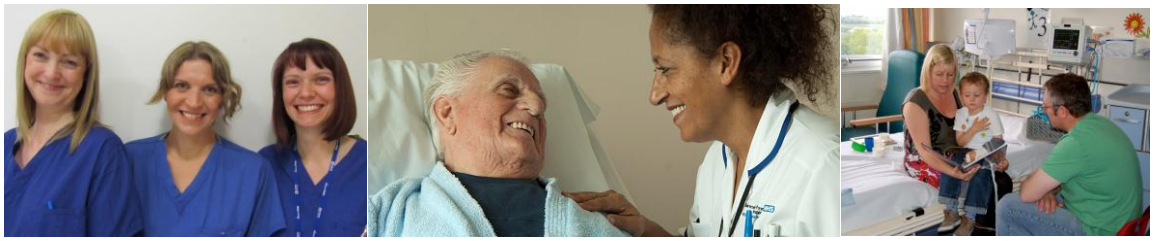
Sherwood Forest Hospitals NHS
NHS Foundation Trust



TRUST BOARD OF DIRECTORS – MARCH 2014

MONTHLY QUALITY & SAFETY REPORT

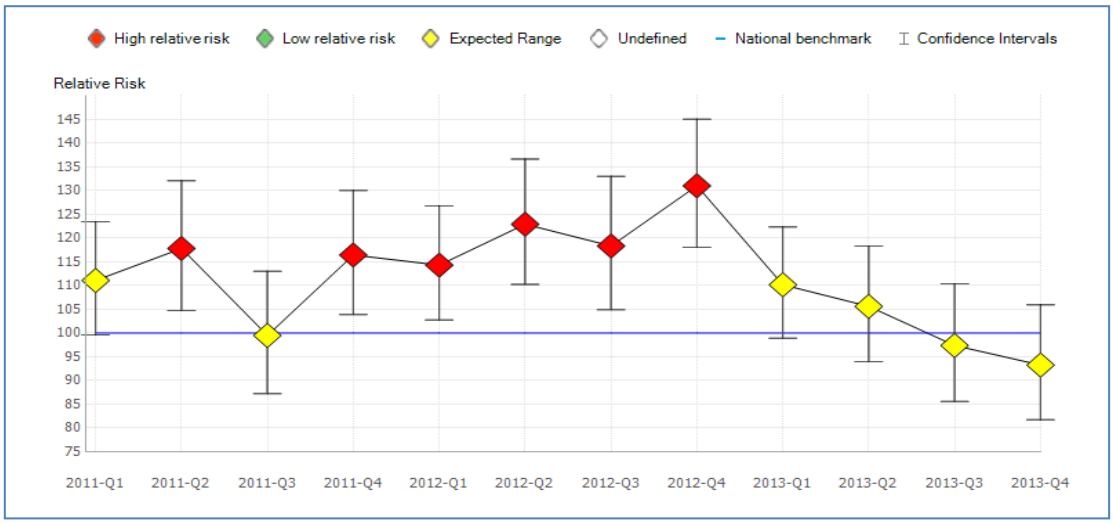
1. Introduction

This monthly report highlights to the Board of Directors key areas in relation to quality and safety. It complements the quarterly quality report, which gives a more comprehensive review of progress against the Trust's quality and safety priorities. The monthly report will include updates on the Trust's top 3 quality priorities for 2013/14, which are:

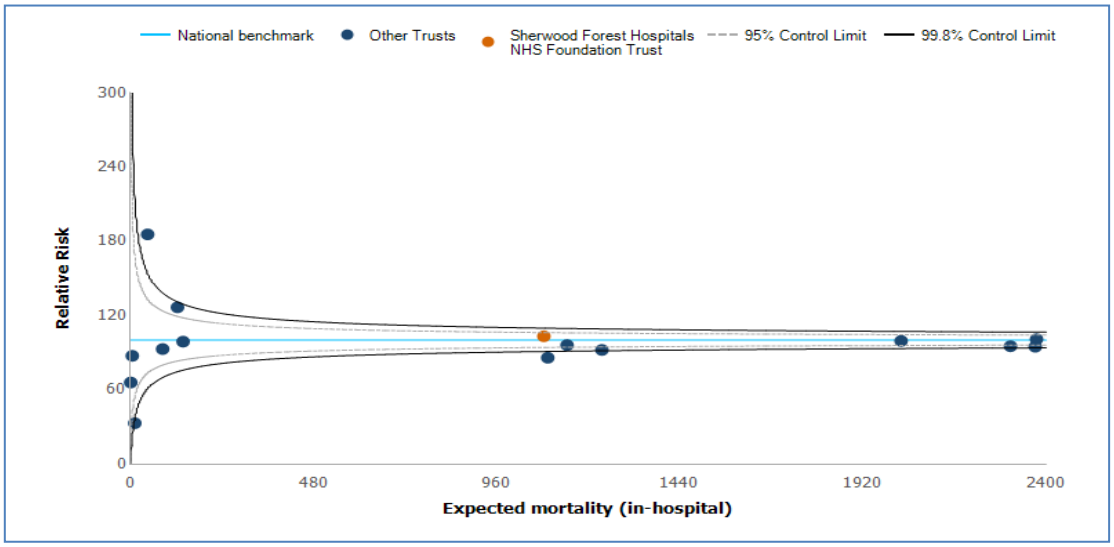
- Priority 1 – Improving the effectiveness of care we deliver by achieving a reduction in mortality (HSMR, SHMI and crude mortality)
- Priority 2 – Delivering Harm Free Care by reducing hospital acquired pressure ulcers
- Priority 3 - To reduce length of stay and readmissions by improving patient flows (i.e. reducing the number of bed movements during the patients inpatient stay)

2. Reducing Mortality (Priority 1)

The Trust's on-going quality, safety and improvement work continues to be reflected in the HSMR data from Dr Foster. The run chart below shows the SFH HSMR per quarter since the start of 2011.



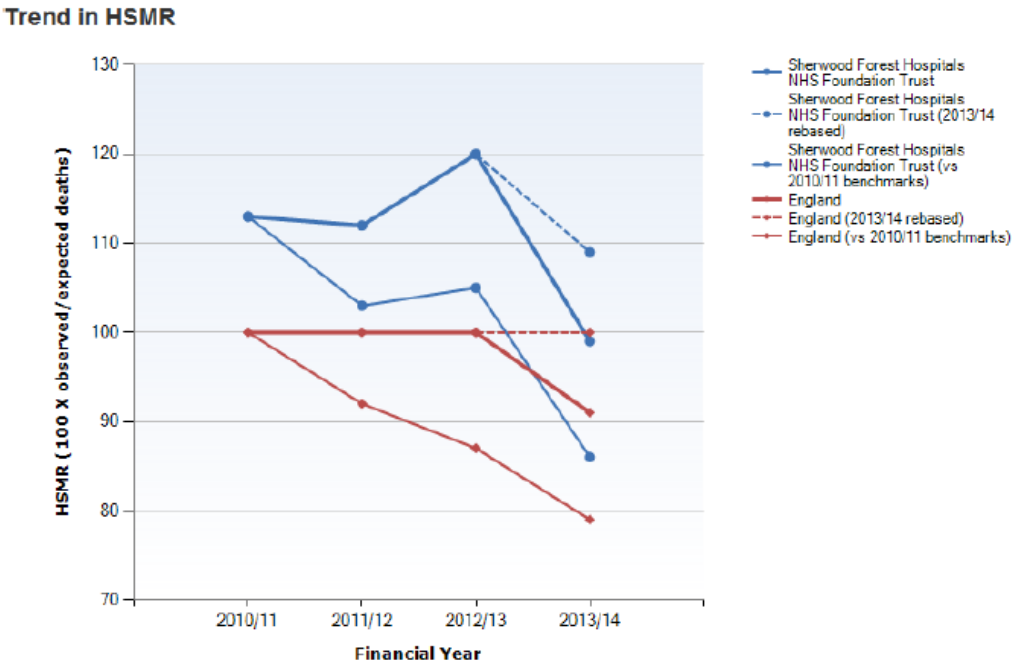
The data for the 4 quarters of 2013 show SFH within the expected range throughout, with a reassuring decrease quarter on quarter keeping us below the national benchmark for the last two quarters of 2013.



The other trusts shown here are our local peers:

- Nottinghamshire University Hospitals NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospitals of Leicester NHS Trust
- Derby Hospitals NHS Foundation Trust
- Northampton General Hospitals NHS Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust

The above figures are shown without rebasing. However, as the chart and data below show, after rebasing our relative position nationally will remain approximately the same.



