Sherwood Forest Hospitals NHS
NHS Foundation Trust

Agenda Item:

Board of Directors Meeting Report

Subject: **Monthly Quality & Safety Report**
Date: **Thursday 27th February 2014**
Authors: **Susan Bowler / Amanda Callow / Andrew Haynes**
Lead Director: **Susan Bowler – Executive Director of Nursing & Quality**

Executive Summary

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

- For HSMR our headline position is therefore on track with an HSMR of 102 and within range reflecting the improvements made in 2013.

- Pressure ulcers – In January two deep pressure ulcers (Grade 3) developed against our target of one. Nine avoidable grade 2 (superficial) ulcers developed against our target of 4. Causes will be investigated at the Ward Assurance Meeting

- The Trust average length of stay (LOS) in January was 6.81 days against a Trust target of 6 days. This shows a slight deterioration. De Foster analytical data confirms that the trust LOS is 0.5 days longer than expected. Since April 2013, a number of service developments have been instigated and as a result of these changes it is becoming paradoxically more appropriate for length of stay to increase rather than decrease.

- Complaints – The Trust is still receiving a high number of complaints (a detailed report was provided last month) – 62 in January 2014. Planned Care and surgery have seen a substantial increase in numbers – this is currently being investigated and will be reported back at the Board meeting. Responses are within the six month legislative timescale but the Trust is challenged to maintain its own internal target

- Infection control – In terms of *C Diff* performance, there have been 30 *C Diff* cases against a total year trajectory of 25.

- Vitalpac – this project is now underway and has the support of a designated project manager. Implementation of the system is currently planned for spring 2014 and the specific timescales and milestones are being discussed at the Vitalpac Programme Board.

- Summary of Discussions from Clinical Governance & Quality Committee

Recommendation To note the information provided and the actions being taken to mitigate the areas of concern

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	Achieve financial sustainability
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	BAF 1.3, 2.1, 2.2 2.3, 5.3, 5.5 Mortality, C Diff & Complaints on corporate risk register
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Failure to meet the Monitor regulatory requirements for governance - remain in significant breach. Risk of being assessed as non-compliant against the CQC essential standards of Quality and Safety Failure to meet 2013/14 infection control trajectories – impacts on governance risk rating
Links to NHS Constitution	Principle 2, 3, 4 & 7
Financial Implications/Impact	Potential contractual penalties for C Difficile, Pressure Ulcers, Never Event and MRSA
Legal Implications/Impact	Reputational implications of delivering sub-standard safety and care
Partnership working & Public Engagement Implications/Impact	This paper will be shared with the CCG Performance and Quality Group.
Committees/groups where this item has been presented before	A number of specific items have been discussed at Infection Prevention & Control Committee, Pressure Ulcer Strategy Group, Nursing Care Forum, Clinical Management Team and Clinical Governance & Quality Committee
Monitoring and Review	Monitoring via the quality contract, CCG Performance and Quality Committee & internal processes, e.g. Clinical management Team & relevant committees/forums
Is a QIA required/been completed? If yes provide brief details	No

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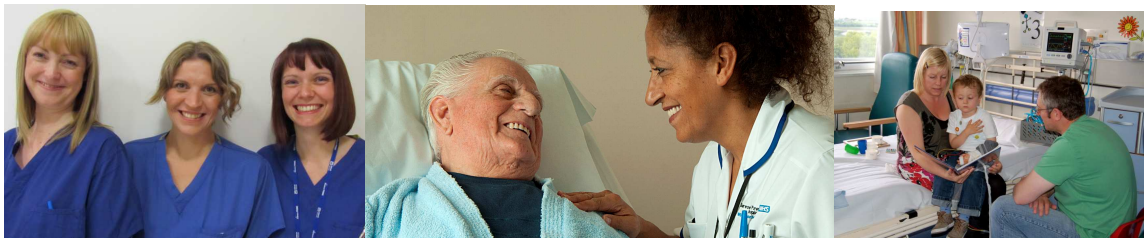


TRUST BOARD OF DIRECTORS – FEBRUARY 2014

MONTHLY QUALITY & SAFETY REPORT

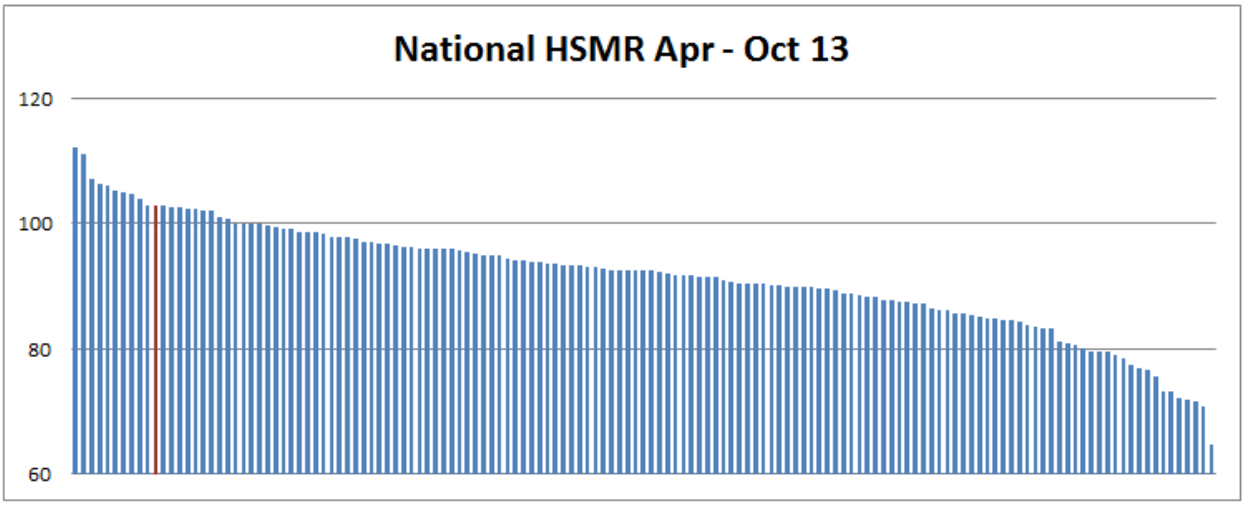
1. Introduction

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 all of 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 latest Dr Foster Intelligence data shows the trust position for April to October 2013 relative to national performance. We have made progress from the April 2012 – March 2013 position where the HSMR was 120.



