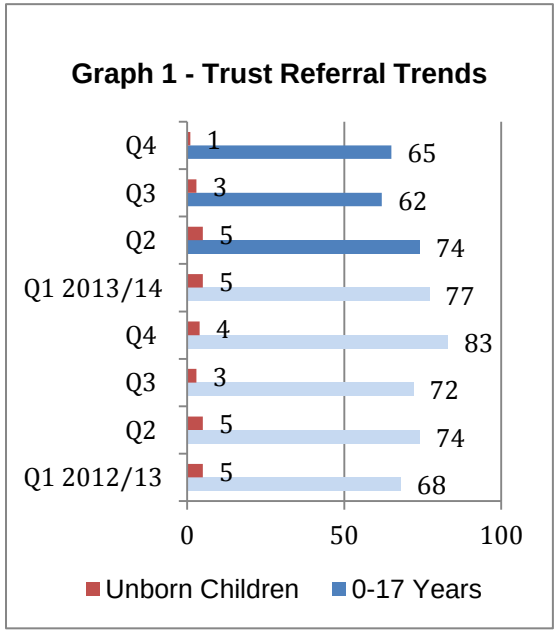
The numbers of staff trained in hour long Health WRAP Prevent has increased as the Midwives are now receiving Health WRAP training.

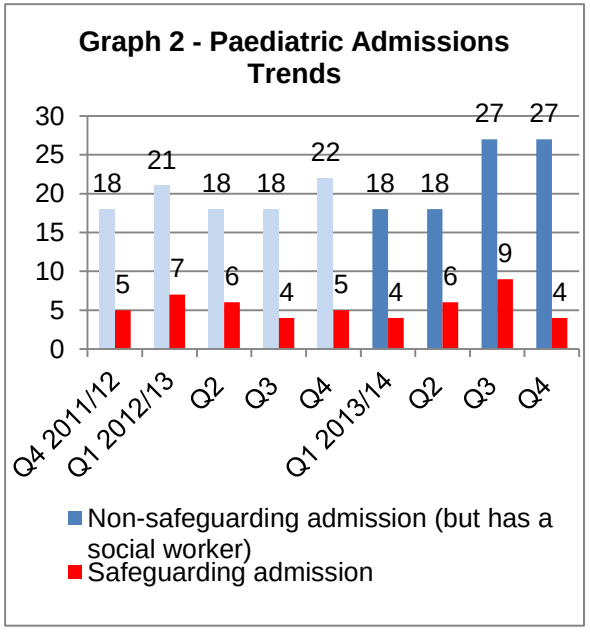
Safeguarding Children & Young People Summary

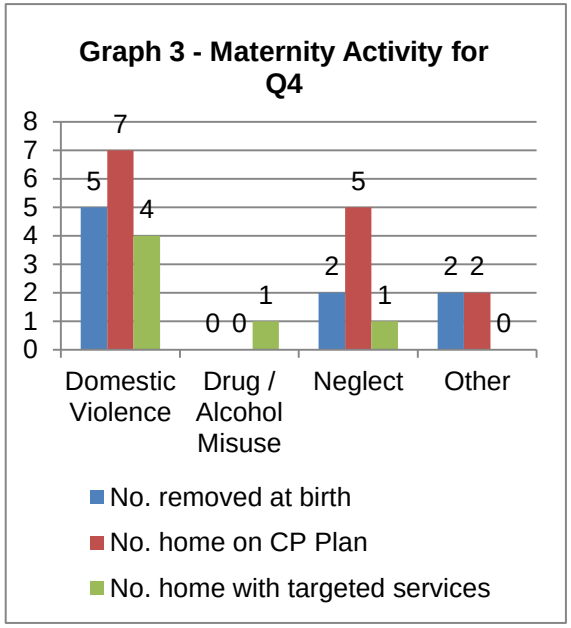
Safeguarding Children and Young people Summary