HSMR Data

Rolling 12-month HSMRs calculated for a **basket of 56 diagnoses**.

	HSMR for the 12 months ending:						HSMR YTD
HSMR	**Mar 2011**	**Mar 2012**	**Mar 2013**	**Jun 2013**	**Sep 2013**	**Dec 2013**	**Apr 2013-Dec 2013**
Sherwood Forest Hospitals NHS Foundation Trust HSMR	**113**	**112**	**120**	**116**	**111**	**102**	**99**
Low	107	106	114	110	105	96	92
High	119	119	127	122	118	108	106
2013/14 rebased	-	-	-	**119**	**117**	**110**	**109**
Low	-	-	-	113	110	103	102
High	-	-	-	126	123	116	117
vs 2010/11 benchmarks	113	103	105	101	97	99	86
No default peer group defined HSMR							
2013/14 rebased							
vs 2010/11 benchmarks							
England HSMR	**100**	**100**	**100**	**99**	**97**	**94**	**91**
2013/14 rebased	-	-	-	100	100	100	100
vs 2010/11 benchmarks	100	92	87	86	85	82	79

The on-going mortality reviews are providing information regarding some of the apparent causes for increased mortality and identifying areas for improvement in our systems. These improvements are intended to create sustainable and robust processes within the organisation leading to increased confidence in the data we are presented with.

There has been a great improvement in coding. Only 10% of discharges were uncoded at the end of January, compared with 26% at the end of December. We aim to continue to decrease the percentage uncoded at the end of each month. This improvement will contribute to more reliable data in which we can have confidence.

3. Pressure Ulcer Reduction (Priority 2)

The organisation has clear targets for pressure ulcer reduction during 2013/14. The table below demonstrates actual numbers of avoidable pressure ulcers (by grade) in comparison to the contractual targets.

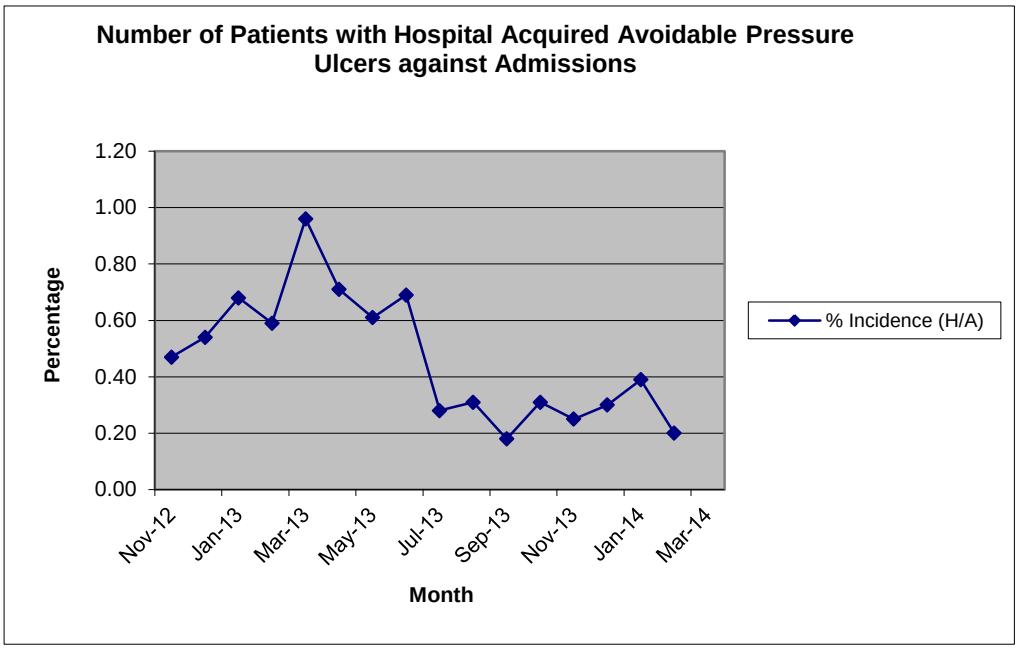
- Five avoidable grade 2 (Superficial ulcers) pressure ulcers developed in February breaching the target by 2. However it is a significant reduction compared to January when nine developed.
- Zero avoidable grade 3 (Deep ulcers) developed achieving the target.
- There have been zero avoidable grade 4 (Deep ulcers) pressure ulcers for 14 months.

Table1: 2013/14 SFH Avoidable Pressure Ulcer Reduction Trajectory

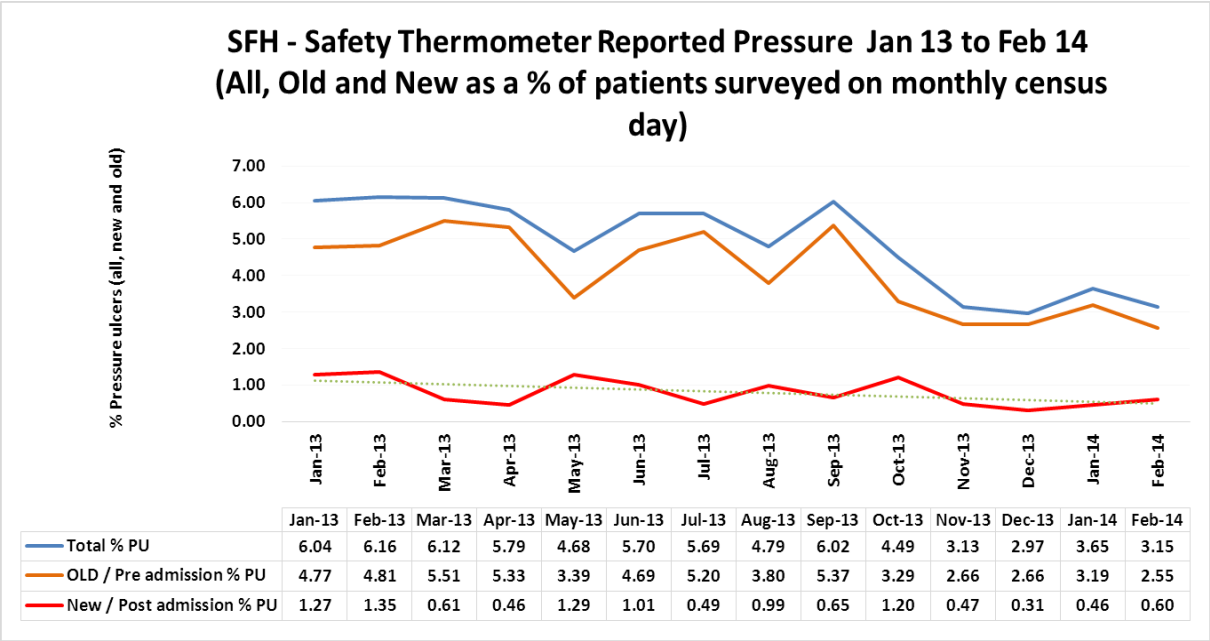
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Totals
GRADE 4													
2012 -13	0	0	1	0	0	0	0	0	1	0	0	0	2
2013-14	0	0	0	0	0	0	0	0	0	0	0		(0)
Target No. 13/14	0	0	0	0	0	0	0	0	0	0	0	0	0
GRADE 3													
2012 -13	0	0	0	0	4	5	1	3	2	4	1	4	24
2013-14	5	4	2	0	1	0	2	1	1	2	0		(18)
Target No. 13/14	3	3	2	2	2	2	2	1	1	1	1	0	20
GRADE 2													
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		(99)
Target No. 13/14	15	20	10	7	7	6	6	7	7	4	3	3	95

There has been 117 avoidable pressures ulcer against a target of 115. However to date the targets for the deep pressure ulcers (Grade 3 and 4) is on track with 18 grade 3's developing against the target of 20.

The number of avoidable pressure ulcers against patient admissions for the last 12 months gives the incidence rates demonstrated below. This graph demonstrates the significant reduction of 0.19% in February.



The safety thermometer data, which is the point prevalence census undertaken once a month across all inpatients areas. January's prevalence rate of 3.6% compares favourably to Chesterfield (6.9%) and Nottingham (4.4%), and the 8th top position within the 32 Acute Trusts across Midlands and East Region.



