Quality Account - Priorities for 2015/16

1.0 Introduction

Quality Accounts are annual reports to the public from providers of NHS healthcare regarding the quality of services that they provide and deliver. The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality in its broadest form across all of the healthcare services offered. It allows leaders, clinicians, governors and staff to demonstrate a shared commitment to continuous, evidence-based quality improvement and for the organisation to openly share its commitment and progress with the general public.

Quality Accounts are not marketing documents, but a chance to enter into an authentic, open and honest dialogue with the general public regarding the quality of care in our organisation. Assurance is therefore required to ensure that the information contained within the Quality Account is accurate and fairly interpreted, the range of services described and priorities for improvement are representative of the services we deliver. The Board is accountable for our Quality Account and therefore, they must assure themselves and then state publicly within the document that the information presented is accurate. To provide further assurance stakeholders including the Overview and Scrutiny Committee (OSC) must be offered the opportunity to comment on our report ahead of publication, and a statement, if offered, must be presented in the final Quality Account

Each year the Quality Account must include the organisations priorities for quality improvement for the coming financial year. To fulfil this requirement the organisation must evidence that it has engaged and involved with a wide range of key stakeholders that are deemed to have an interest in the organisation

2.0 Patient Experience & Involvement / Quality & Safety Strategy

During 2014 the Trust designed and implemented a framework that described our intention to provide high quality, safe and effective care across the organisation. This was underpinned by four key strategies namely our:

- Quality For All Strategy. This strategy describes the attitudes, values, beliefs and behaviours that we expect to be portrayed by our staff and from the organisation as a whole
- Patient Experience and Involvement Strategy describes our intention to gain a greater and more informed insight into how patents view our services
- Organisational Development Strategy focuses on the work we are doing to ensure our staff are passionate about working for our organisation, proud of the difference we make for people and inspired to continuously improve all we do.

- Our Quality and Safety Strategy (This can be provided as requested or assessed via our internet site) ensures our patients are first and foremost in what we do every day and to make quality everyone's business. The implementation of our Quality and Safety Strategy strengthens confidence and pride in our Trust and our patients will be assured that we are working towards being the best in our class. As we had undertaken a large patient, staff and stakeholder engagement to create our 2014-17 quality strategy we felt it was important that the content of the quality account reflected this engagement.

3.0 2014/15 Quality Priorities

Our three main quality priorities for 2014/15 were as described below

Quality Domain	Theme / Measure of Success
Patient Safety	• Reduce mortality as measured by HSMR to within expected range • To implement and embed a mortality reporting system that is visible from service to board • Eliminate the difference in weekend and weekday HSMR
Clinical Effectiveness	• To reduce the total number of falls reported to < 7 per 1000 occupied bed days by Quarter 4 (quarter on quarter reduction) • To reduce the total number of falls resulting in harm < 2 per 1000 occupied bed days by quarter 4 (quarter on quarter reduction) • To reduce the number of patients that fall more than twice during their hospital stay (Baseline quarter 1 14/15) • To reduce the number of fractures incurred following a fall to < 25 for 2014/15
Patient Experience	• To improve the response rates and scores in the patient and staff FFT • To achieve a 50% (Patient FFT) response rate by October 2014 • To achieve an 80% (Patient FFT) response rate by March 2015

Appendix 1 identifies where we are at against all of our quality priorities at the end of Q3 for 2014/15.

4.0 Other Developments

The Trust has delivered many successes over the past 12 months including:

- During Q3 our falls reduction work has continued to show some good improvements with a comprehensive programme of work in place, led by the Falls nurse. Our falls resulting in harm has reduced and is very close to our 2014/15 target. We have recorded <1.73% against a target of <1.70% per 1000 occupied bed days. We also aim to reduce the total number of patients who fall to < 7 per 1000 occupied bed days by quarter 4 (quarter on quarter reduction). Currently the average fall rate for

April to Dec 2014 is 7.68% and again there is a possibility that we may achieve this target. We still have lots of work to undertake but we are demonstrating sustainable changes

- Q3 has seen fantastic results for hospital acquired pressure ulcers. December is the first month since data collection commenced we have recorded NO avoidable Grade 2-4 Pressure Ulcers. There have been no avoidable Grade 3 pressure ulcers since April 2014 and no Grade 4's for 2 years. We are now concentrating on eliminating Grade 2 Ulcers.
- The Safety Thermometer is demonstrating excellent results for those patients in our care. 97.87% of Sherwood Forest Hospital patients were receiving harm free care during Q3. Plans are being progressed to implement the Medicine Safety Thermometer.
- Due to technical problems Dr Foster has been unable to provide the trust with any recent HSMR validated data, but our latest SHMI demonstrates we are within the expected range at 103 with no alerts. The recent incidence of flu outbreaks within the East Midlands will have impacted upon our crude mortality. Our Sepsis targets for 2014/15 are to achieve 75% compliance with the Sepsis bundle by Quarter 2, improving to 85% compliance by Quarter 3 & 95% by Quarter 4 2014/15. The validated audit data for Q1 & Q2 evidences a Trust-wide compliance of 50%. We are failing to achieve our own internal target and feel this should be a key priority for 2015/16.
- We have failed our C Difficile target for the year with 54 cases against a target of 37 (Dec 15). We have sought the support of our health community partners to help identify solutions. Our CCG have facilitated a community wide task and finish group, in which all partners attend.

5.0 Quality Priorities for 2015/16

The Quality Account in addition looks forward to 2015/16 and the measures of success in achieving the Trust Quality Goals in three dimensions:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

For 2015/16 we are proposing we that we commit to delivering the priorities described within our Patient Experience and Involvement Strategy for year 2.

There is evidence that we still need to make improvements within mortality (HSMR), falls reduction and sepsis. We are therefore proposing that these themes are our three main priorities. The other priorities for discussion are:

PATIENT SAFETY
Pressure Ulcers **Falls** **Urinary Tract Infection** **VTE** **Medication Safety**
CLINICAL EFFECTIVENESS
Care and Comfort Rounding **Stroke** **COPD**
IMPROVED PATIENT EXPERIENCE OF CARE
Workforce Strategy
Nursing & Midwifery Strategy
Patient Experience and Involvement Strategy
Dementia Strategy
Nursing Leadership Programme
Training Programme for HCAs and support workers
QUALITY GOVERNANCE
Data Quality Review and Accreditation
Development Programme for Clinical Directors and Clinical Leaders
Realignment of Clinical Audit Plan to Patient Safety & Quality Priorities

6.0 Selection of Priorities

In order to gather the views of patients, staff, members, governors and other key stakeholders on what they feel the trust needs to focus on in order to ensure on-going improvements in the delivery and provision of high quality care; the following approaches were agreed:

1. Survey of patients, staff, members, governors and stakeholders (Survey Monkey)
2. Quality & Safety Reports

3. Council of Governors / Sub Committee
4. Quality & Scrutiny Committee
5. Healthwatch
6. CCG

7.0 Audit / Completion of the Quality Account

From an audit perspective the trust will commission both the internal and external auditors to formally audit the delivery of the 2014/15 Quality Account.

The 2014/15 Quality Account is to be completed in line with the Annual Report timescales and posted / uploaded to the Monitor portal with the Annual Report on 29th May 2015. It is to be sent to the Parliamentary Clerks office, with the Annual report on 23 June 2015, and published externally by 30 June 2015. A more detailed list of the dates for delivery of the Quality Account is included in Appendix 2.

8.0 Recommendations

The Committee are asked to:

1. Note the proposed timeline for production of the 2014/15 Quality Account and the 2015/16 Quality Account objectives

2. Discuss and make suggestions for the 2015/16 Quality Account objectives / priorities.

Appendix 1 Quality & Safety Report (Q3 2014/15)

Quarterly Patient Safety & Quality Report

Quarter 3 summary 2014/15

Susan Bowler, Executive Director of Nursing & Quality

Andrew Haynes, Executive Medical Director

Executive Summary

Within the 2014/15 Quality Account, the Trust set itself a number of key Quality and Safety targets which had also been translated from our Patient Quality and Safety Strategy. This report gives an assessment and future plans against those priorities. This report also needs to be read in partnership with the Quality Improvement Plan

Due to technical problems Dr Foster has been unable to provide the trust with any HSMR validated data, but our latest **SHMI demonstrates we are within the expected range at 103 with no alerts.** The recent incidence of flu outbreaks within the East Midlands will have impacted upon our crude mortality. We have received an alert in relation to deaths from therapeutic endoscopic procedures. The notes of all the patients have been reviewed and assurance can be provided that the Endoscopic Procedures are carried out safely and for the appropriate care of patients

During Q3 our falls reduction work has continued to show some good improvements with a comprehensive programme of work in place, led by the Falls nurse. Our falls resulting in harm has reduced and is very close to our 2014/15 target. **We have recorded <1.73% against a target of <1.70% per 1000 occupied bed days**. We still have lots of work to undertake but we are demonstrating sustainable changes

Q3 has seen fantastic results for hospital acquired pressure ulcers. December is the first month since data collection commenced we have recorded **NO avoidable Grade 2-4 Pressure Ulcers**. There have been no avoidable Grade 3 pressure ulcers since April 2014 and no Grade 4's for 2 years. We are now concentrating on eliminating Grade 2 Ulcers.

The Safety Thermometer is demonstrating excellent results for those patients in our care. **97.87% of Sherwood Forest Hospital patients were receiving harm free care during Q3.** Plans are being progressed to implement the Medicine Safety Thermometer

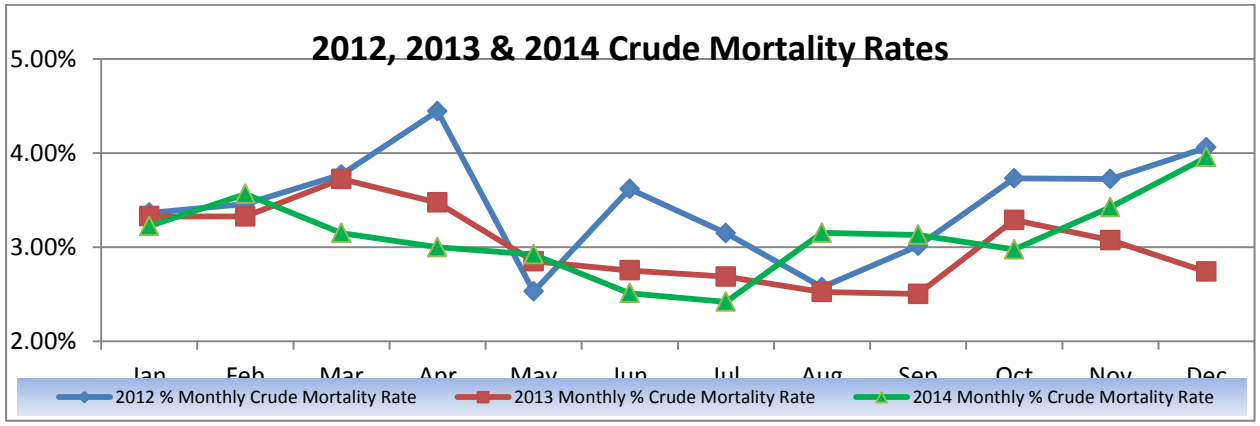
We have failed our C difficile target for the year with 54 cases against a target of 37 (Dec 15). We have sought the support of our health community partners to help identify solutions. Our CCG have facilitated a community wide task and finish group, in which all partners attended. It has been agreed that SFH will join the .