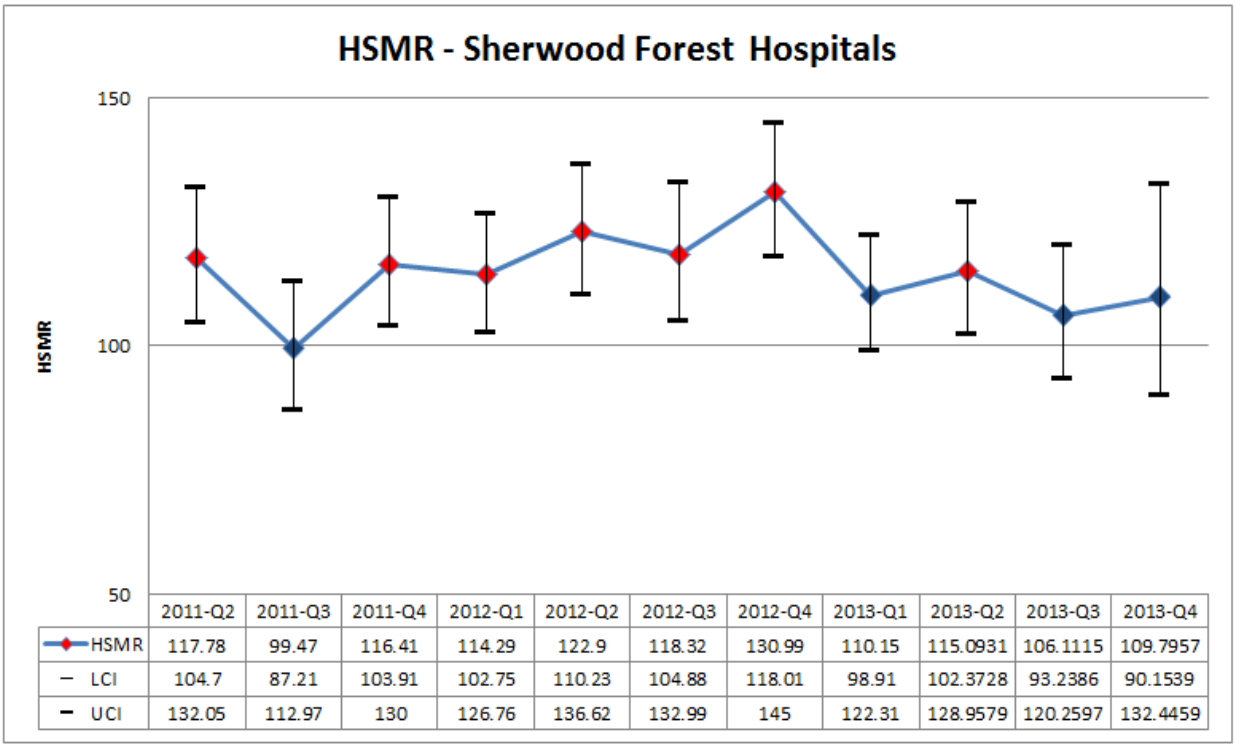
Local benchmarking shows our performance against a peer group and Newcastle as a buddy organisation.

Basket: Diagnoses - HSMR Benchmarks: Data Year Outcome: Mortality (in-hospital)
Chapter: All Diagnosis Group: All Department: All Team: All
Admission Type: All Sex: All Deprivation: All Age Range: All
Spells: 2582132 Superspells: 2542246 (1609511 / 932735) First / Last: Apr-13 / Oct-13 Deaths: 93926 (3.7%) Expected: 102542.8 (4.0%)
Relative Risk: 91.6 (91.0 - 92.2) C-Statistic: 0.84 (High) LoS: 7.7 / 8.5

Peer (NATIONAL)	Spells	Superspell	% of a	Death	%	Expecte	%	RR	Low	High	
Sherwood Forest Hospitals NHS Foundation Trust	13522	13383	0.50%	648	4.80%	630.1	4.70%	102.8	95.1	111.1	11
Nottingham University Hospitals NHS Trust	38555	37910	1.50%	1273	3.40%	1272.7	3.40%	100	94.6	105.7	21
Derby Hospitals NHS Foundation Trust	25666	25483	1.00%	1067	4.20%	1099.5	4.30%	97	91.3	103	37
Chesterfield Royal Hospital NHS Foundation Trust	13508	13316	0.50%	607	4.60%	648.6	4.90%	93.6	86.3	101.3	60
Sheffield Teaching Hospitals NHS Foundation Trust	48151	47405	1.90%	1294	2.70%	1399.7	3.00%	92.4	87.5	97.6	73
United Lincolnshire Hospitals NHS Trust	31302	31207	1.20%	1236	4.00%	1348.7	4.30%	91.6	86.6	96.9	77
University Hospitals Of Leicester NHS Trust	41412	40819	1.60%	1379	3.40%	1510.9	3.70%	91.3	86.5	96.2	81
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	37501	36126	1.40%	820	2.30%	951.6	2.60%	86.2	80.4	92.3	110
Northampton General Hospital NHS Trust	17747	17513	0.70%	601	3.40%	701	4.00%	85.7	79	92.9	111
Kettering General Hospital NHS Foundation Trust	14131	14015	0.60%	524	3.70%	614	4.40%	85.3	78.2	93	113

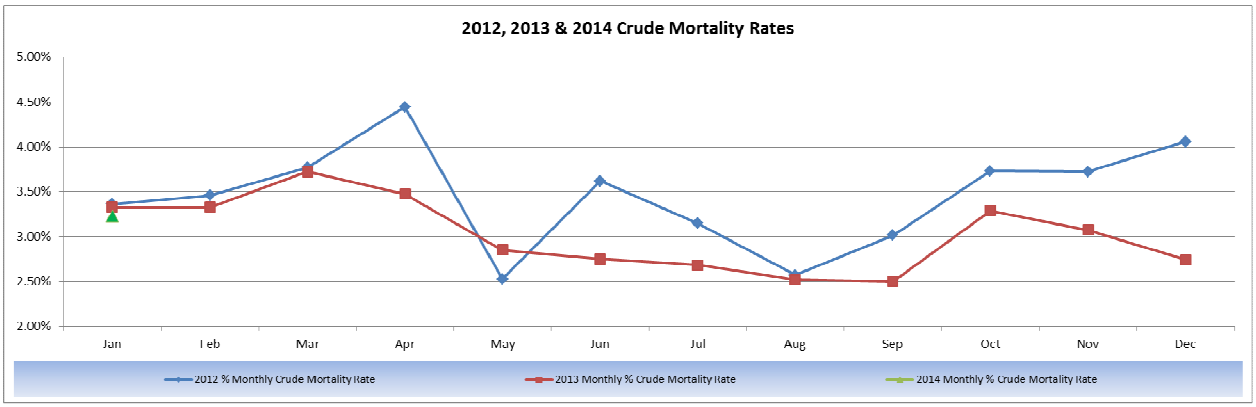
Our headline position is therefore on track with an HSMR of 102 and within range reflecting the improvements made in 2013.

The more recent performance is reflected in the Quarterly reports but the data for Q4 2013 is still incomplete with uncoded episodes and we expect the error bars to narrow and the average to change as the data is completed.

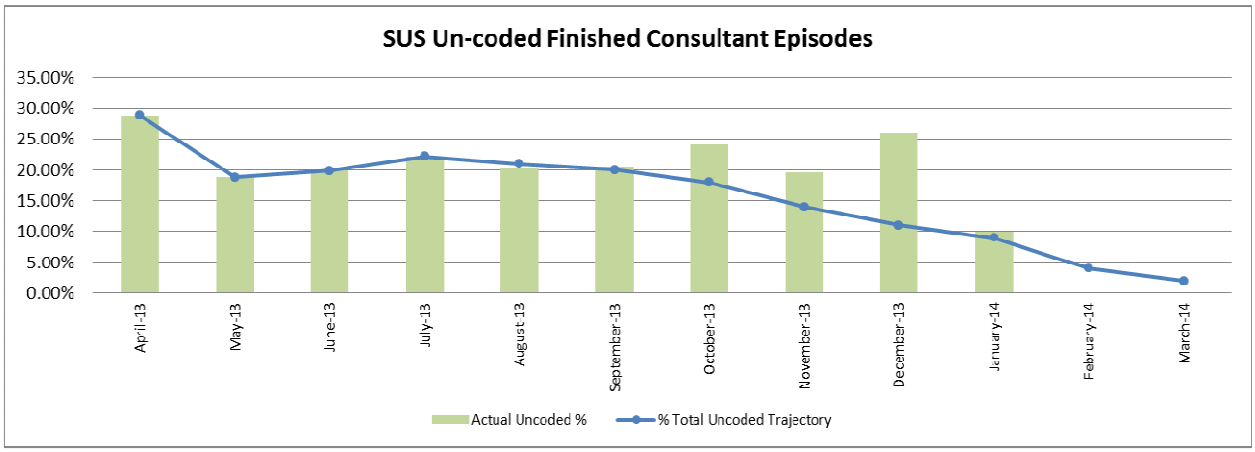


	2011-Q2	2011-Q3	2011-Q4	2012-Q1	2012-Q2	2012-Q3	2012-Q4	2013-Q1	2013-Q2	2013-Q3	2013-Q4
HSMR	117.78	99.47	116.41	114.29	122.9	118.32	130.99	110.15	115.0931	106.1115	109.7957
LCI	104.7	87.21	103.91	102.75	110.23	104.88	118.01	98.91	102.3728	93.2386	90.1539
UCI	132.05	112.97	130	126.76	136.62	132.99	145	122.31	128.9579	120.2597	132.4459

The crude mortality rates for 2013 are consistently improved compared to 2012 and the rates for November and December are encouraging suggesting that the Q4 2013 position should be no worse than demonstrated and may improve.