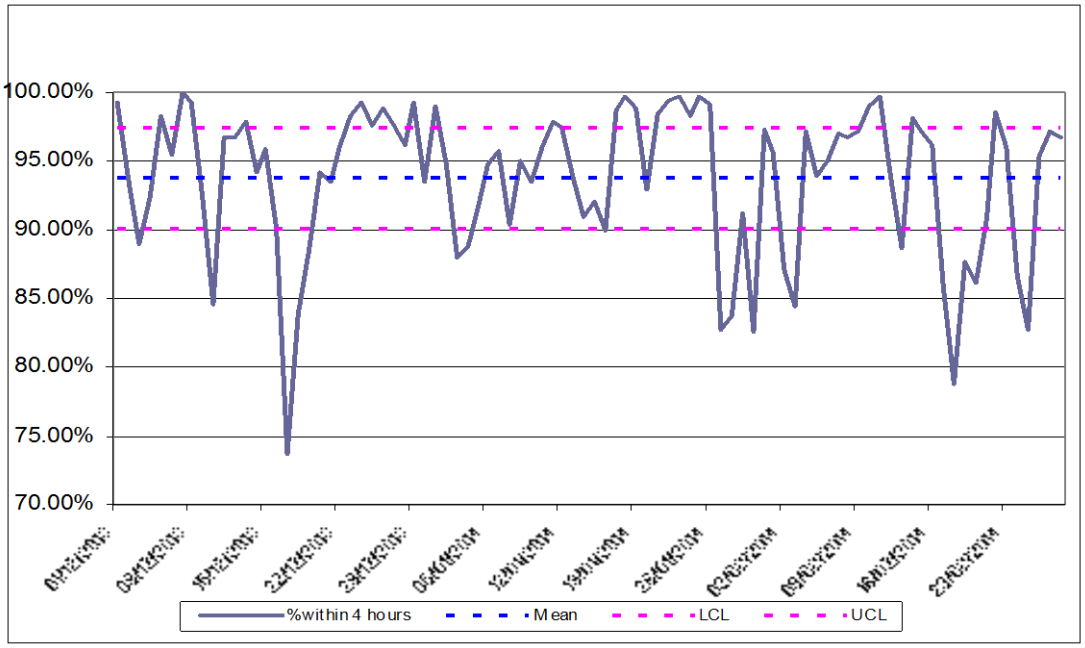
	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
Total % PU	6.04	6.16	6.12	5.79	4.68	5.70	5.69	4.79	6.02	4.49	3.13	2.97	3.65	3.15
OLD / Pre admission % PU	4.77	4.81	5.51	5.33	3.39	4.69	5.20	3.80	5.37	3.29	2.66	2.66	3.19	2.55
New / Post admission % PU	1.27	1.35	0.61	0.46	1.29	1.01	0.49	0.99	0.65	1.20	0.47	0.31	0.46	0.60

The start of this year has seen a focus on analysing the triangulated tissue viability data to clearly identify key areas where support is required. Collaboratively working with The Safety Team and the Falls Team who report similar findings with this group of vulnerable patients, has led to the development of a structured approach to manage their improvement, and reduce the harms, in the identified wards and departments.

4. Improved Patient Flow (Priority 3)

4.1 Flow within ED

Figure 1 Flow within ED

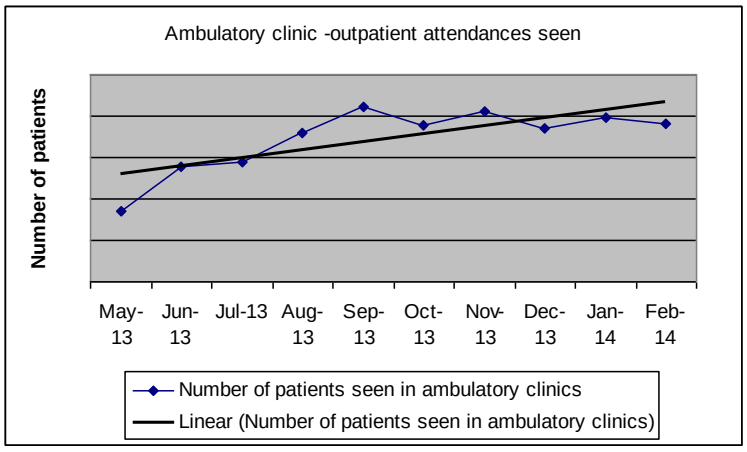


The Trust performance level for the four hour target in ED for the last quarter is shown above. Principle reasons for the variation remain periods of high demand, high occupancy of resus facility, wait for inpatient and psychiatric beds. Ambulance turn around for KMH variation is 19.13- 16.37 minutes and for Newark is 13.42 -10.06 minutes. We remain one of the most consistently achieving Trusts in the East Midlands on this measure. The number of ambulances has remained fairly consistent over December, January and February, averaging 76 to 78/day against the contracted number of 80.

Ambulatory Attendees

The number of ambulatory attendees has doubled since May 2013, see Figure 3. This is a very positive move, allowing patients to receive treatments that were in the past only available as an in-patient. However the number of patients has reached a plateau, due to current pathways and location, indicating that we need to do further work to explore ambulatory pathways both here and at Newark. A principal action for the next few months is to prioritise exploring new patient pathways to be treated in CDU or clinics.

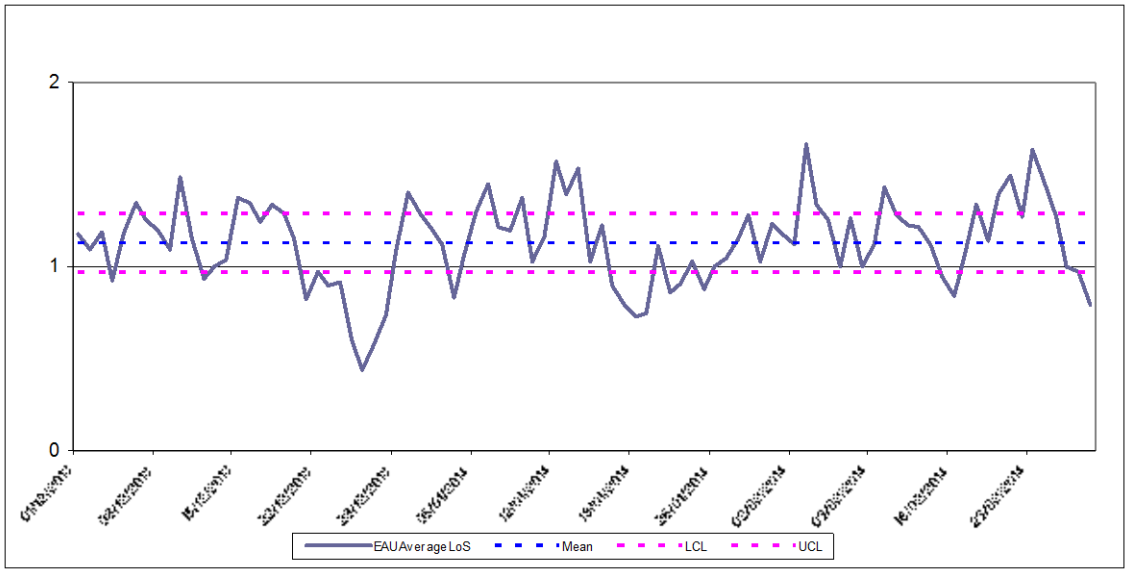
Figure 2 Ambulatory attendees



4.2 Flow within EAU

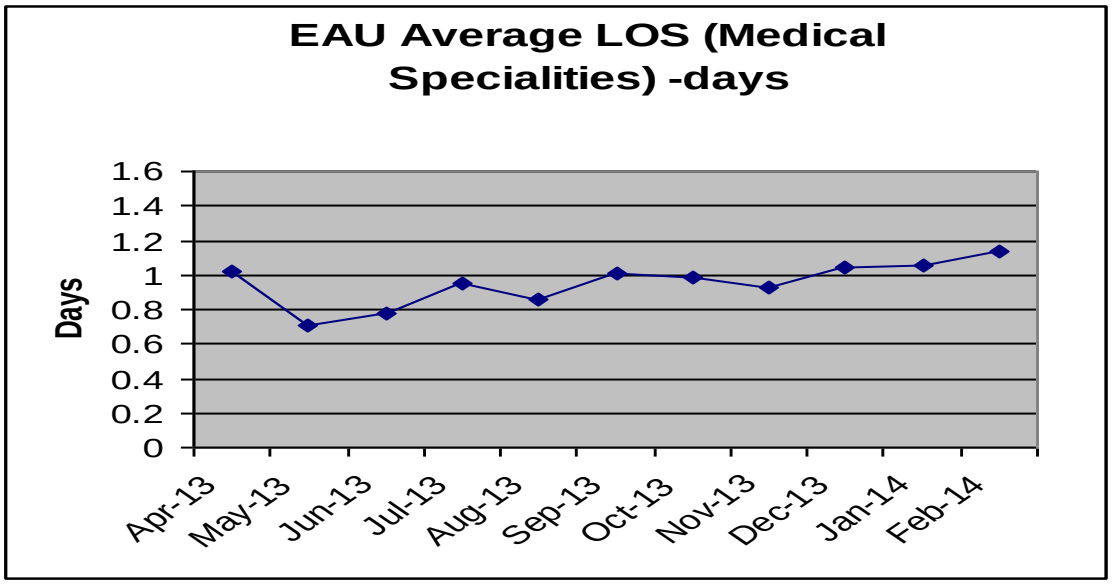
The overall flow for all patients for the last three months in EAU is shown in the graph below, the graph shows a system which is in control. Additional capacity within EAU has been open over the winter months. Principal actions are to research and write business case for a bedded and seated discharge lounge for later this year to help free capacity earlier on the wards, EAU and ED and create flow and focus on review of CDU and increase in ambulatory pathways.