The Trust Board is asked to discuss the contents of this report and note the improvements that are being made in relation to a number of quality priorities, however to be aware there are still areas that are receiving focused attention to ensure improvements are maintained and driven further.

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

Data

Due to a technical problem with their systems, Dr Foster has not been able to provide any trust with validated data in January. Therefore the most recent data we have is to August 2014, as reported in December. Our SHMI up to June 2014, the latest available is within the expected range at 103 with no alerts.



The HPA flu surveillance report shows a significant increase in mortality in the 65+ age group in Dec and Jan with up to 2000 deaths a week above expected and the E Mids has had the highest incidence of flu outbreaks. This will have impacted on our crude mortality.

Work on mortality continues, monitored by the Trust Mortality Group and using the data collected in Mortality reviews.

Morality

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

Alerts

Therapeutic Endoscopic Procedures

We received an alert from Imperial (the data source for Dr Foster) that there has been a higher than expected number of deaths of patients who had a therapeutic Endoscopic procedure during the course of their admission. This listed 19 spells over the period of a year between September 2013 and August 2014.. When analysed, this was actually 18 patients as one of them had 2 spells split by going to QMC for a procedure.

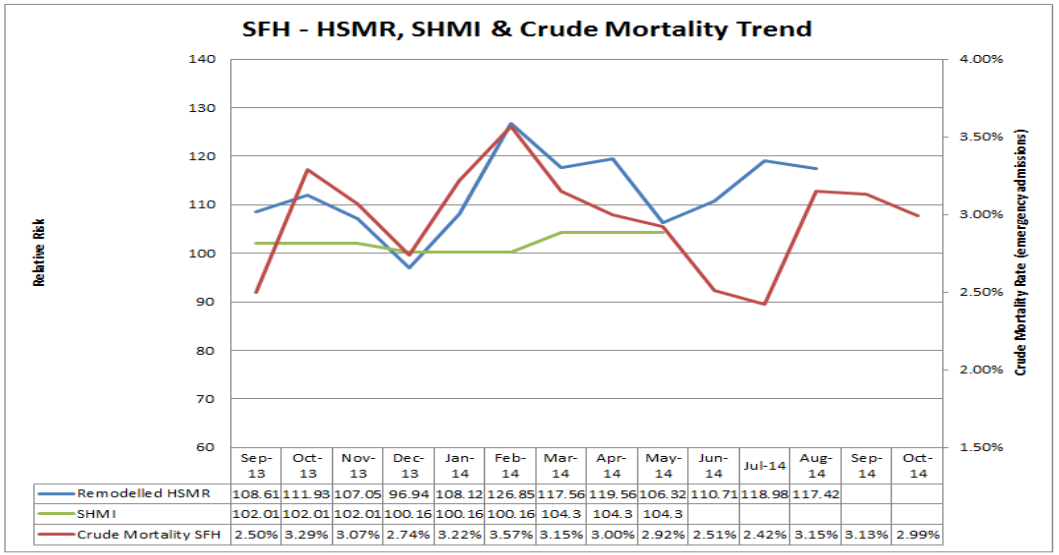
The notes for all 18 patients have been reviewed. The procedures carried out during these admissions were all appropriate under the circumstances of the admission. Clinically all the procedures were indicated and carried out with no complications. The length of stay varied according to the patient's underlying condition. In some case the endoscopic procedure was carried out several weeks prior to death. Gastroscopy is frequently carried out on high risk patients which is reflected in the patients in this review. 11 of the procedures were done in patients who were bleeding. 5 of these were emergencies where the bleeding was catastrophic. 2 cases were for the insertion of stents in patients with cancers that were causing obstruction of the oesophagus and the remaining three were for the insertion of Gastrostomy feeding tubes in patients who were unable to swallow due to frailty and their other co-morbidities. The cause of death in each of these patients has been considered and none of them were related to the procedure being carried out, ranging from Metastatic Lung Cancer and End-Stage Parkinson's Disease to Chronic Liver Cirrhosis and Massive Oesophageal Haemorrhage.

This review provides assurance that the Endoscopic Procedures are being carried out safely and for the appropriate care of patients.

Morality

HSMR in July

In July 2014, we saw a rise in the HSMR against a dip in the crude mortality. In August, the two figures returned to the proximal position that we expect to see. This gap identified in the July data has led to a review of all deaths during that month. The review is not yet complete. However, a clear picture is emerging. There were 88 deaths in July. So far, half have been reviewed in detail, including an in-depth review of the coding associated with these deaths. The coding, in particular of Co-morbidities, contributes to the calculation of relative risk for the patient on which the HSMR is based.



	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Remodelled HSMR	108.61	111.93	107.05	96.94	108.12	126.85	117.56	119.56	106.32	110.71	118.98	117.42		
SHMI	102.01	102.01	102.01	100.16	100.16	100.16	104.3	104.3	104.3					
Crude Mortality SFH	2.50%	3.29%	3.07%	2.74%	3.22%	3.57%	3.15%	3.00%	2.92%	2.51%	2.42%	3.15%	3.13%	2.99%

The crude morality shown is taken from internal SFH data and relates to emergency admissions only

None of the deaths reviewed have raised concern regarding care, nor has a theme emerged around any particular area or speciality to require investigation.

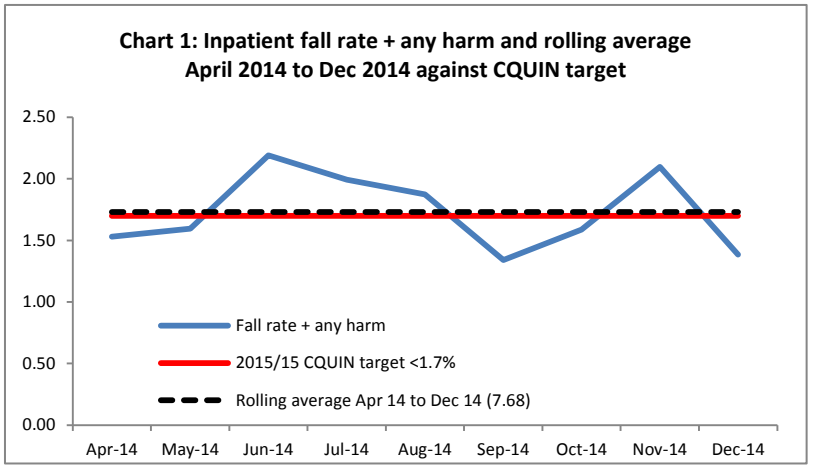
These reviews have been carried out by a clinician taking an overview of the patient and their co-morbidities along with the coding. Some discrepancies have started to be seen and work has been going on with the coders to understand these. This is not down to a failure to code – our coders are working very well and are not behind with coding. There is a combination of the rules under which coders are required to work (HSCIC guidelines and audits) and the way that clinicians record information. Dr Foster uses an internationally recognised index of co-morbidity to calculate the relative risk of patients. The HSCIC mandatory co-morbidity list is different.

As a result we are now working with the coding team to identify the areas where we need to use different codes to improve our HSMR. We are also working with clinicians to look at how we can improve the recording of co-morbidities. In Planned Care & Surgery there has been an initiative to increase the recording of co-morbidities. Emergency Care and Medicine are launching a new admissions booklet including a clear page for completing co-morbidities that is clear for both doctors and the coding team.

Falls (Priority 2)

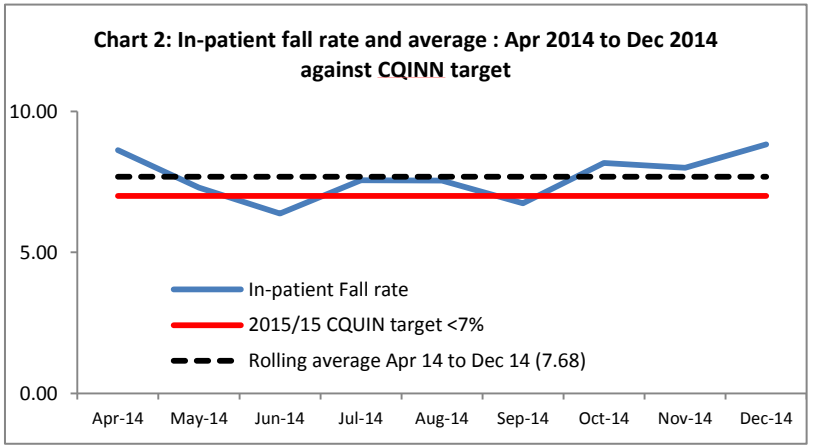
FALLS targets for 2014/15 are to:

1. 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
2. Reduce the number of patients who fall resulting in harm to **<1.7 per 1000 occupied bed days** by quarter 4
3. Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
4. Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15)
5. Reduce the number of fractures from falls to **<25** for 2014/15
6. Reduction in repeat fallers and undertaking falls assessment is a CQUIN for 2014/15.



How are we performing against this target:

1. This data is being captured on EAU by the CQUiN support workers.
2. Reduce the number of patients who fall resulting in harm to **<1.7 per 1000 occupied bed days** by quarter 4. Currently the average harm rate for April to Dec 2014 is **1.73%** and there is a possibility that we may achieve this target. **Chart 1**
3. Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction) Currently the average fall rate for April to Dec 2014 is **7.68%** and again there is a possibility that we may achieve this target. **Chart 2**
4. Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15) We are above trajectory for this quarter as we had 22 repeat Fallers (baseline set as 20)
5. Reduce the number of fractures from falls to **<25** for 2014/15 We have not achieved this target as we had **12** fractures for this quarter taking us to **27**.



Mitigation plan: Inpatient falls resulting in harm to patient

Monitoring for repeat Fallers forms part of the Datix daily review and support with patients who are at risk and include some cover at the weekends.

The majority of our Falls are **NO Harm** but we will focus on efforts on addressing what we have learnt from our 'themes and trends' in relation to patients who sustain un-witnessed falls near their beds by monitoring if falls are related to patients slipping from pressure relieving mattress for example.

Falls care plans being reviewed appropriately is also being monitored and supportive interventions discussed on ward visits from the Falls Team.

In addition there is a focus on ensuring the ward teams understand the Enhanced Care Tool and are assessing patients level of risk appropriately and putting in the correct level of observation.

Laminated information cards that will be displayed on the nursing station as prompts for staff. These will be distributed at the Falls Champion meeting in January.

Evidence of escalation and de-escalation is also being supported.

Mitigation plan: Inpatient falls

The work continues with a focus of prevention rather than reaction being the message. The staff need continued support in treating what they find in patients at risk of falls. With support from the Patient Safety Team a campaign to address staff checking the 'lying and standing blood pressure of patients at risk' will be launched shortly with guidance for staff on how this diagnostic test should be done correctly and what actions should be taken.