During Q4 Trust **r**eferrals to Children's Social Care for 0-17 year olds and unborn children increased slightly [graphs 1& 4]. Paediatric safeguarding admissions decreased, paediatric admissions of children who were already under the care of a social worker remained unchanged [graph 2]. Maternity activity for Q4 [graph 3] remained comparable with Q3 [graph 3], although those with 'neglect' identified increased. The development of the electronic safeguarding alert for ED which will automatically notify staff if a presenting child is subject to child protection plan continues to await development by TPP. Concerns that the development has not progressed have been escalated via the Safeguarding Children & Young People Governance Meeting and this is now being expedited by our IT department . A Serious Case Review involving the Trust is currently underway, with the final report expected early May.

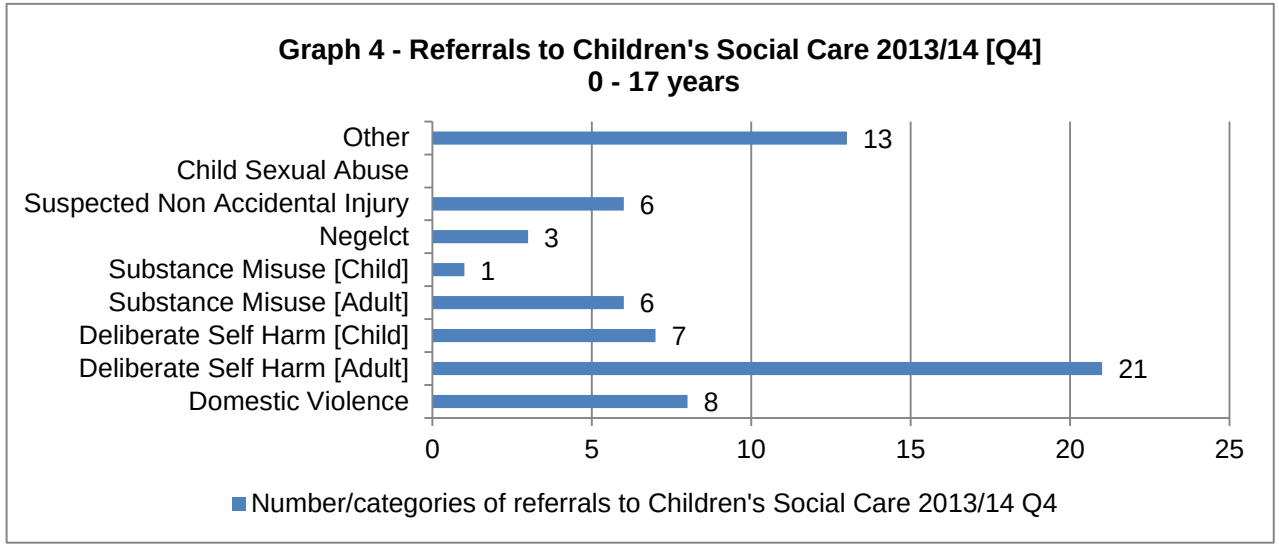
As part of the national programme there is expected to be an unannounced, Trust-wide inspection of Safeguarding Children & Young People by the CQC during 2014-2015. The Trust is preparing for an unannounced visit