Previous papers have highlighted the importance of coding and despite issues with an 8% increase in Finished Consultant Episodes in October and national training for our coders in November we are back on trajectory to improve the timeliness of our returns. This impacts on HSMR because uncoded episodes result in estimated figures which may lead to inaccuracy in the quarterly returns and cause inappropriate monthly alerts.



Work continues to focus on Sepsis, Acute Kidney Injury, Stroke, weekend and outlying mortality through the Patient Safety and Mortality Steering Groups.

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.

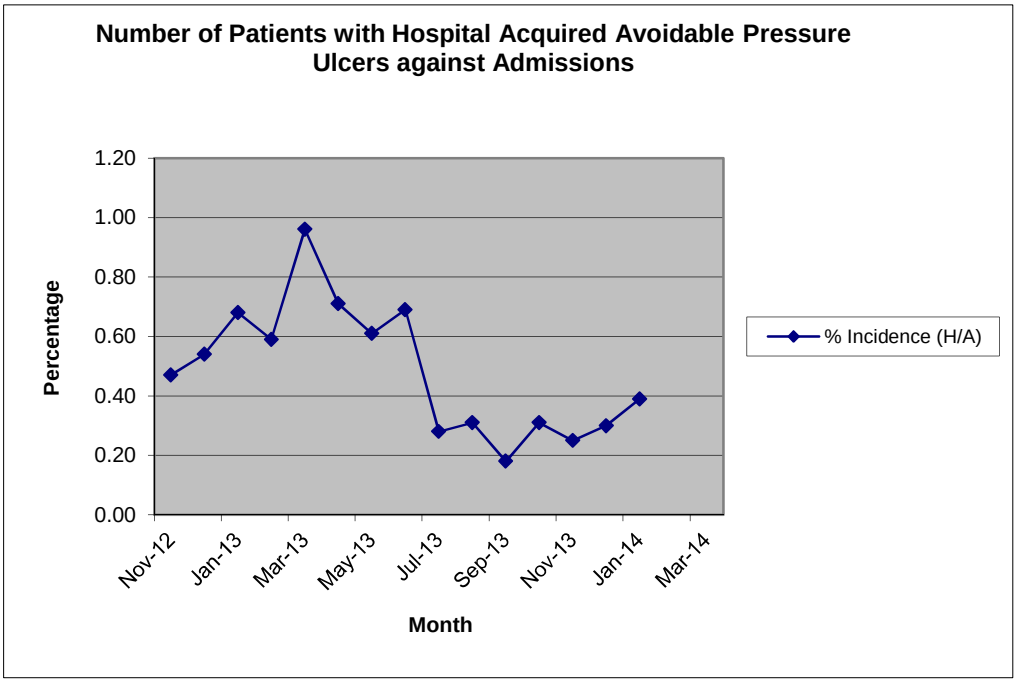
- In November and December we achieved our targets.
- In January two deep pressure ulcers (Grade 3) developed against our target of one. Nine avoidable grade 2 (superficial) ulcers developed against our target of 4. Preliminary information indicates this is related to the introduction of PUP's (pressure ulcer prevention plan) in which staff require further support in categorising avoidable or unavoidable ulcers, but the detail and causes will be ascertained further in the ward assurance meeting led by the Director of Nursing on Tuesday 25th February 2014.
- There have been no avoidable grade 4 pressure ulcers for 13 months.

Overall in 2013/14, there have been 112 avoidable pressures ulcers against a target of 115.

Table1: 2013/14 SFH Avoidable Pressure Ulcer Reduction Trajectory

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	April 14
Target No Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0
Actual No.	0	0	0	0	0	0	0	0	0	0			
Target No. Grade 3	3	3	2	2	2	2	2	1	1	1	1	0	0
Actual No.	5	4	2	0	1	0	2	1	1	2			
Target No. Grade 2	15	20	10	7	7	6	6	7	7	4	3	3	0
Actual No.	14	13	16	8	7	5	9	6	7	9			

The number of avoidable pressure ulcers against patient admissions for the last 12 months gives the incidence rates demonstrated below which shows a stable performance over the last 8 months.



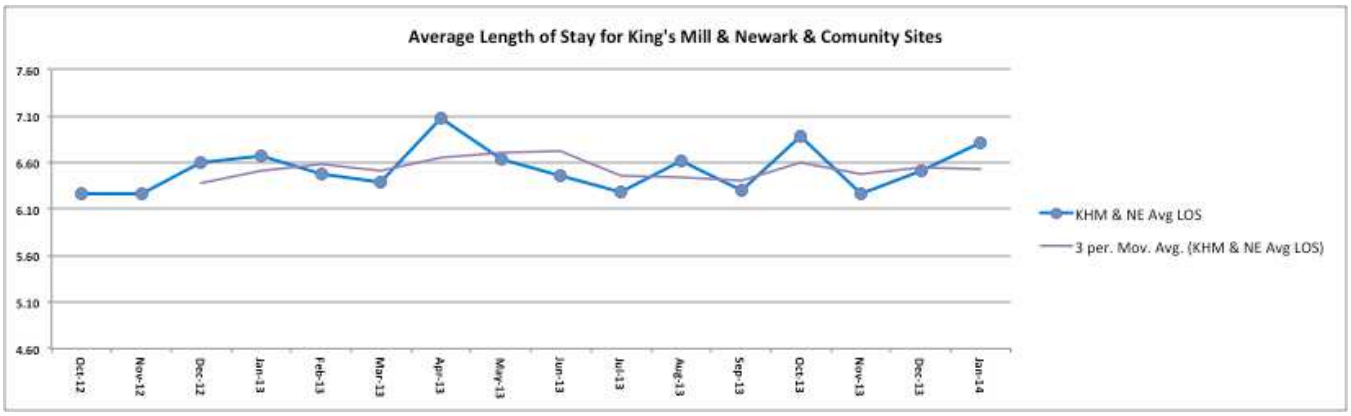
In quarter 4 key priorities within Tissue viability is to embed the Pressure Ulcer documentation which is place across the Trust now. Also to continue with device related Pressure Ulcer training, which appears to be on the increase both locally and nationally due to the increased recognition and knowledge of the problem. We are also working with commissioners to agree the targets and CQUIN requirements for next financial year. This will help us to shape our 2014/15 action plan. We are currently undertaking a benchmarking exercise to assess our performance against peers (this will be presented in future reports). Our Tissue Viability Nurse consultant has also been invited to join a national forum that will offer us further opportunities to influence national initiatives and illicit shared learning.

4. Improved Patient Flow (Priority 3)

4.1 Average Length of Stay

The urgent care workstream have continued to progress actions to improve overall length of stay and the experience of patients using urgent care services in our hospitals.