Information on icare 2 will also be sent out to staff in relation to categories recently added that include ' patients who roll off an ultra-low bed and patients lowered to the floor' to support us in the analysis of the Falls that occur.

Sharing good practice from Ward 41 is also a theme as we recognise the high number of falls in relation to patients left unaccompanied in toilets and bathrooms. A focused piece of work on 'Supervision meaning supervision' will be undertaken from mid-January.

Friends & Family Test (FFT) Priority 3
Response Rates (RR)

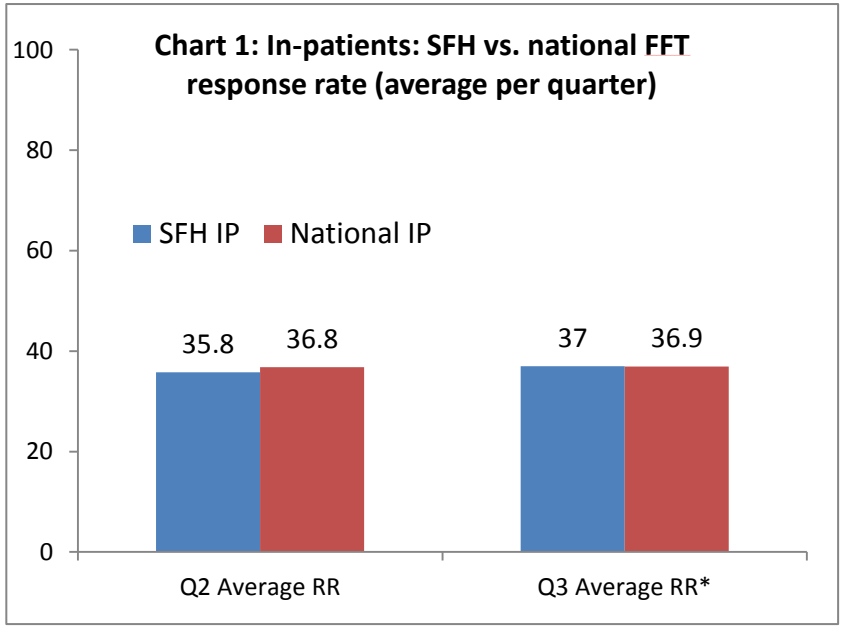
FFT targets for 2014/15 are :

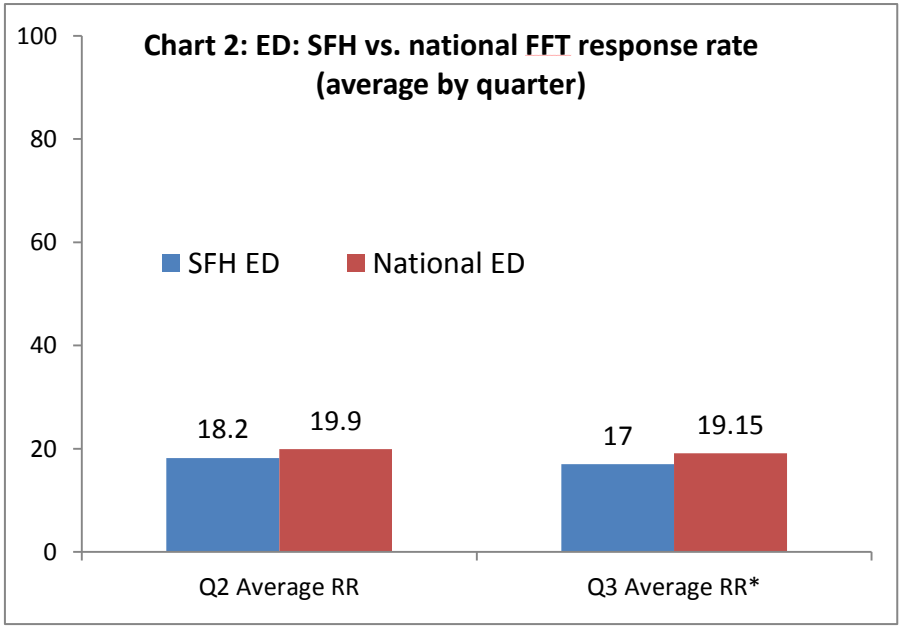
CQUIN – 1. Phased Friends & Family Test (FFT) expansion to outpatients and Day case
2. Increase response rate & improve performance
3. Staff F&F

Internal – Increase Inpatient and Emergency Department FFT response rate to **50%** by March 2015

Sherwood Forest Hospitals NHS FT Response rates vs. National Response Rates

Although we are currently not achieving our internal target of a **50%** response rate, the RR for SFH is on par with the National RR for the in-patient and ED Friends and Family test (national maternity RR is not available to compare).





How are we doing? (Response rate)

Month	Response Rate In Patients (%)	National IP RR(%)	Response Rate ED (%)	National RR ED (%)	Response Rate Maternity (%)	National RR Mat. (%)
July 2014 (Q2)	38.1	38.0	12.4	20.2	10.5	*Not available*
Aug 2014 (Q2)	34.3	36.3	20.7	20.0	12.0	*Not available*
Sept 2014 (Q2)	34.9	36.2	21.6	19.5	11.8	*Not available*
Q2 Average RR	**35.8**	**36.8**	**18.2**	**19.9**	**11.4**	*Not available*
Oct 2014 (Q3)	40.5	37	19.8	19.6	13.8	*Not available*
Nov 2014 (Q3)	33.8	36.8	15.6	18.7	16.3	*Not available*
Dec 2014 (Q3)	36.6	*Not yet available**	15.6	*Not yet available**	19.3	*Not available*
Q3 Average RR	**37.0**	**36.9***	**17.0**	***19.15****	**16.5**	*Not available*

Trust Future Plans

- A communication strategy is underway including posters and banners distributed across all of our wards, departments, entrances and exits in order to raise overall awareness. The use of social media, iCare2 and local press is also being explored.
- A pilot of the use of a FFT Online Application on IPAD/Android touch screen equipment to capture the views and opinions providing real time feedback in the Outpatient and Emergency Departments will commence in February 2015.
- A regional hub is currently developing a framework to provide an approved list of external providers to support FFT within NHS Trusts which will ensure comparable data between local trusts. The current timescale for this is within 4 months from January 2015.

Source of national data: http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

Safety Thermometer

Safety Thermometer targets for 2014/15 are :

Aim to : ensure harm free care for patients (>95%), as measured by the safety thermometer .

The Safety Thermometer was fully implemented across our Hospitals in 2012 and harms data is collected for every inpatient on the same day, once per month with the exception of paediatrics. The Safety Thermometer allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportions of patients that are 'harm free' in relation to:

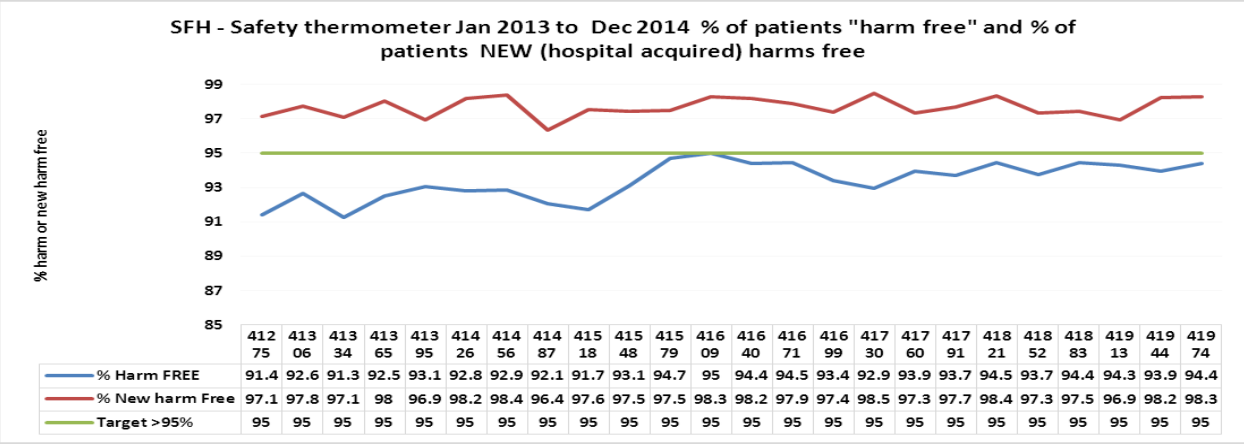
- **Grade 2, 3 and 4 pressure ulcers** -Old pressure ulcers developed within 72 Hours (3 days) of admission to organisation. New pressure ulcers developed 72 Hours (3 days) or more after admission to organisation .
- **Catheter acquired urinary infections (CAUTI)** -An indwelling urinary catheter in place and patient being treated for a UTI. Treatment started before the patient was admitted to organisation (Old) or after admission (New)
- **Falls** -Any fall that the patient has experienced within the previous 72 Hours in a care setting .The severity of the fall is defined in accordance with NRLS categories
- **Venous thrombo-embolism (VTE)** New VTE where treatment for the VTE was started after admission to organisation. Old VTE where treatment for the VTE was started before admission to organisation.

How are we performing against this target

The Trust continues to achieve 100% compliance in submitting data to the NHS Safety Thermometer.

A total of 1921 patients were assessed using the Safety Thermometer during Q3. In Q3 **97.87%** of SFH patients were receiving harm free care. If we include those patient's admitted with a degree of harm this figures falls to **94.22%**, just below the national goal of 95%, which is a slight improvement on the average of **94.20%** in Q2.

Safety Thermometer



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% Harm FREE	91.4	92.6	91.3	92.5	93.1	92.8	92.9	92.1	91.7	93.1	94.7	95	94.4	94.5	93.4	92.9	93.9	93.7	94.5	93.7	94.4	94.3	93.9	94.4
% New harm Free	97.1	97.8	97.1	98	96.9	98.2	98.4	96.4	97.6	97.5	97.5	98.3	98.2	97.9	97.4	98.5	97.3	97.7	98.4	97.3	97.5	96.9	98.2	98.3
Target >95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
% Harm Free	91.41	92.64	91.28	92.53	93.05	92.8	92.85	92.07	91.71	93.11	94.68	95	94.38	94.45	93.4	92.94	93.93	93.71	94.45	93.73	94.44	94.32	93.93	94.41
% New Harm Free	97.14	97.75	97.09	98.02	96.93	98.16	98.37	96.36	97.56	97.46	97.5	98.28	98.18	97.9	97.39	98.5	97.33	97.68	98.35	97.34	97.46	96.93	98.24	98.29
Target>95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Mitigation Plans

The Patient Safety Team along with the Tissue Viability Team, IPCT and Lead Matron for falls prevention continue to attend the wards and validate each harm and identify valuable learning opportunities. The monthly information will be able to be shared more widely through the use of the (I) care 2 share learning boards and encourage teams to come up with their own improvement ideas.

Work has been progressing across the health community in relation to reducing the incidence of UTI's in patients with catheters. A draft patient passport has been developed that would be given to every patient that has a catheter inserted either in the community or whilst in hospital, this would detail reason for insertion, who the contact person is for any issues or concerns and what equipment is required. This will help to standardise the treatment and care. Plans are being progressed to commence both the Medicines and Maternity Safety Thermometer within the next quarter.