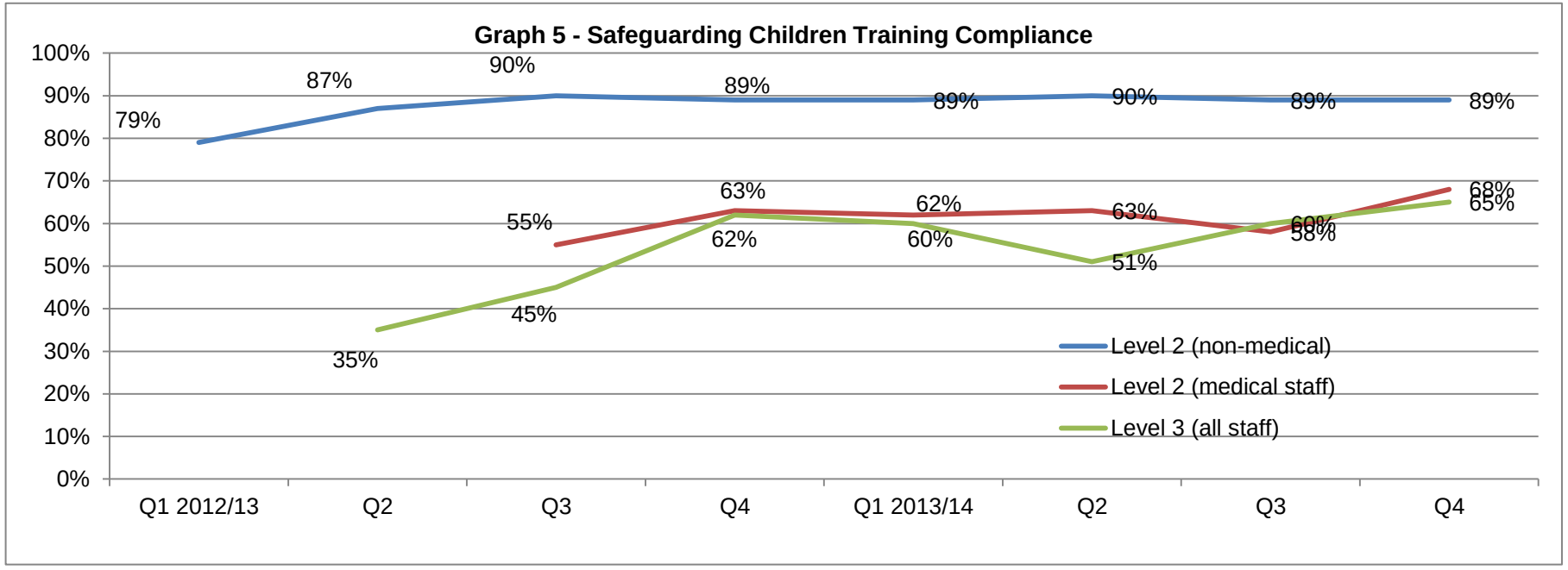


Safeguarding Children & Young People Summary cnt



Training of Staff

Training compliance has increased, but continues to remain challenging despite additional training sessions being offered in Q2; compliance concerns have been escalated to Divisional Governance Meetings.



Learning Disability Summary

- **During Q4 there have been 78 referrals to the Learning Disabilities nurse to support with complex patients.**
- **The Hospital's Learning Disability Steering Group met in February 2014 – Main discussion points were:**
  Reviewing the Learning Disability risk assessment and care plan, discussing new items to include in the Learning Disability policy update, updating members on progress for the adults changing places toilet (KMH & NH), Update on the car parking meter at Newark Hospital, sign off for the article for hospital best magazine.

Involving Patients in Auditing Care

The 'Patient checkers' tool on the left was developed by the Learning Disability Steering Group to support people with Learning Disabilities to audit the wards on the trusts guardianship visits.
The Patient Checkers will be interviewing staff on outcomes 2 & 7 Consent and Safeguarding.
The Patients checkers will pilot the use of the tool on ward 35 in April.

Comments from family care following consultation with our LD Nurse:
'I feel much more reassured now I know you are here to support us with this, we were worried that the minute R***** started to show some improvement we would have him back with us, but without the help/support we need'.

1709 staff members have received Learning Disability Awareness training during quarter 4 (80%).

Maternity Summary – Midwife to Birth Ratios

What did we set out to achieve during 2013/14: To ensure that midwife to birth ratios are at recommended levels

Progress: We are really proud that we have achieved the target of 1:28 as nationally recommended against the staff we are funded for.