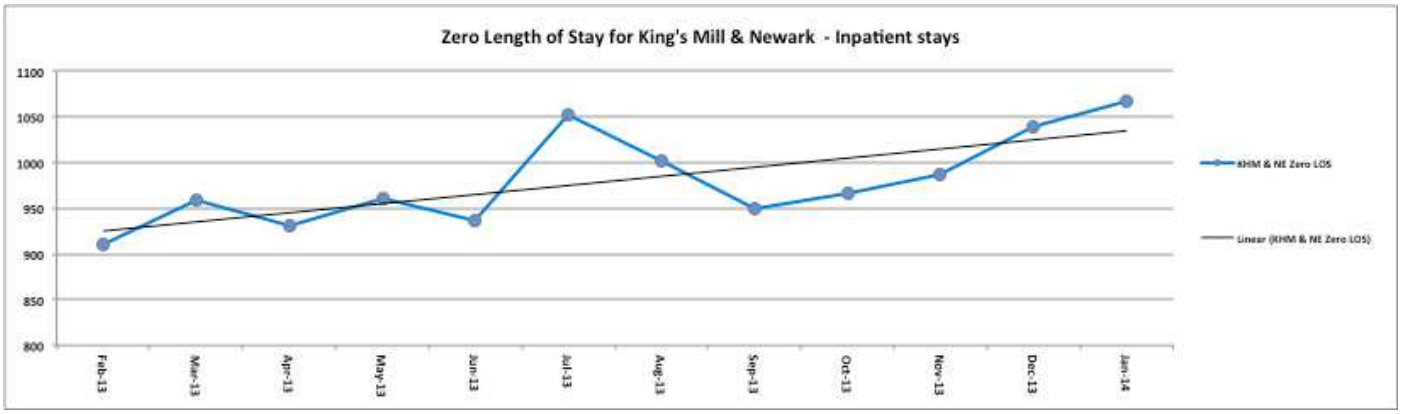
Using previously reported methodologies (excluding patients that say less than 1 day in hospital) average length of stay in January was 6.81 days against a Trust target of 6 days. Reviewing this against this alongside last year's average length of stay it shows a slight deterioration to 6.67 days.
It is expected that complexity and acuity of patients' skews to longer lengths of stay over the final quarter, however this in itself does not explain the increase year on year from 2013.



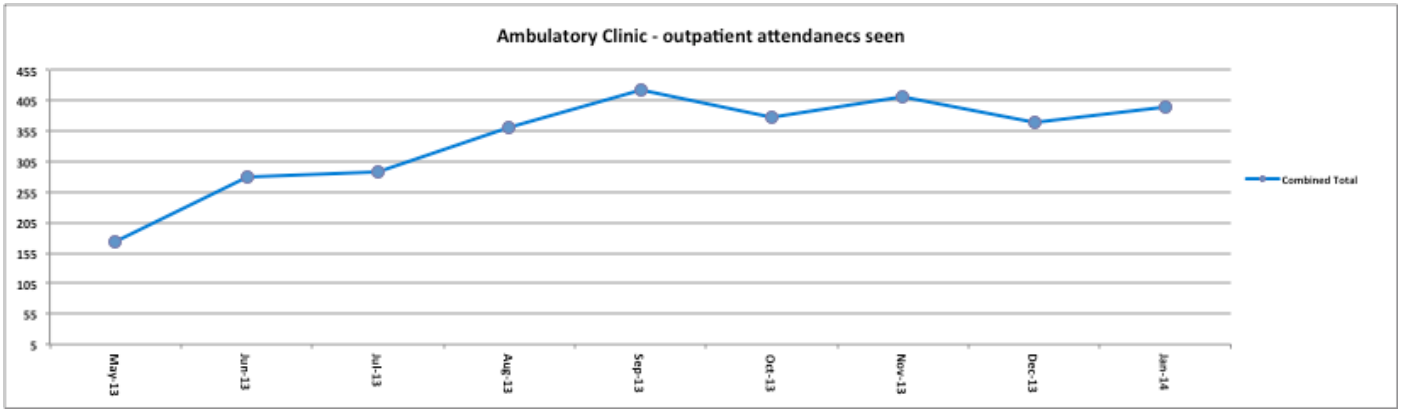
Using the Dr Foster analytical benchmarking tool this corroborates a deterioration of the overall trust average length of stay (which includes all groups) moving from an average of 4.9 days in 2012/2013 to 5.0 days in 2013/2014 Q1 and Q2.
In comparison with expected length of stay (a calculation provided by Dr Foster which examines the length of stay of all trusts) the trust is indicated at 0.5 days longer length of stay than it should have. A figure presented to the trust by recent management consultancy firms.
Nationally the Trust's length of stay is ranked 141st out of 258 trusts entering data about inpatient stays.
**Source Dr Foster Performance Analyser http://da.drfoster.co.uk*

4.2 Admission Avoidance and Sign-Posting Patients to the Most Appropriate Urgent Care Service

In order to fully understand the average length of stay of patients and subsequent improvements in pathways in our hospitals it is important examine all admitted patients, including those that are discharged the same day.
In 2012 the Department of Health released a number of "best practice" same day emergency ambulatory care pathways. These pathways described patients who ideally should be seen diagnosed and treated without requiring an overnight stay in hospital, but who traditionally would experience at least an overnight stay and in some cases two or three nights.



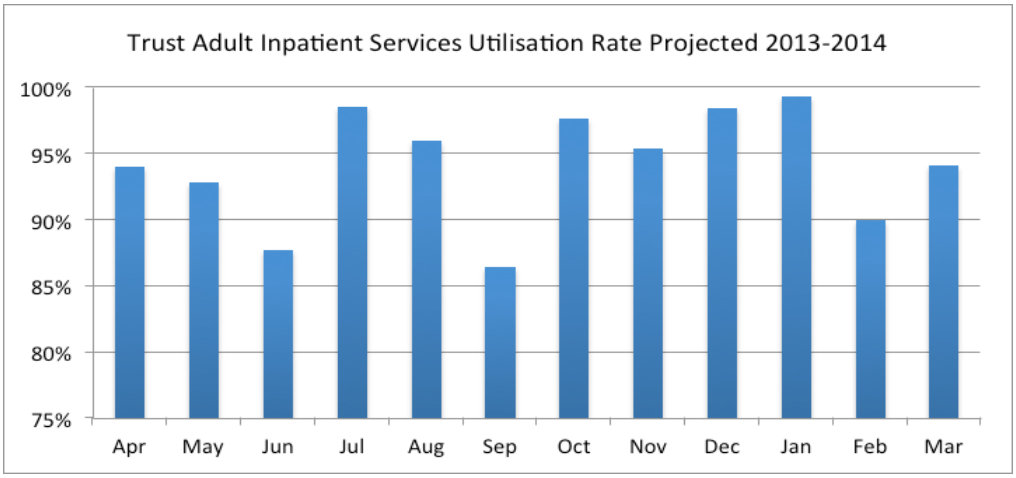
Building on work done in 2012/2013, the clinical decisions unit was opened in April/May 2013 and provided a fit for purpose environment to review these patients along with other further admission avoidance services such as the out patients antibiotics service, the surgical assessment unit triage service and the hot week emergency appointment clinics for Respiratory and latterly Geriatrics and Gastroenterology.



The outcome of these services was that previous short stay admissions moved in some cases to become 0 day length of stay and in some cases moved to become outpatient attendances and completely avoided admissions.
As a result of these changes it is becoming paradoxically more appropriate for length of stay to increase rather than decrease. Patients are navigated to more and more appropriate services that prevent them from being either admitted, or admitted for an overnight stay. Future board quality reports including length of stay analysis and describing the impact of any improvements will therefore include both 0 day length of stay patients as well as those that stay overnight.

4.3 4 Hour A&E Standard and Flow

4 hour accident and emergency standard in January deteriorated to 93.85%, however, year to date performance remains strong at 96.15%. The Trust trajectory for 4 hour achievement makes a step change in Q4 down to 95.00% recognising the challenges that the increase in case mix and complexity of patients being admitted puts on services. The trajectory is set assuming that both January and March 2014 will be particularly difficult months and are likely to fail to achieve the 4 hour 95% standard, however February should still achieve.
Performance of the 4 hour target and overall flow are intrinsically linked to inpatient capacity utilisation. Using analysis from previous years the chart below demonstrates the anticipated utilisation over the remaining months of the year and highlights the significant challenges faced in January as utilisation reaches almost 100% usage.