Figure 3 Average length of stay in EAU



However for the last 12 months, the graph below shows a fairly static situation for average LOS for medical specialties, indicating that the regular board rounds on EAU, where the patients are reviewed against clinical need, length of time spent on EAU and beds available is ensuring patients do move to appropriate base wards.

Figure 4 Average length of stay EAU (Medical specialties)

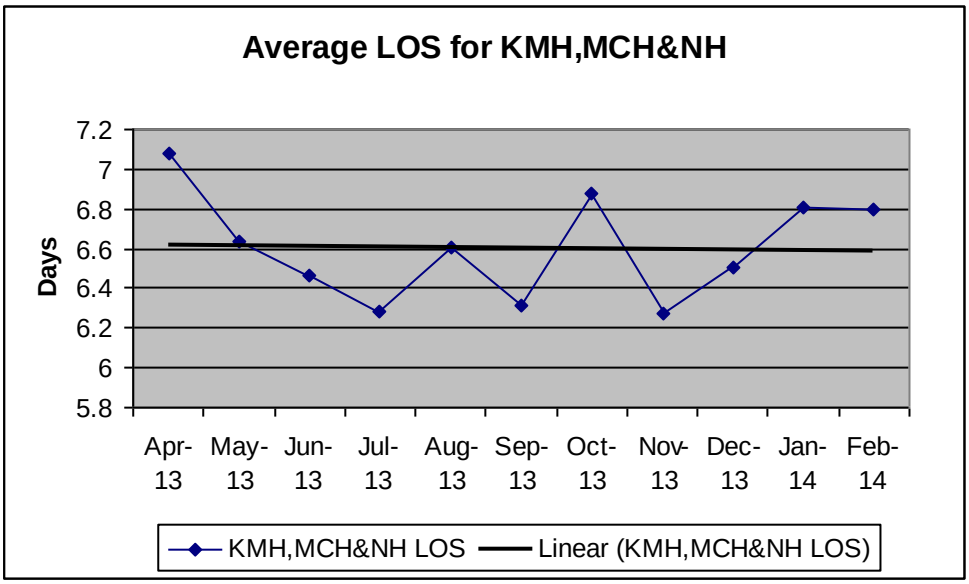


4.3 Flow within the hospital

Average Length of stay

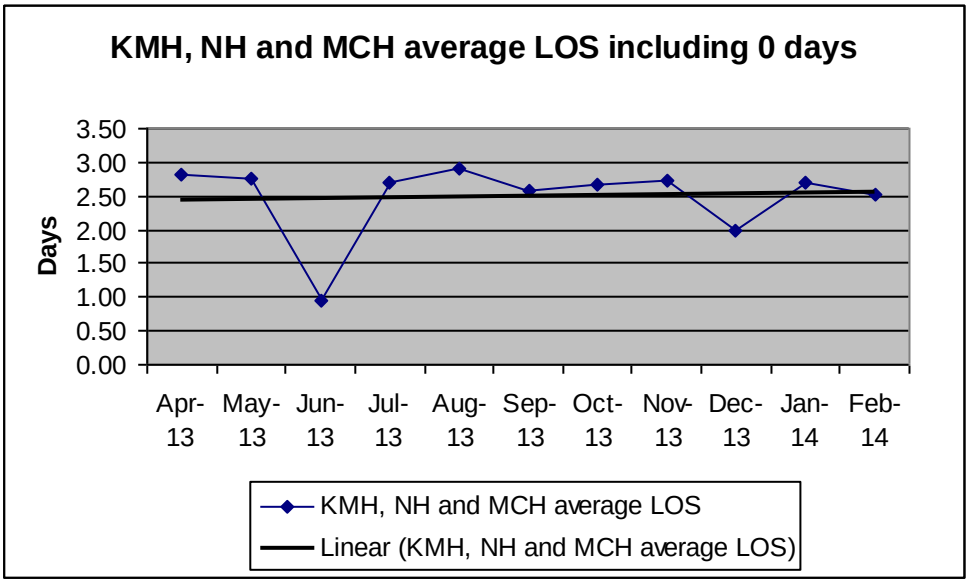
There are many ways of representing length of stay and we are investigating this further, however for this year we have reported average length of stay excluding zero length of stay and well babies.

Figure 5 Average length of stay



Many organizations include zero length of stay in their overall LOS calculation. This ensures all the work that has been done to ensure only patients who need to kept in hospital overnight is not lost

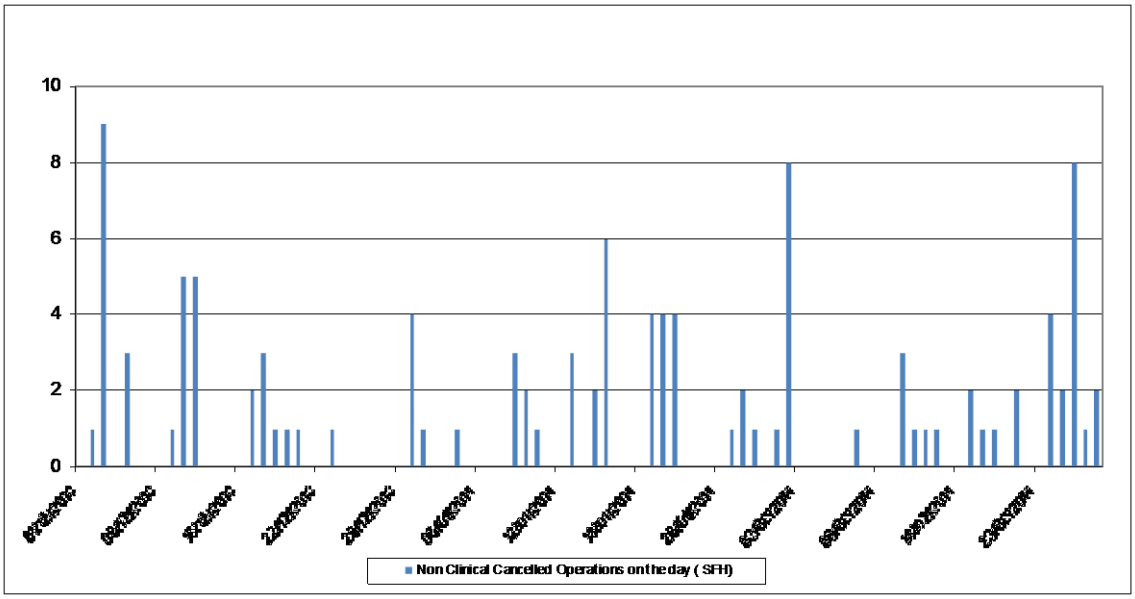
Figure 6 LOS including Zero length of stays



We remain focused on trying to improve the bed management system by reviewing the bed meetings and the use of Jonah to try to find a solution that works for all. An ECIST review is planned for patients who stay over 7 days in May, to involve primary and secondary care providers. Working with community partners to tag patient records if on a virtual ward or known to a community matron is also being explored as is an increase in training and support for ward staff on discharging patients.