Year	13/14	12/13	11/12	Nationally
Births	2997**	3414	3499	
% from last year	↓**	↓2.4%	↑2.1%	
Caesarean Section rate	18.79%**	18.48%	17.96%	23-25%
Vaginal Birth Rate	81.21%**	81.52%	82.04%	
Home Birth Rate	4.94%**	4.7%	5.17%	2%
Midwife to Birth Ratio	#1:27**	1:32	1:33	

** to end Feb. NB: This is full year effect however the support workers were not included in the midwife to birth ratio prior to quarter 3 i.e. Oct –Dec calculations

In order to achieve this we set out to secure investment into the service to increase midwifery post and in line with National guidance introduced trained midwifery support workers at a band 3 into the hospital and community setting. We are really proud of these outcomes which we achieve by the strong philosophy of care the maternity team share and the investment into the maternity staffing.

Baby Friendly Assessment February 2014

The Baby Friendly Initiative unicef

The baby friendly initiative established by UNICEF and the world Health organization is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. In the UK, the imitative works with Health professional to ensure that mothers and babies receive high quality support it facilitate successful breast feeding. The award is given to maternity services after an assessment by a UNICEF team.
We were assessed against level 3 and we passed on 43 out of 45 standards (Often with 100%) Sadly we only got 72% and we needed 80% on showing and teaching positioning and attachment for breast feeding. We are awaiting the final report to confirm our next steps.

CQC External Assurance Process

Sherwood Forest Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC). Sherwood Forest Hospitals NHS Foundation Trust has no conditions on its registration.

Following a number of governance concerns and intervention by Monitor, in which the Trust was placed in significant breach of its Terms of Authorisation, the Care Quality Commission (CQC) undertook a responsive visit in October 2012. As a consequence of their findings, the Trust was found to be compliant in CQC Outcome 4 – Care and Welfare of People who use the Service and received a moderate compliance action in Outcome 16 'Assessing and monitoring the quality of service provision'.

During 2013/14 the Trust has experienced a challenging time in relation to demonstrating the quality of its healthcare systems. The Care Quality Commission has undertaken two visits during 2013/14, with a further visit planned week commencing 21st April 2014, using the new CQC regulatory model.

Following the first unannounced visit in June and July 2013 the CQC found that the Trust was non-compliant in five outcomes in the following areas:

Outcome	Title	Judgements: September 2013	
4	Care and Welfare of People who use the Service	Minor impact	
5	Meeting Nutritional Needs	Moderate impact	
6	Cooperating with other providers	Met this standard	
8	Cleanliness and infection control	Met this standard	
13	Staffing	Moderate impact	
14	Supporting workers	Met this standard	
16	Assessing and monitoring the quality of service provision	Enforcement action – September 2013	Minor impact – January 2014
17	Complaints	Moderate impact	

Definitions

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

Regulatory response

Where the CQC have evidence that registered persons are not currently meeting legal requirements or have demonstrated repeated non-compliance over time, the CQC may take enforcement action. For Standard 16 – 'Assessing and monitoring the quality of service provision' the Trust failed to demonstrate to the CQC (during its June & July 2013 visit) that instigated actions were embedded and continuous to enable the CQC to reduce the moderate impact judgment. N.B The Trust already had a moderate compliance action against this standard ((October 2012). The CQC inspection report showed that the Trust needed to strengthen Governance structures and processes within the hospital. This predominately reflected the need for the Trust to 'learn' from its systems and processes when these identify where services could improve. This further judgment of a moderate compliance action resulted in an Enforcement action through a warning notice, which demands compliance within a timescale. For the Trust this timescale was 31st October 2013.