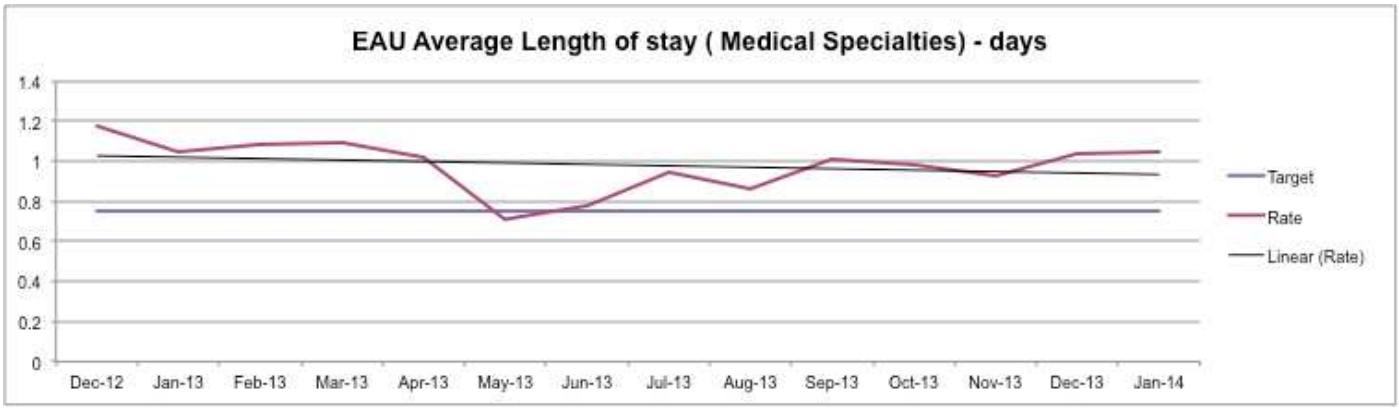
**Source 2012-2013 actual discharge and ward stay information with projections based on growth from 2011/2012 and independent clinical review assuming bed stock excluding admissions, paediatrics and maternity capacity.*

A significant review of one of the trusts main co-ordination meetings known as the "Jonah" meeting was completed in January. Recommendations on developments and changes to the format of this are expected to be approved and implemented in February. This meeting was one of the main improvements in early 2014 that led to the significant improvement in flow and 4 hour standard achievement. It is expected that further development will once again provide a step change in the effectiveness of our discharge processes.

4.4 The Emergency Assessment Unit (EAU)

In response to increased pressure on the emergency medical pathway in December and January the Emergency Assessment Unit opened 12 additional beds to accommodate patients that could not otherwise move off to the specialty ward they required.

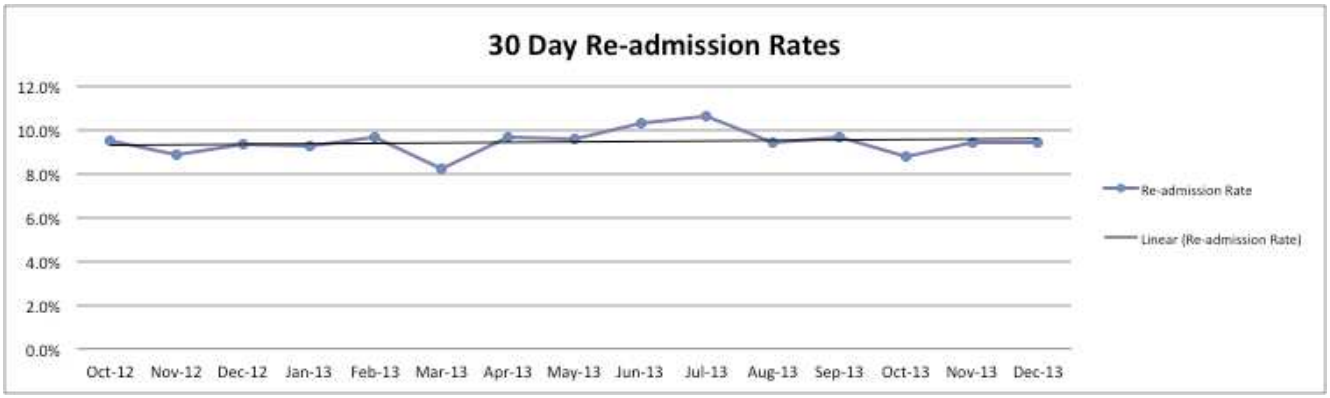
Whilst this additional capacity did in some way undo some of the good work to reduce the amount of time patients spend on EAU, it is positive that the units average length of stay remains below 2012/13 average length of stay despite the impact of opening another short stay unit (the clinical decision unit).



4.5 Readmissions

January readmissions information is not fully reliable until all coding has concluded and therefore has been excluded from the report. The most up to date reporting therefore in December shows that by deploying innovative schemes such as the out-patients antibiotics service, the hot week emergency consultant clinics and GP telephone advice

lines, readmissions continue to stay below the 10% level even when emergency pathways are under such pressure in winter.



In addition to the new services described above, a new risk assessment tool is being piloted in discharge teams. This tool is designed to improve communication whilst maximising the number of services that can be accessed to support patients being cared for in the most appropriate environment. The tool will be evaluated in March.

5.0 Patient Experience & Complaints

5.1 Complaints Performance - Current Position

The Trust continues to receive a high number of complaints; receiving 62 in January 2014. Although Workforce Change is underway to implement the new Patient Experience team structure, the complaints department has suffered the loss of a member of staff and a further member of staff is leaving during February. A backup plan has been put into place to cover this in order for the complaints department to function effectively. This includes the temporary appointment of an additional complaints manager and four complaint officers, of which two will work directly with the Divisional Matron's to relieve some of the workload on them.

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.

5.2 Comparison of complaints received in January 2013 and 2014

Number of complaints received January 2013 = 51

Number of complaints received January 2014 = 62

Table 1

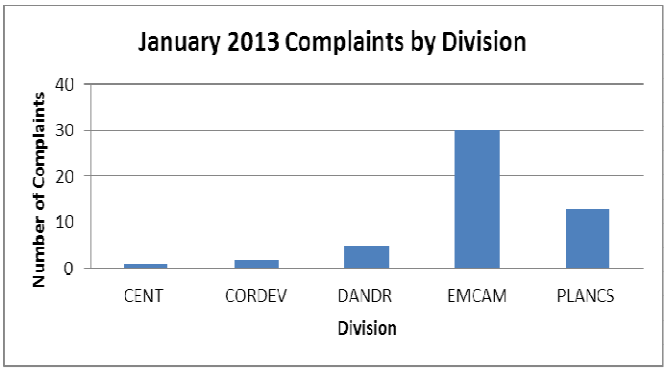
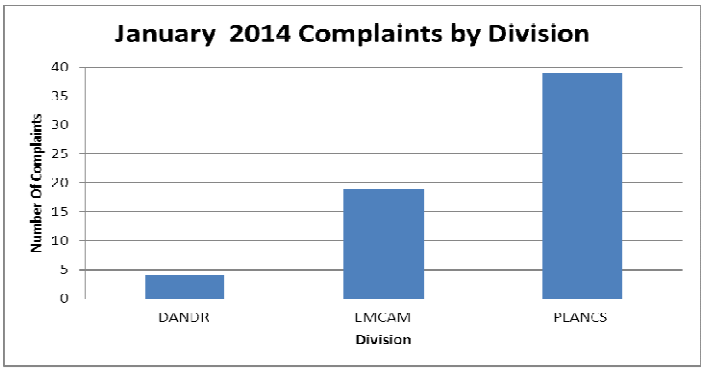