Sepsis

Sepsis targets for 2014/15 are :

CQUIN – Achieving 75% compliance with the Sepsis bundle by Quarter 2, improving to 85% compliance by Quarter 3 & 95% by Quarter 4 2014/15.

How are we performing against this target

The validated audit data for Q1 + Q2 evidences a Trust-wide compliance of 50%.

Q1 (n=80) 48.8%

Q2 (n=80) 51.3%

The Emergency Department has recorded a compliance rate of 65.3% in comparison to a 28.6% being recorded across the in-patient wards.

The Quarter 3 data is currently being finalised & validated. This will be available at the end of January 2015. We will not meet the Q3 target of 85%

Mitigation plan (actions to date and future planning)

1. In light of current performance a decision was made to increase the allocated hour apportioned to the Sepsis nurse in order to significantly improve compliance to achieve the target.
2. Following the recent resignation of the medical lead for sepsis a successor has been appointed where by the multi-disciplinary Sepsis Working Group will be recommenced January 2015. The membership of the group has been reviewed to include Paediatric representation.
3. Recent improvements in audit systems and processes have addressed the backlog resulting in bi-monthly audit information for respective specialties.
4. There is a robust governance system that enables learning and improvement **:** areas where poor care is evident can learn from errors and have support to improve practice. The Sepsis Nurse will ensure governance procedures are followed and that clinical teams have the support needed to share their “lessons learned”.
5. A deep-dive review is being undertaken in January 2015, to look at sepsis related HSMR figures from April – August 2014.
6. The Trust sepsis policy is being reviewed to incorporate paediatric sepsis care. This will be published alongside a Trust-wide awareness campaign.
7. Education programs will be held throughout the remainder of the year for both medical & nursing staff. Poor performing areas will have additional targeted training. Sepsis is to be included in the mandatory training workbook for nursing staff from April 2015.
8. The Sepsis Nurse is now working with the CCG to support improvements regarding sepsis care across the wider health community.
9. The Sepsis Nurse is working with the NHS England sepsis collaborative to improve sepsis care nationally.

Pressure Ulcers

Pressure Ulcer targets for 2014/15 are :

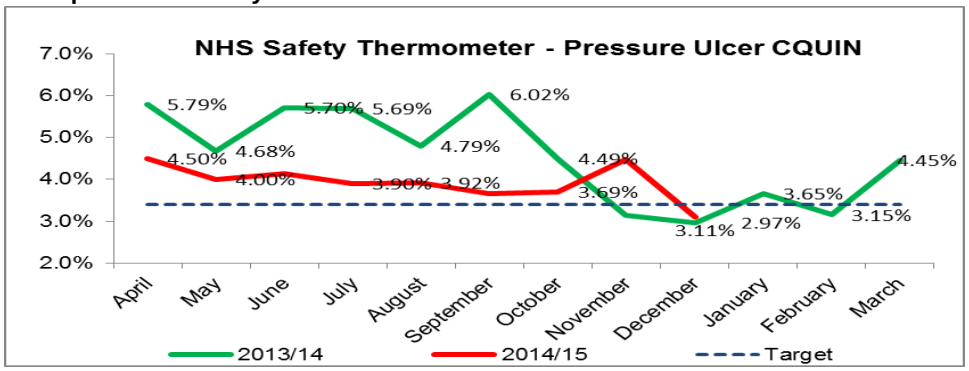
1. **CQUIN** – A 50% reduction in all PU's (both inherited and hospital acquired) using the safety thermometer data
2. **Contractual** – A 50% reduction in avoidable PU's
3. **Internal** – The elimination of grade 3 and 4 avoidable hospital acquired PU's by October 2014 and achieve zero by March 2015

How are we performing against this target

1. **CQUIN**

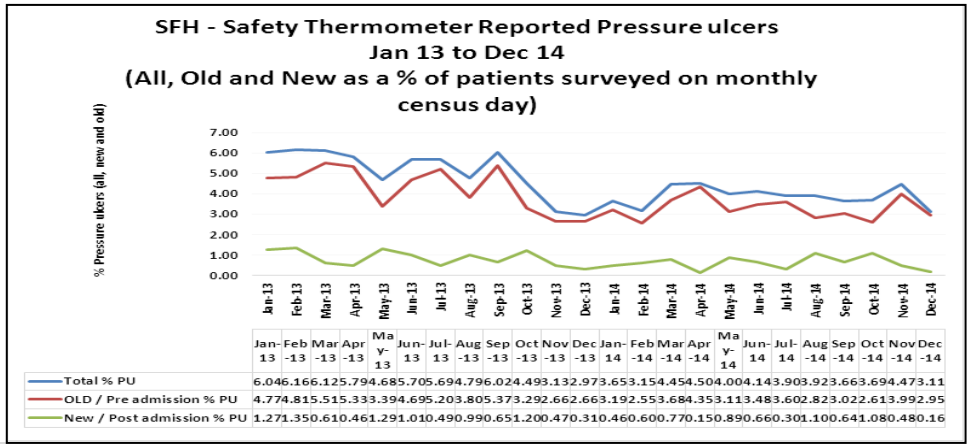
During 2014 the trust has evidenced a gradual reduction in the number of pressure ulcers reported both from an inherited and hospital acquired perspective with the exception of November. In December further reductions were seen resulting in the number of pressure ulcers reported dropping below the median (Graph 1)

Graph 1: NHS Safety Thermometer



Graph 2: NHS Safety Thermometer

Analysis of Graph 2 Demonstrates an overall reduction in the number of inherited and hospital acquired pressure ulcers reported.



2. Contractual

During Q3 a total of 9 avoidable Grade 2 (superficial) PU's were reported against a target of 12. From a year to date perspective a total of 55 Grade 2 PUs have been reported against an annual target of 53.

There have been no Grade 3 pressure ulcers reported since April 2014.

Graph 3 illustrates a significant reduction in reported hospital acquired Grade 2 pressure ulcers whereby we have achieved six consecutive months below the mean and four consecutive months below the LCL for grade 2 PU's.

December is the first month since data collection started that there have been NO avoidable PUs (Grades 2-4)

3. Internal

Targets for grade 3 and 4 (Deep) PU's have been achieved from a year to date perspective.

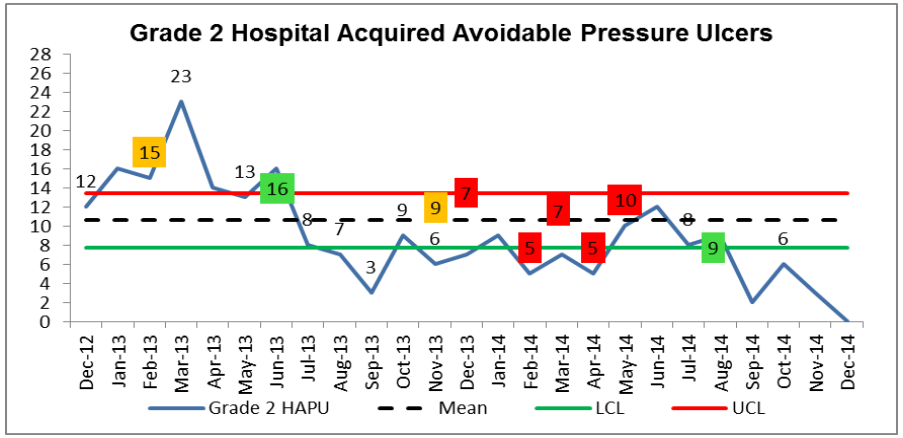
Mitigation plan (actions to date and future planning)

1. The CQUIN support worker continues to assess all patients to the Trust with suspected pressure damage which facilitates accurate PU data collection from other providers
2. Collaborative working with the Practice Development Matrons, auditing tissue viability care on wards with on going bespoke support and education to wards
3. The Tissue Viability Link Nurse Meetings revamped to include formal education and encourage attendance from January 2015

Table: Total Number of Pressure Ulcers Reported

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Totals
GRADE 2 - is superficial and may look like an abrasion or blister										
2012 - 13	12	12	10	4	7	11	8	10	12	86
2013 - 14	14	13	16	8	7	3	3	4	7	75
2014 - 15	5	10	12	8	9	2	6	3	0	55
Target No.	5	5	5	5	5	4	4	4	4	41
GRADE 3 - goes through the whole layer of skin with damage to the tissues underneath the skin										
2012 - 13	0	0	0	0	4	5	1	3	2	15
2013-14	5	4	2	0	1	0	1	1	1	15
2014 - 15	2	0	0	0	0	0	0	0	0	2
Target No.	2	2	2	1	1	1	0	0	0	9
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	2
2013 - 14	0	0	0	0	0	0	0	0	0	0
2014 - 15	0	0	0	0	0	0	0	0	0	0
Target No.	0	0	0	0	0	0	0	0	0	0

Graph 3: Total Number of Grade 2 Pressure Ulcers Reported



Venous Thromboembolism (VTE)

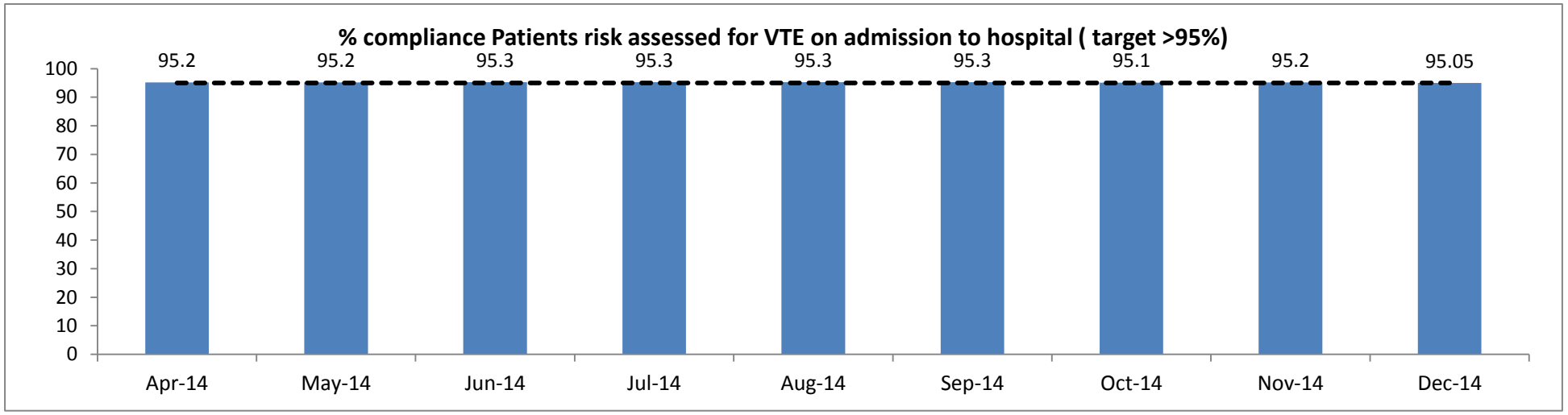
VTE targets for 2014/15 are :

Contractual: 95% of all patients will undergo a VTE (venous thromboembolism) risk assessment

Internal: 100% of cases of hospital acquired thrombosis (HAT) have a root cause analysis performed.