Cancelled operations

Figure 7 Cancelled operations

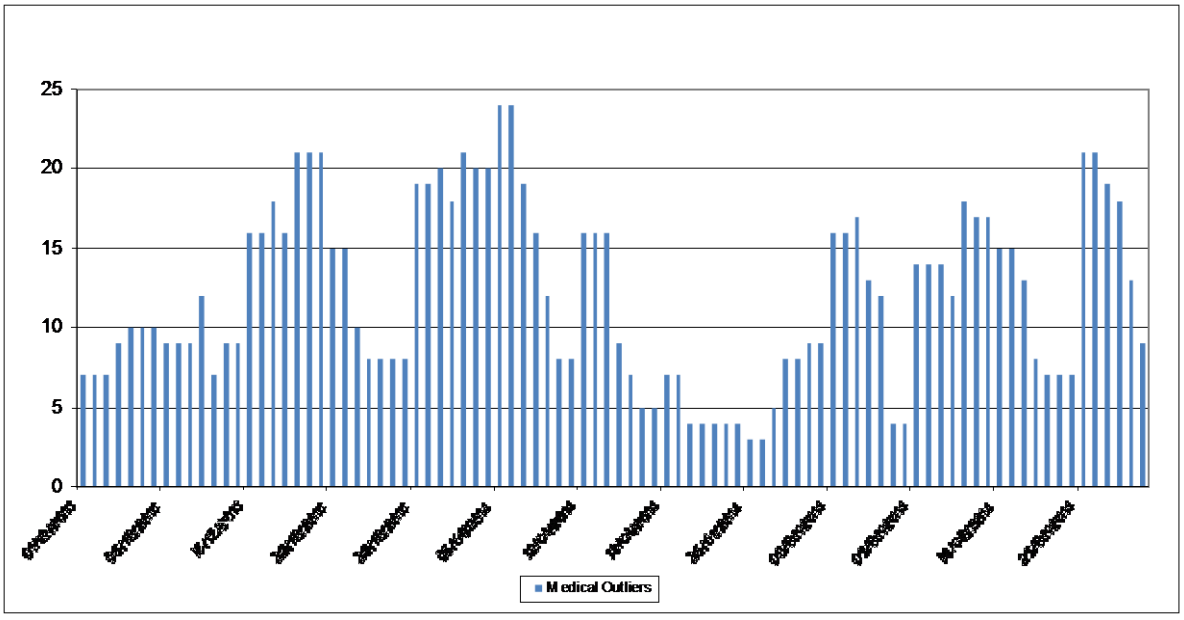


The Lists overrunning have been the principle reason for cancellations. Newton Europe have been working with theatre staff and two strategies have recently been introduced to address this problem. Morning and afternoon lists have been extended from 3.5 hours to 4 hours and the theatre staff now have regular scheduling meetings when then plan for the next month so they improve the utilization of facilities and people.

4.4 Medical Outliers

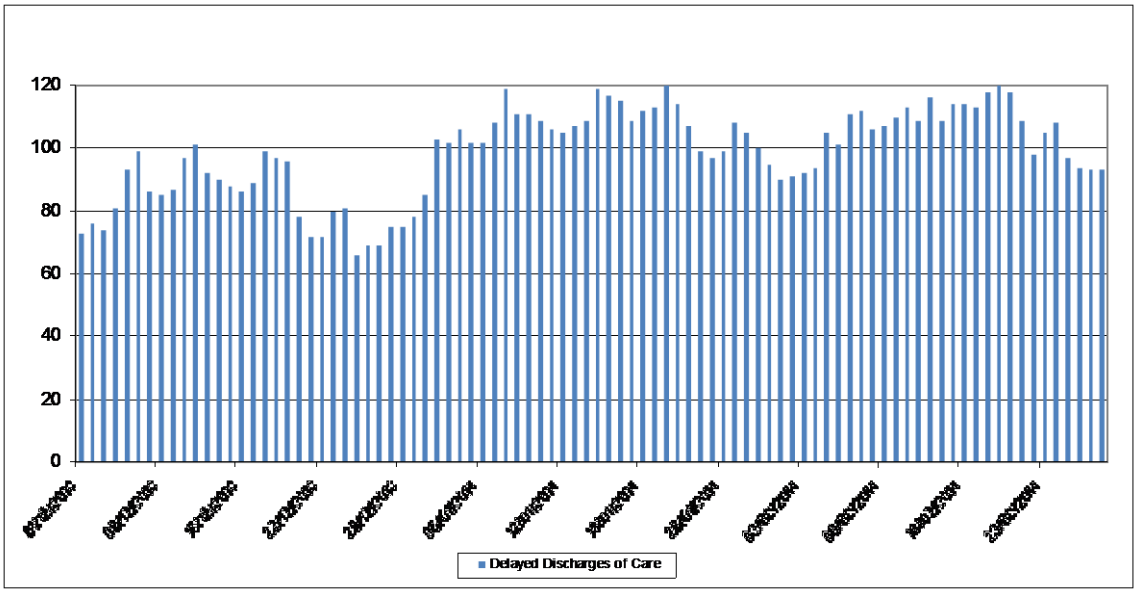
The graph below shows significant variation in medical outliers. The measure of medical outliers appears to be a good measure of when the system feels under stress. The overall number has increased from the previous quarter however the degree of variation remains the same. An outlier policy has now been ratified and the risk assessment process is being regularly audited so that if patients do have to outlie it is a safe process.

Figure 8 Medical outliers



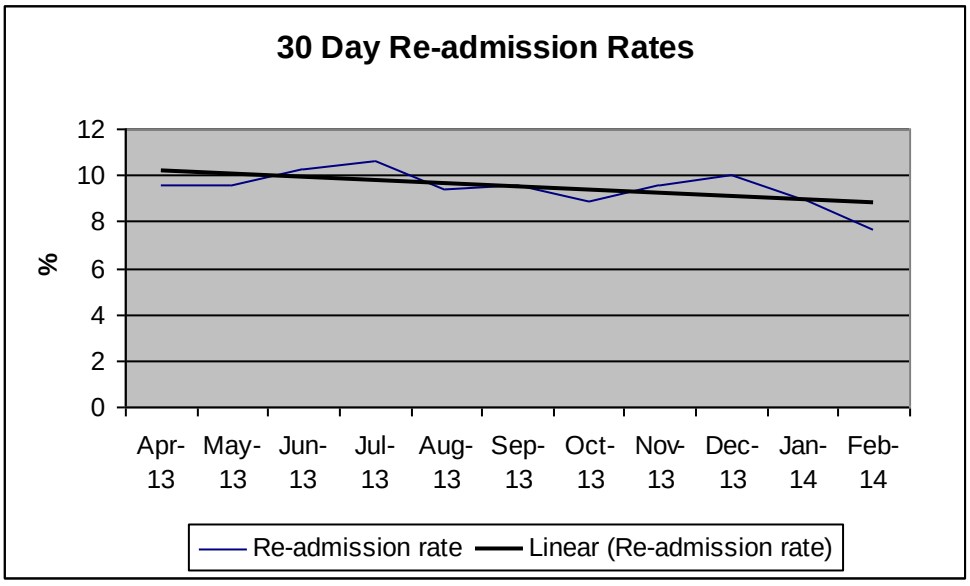
4.5 Delayed Discharges & Readmissions

Figure 9 Delayed discharges



The delayed discharge of care has increased over the last quarter. These are medically fit patients who are ready for discharge but are waiting for care packages, care home beds, or families to make choices over care. 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 policy is currently being reviewed to ensure staff receive the right level of support to implement.

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. A group has been set up where SFHT staff can contribute to analysis of failed discharges and inappropriate admissions. This goes across the community and hospital environment.



4.6 Monitoring & reporting for sustained improvement.

We are currently carrying out a review of quality reporting methods, data available within the organisation and appropriate benchmarking information so similar data is being compared. The aim is to move towards incorporating specific HRG level data to allow meaningful comparisons for LOS data for next financial year.

The 'Better Together' CQUIN for 2014/15 which is about supporting the whole system to improve care for emergency admissions provides us with an excellent opportunity for collaborative working and transformational change. This will underpin this improvement work in the coming months.

5.0 Patient Experience & Complaints

5.1 Complaints Performance - Current Position

During February 2014 the Trust has seen a drop in complaints received; receiving 33. The workforce change to establish a new patient experience (complaints, PALS, volunteers) structure is still underway and is expected to be in place by June 2014. The complaints department has suffered the loss 2 members of staff however this has been rectified by employing an interim complaints officer who has many years' experience. Interviews have taken place for 4 secondment positions and 3 candidates were appointed; one of which will start in the next two weeks followed by the other two in a month's time.

The complaints manager has continued to be visible on the wards, which is continuing to be beneficial.

Many complaints continue to be resolved locally by front line staff where possible. The Trust actively encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. This timely intervention can prevent an escalation of the complaint.

Planned Care & Surgery have visited people in their homes in the past 12 months to discuss their complaints as a way of resolution and this has proved to be successful.