Table 2



5.3 Complaints received by specialty and type for January 2014

Table 3

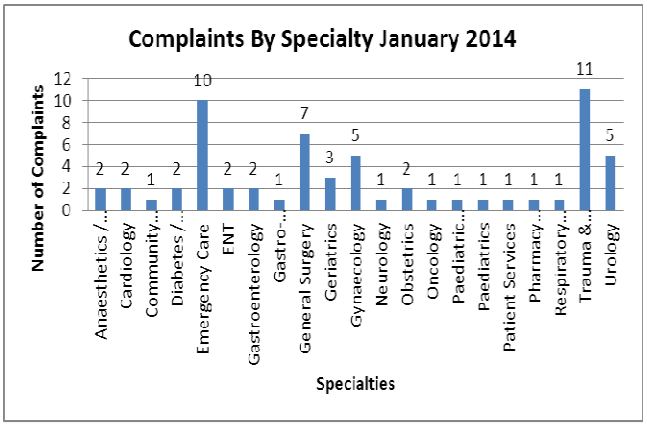
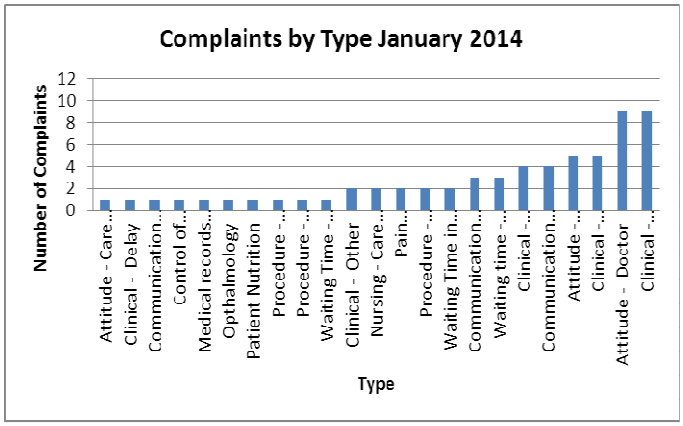


Table 4



It can be seen throughout the breakdown above that attitude is still a problem with both doctors and nurses (12). We have working with the Training department to develop a training programme that will include 'Duty of Candour', supporting openness and honesty and complaints training – facilitated by external expertise. This action has just been initiated but will report its progress in future reports

5.4 Complaint Response Times

Complaint response times assist the Trust in learning how effective it is at meeting the expectations of those who complain in both a timely and effective manner. Although all complaints are given a timeframe of 40 days we do, where possible, respond as quickly as possible. During January we responded and closed 60 complaints. Twenty-eight of these were responded to in the agreed timeframe and 32 needed to be extended because of their complexity, as well as a lot of staff being on annual leave over the Christmas period. Under the Complaints regulations there is a timescale of 6 months that needs to be adhered to in which to respond to a complaint. Performance has been escalated for further discussion at Trust Management Board in February 2014.

The current legislation states that all complaints should be acknowledged within 3 working days and this target was met throughout January at 100%.

6.0 Healthcare Associated Infection

***C. difficile* Infection**

As of 10th February 2014, the Trust has identified 30 cases of Trust acquired *C. difficile* infection against a year to date trajectory of 21 cases. There has been two period of increased incident (PII - 2 or more new cases occurring > 48 hours post admission (not relapses) in a 28 day period on one clinical area). Appropriate actions were taken at the time

Ward	No of cases	Ribotyping			
WD 24	2 cases	078	078		
WD 51	4 cases	029	081	029	020

- Ward 24: the ribotype was the same, implying that cross infection could have occurred
- Ward 51: two of the samples were the same ribotype, implying that cross infection could have occurred. The other samples tested at this time reported different ribotypes

Root cause analysis (RCA) was conducted for all confirmed cases; the remaining cases did not suggest any issues with cross-infection, with the evidence indicating that majority of these cases were sporadic. Review of the HAPPI audit hasn't highlighted any major issue regarding the inappropriate antibiotic usage. An interim trend analysis has been submitted to the CMT.

Chart 1: *C. difficile* infection cases against average reduction target April 2013-

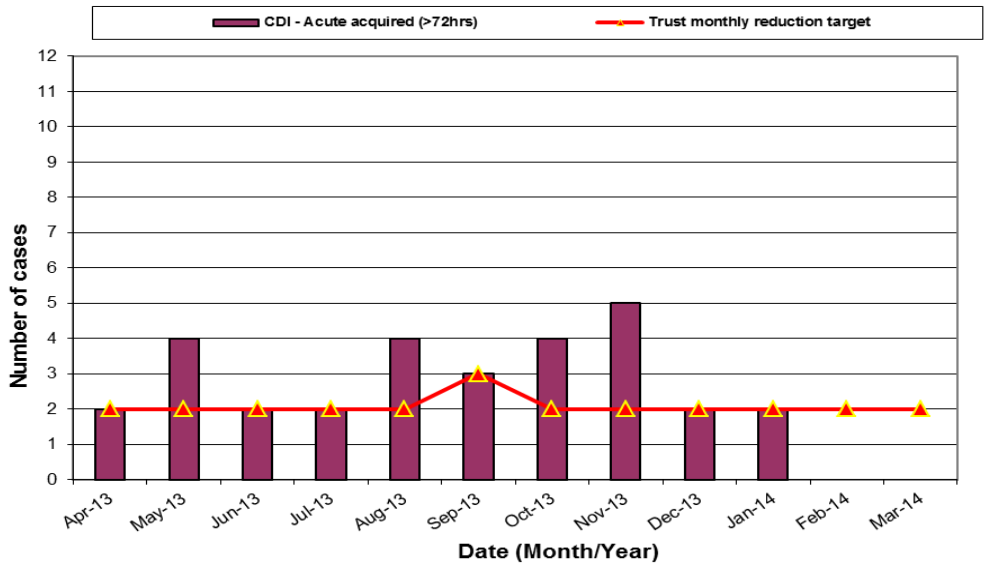


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Chart 2: Number of *C. difficile* infection processed at Sherwood Forest Hospitals NHS Foundation Trust split by 'Trust apportioned' cases and 'Non-Trust' cases by quarter from April 2010 to February 2014