How are we performing against this target

Contractual: For every month during Q3 we achieved the required **95%** target and evidenced in the graph below.



Internal: All the potential HAT cases are reviewed at the VTE Group whereby those deemed to be potential avoidable are forwarded to relevant consultant to undertake an RCA. The results of which are subsequently discussed at Specialty Clinical Governance Meetings in order to facilitate organisational learning.

Dementia

Dementia targets for 2014/15 are:

- **CQUIN –**

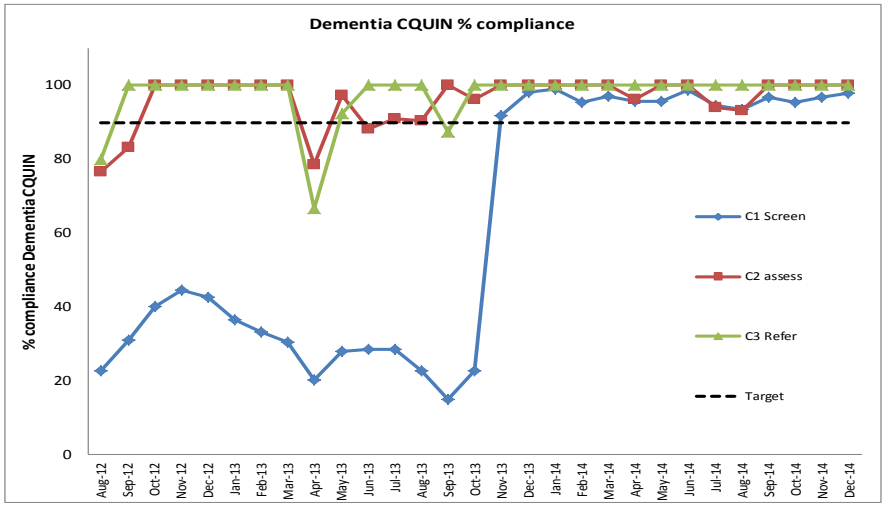
1. 90% of emergency admissions aged 75 years & over are screened, assessed and referred on to specialist services.
2. Named lead clinician and appropriate training for staff.
3. Carer support audit

How are we performing against this target

1. `We have achieved this target as we are recording 95%. We achieved 100% in C2 (Assessing possible new dementia cases) and C3 (referrals to specialist services).

2. Since September 942 members of staff have received tier 1 dementia training. This represents 88 % of staff trained.

3. Here are a selection of comments made;
   - 'I know the staff are busy but no one has offered me a drink or anything to eat. I was here from 1pm until 9pm yesterday.' - **Ward 34**
   - 'Everyone has been brilliant. I know they cannot give out information over the telephone but I ring a couple of times a day and they always tell me what they can' - **Ward 34**
   - 'The staff on this ward are wonderful, nothing is too much trouble, they really help me with my husband who has Lewy Body dementia' - **Ward 22**
   - 'My mum has been on Ward 43 and now on this ward and I have absolutely no concerns from either ward. I have been informed what is happening every step of the way' - **Ward 35**
   - 'Mum was on this ward before the changes and its amazing how much of a difference it has made having the mental health nurses and the general nurses together in one place' - **Ward 52**



Dementia Carer Support Survey - Q3 2014/15

As a carer of someone living with dementia, how supported have you felt during this stay at Sherwood Forest Hospitals NHS Foundation Trust?

Answer Options	Very well supported	Supported	Neither supported or unsupported	Unsupported	Completely unsupported
Oct	5	1	0	1	0
Nov	8	4	0	0	0
Dec	8	7	1	0	0
Total	21	12	1	1	0

Mitigation plan (actions to date and future planning)

Work currently being undertaken at Sherwood Forest Hospitals to improve the experience of our dementia patients.

Training

In addition to tier 1 training, staff have had the opportunity to attend Meaningful Activity training and study days provided by our colleagues in Nottinghamshire Healthcare.

Ward 52

The business plan to develop ward 52 into a geriatric medical mental health ward has been approved by the Trust Corporate Development Group and Charitable Funds Committee. Work will begin early in 2015 and will involve environmental changes to improve the experience and care of our patients living with dementia.

Dementia Champions

Wards have now identified dementia champions. The first meeting took place in December. Meetings will take place alternate months and provide a platform for staff to share good practice and to develop new skills to cascade within their work areas.

Forget Me Not Project

The medical records steering group have approved the use of the forget me not emblem on the front of the case notes of patients with a known diagnosis of dementia. The forget me not magnets will also be used on the care and comfort boards.

Stickers detailing further information about the patient will be placed on the internal alert notification page of the case notes.

'Forget Me Not' enables staff to immediately identify a disorientated patient, needing more time and support or special care.

Dementia Friendly Environment

Medirest have agreed to fund the purchase of coloured drinking beakers for patient areas. Research has shown that patients with dementia will drink more from a coloured beaker so the expectation is to improve the hydration amongst this vulnerable group.

Carers Audit

This monthly audit of has been developed into a written questionnaire and expanded to include questions relating to care planning and discharge arrangements.

Infection Control

Infection control targets for 2014/15 are :

- **Contractual** – 1. Zero tolerance Hospital Acquired MRSA
  2. Minimise rates of Clostridium difficile – No more than 37 cases.
- **Internal** – No more than 5 Urinary Catheter Related bacteraemia
-

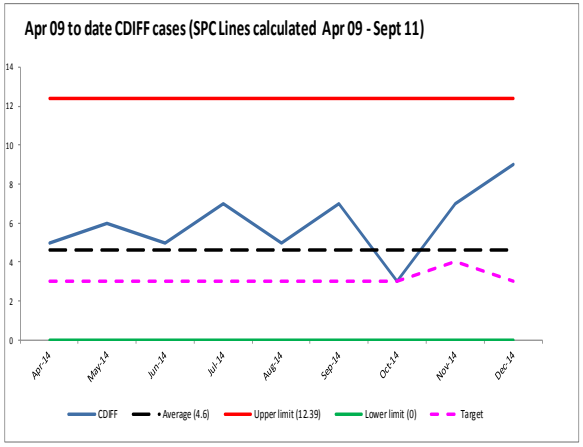
How are we performing against this target

MRSA bacteraemia: There have been zero cases of hospital acquired MRSA bacteraemia so far this year

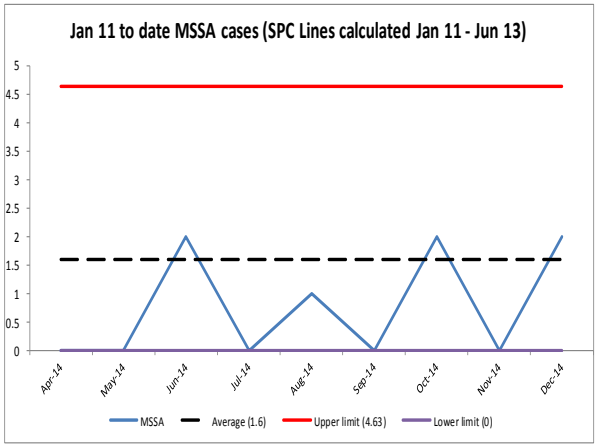
Clostridium Difficile: There have been 19 incidents of *clostridium difficile* toxin during Q3 bringing the rolling total to 54. This breaches our target of 37 in one year (Graph 1) RCA's have been performed and on one occasion there was a delay in sampling, 4 cases were identified as part of a period of increased incidence of *norovirus* and were not treated for their *clostridium difficile* toxin diagnosis.

Catheter associated bacteraemia: There have been 3 (Q3) cases of hospital acquired catheter associated bacteraemia, bringing the total to 8 since April 2014. The main causative factor is related to prolonged insertion and practice compliance problems. Mandatory reporting of all bacteraemia caused by either methicillin sensitive *staphylococcus aureus* (Graph 2) and *eschericia coli* is required. E.coli bacteraemia were the causative organism in the 2 of the catheter related bacteraemia identified (Graph3)

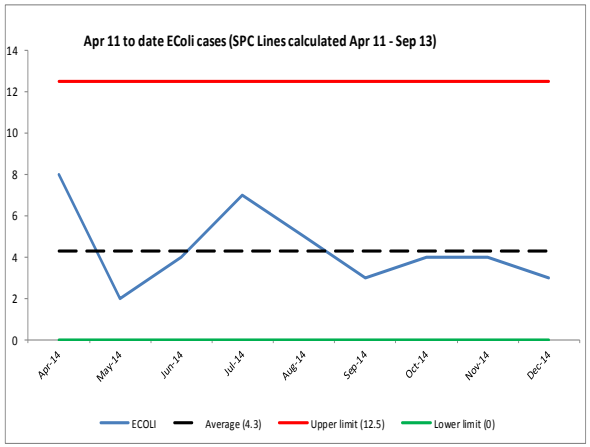
Graph 1



Graph 2



Graph 3



Mitigation plan (actions to date and future planning)

Clostridium Difficile: this remains high on the agenda and a comprehensive action plan is in place with clear, measurable goals. A meeting has taken place to discuss future management across the whole health economy, identifying triggers and practice issues. It has been agreed;

- SFH will join the area prescribing group
- Education of GP's in antibiotic stewardship
- The IPC teams will meet w/c 26th January 2015
- Invited the patient safety collaborative to assess our internal measures

Bacteraemia: Any bacteraemia are reviewed by an IPCN and a consultant microbiologist, where identified as Trust acquired and/or device related, an RCA is performed to explore the relevant practice issues.

Surgical Site Infections: The Trust performs both mandatory and non-mandatory surgical site surveillance on four areas. During quarter 3, it was identified that at present no infections were identified via the mandatory surveillance of Total Hip Replacements and Total Knee Replacements. It should be acknowledged that this data is subjected to formal validation by Public Health England in February, therefore may alter. Within the non-mandatory fields it appears that the rate of infection for Hemi-arthroplasty sits at 4.5%; 3 infections identified from a total of 67 surgical procedures. The rate for caesarean section surgical site sits at 2.2%; 4 infection from 178 procedures.

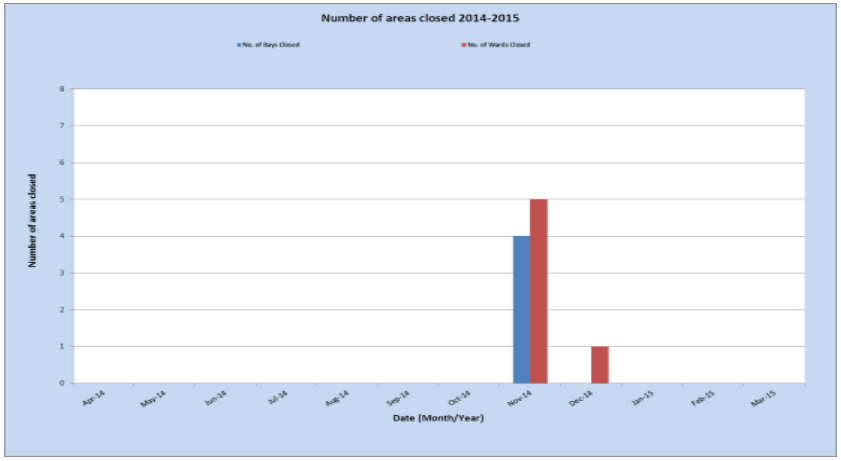
Catheter Associated Bacteraemia: Cross health economy working has identified that there are communication shortfalls between primary and secondary care. The use of the catheter passport being designed by community colleagues is anticipated to mitigate against catheters remaining insitu with no documented reason. The passport implementation is expected during Q4.