Number of complaints received February 2013 = 73 **Number of complaints received February 2014 = 33**

The flow of complaints within each department has dropped significantly in February, although the number of complaints received in PLANCS continues to remain the highest. February 2013 saw PLANCS receiving 25 formal complaints compared to 17 for February 2014, this equates to a 68% decrease. EMCAM has received a decreased number of complaints (11) compared to the same period last year (38), D&R has also seen a drop (5) compared to the same period last year (7). Corporate Development/ Central Services have not received any complaints in February 2014 compared to 3 complaints received in February 2013.

5.2 Comparison of complaints received in February 2013 and 2014

Table 1

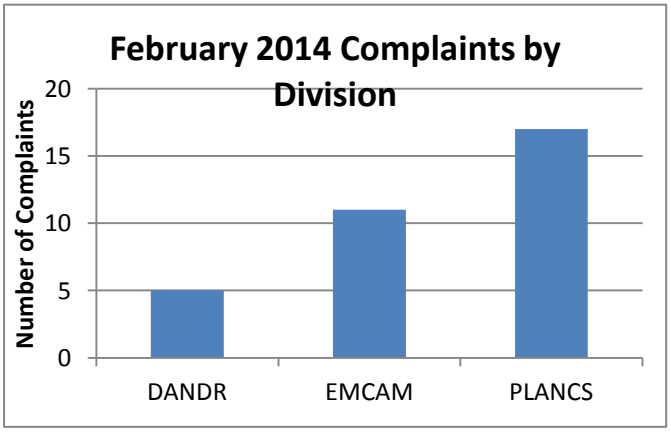
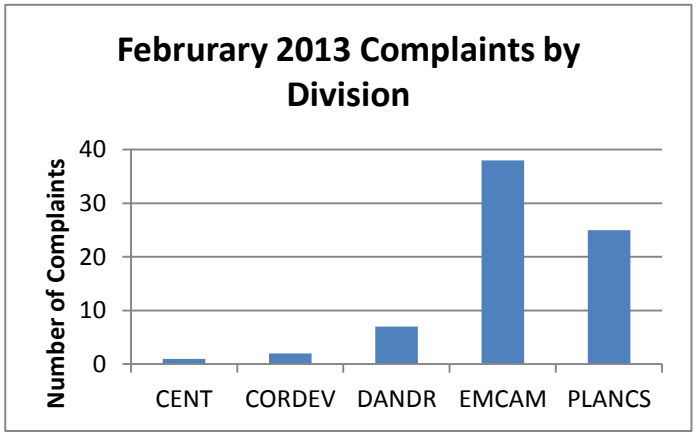
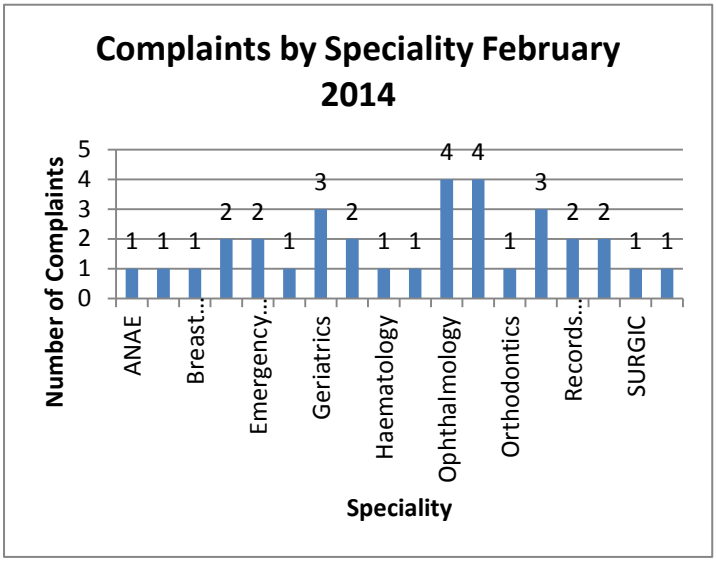


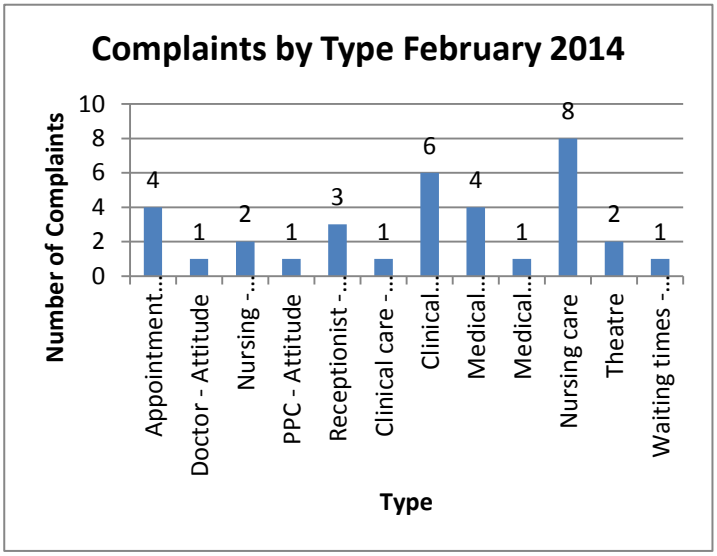
Table 2



5.3 Complaints received by specialty and type for February 2014

Table 3 & 4





5.4 Complaint Response Times

During February we responded to and closed 42 complaints. Twenty-five of these were responded to in the agreed timeframe and 17 needed to be extended because of their complexity. This performance equates to 60% of complainants receiving their response within the given timeframe however within legislation this is acceptable as the overall timeframe given is 6 months. All complainants are sent a holding letter if their response is going to breach the 40 day timeframe originally given.

The current legislation states that all complaints should be acknowledged within 3 working days and this target was met throughout February at 100%. The Trust standard is that all complaints are acknowledged on the day of receipt and a full and final response within the agreed timescale of 20, 40 or 60 days however due to the volume of complaints received a timeframe of 40 days is given .

5.5 Reopened complaints

Since the beginning of this financial year (1.4.13 – 28.2.14) 650 complaints have been received. The Trust has reopened 77 of these complaints (12%) for further investigation and response; however some of these relate to the previous financial year. In comparison to the same period last year there were 699 complaints received with 87 reopened (13%).

The complaints department continues to offer every complainant (new or reopened) a Local Resolution Meeting (LRM) to discuss their complaint with the appropriate members of staff. This has proven to be extremely beneficial to both the complainant and the Trust and at present we are in the process of setting up 35 meetings. During February there has been 7 LRM's with 1 being held for a reopened complaint.

Table 5

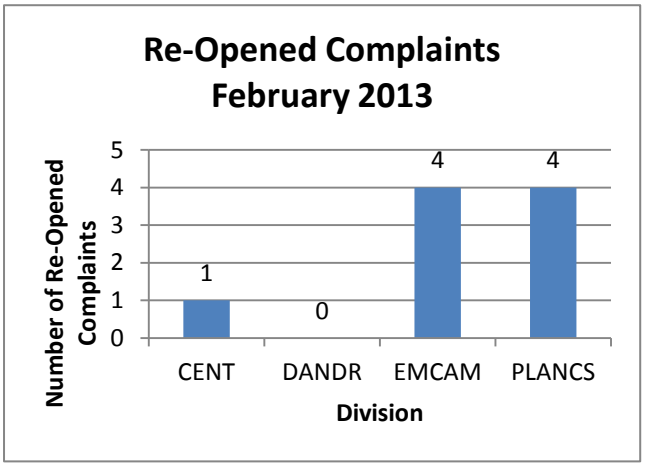
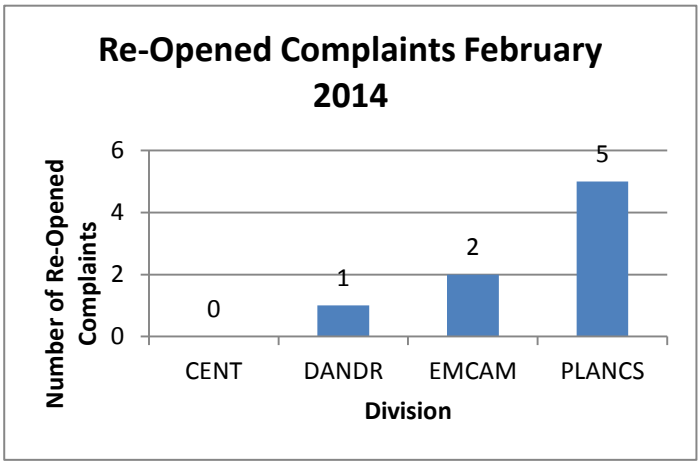


Table 6



5.6 Themes

The Trust actively monitors the key themes identified in complaints and is now working towards triangulating this information with information generated through other sources of feedback such as patient surveys. Each Division is responsible for critically reviewing key themes to identify actions required to improve service delivery and the patient experience. The Trust recognises the importance of lessons that can be learned from complaints, and the Trust wide value in sharing these with appropriate members of staff.