The Trust was re-inspected on the 4th December 2013. The CQC undertook this inspection to review the Trust's actions against Standard 16 – assessing and monitoring the quality of service provision. The CQC at this point acknowledged the progress with the work that the Trust had undertaken and importantly this resulted in the moderate impact judgment being reduced to a minor impact judgement

'Many of the staff described the trust as, "Being on a journey'. The challenge for the trust is to complete work on planned initiatives, embed new arrangements across the trust and ensure improvements are sustained in the long term. This will require a commitment from the Trust Board, particularly in ensuring the pace of change is timely with a continuous review of effectiveness going forward' extract from December 2013 inspection report pg5

Special Measures

Sir Bruce Keogh, NHS Medical Director undertook a review of the quality of care and treatment being provided by those Trusts in England which had persistent outliers on mortality statistics. Sherwood Forest was one of 14 trusts which fell in the scope of this review

The initial Rapid Response Review took place on 17th and 18th June 2013, and resulted in a report and risk summit which identified 13 urgent and 10 high and medium actions.

An assurance review was undertaken by the Keogh panel on the 4th December 2013. This review identified that of the 23 actions the Trust had been required to implement, they felt 'assured' on 6 actions and 'partially assured' on 17 actions. Where there was evidence of progress with implementation, but implementation was not complete, the outcomes were not yet evident or it was too early to tell if the changes were embedded and sustainable, the panel recorded an outcome of 'partially assured'. There were no areas or actions recorded as 'not assured'. The table below shows the actions.

The actions identified from the assurance review in June and December 2013 were consolidated with actions from the parallel CQC inspection and quality governance reviews. It is anticipated the majority of these actions will be further assessed and tested as part of an impending CQC visit planned for April 21st, 2014.

Internal Assurance Process & 15 step visits

We commenced the Guardians of Care and Internal Assurance Team visits in 2012; these have provided the Trust with an opportunity to review the 'workings' of the organisation. We have seen many benefits since introducing these visits including an increased staff awareness of patient quality, improved visibility of senior staff and the opportunity for clinical teams to discuss their practises in clinical area and opportunities to explore their challenges.

Going forward in 2014

A Trust assurance framework needs to be constantly reviewed and where necessary re-designed to ensure that it provides the organisation with assurance that its systems and processes are happening on a day to day basis.

The next stage of our assurance development is introducing the 'peer' review model. It facilitates ward/department leaders as well as senior managers, Executive and Non-executive members the opportunity to 'review' the clinical areas. It is essential that we are asking ourselves how the experience of our patient 'feels' and so going forward we will expect staff to challenge and more importantly support each other to highlight 'best' practice and shape actions to improve practice. The nursing and midwifery strategy builds upon the need for senior staff to recognise their responsibility to create improvements, the process of peer review builds on these foundations.

Within the various layers of the organisation it has been essential to develop Key Lines of Enquiry (KLOE), which represent the aspects of patient care that a particular group of staff would need to concentrate upon. The KLOE's are based on 'what we know'; they are not exhaustive but signpost the reviewer to the areas where the Trust from either internal or external review is not fully assured.

The 'Health check' approach fosters a whole organisational approach to assurance.

Feedback from Quality Committee

HIGHLIGHT REPORT – Quality Committee 25 March 2014

Members

Peter Marks	-	Non-Executive Director (Chair)
Claire Ward	-	Non-Executive Director
Susan Bowler	-	Executive Director of Nursing and Quality
Andrew Haynes	-	Interim Executive Medical Director

Attendees

Nichola Crust	-	Head of Governance
Anne-Louise Schokker		Clinical Director Emergency Care and Medicine

Apologies

Tim Reddish	-	Non-Executive Director
Jacqui Tuffnell	-	Director of Operations
Elaine Moss	-	Director of Quality and Governance – Newark & Sherwood and Mansfield & Ashfield Clinical Commissioning Group
Fran Steele	-	Chief Financial Officer
Karen Fisher	-	Director of Human Resources

This report summarises the discussions and decisions made, and the assurances received at the Quality Committee held on March 25 2014.

Key headlines/ issues/ emerging risks (with assurances)

Agenda item 6 – Serious Incident MB
SB stated that the RCA has been completed for the SI; however this has not yet been formally signed off through the new SI Review and Sign Off Group. The commissioners are compiling an overarching report from Kingsmill, EMAS and NUH which will be received by our Quality Committee.