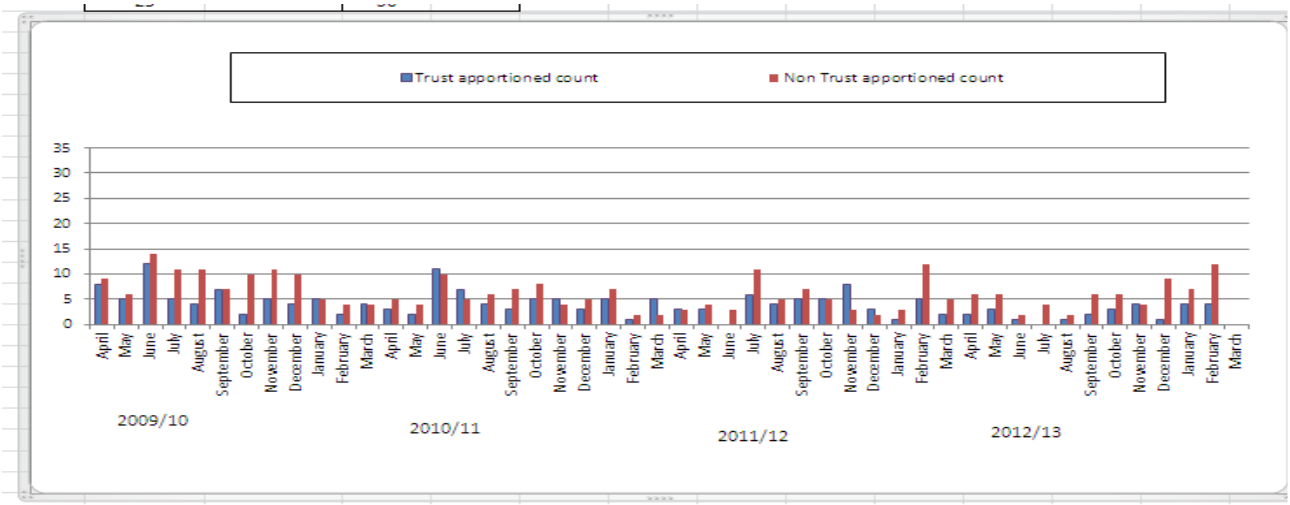

Table 1: Rate of all *C. difficile* infection cases per 100.000 bed days by month, from April 2013 – December 2013. Includes acute trust data for Chesterfield Royal Hospital Foundation Trust, Sherwood Forest Hospital Foundation Trust, Nottingham University Hospital Trust, Derby Hospital Foundation Trust, University of Leicester Hospitals Trust and United Lincolnshire Hospital Trust.

Year	Month	Chesterfield Royal Hospital NHS Foundation Trust	Derby Hospitals NHS Foundation Trust	Nottingham University Hospitals NHS Trust	Sherwood Forest Hospitals NHS Foundation Trust	United Lincolnshire Hospitals NHS Trust	University Hospitals of Leicester NHS Trust	East Midlands
2013	April	25.1	26.5	19.0	9.9	19.6	13.8	18.5
2013	May	18.2	18.4	9.2	19.2	15.8	15.6	15.2
2013	June	12.6	22.8	40.3	9.9	26.1	4.6	20.7
2013	July	12.8	34.4	14.1	9.8	10.0	14.0	15.8
2013	August	25.6	30.5	21.2	19.7	26.7	11.7	21.4
2013	September	26.4	15.8	26.7	20.3	24.2	21.8	22.7
2013	October	12.8	34.4	18.8	24.6	10.0	14.0	18.6
2013	November	19.8	19.7	7.3	25.4	27.6	14.5	17.5
2013	December	19.2	3.8	18.8	4.9	20.1	11.7	13.5
2014	January							
2014	February							
2014	March							

7.0 Serious Incidents

There were 5 Serious Incidents uploaded onto STEIS (Strategic Executive Information System) during January 2014. This compares to 6 incidents reported during December 2013 and 7 in November 2013. The total number of SI's year to date is 83. The numbers of Serious Incidents reported per month can be seen in the table below.

July 2013 – January 2014	July	August	September	October	November	December	January
Number of Serious Incidents	**9**	**3**	**5**	**10**	**7**	**6**	5

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

- As at 7th February 2014 there are a total of 23 serious incidents open on Strategic Executive Information System (STEIS)
- As at 7th February 2014 there are a total of 12 serious incidents which are within timescales and being investigated and 5 which are outside of timescales. This is due to a short term divisional staffing issue in Emergency Care & Medicine, which is now resolved. The Governance Support Unit have plans for each of the 5 overdue incidents, drawing on additional support from our Tissue Viability Nurse Consultant and our falls nurse.
- As at 7th February 2014 there are a total of 6 serious incidents for which closure has been requested from the Clinical Commissioning Group but remain open on STEIS.
- There were no Never Events in January 2014

8.0 VitalPAC

The VitalPAC project is progressing and “go-live” of the core part of the VitalPAC system on the wards at King’s Mill is currently projected to commence on 24 March 2014, subject to acceptance testing of software.
A project manager is now in post and is supervising the day-to-day implementation of the VitalPAC system. The VitalPAC Project Board have met monthly to oversee the project roll-out and to monitor governance aspects related to the project, including finance, patient safety and benefits realisation.

In the last month, The Learning Clinic have informed us of some strategic changes at their company, which have led to alterations in some of the localisation specification (i.e. customisation of software) originally agreed in November 2013. They have also announced changes in the time frames for delivery and testing of various software components of VitalPAC, which the project team have escalated and negotiations are taking place to resolve some of these potential concerns.

The launch dates for some components or modules of the system will be affected by the changes announced by The Learning Clinic, but it is hoped that this will have only a minor impact in terms of the over-all delivery of the project. By delaying some components of the VitalPAC system, The Learning Clinic assures us we will be getting a better quality of product. We have been informed that more of the software testing will be completed at The Learning Clinic, so that the product we receive will be more assured and require less testing on site. A paper detailing the changes to the roll-out plan is currently in preparation for presentation to the Trust Board.
Familiarisation sessions have been held for senior nursing staff and a ward users group has been set up and the first session was well attended. Wards will be informed of the order of roll-out and the date on which they will “go-live” in the next few weeks; and trainers to assist with staff training on the wards are presently being interviewed and recruited.

Hardware (i.e. iPods and iPads) has been purchased and these devices have arrived and are awaiting the upload of the software once this is delivered by The Learning Clinic. Protective cases for the iPods and iPads are being evaluated with the assistance of Infection Prevention and Control, and charging/storage cabinets for devices are being sourced.

Roll-out of the VitalPAC system on the wards will commence with VitalPAC Core. This is the most fundamental part of the system which will be used by the nursing staff on the wards to collect patient observations and calculate early warning scores (NEWS). Additional modules, such as VTE screening, Dementia assessment, and Nutrition screening, will then be added over subsequent months once staff have become familiar with the basic system. A third software delivery will then occur in early 2015, which will comprise of the remaining components of the system that we chose, including Fluid Balance and Infection Prevention & Control (IPC) Manager.

Medical staff and other healthcare professionals, who will need to be able to view patient observation charts, will receive “familiarisation” training with the system as it rolls out on the wards, to enable them to view observations and use VitalPAC Clinical and Ward. More extensive junior doctor training will commence following junior doctor’s change-over in August 2014, and delivery of the “closing-the-loop” component of the VitalPAC software, which enables doctors to respond to escalation alerts indicative of patient deterioration, will begin in the last quarter of 2014.

Communications by various media are planned prior to the launch on 24 March and VitalPAC will be highlighted as part of the Patient Safety Week in April. VitalPAC now has its own webpage on the Trust intranet, which is accessible via the VitalPAC icon on the homepage. Information relating to VitalPAC will be added as the project progresses.

9.0 Nurse Staffing Investment

At the December 2013 Board of Directors Meeting, it was agreed that a circa £4million investment would be made to enhance the skill mix and staffing levels across the adult and paediatric wards at Sherwood Forest Hospitals Foundation Trust. This decision enables us to begin work to design our nursing workforce recruitment and development plan.

As part of the 'Case for Ensuring Safe Nurse Staffing Levels' paper that was presented to Board in December, there was an accompanying action plan. Since December, the Nursing Workforce Forum has been overseeing the delivery of this plan.

Since December the following actions have been initiated:

- Paediatrics have been instructed to begin their recruitment process
- Actions have been agreed to increase our presence at recruitment fairs and we will be working with an advertising agency on our promotional materials and nursing and midwifery website.
- We have reviewed our international nurse recruitment strategy and have undertaken recruitment fairs in Italy as well as recruiting nurses from Spain.
- A 'preceptorship development nurse' has been recruited to support our newly registered staff and a new development programme is being implemented.
- Health Education England have asked the Nottinghamshire workforce team to lead on 'return to practice' for the region. We have put ourselves forward to be a national pilot site, along with NUH and hope to trial new courses to bring nurses back into the profession.
- We have allocated a Practice Development Matron to support the senior nursing team to drive the action plan, give the need for accelerated and focused work.