Outbreak management: In common with the national profile a surge of 10 wards (Graph 4) across the trust were fully or partially closed due to *norovirus* outbreaks during Quarter 3, affecting 91 Patients.

Two areas identified positive patients but were able to fully contain the infection.

A total of 146 bed days were lost and 8 patients had a delay in discharge.

Graph 4



Audit

A programme of Bi-weekly audits are performed by the IPCT in all clinical areas. Table 2 shows the results by division and provides the overall percentage score for the organisation. To be considered compliant the minimum score should sit at 90%. Newark consistently achieves a high mark in all elements, which has ensured the overall organisational score is above 90% in most areas, except hand hygiene and sharps management. The table identifies the individual divisional scores, this information is shared within their divisional governance processes. Areas which show high levels of non-compliance will be re-audited within 6 weeks.

Oct-Dec 2014

		%Score			
Audit	**Total Areas**	**ECM**	**PCS**	**NWK**	**%Trust Score**
Hand Hygiene	36	75	100	100	86
PPE	36	100	100	100	100
VIPS	36	50	83	100	91
Isolation	36	95	75	100	91
Sharps	36	30	35	100	47
Linen	36	90	100	100	94

Education and Training

- Mandatory education across all clinical groups includes details on management of patients with an identified infection. A compliance rate of 79.9% has been achieved across all groups by the end of Quarter 3
- Hand hygiene Training is now mandated across all staff groups and processes are being put in place to ensure compliance is achieved during 2015/2016

Decontamination

- The business case to upgrade the equipment for enhanced environmental decontamination was approved and 5 new ‘Deprox’ machines were deployed at the end of November. There has been a demonstrable reduction in turnaround times since using them
- In addition three new chemicals cleaning products are being trialled that are effective and not detrimental to equipment. A decision will be made mid to late January 2015 to identify the preferred product. This decision will be based on both microbiological efficacy and usability

Medicines Safety

Medicine safety targets for 2014/15 are :

Internal:

1. Zero medication-related 'Never-Events'.
2. To increase the number of reported medication-related incidents (including near-misses) by **20%** (compared to 2013/14)
3. To reduce the number of medication-related incidents resulting in moderate/severe harm by **25%** (compared to 2013/14 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation etc.

How are we performing against this target:

1. **Zero Medication related 'Never Events'.**

There have been **no** reported medicines-related 'never-events' during Quarter 3 of 2014/15.

2. **To increase the number of reported medication-related incidents by 20% (compared to 2013/14 data).**

There has been no significant change in the total number of medication incidents reported in Q3 for 2014/15 compared to 2013/14

Year-to-date there has been a **21% increase** in the total number of medication incidents reported compared to the same period in 2013/14; most were reported in the period Apr – Jul 2014 (549) compared to 475 for Aug – Dec 2014. The underlying cause of this shift is being investigated. (Graph 1)

Most reported incidents year-to-date continue to relate to **medicine administration/supply,** of which medicine **non-administration** (particularly for critical medicines such as antibiotics, antiepileptics etc.) is most reported, an **increase of 74%** in 2014/15 Q3 compared to Q3 in 2013/14. This reflects an increase in awareness and improved reporting; such omissions remain a particular concern locally and nationally, and significant focussed work is on-going across the Trust to further increase awareness and improve practice . (Refer to QIP)

3. **To reduce the number of medication-related incidents resulting in moderate/severe harm by 25%, particularly for high-risk medicines.**

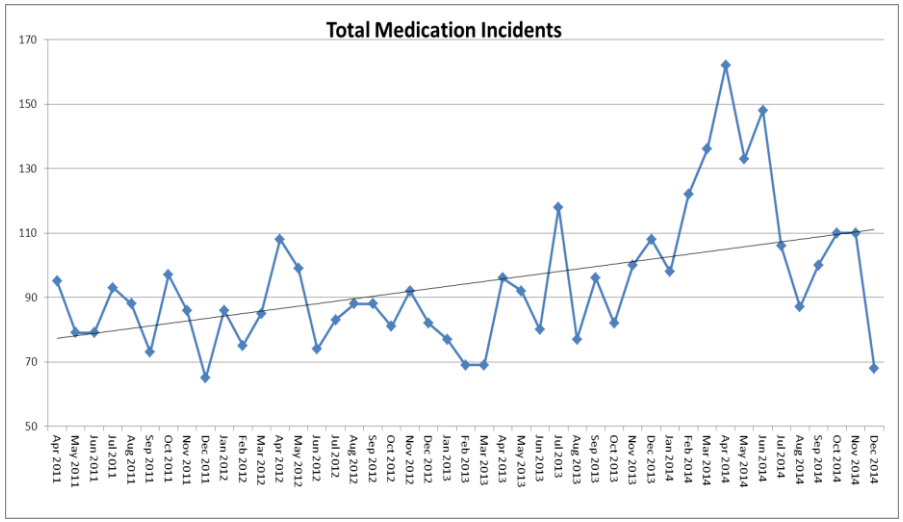
Overall numbers remain very low. There has been a **30% increase** in such reporting from Apr to Dec 2014 compared to the same time period 2013/14 for all medicines; there have, however, only been 2 such reports during Q3. (Graph 2)

Over 80% of medication-related incidents reported in 2014/15 Q3 were allocated a level of 'no harm' severity to-date. Further work is required for analysis on harm associated with specified high-risk medicines. There were no 'severe' or 'catastrophic' harm outcomes.

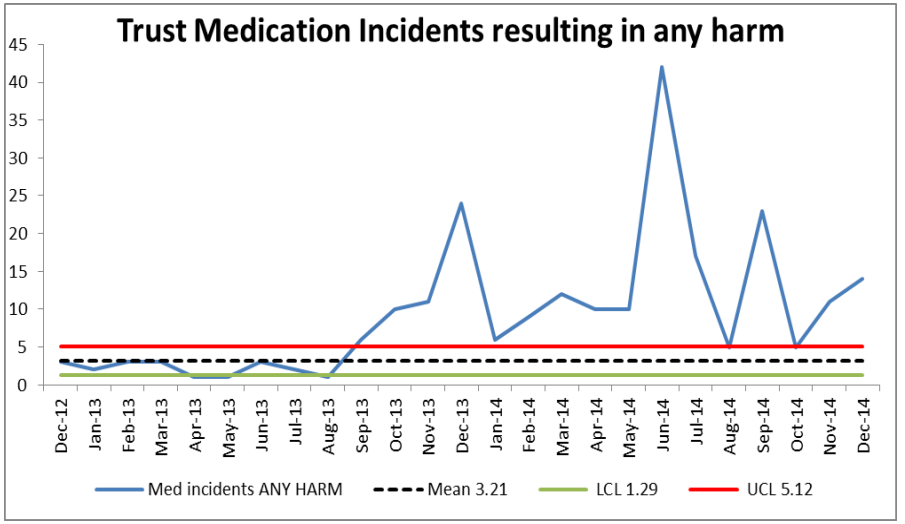
Any 'harm' classification should be viewed with caution as it is often subjective and sensitive to potential bias from either the incident reporter or investigator/handler, with inconsistent interpretation of outcomes against the NPSA standard definitions between individuals. The role of the Medicines Safety Officer may help provide a more consistent assessment of harm in future. However, the general trend increase in reporting of any harm since September 2013 has been maintained. Future reports will provide more insight to this trend

Medicines Safety

Graph1



Graph 2



Analysis of medicines incident reporting rates from recently updated National Reporting and Learning System (NRLS) data (to Oct 2014), continues to demonstrate a reporting rate at the Trust equivalent to other medium acute Trusts in the region. This suggests a continued positive culture within the organisation to report incidents and near-misses relating to medicines.

Mitigation plan (actions to date and future planning)

1. Medicines-related 'never-events' categories continue to be included in induction and mandatory update training for nursing staff, related posters are on display for all staff in clinical areas and on the intranet (note: the Department of Health are likely to be changing 'never-event' categories and triggers early in 2015/16).

2. All staff are encouraged to report medication incidents and 'near-misses', but a particular focus is required to encourage reporting by medical staff. Focussed work is continuing within the Medicines Management Task/Finish Group and Pharmacy to address on-going issues regarding missed/delayed doses of medicines. Fortnightly data collection on missed doses is being undertaken by pharmacy staff and nursing medicines champions. A revised Trust drug chart was launched in Dec 2014 containing a new section for nursing staff to record actions taken in the event of medicine non-administration; this should help to reduce inappropriate dose omissions in future. Plans are being drawn for the Trust to start collecting data for the national Medicines Safety Thermometer in Jan 2015, which focuses on omitted/delayed medicines, particularly for named critical medicines (such as opioids, insulin, anticoagulation etc.). This will provide opportunities for benchmarking with other Trusts both locally and nationally. The role of the Medicines Safety Officer at the Trust should help promote medicines incident reporting going forward.

3. The assessment of 'harm' using NPSA definitions is now more open based on details provided in incident reports. Future reports should demonstrate a reduction in actual harm compared to current baseline data rather than historical data, plus greater learning from incident investigations

Hydration Q3

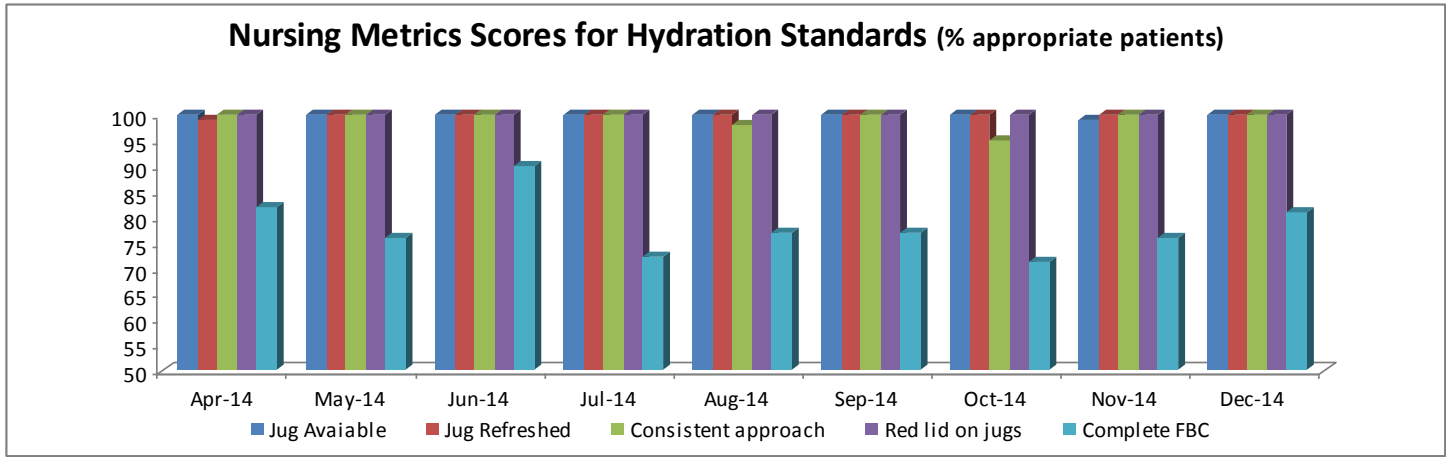
Hydration targets for 2014/15 are :

Internal – Our focus is to ensure that all patients in our hospitals receive adequate hydration and that their needs are assessed, monitored and optimised correctly

- Fundamental Standards for Hydration Care
- All patients will have immediate access to fresh water at their bedside unless restricted or inhibited by their clinical condition.
- This will be within the patients reach.
- Water will be served from clean, intact, drinking vessels, suitable for individual patient dependency needs.
- Patients will be provided with a hot/cold drink seven times per day from the beverage trolley but should feel able to ask for additional drinks at any time of the day or night.
- For those patients requiring fluid balance monitoring there will be a consistent approach to the measurement of oral fluids.
- Where fluid balance charts are required they will be completed.