In response to learning following this SI and the complaint involving the transfer of a patient from Newark to SFHFT and being diverted to NUH, the Quality Committee requested an action to review the services across SFHFT that have out of hour arrangments with other providers to

ensure we have robust handover systems. The purpose of the review is to identify if handover protocols are robust and confirm that there is clear guidance about responsibility and accountability for patient care between the organisations and that timeframes are clear.

Agenda Item 7 CQC Assurance framework
SB informed members of the new wave and style of reviews SB advised there was a Quality Governance Confirm and Challenge event and levels of assurance will be confirmed there. A discussion took place regarding our preparation, current evidence and work required to support a successful visit

Agenda Item 8 - Falls Update Report
ALS presented a falls paper which provided an indepth analysis of our falls performance, metrics and work in progress. The 14/15 falls CQUIN was referred to in relation to reducing the number of repeated fallers. ALS also advised of work on a falls bundle being developed. ALS report was well received and the Quality Committee were assured around the falls update report and welcomed the fact that it contained data; it was informative and contained narrative. There was an acknowledgement within the meeting and following the presentation that there needed to be some additional dedicated resource to support the falls work programme and to consider pump funding an additional post for a year. SB agreed to take this action forward.

Agenda Item 9 – Quality Account
SB led the discussion on the Quality Accounts and status of the draft 13/14 accounts to date. SB advised a draft has to be ready by 14 April 2014 and there would be a requirement for an extraordinary meeting with members of the Quality Committee to review

It was suggested a measurable outcome for discharge planning and agreement to involve the ABC team to identify a measurable improvement for discharge should be included within the key priorities.

Agenda Item 10 – Patient Safety and Quality Strategy
The Patient Safety and Quality Staregy was discussed in detail . Positive feedback received. Minor amendments to be made to reflect other strategies, the operational plan and the quality priorities and to be more aspirational around the targets.

Agenda Item 11 – BAF and Corporate Risk Register
BAF reviewed and consideration by members as to which risks were appropriate to receive assurances on directly to the Quality Committee and to identify which risks were to be monitored by other sub-board groups. The BAF requires further detailed review to ensure it adequately reflects the risks to the organisation in meeting the strategic objectives and that work is required to robustly map the risks to the relevant sub-committees. This process is essential for the Quality Committee to assure themselves that all risks have been identified, prioritised and there is effective management of risks to ensure that there is assurance that the Board has been properly informed about the totality of risks to

achieving the Trusts strategic objectives. Initial attempt to align Strategic Objectives to the relevant groups was commenced however specific risks did not necessarily link to the assigned committee. Consideration that the Audit Committee should become the custodian of the BAF.

Agenda Item 12 – Committee Effectiveness
It was agreed an item for the next Quality Committee meeting in May would be to review the work plan and terms of reference of the new Quality Committee and this will be better achieved with reflections on the new committee structure and reporting lines.

Agenda Item 13 – Early Warning Scoring and Ward Assurance Dashboard
SB advised the medication harms needed further review and will request a paper from the lead for medicines management to review. Subsequently following the Quality Committee, a Medicines incident trend analysis report was presented to the Clinical Quality and Governance Committee.

Staffing levels remain a concern as not fully recruited to required establishment however divisions investing significant time and energy both locally and internationally to improve recruitment. SB spoke specifically about ward 36 and actions being taken and also noted that ward 22 are showing signs of improvement across a number of indicators.

PM advised it would be helpful if the metrics could include a commentary regarding the assurance framework and it was agreed SB would write a paper and bring this back to the next meeting.

AOB – Serious Incident Review and Sign Off Group
NC and AH confirmed that a draft process for Serious Incident Review and Sign off was being proposed. NC agreed to write an SI report for the preceding month to be presented to TMB.