We are currently actively pursuing opportunities to work with an education partner to undertake a nurse staffing research project. This work will be focused on understanding the impact and benefits realised by introducing additional nurse staffing. Following conversations with East Midlands Academic Health Science Network, We have discussed opportunities with the Centre for Health Innovation, Leadership & Learning (CHILL) at Nottingham University Business School. The Academic Health Science Network has an arrangement whereby themselves and CHILL will collaborate if learning is generalizable and transferable across the region. We are therefore meeting with them in February to explore options to take this forward.

10.0 Update on Our Quality & Safety Strategy

A newly developed quality strategy was developed and received at the October 2013 Trust Board. It described our quality priorities based upon consultation with our divisional teams, clinicians and governors. Running in parallel to the development of the quality strategy was the development of the Trust's Patient Experience and Involvement Strategy, Workforce and OD Strategies, Estates Strategy, IT Strategy and Nursing and Midwifery Strategy. It was agreed that the Quality Strategy should be refreshed once these other strategies were completed as it is important that the quality strategy unites in supporting the delivery of all our priorities. We are now in a position to refresh our quality strategy and this is being prepared in readiness for the Board of Directors meeting in March 2014. Many of the priorities we identified within the original Quality & Safety Strategy aim to continue the work we have undertaken during 2013/14 to improve safety, clinical effectiveness and patient experience. We review our progress against these priorities quarterly and are currently undertaking an annual review. Our progress against these

priorities will be set out in full in the Quality Account, which is currently in development and will be presented to the Board of Directors in May 2014.
Safety priorities for the Trust are progressing well e.g. significant improvements in our mortality rates, a demonstrable reduction in our avoidable pressure ulcers, our achievement of 95% patients undergoing a VTE risk assessment and 95% of our patients over the age of 75 being screened for dementia.

11.0 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 3rd 2014.

Present

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

In Attendance

Nigel Nice	-	Public Governor
Karen Fisher	-	Director of Human Resources
Fran Steele	-	Chief Finance Officer
Jacqui Tufnell	-	Executive Director of Operations
Ann Gray	-	Patient Services Manager *(Security of notes transported from Newark item only)*
Denise Berry	-	Clinical Governance Lead
Joanna Richardson		Patient Safety Fellow *(Mortality update item only)*
Colin Dunkley	-	Consultant Paediatrician *(2013/37491 Never Event – Opioid overdose of an opioid naïve patient item only)*
Martin Bullock		Assistant Chief Pharmacist (Medication incident paper)

Serious Incident Log

During December there were 6 new serious incidents opened on STEIS and these were all within the Planned Care & Surgery Division. It was noted that although these were all very different incidents a review would consider whether there are any core elements or themes.

There were 7 serious falls reported during Quarter 3. Although these had been separately investigated there are other key developments that have taken place within the Trust in relation to falls. There has been an appointment of a falls nurse who will review the patient's care provision post a serious fall in a time sensitive manner, to ensure alongside ward staff, that appropriate action plans are in place for these patients. The falls specialist nurse will also establish the circumstances of the causes of the fall, this information is not always well captured and is required to inform the investigation. The apparent delays in requesting x-rays to exclude fractures was also discussed and the committee were informed that Anne-Louise Schokker has informed Junior Doctors to lower the criteria for x-ray requests. A new post fall proforma is currently being trailed and a review of falls risk assessment tools is also planned. The Committee were informed this is an area of concern. As a consequence it is proposed this becomes a key priority within the quality account for 2014/15. The committee were also informed that increased falls had been highlighted through the early warning dashboard and that the Governance Support unit are currently compiling a

report which will triangulate a number of factors that impact on falls management. **The committee identified this is an area of concern and will receive a future report in March 2014**

Retinopathy Screening Incident

A summary of the incident which highlighted a number of patients who had not been added to the tracking system for the North Notts Diabetic Eye Screening Programme was noted. An internal investigation has been conducted and immediate actions implemented. This is a national system which informs the GP and patient who then make the appointment and our reconciliation is a back up system.

Never Event – Opioid overdose of an opioid naïve patient

The Committee was provided with a detailed understanding of a never event which took place in December 2013. Immediately following the incident a number of actions were instigated. The investigation is on-going. It was recommended that the NPSA checklist for never events could be used to help identify if this was a system error or human error. The Medical Director requested that a Multi-Disciplinary Team reflection of the never event should take place to include the possibility of instigating Schwartz rounding.

Report on open incidents by the handler on Datix

The Committee were informed that there had been a continued improvement in reducing the time scales for investigating and closing incidents. The proposed changes to the management of incidents on Datix will be presented at the next Committee meeting**. The committee noted an improvement in the closure of outstanding Datix incidents and recognised the work Trust staff had undertaken to deliver this**

Report on the management of case notes during transportation.

Following concerns regarding the ways in which case notes were transported both on site and between sites and to external recipients. Ann Gray, Patient Services manager informed the committee that new procedures have been put in place for the storage of case notes following transportation across sites after hours. The group were informed that out-of-hours admissions staff would be able to retrieve notes from the agree storage point in the case of an emergency admission**. The Committee were assured with the actions undertaken and the recommended way forward**

Mortality Update

A paper was submitted to the committee summarising the current mortality status of the Trust. It was reported that improvements have been made and that we are in the expected range for HSMR. It was noted that Sepsis and Urinary Tract Infection have seen a vast improvement. Work is on-going in the review of the findings which relate to outliers within the report of the Mid Nottinghamshire Mortality review. **The Committee commended the knowledge and confidence the patient safety fellow displayed in presenting this item and the responses to challenge which added additional assurance to the management of mortality.**

Medicines incident report

The Assistant Chief Pharmacist appraised the committee of the medicines incident data comparing SFHT with other similar sized Trusts. It was reported that medicines safety is being recognised as a patient safety priority at SFHT.

Most medicines related incidents are reported by nursing (40%) and pharmacy staff (31%), with medical staff reporting only 3% (20% are unassigned to a staff group). The importance of reporting all patient safety incidents is being promoted in various arenas including staff induction and mandatory update training. There is a significant need to encourage more incident reporting by medical staff, this is not unique to SFHT. A regular Medicines Safety Bulletin will be produced for all SFHT staff by the Medicines Safety Group based on a variety of topics highlighted by incident reports. **The committee noted the usefulness of the external benchmarking and requested this agenda item is reported every six months**

Update report – Clinical Letter Backlog

The Committee were informed that the Trust achieved the 10 days typing turnaround by 31 July 2013 which has been maintained to date. It was noted that each senior Patient Pathway Coordinator has dedicated support from an information analyst providing targeted typing reports to each team on a daily basis. The aim is that once all typists have reached their potential for performance, reports will be released by specialty. **The committee were assured actions to address this concern have been sustained and maintained**

Radiology Plain Films Backlog

This agenda item was discussed in relation to the 'radiology backlog reporting' concern previously identified. A look back audit had been commissioned and completed. The results of this audit were discussed. This conversation led onto a further discussion regarding the future and sustainability of our radiology service in relation to the nationwide problem of recruiting radiologists, of which SFHFT has vacancies. This concern is documented on our risk register but has been escalated to the BAF. **It was requested this concern required immediate discussion amongst the Executive Team and was escalated accordingly**.

Feedback from Keogh and CQC visit during December 13

Committee members received copies of the correspondence regarding the feedback from the Keogh and CQC visits during December 2013. It was noted by the committee that there were a significant number of actions from the Keogh report and a conversation was undertaken regarding which actions had limited assurance. The group agreed that Shirley Clarke from the Programme Management Lead would be requested to provide an update and assurance of where we are with the action plan to the next committee meeting. The Committee discussed the action plan and noted assurance around complaints management would be part of the confirm and challenge event planned for 13th February, 2014

Susan Bowler
Executive Director of Nursing