To ensure organisational learning from complaints, any recommendations made following investigation of a complaint are recorded and monitored.

It can be seen in Table 8 that the Trust has received a decreased number of complaints in all areas compared to the same period in February 2013.

Table 7

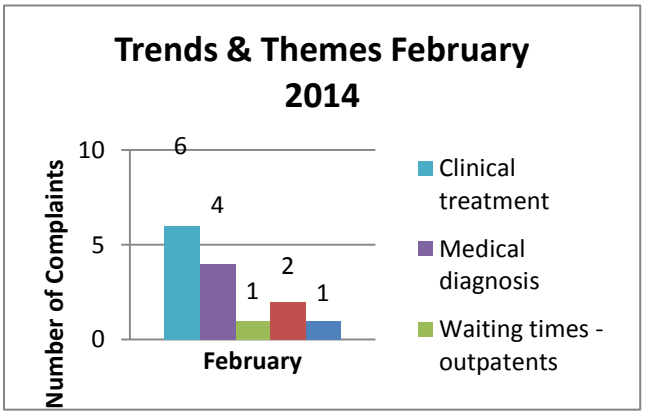
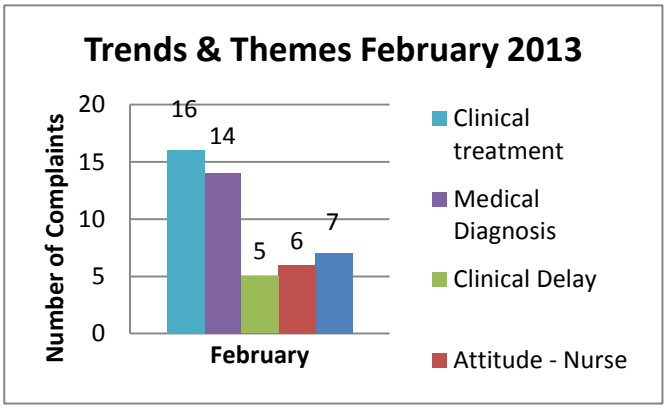


Table 8



Clinical treatment is the top theme for complaints received in February 2014; there is a significant drop in complaints received regarding attitude of doctors and nurses compared to the same period last year. However overall attitude is still a problem receiving a further 3 complaints about receptionists (2 in the Bereavement Centre, 1 in clinic) and 1 about the attitude of a Patient Pathway Coordinator on top of those received about doctors and nurses. The 'Quality for All' initiative being launched at the Trust in March 2014 will be a vehicle for strengthening staff values and behaviours.

5.7 Complaints Satisfaction Surveys

During Quarter 4, we have begun sending patient satisfaction surveys out to complainants approximately 6 weeks after their complaint has been closed. Forty-two surveys have been sent out during February 2014 however to date we have not received any back as yet even though we do provide a SAE. This is a common problem throughout complaints nationally and there has been some talk of withdrawing this element of the process. We are therefore looking at other ways for complainants to feedback, such as on line options to make it as easy as possible for them to respond.

The Complaints department will complete the annual KO41 returns to the Department of Health at the end of March 2014.

5.8 Parliamentary Health Service Ombudsman (PHSO)

Under the current complaints legislation, Trusts have six months in which to endeavor to resolve a complaint to the complainant's satisfaction. If the complainant remains dissatisfied with the response they receive, they can ask the Ombudsman to independently review their complaint.
The Ombudsman may:

- Refer the complainant back to the Trust to complete 'local resolution'
- Ask the Trust to consider if further local resolution is an option
- Request the case file for screening assessment
- Having assessed the case file, decide not to investigate further
- Having assessed the case file, appoint an Investigating Officer to carry out a review 'on paper'

In February 2014, 2 new complaints were referred to the PHSO for review.

Currently there are 18 cases with the PHSO however one of these is on hold whilst the GMC are investigating. One case was partly upheld relating to nursing care and the Trust was asked to pay the complainant £750; one case investigated by the PHSO and was not upheld.

5.9 Lessons learned and actions taken:

The following are examples of complaints closed from each Division during February and actions taken:

Emergency Care & Medicine

Complaint: Transfer of a patient from one ward to another

We answered……

I believe some of the important information, particularly relating to his transfers, should have been communicated to you, but it appears that there is a lack of communication on our part.

I am extremely sorry for the lack of communication on the part of my team and extend my apologies for any distress this has caused. I would also like to mention, learning from the above, changes have been made in the department to ensure that all relevant information is given to family members in future.

Planned Care & Surgery

Complaint – Clinical treatment at Newark Hospital (availability of services)

We answered…..

With regards to your attendance at Newark Hospital, we endeavour to balance between the (definite) need for timely assessment and the (possible) need for more intervention or care than can be offered at Newark Hospital. Many patients who ring for advice in these circumstances are quickly assessed at Newark and are re-assured or given basic level treatment, and sent home. For those patients who live closest to Newark Hospital, we save them a wasted journey and time on an unnecessary attendance at King's Mill Hospital.

For the few patients who do require more in-depth investigations and treatment, we can phone ahead to King's Mill Hospital to alert the appropriate medical team, gain some advice for the interim period and then quickly transfer the patient to the right team at King's Mill Hospital. I can understand that attending Newark Hospital and then needing to be transferred to King's Mill Hospital was a stressful and difficult time for you. The team will re-examine the advice they give to patients in the circumstances you describe to see if we can improve the patient journey in the future.

6.0 Serious Incidents

There were 9 Serious Incidents uploaded onto STEIS (Strategic Executive Information System) during February 2014. This compares to 5 incidents reported during January 2014. The numbers of Serious Incidents reported per month can be seen in the table below.

July 2013 –February 2014	October	November	December	January	February
Number of Serious Incidents	10	7	6	5	9

- As at 5th March 2014 there are a total of 29 serious incidents open on Strategic Executive Information System (STEIS)
- As at 5th March 2014 there are a total of 24 serious incidents which are within timescales and being investigated and 5 which are outside of timescales
- As at 5th March 2014 there are a total of 5 serious incidents for which closure has been requested from the CCG but remain open on STEIS.
- There were no Never Events in February 2014

Serious Incidents by Division

	January 14	February 14
Emergency Care Medicine	3	5
Planned Care & Surgery	2	3
Diagnostics & Rehab	0	1

6.1 Patient Safety Incidents (Datix reported)

Over the next 3 months, Datix Reported Incidents with severity coding of either **'Catastrophic death'** or **'Severe harm'** will be revalidated and re categorised to either patient safety related on Non-patient safety related codes. Datix does not have the functionality at the present time.

The patient safety lead and the clinical governance lead will be undertaking this piece of work to ensure robust and correct identification of patient safety incidents for the start of the new reporting year.

7.0 Nursing Update

7.1 Successful Technology Fund Bid

In 2012, Prime Minister David Cameron announced that £100m would be made available over the next 2 years to fund nursing technology projects that deliver real improvements to patient care and safety. At the start of 2014, Trusts were invited to bid for £30m for the first round of funding, with a further £70m to be released next financial year. The applications had to be led by nurses and each trust could apply for a maximum of three projects in the first round.

We have been successful in being allocated £191,145 to deploy the VitalPAC vital signs monitoring system, which will help nurses to work in new ways to strengthen observations and assessment of patients. The funding will contribute to the overall costs of the implementation of VitalPAC in Spring 2014.

Jane Cummings, chief nursing officer for England, said: “We received an amazing response to application process and the decisions on choosing the successful projects have been difficult. "It has always come back to one key question – how will this project deliver real, practical benefits for nurses, midwives and care staff and their patients.”

We have also submitted an outline bid for the 2014/15 nursing technology fund. This would enable us to:

- Deploy tablet devices to nursing staff within our wards and clinics. We would allocate these to the ward and department coordinators within clinical areas and senior nurses to undertake their nursing metrics
- Provide mobile devices and smart phones for use outside of the hospital location. These would be deployed to relevant nurse specialists who run community clinics or make home visits.
- Maternity IT solutions would be implemented within both hospital based and community midwifery services.
- Procure mobile devices to support patient experience data collection that would be allocated to the ward and department leaders in relevant clinical areas.

We await the outcome of this submission, which is expected in the next few months.

Last year, we successfully bid for £65,000 from the Safer Hospitals, Safer Wards Technology Fund. We are utilizing this funding to replace our current care metrics system and are currently working with IT colleagues to identify a suitable system that will help to support the work we are doing to drive improvements and create a robust assurance framework.

7.2 Compassion & Nursing Care Master Class

In March 2014, 10 of our senior nurse leaders attended a Master class on Compassionate Care. This was an event that brought nurses together from a number of local organisations to hear senior academics from the National Nursing Research Unit, Kings College and the Institute of Care and Practice Improvement. There was opportunity to reflect on current nursing practice and debate key areas of work that we could take forward across our organisations, including the implementation of Schwartz Rounds, which allow NHS staff to assemble monthly to reflect on individual dilemmas and professional challenges they have faced.

We hope this will be the start of some further collaborative working between SFH, NUH and other partners and will support the delivery of our Nursing and Midwifery Strategy.

8.0 PLACE (Patient Led Assessments of the Clinical Environment)

8.1 Background

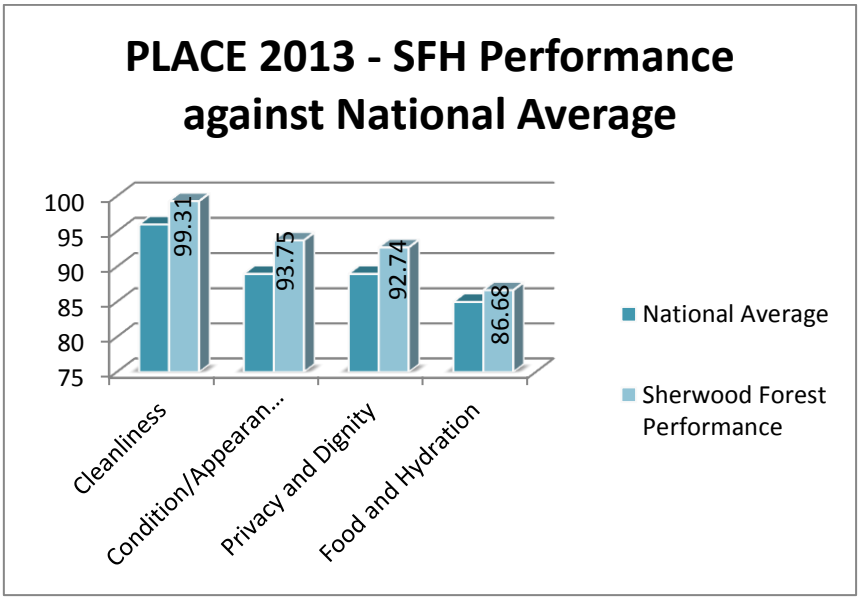
- In 2013 the annual PEAT (Patient Environment Action Team) audits were replaced by PLACE (Patient Led Audits of the Care Environment)
- The focus of the audit remains the care environment from a patient perspective
- The Trust has always had enthusiastic support from a dedicated team of patient representatives throughout the PEAT process and has never undertaken an audit without patient involvement
- The changes were around the structure and format of the audit

8.2 Recent Changes

- The audits must involve a 50/50 split between staff and patient representatives – we have always have an excellent level of engagement with our patient representatives and it has been good to further strengthen this.
- As well as participating in the audit each patient representative is required to complete a section independently on how the audit was undertaken and to confirm their voice was heard
- Every individual area audited has to have the findings submitted on separate audit sheets
- Changes to the scoring regime to pass, qualified pass or fail
- Introduction of a number of organisational sections, food service and the estate
- The team are to develop an action plan which is then signed off by the Board, publicised and performance against the action plan is monitored during the year

8.3 2014 Audits

The PLACE audits for 2014 have now begun. Newark hospital was completed on 28.02.14 and indicative results show an excellent audit. These results are currently being processed. Further audits will be undertaken at Mansfield Community Hospital and Kings Mill Hospital over the next two months. Our 2013 results are shown below and the Board will receive an update once all of these reviews have been undertaken across all sites.



9.0 Summary of Discussions at Clinical Governance and Quality Committee

This report summarises the discussions and decisions made, and the assurances received at the Clinical Governance and Quality Committee (CGQC) held on February 26th 2014.

Members

Peter Marks	-	Non-Executive Director (Chair)
Susan Bowler	-	Executive Director of Nursing and Quality
Tim Reddish	-	Non-Executive Director
Gerry McSorley	-	Non-Executive Director
Claire Ward	-	Non-Executive Director

Attendees

Karen Fisher	-	Director of Human Resources
Nichola Crust	-	Head of Governance
Nigel Nice	-	Public Governor
Elaine Moss	-	Director of Quality and Governance – Newark & Sherwood and Mansfield & Ashfield Clinical Commissioning Group
Suzanne Morris	-	Nurse Consultant, Infection, Prevention & Control *(E-Coli and ICNET item only)*
Haneef Khalid	-	Datix Project Manager *(Outline of the Datix Project item only)*
Shirley Clarke	-	Head of Programme Management *(Keogh and CQC action plan item only)*

Apologies

Jacqui Tuffnell	-	Director of Operations
Andrew Haynes	-	Interim Executive Medical Director
Fran Steele	-	Chief Financial Officer

<u>Serious Incident MB</u>

SB provided information of the serious incident regarding a stroke patient who was referred from EMIAS to SFH for thrombolysis. A complaint has been received and a full multi-agency investigation has commenced to ascertain the facts of what happened from the point of the emergency call through to the eventual admission.

The group agreed that the draft response to the CCG's should be presented at next month's meeting along with an update on this serious incident.

<u>BAF and Corporate Risk Register</u>

It was noted that the BAF and Corporate Risk Register had been circulated to the group to map the risks that may concern and be driven by the Clinical Governance & Quality Committee. It was agreed that the BAF should drive this agenda.

The committee agreed that we should ensure that risks are being scored correctly, that the mitigating controls are evidenced and any actions still required to mitigate the risks. It was noted that some risks may not fit into a sub-committee and these may need to be allocated out.

It was agreed that part of the next meeting should be used to identify items for monitoring at the Quality Committee and how other committees will provide assurance of their risks. Regular updates would be required to ensure the BAF remains a live document.

Keogh & CQC Action Plan

This item was discussed in detail.

It was noted that an initial Rapid Response Review undertaken by the Keogh panel took place in June 2013 and resulted in a report and risk summit which identified 13 urgent actions and 10 high and medium actions. An assurance review was undertaken by the Keogh panel in December 2013. The review assessed the Trusts 23 actions and recorded 6 as 'assured' and 17 as 'partly assured'.

The actions identified from the Assurance Review in December were consolidated with actions from the parallel CQC inspection and the PWC report in respect of quality governance. Once all the actions have been implemented there will be an audit of the relevant areas to ensure sustainability is achieved and evidenced.

Committee members agreed to complete ward to board visits throughout March and that the time out day on 10th April should be used to decipher any actions that have not been completed.

Timetable for Quality Account

It was agreed that the Quality account will be submitted to Quality Committee, then audit committee and finally to the Trust board. We will require an extraordinary meeting to review the quality account in April.

This committee has the responsibility for ensuring its accuracy and recommending to the Board it is ready for further board input.

Mandatory Training Update

KF reported that the achievement of acceptable levels of mandatory training compliance remains a priority for the Trust but continues to be a significant challenge. Part of the problem with achieving agreed compliance rates is due to the unacceptable levels of DNAs/short notice withdrawals. This means that a significant number of places (797) have been lost since April due to non-attendance/late cancellation and managers are now struggling to book staff onto programmes due to lack of availability.

Initiatives have/will be introduced in order to secure increased compliance levels. These will be reviewed in eight months in order to assess their effectiveness and identify further actions required.

Breakaway and Physical Intervention Training

KF reported that as a result of a Health and Safety Executive visit an action plan was developed to mitigate the risks and issues identified. As part of the action plan the Trust identified 10 high risk areas for which a physical intervention training was required and a programme was developed and implemented for nursing staff.

Training programmes have been on-going utilising both internal and external resources. However, challenges remain in releasing staff to attend the programmes available. A review of the risk assessed areas has been undertaken and there are now 11 high risk areas for whom the training will be made available.

Susan Bowler

Executive Director of Nursing & Quality