How are we performing against this target

The chart below shows compliance with each of the components of the monthly hydration audit taken as part of the Nursing quality metrics.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14
Jug Available	100	100	100	100	100	100	100	99	100
Jug Refreshed	99	100	100	100	100	100	100	100	100
Consistent Approach	100	100	100	100	98	100	95	100	100
Red Lid on Jugs	100	100	100	100	100	100	100	100	100
Complete FBC	82	76	90	72	77	77	71	76	81

The table above shows the % compliance with the components of the monthly hydration audit across the Trust .
We continue to ensure that 100% of our patients have drinks available and that jugs are being regularly refreshed. The Red lidded jug system continues to be utilised well to support those patients who require additional support with their hydration needs.

The results tell us that patients continue to feel that they can ask staff for drinks when they would like one.
We still have to further improve the completion of fluid balance charts although it is positive to note that in December 81% of fluid charts were noted to have been completed correctly which has been the highest compliance observed since June 2014.

Mitigation Plan
Nurses continue to use Accountability handover to provide a focus on fluid balance chart completion and challenge when standards are not being achieved .

There are plans to introduce a new Consultant Ward round checklist during the next quarter which will ensure that a patients fluid status is assessed and discussed during the ward round.

Safeguarding Adults

Safeguarding Adults targets for 2014/15 are :

1. Undertake and report against The Safeguarding Adults Self Assessment (SAFF)
2. Implement the National Capability framework
3. Actively participate in the Multiagency Safeguarding Hub (MASH)

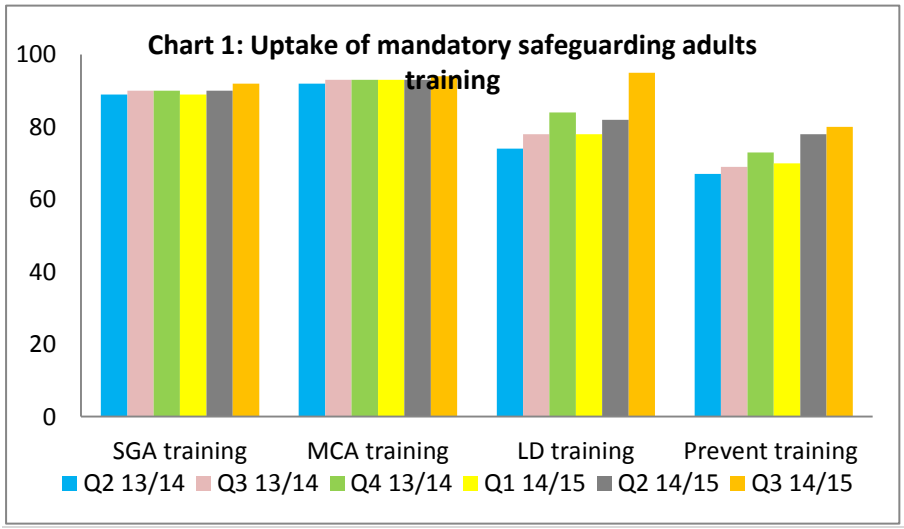
How are we performing against this target (Quarter 3)

Target 1: The Safeguarding Adults Self Assessment (SAFF)

This has been completed and submitted to the Nottinghamshire Safeguarding Adults Board (NSAB) and Clinical Commissioning Group (CCG). The output of the self assessment forms the basis of the safeguarding adult's work plan. Progress against this plan is monitored via the joint SFH / CCG quality and performance committee.

The Safeguarding Adults Work Plan – Outstanding Issues:

1. The Complex Discharge Planning proforma has been ratified and is awaiting inclusion in The Discharge Policy
2. Audit of discharge / transfer letters to residential / nursing home care will be completed by March 2015.
3. Domestic Violence alerts to be added to ED system by March 2015.
4. Mental Capacity Audit undertaken across Wards 51, 52, Stroke Unit, Ward 36, ED and EAU. Outstanding are Ward 33 to be completed by March 2015.



Target 2. Implement the National Capability Framework : Training:

Safeguarding Adults training is facilitated via the Trust's mandatory training programme as well as range of specialist study days.
It is compliant with the National Capability Framework.
The Trust's training plan is submitted to NSAB.
As shown within Chart 1 The uptake of Safeguarding Adults training exceeded the 90% target for Q3 13/14

Safeguarding Adults

Target 3: MASH:
The Trust's Safeguarding Adults Team has a close working relationship with the Multi Agency Safeguarding Hub (MASH) and the Safeguarding Adults Advisor attends the quarterly MASH health meetings.

Mitigation Plan (actions to date and future planning)

1. Vulnerable Adult assurance visit undertaken in December to ED in order to seek assurance regarding a number of emergent themes highlighted in the action plan.

2. The Vulnerable Adult resource File has been distributed to all wards and departments.

3. Vulnerable Adults champion role established across the organisation. Two training days scheduled for February 2015.

4. The Adult Safeguarding Team are present at the Proud To Care study days in order to raise overall awareness of adult safeguarding and promote the introduction of the resource files.

5. Documentation pertaining to Mental Capacity Assessments and Best Interest decisions have been updated and ratified.

6. Work is currently in progress to amalgamate the children's, adult, domestic violence and prevent training within the mandatory training programme

7. Inconsistent application of the Mental Capacity Act was confirmed following a recent quality visit undertaken by the CCG, therefore Specialist Mental Capacity and Deprivation of Liberty study days will be facilitated on a monthly basis WEF: March 2015 with an expectation that all Registered Nurses will attend.

The Vulnerable Adults Champions Network.

- Each ward/department will have a nominated Champion for Vulnerable Adults by the 31/01/15
- 38 champions have been identified from 57 requests for nominations for wards and departments across the Trust.
- Follow up emails have been sent to ward/department leaders were it has been identified that there have been no replies to requests for a nominated champion.
- 21/01/15 emails have been sent to Heads of Nursing requesting a nomination from the areas that have not nominated anyone.
- The Vulnerable Adults Champion will be supported by the Safeguarding Adults Team.
- Two study days have been arranged in February 2015 to give the Champions a wider base of knowledge to enable them to support staff in their area.
- During 2015 there will be a further 2 study days arranged to support the champions in their role.
- The Champions will carry out an annual peer audit of Medical and nursing documentation to assess how health professionals use the Mental Capacity Act in practice, they will also assist with the implementation of any actions that arise from the audits within their area.
- Their role will also be to act as a support to all staff in their ward/department area. Each ward/ department has a Vulnerable Adults folder (Yellow Folder) with examples of completed documentation and information to support the Champion. These folders will also have a register of the contact details of other champions within the hospital that will provide support in the absence of their Champion.

Safeguarding Investigations

- Nine investigations (allegations about the Trust) are in the process of being completed.
- Outstanding themes from completed ones are:
- Nursing staff Transfer/Discharge letters not detailed and not containing detailed information
- Not following the Mental Capacity Act process for Patients lacking capacity (medical staff & Nursing staff).

Adult ED/MIU assurance visit:

An Internal MIU visit by the Trust's Vulnerable Adults Team and Deputy Assistant Director of Nursing-Quality and Assurance took place in November 2014. The agreed actions were to:

- Raise awareness in ED around the importance of mental capacity assessment.
- Ensure plans for future staffing in ED are shared with staff working in the department.
- Ensure that staff are fully aware of the process of using 'flags' to identify vulnerable patients on System One.
- Review the need for restraint training for staff in ED (Clinical holding).
- Ensure body maps are easily available in minors (ED).
- Repeat this assurance visit in EAU

Safeguarding Children

Safeguarding Children targets for 2014/15 are :

- Trust to continue to assess & report to CCGs against the **NSCB Markers of Good Practice**
- Trust to implement **Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document,** RCPCH (2014)
- Active participation in **MASH**

How are we performing against this target

The self-assessment against the NSCB Markers of Good Practice showed that as a Trust, we are green against 57 of the 61 outcomes. There were no 'red' areas. 4 Amber areas were highlighted for action as below -

1. A system is in place to review named professionals competencies against the Roles and Competencies of Health Care Staff :Intercollegiate Document 2014 – (compliance 66.6% - there are only 3 named professionals within the Trust)
2. All new starters to organisation attend a safeguarding children awareness session within an induction programme or within 6 weeks of taking up post within a new organisation
3. Supervisors should be trained in supervision skills and have an up to date knowledge of legislation, policy and research relevant to safeguarding children – (compliance 89%)
4. Supervision should take place on a minimum of a quarterly basis – we do not fully meet this target

Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document –

Staff	Level 2		Level 3	
	Q2	Q3	Q2	Q3
Medical	70%	65%	46%	53%
Other	93%	93%	52%	61%

Staff compliant with mandatory training Q2 & Q3 14-15

Safeguarding Children

From a minimum staffing standard perspective we employ a part time (0.5 WTE) organisational wide Named Nurse for safeguarding children and young people (the National Standard is 1.0 WTE) and are currently in the process of recruiting a safeguarding nurse specialist to further support the service.

MASH

The safeguarding team actively participate in MASH and are signed up to being an information point for health.

Mitigation plan (actions to date and future planning)

NSCB Markers of Good Practice -

a. The Named Nurse is undertaking training to ensure that all competencies are achieved.
b. Whilst a report is produced, continued non-compliance needs to be followed up by TED in the longer term and reports produced for action.
c. Some supervisors require training to be updated. Training is planned for Q1 of 2015-2016, with the CCG Designated Nurse, for all untrained supervisors and to refresh current supervisors.
d. Compliance rates are 100% for 1:1 supervision, but not all staff attend group supervision. Supervision sessions for ED and MIU staff are being reviewed. Sessions will continue to be offered on a drop in basis and additional timetabled sessions will be run.

Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document,

1. Safeguarding CYP training offered at levels 2 & 3 will meet RCPCH standards from April 2015. Compliance of staff in attending training however remains an issue across the trust.
2. All staff who do not have up to date Level 3 training have been / will be contacted personally by the Medical Director and Executive Nurse and advised of their obligation to undertake training and how to access this.

Learning Disability

Learning Disability targets for 2014/15 are :

- **External -** Joint Health & social care Learning Disability Self-assessment Framework (LDSAF) to be submitted for January 2015.
- **Internal -** To deliver Learning Disability Awareness Training on the trust induction programme, mandatory booklet for all staff and face to face on the midwives mandatory training day, To have a Quarterly Learning Disability Steering group meeting to drive the agenda forward in the trust, involving Patients with LD and family carers, To provide support to patients with LD and carers during hospital admissions & outpatient department, To continue to work towards the annual safeguarding adults & Learning Disability work plan

How are we performing against this target:

External

Learning Disability SAF information collected for submission to NHS England, this self assessment will collate information across Nottinghamshire.

- SFHFT having a LD nurse in post – Green
- Primary care communication of learning disability status to other healthcare providers – Red. The measure for this indicator is our trust having information on LD status and the adjustments LD patients need for attending the hospital being highlighted by GPs and our trust ensuring this is acted on. This action has been discussed at the LD steering group and we are currently mapping what systems are used in outpatients and how the information we have relating to patients with LD can currently be displayed to inform staff. Further work will possibly be needed after this mapping exercise to establish better communication from CCG's.
- Complaint led changes - Amber. One formal compliant was received in the time period for which the trust apologised for loss of property. The trust also developed a discharge planning prompt as a result or a safeguarding incident involving the trust where there was inadequate information discussed prior to discharge despite full MDT.
- Data was requested on how many inpatient admissions took place, how many outpatients attendances and how many attendances in ED
- A range of patient stories have also been submitted as evidence.

Internal

- **Training –** Induction programme for Quarter 3 83% compliance (1857 staff members trained).
  Mandatory Workbook for Quarter 3, 95% Compliance (528 staff members)
- **LD steering Group Meeting –** Meeting held in November. Main Discussion points: Awaiting the Changing places facility to open due to difficulties in displaying information on moving & Handling equipment. Senior Capital Project Manager is visiting Nottingham University Hospitals to see what/how information is displayed in there hospital. Discussed the LD self assessment and agreed RAG ratings, Autism poster drafted and discussed the aim of the posters is to raise awareness for staff & visitors on autism and suggest changes to help the hospital visit. Discussions with training & development on the possibility of autism training for staff starting in April 2015 (not mandatory).
- Referrals to Learning disability Nurse Specialist during quarter 3 – 88 patients.

Mitigation plan (actions to date and future planning)

Internal meeting arranged to look at putting in place a process for better communication between primary & secondary care. First step to ensure a robust system for providing those reasonable adjustments for the patients that we already know about. Next step to approach Learning Disability CCG lead to look at GP referral process.

The Trust is compliant with the requirements regarding access to healthcare for people with a learning disability.

End of Life Care

End of life care targets for 2014/15 are :

1. To produce an overarching End of Life Care (EOLC) Strategy.
2. To deliver EOLC training on the SFHFT induction and mandatory training programme in conjunction with the provision of communication skills.
3. To facilitate the following EOLC key enablers within the Transforming End of Life Care in Acute Hospitals Programme:
    - Last Days of Life
    - Gold Standards Framework Register & Advance Care Planning
    - AMBER care bundle
    - Rapid Discharge Home to Die – including Preferred Place of Care; Anticipatory Prescribing
    - Electronic Palliative Care Coordination System (EPaCCS)
4. To capture patient/carers experience in the last days/hours of life by conducting a bereavement survey

How are we performing against this target (please refer to QIP for detailed information):

1. The End of life care strategy is now complete and work is underway to implement this.
2. End of Life Care has now been incorporated into Mandatory Training for all staff and plans have been worked up to deliver communication skills training for all staff at intermediate and advanced level. Over 400 staff have received this training via induction
3. Transforming end of life care:

- Last days of life care has been the main focus for the End of Life Care Team in this quarter. The guidelines and care plans are being used on all wards across the Trust and a full evaluation of the impact on the quality of care is underway.
- The Lead Nurse has been working collaboratively with Primary and Community Care staff in developing an unified Advance Care Plan that is recognised in all care settings.
- Patients and carers continue to be supported to die in their place of choice and in particular a rapid discharge home to die is initiated if home or normal place of residence is the place of choice.

4. A bereavement survey was commenced in October. 89 questionnaires were sent out and to date 15 have been returned. Findings are currently being analysed for quarter 3.

Mitigation plan (actions to date and future planning

- EOLC MDT training & education –delivering x 1 Advanced Communication Skills Training programme; x 2 Dying to Communicate courses in Q4.
- Last Days of Life - Complete evaluation and refine documentation by end of January then re-launch. EOLC Champions to measure the quality of care by conducting the on-going audit then feeding back the results at ward meetings and on learning boards.
- Gold Standards Framework Register & Advance Care Planning & AMBER care bundle - Commence GSF & ACB training in Quarter 4
- Work with Ward Leaders and Consultants to refine the method of capturing data to measure outcomes of ACP and patient outcomes

and use of documentation.

- Patient and Carer Experience - Analyse and report findings of bereavement survey by end of quarter 4.

Maternity

Maternity targets for 2014/15 are :

- **CQUIN –** 1. 8% Reduction in Smoking at the Time of Delivery (SATOD) to achieve 15% by March 2015.
  2. To deliver smoking cessation support (Rotherham Model) by March 2015.
- **Contractual –** Midwife to birth ratio of 1:28

How are we performing against this target

- **CQUIN**

1. Regular monitoring in place – last quarter 20.67% and for this quarter 22.81%.
2. Rotherham Model Implemented, to deliver smoking cessation support

- **Midwife to Birth Ratio.**

MW:birth Ratio for quarter 3 is at 1:30 against funded establishment.

On the same quarter last year we are up on births by 6.25% and current activity we are showing a 9.2% increase on births.

Mitigation plan (actions to date and future planning)

- **CQUIN**

1. Meetings with public health and smoking cessation continue.
   - The impact of risk perception (Rotherham Model) is starting to show in the reducing figures with exceptional
   - results in Sept 15 of 17.98% .
2. Discussions commenced re funding for sustainability of Rotherham Model for 15/16.

- **Midwife to Birth Ratio.**
  - Monitor Quarterly
  - Currently recruiting to community midwifery posts.
  - Midwifery staffing Paper shared with board end October, demonstrating current position against various
  - aspects of midwifery workforce.

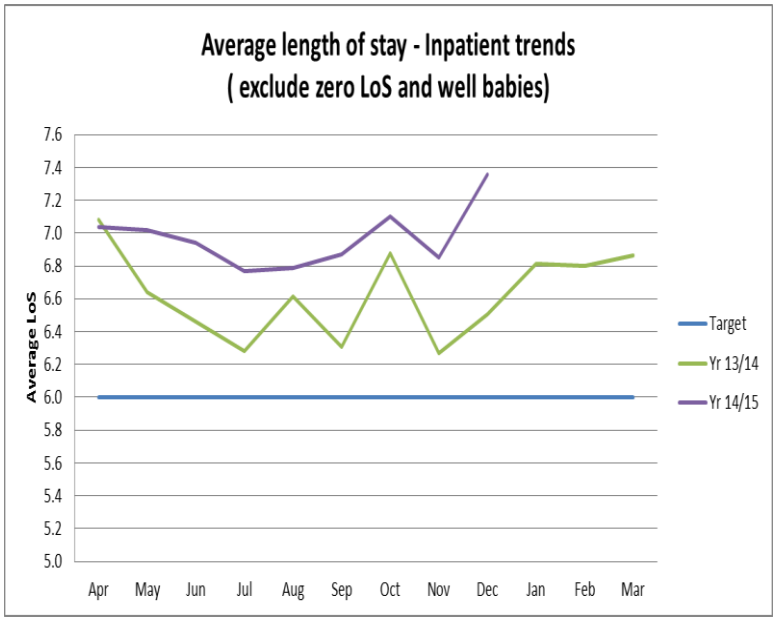
Improving Patient flow and discharge processes

Improving Patient Flow targets for 2014/15 are :

- **CQUIN -** To reduce LOS (excluding 0-1 day LOS) to **6 days**
-

How are we performing against this target

A recovery plan has been implemented to improve our performance across unscheduled care pathways including discharge (detail below) The CCG have commissioned 60 Transfer to Assess residential beds across the community supported by integrated nursing teams and GP medical cover. During December a total of 94 patients have been transferred on to this scheme.



- The internal bed capacity meetings have been redesigned to facilitate proactive and consistent management of patient flow throughout the organisation. In addition to this our escalation policy has been reviewed to ensure that robust and appropriate decision making processes are in place to support patient flow.

- Morning board rounds are currently being embedded across our in-patient wards and are further supported by the 'Pull Team' . This is to ensure that complex discharges are facilitated and patients are cared for in the most appropriate environment to meet their on-going needs.

NOTE: LOS will have increased recently as the actions described above have enabled the hospital to discharge a number of patients with a very long LOS. The LOS is recorded on discharge which means the average LOS in graph 1 above will be higher than expected for Dec14 and Jan 15.

Mitigation plan (actions to date and future planning)

A comprehensive Emergency Flow Action Plan has been developed to address all of the issues raised with in the recovery plan.

Details of Trust actions contained in the Recovery Plan are:

- Revised signposting for ambulatory care to ensure all appropriate patients are managed on an ambulatory pathway
- Revised streaming arrangements of patients from ED to PC24
- An additional acute physician working in ED to prevent admission where appropriate
- Pilot project running to provide GP access to acute physicians to discuss patients pathways – and alternatives to hospital admission
- Two additional middle grade doctors working in ED
- Strengthened floor management in ED
- Standardisation of progress chaser roles in ED to improve flow management
- Increased monitoring and internal escalation
- Development of Internal Professional Standards to improve clinical support service contribution to patient flow
- Continued implementation of Morning Board Rounds on all wards
- Full utilisation of the Discharge Lounge
- Pilot project for ward led discharge
- Development of a senior led, dedicated improvement team
- Redesign of internal pathways for GP referred and ambulatory patients

Week commencing 12th January 2015;

- There have been 0 X Ray breaches attributed to ED breaches
- Breaches caused by ‘waiting for a bed’ have reduced by 50%
- Our 4 hourly performance has improved from 82% to 89%
- Highest use of the discharge – 61 patients with an average LOS of , 3 hours

Incidents, Serious Incident & Never Events

Never Events

There have been no 'Never Events' reported since December 2013.

Incidents

The table below shows the top ten incidents reported and the associated harm for Quarter 3. Falls remain the highest reported incident with either low or minimal harm, of the 12 Moderate incidents all are or have been subject to an investigation and follow the Serious Incident process (not all moderate falls are STEIS reportable) Action plans are tracked to ensure that all actions are completed and lessons learnt are presented at Divisional and Speciality Governance meetings.

There were no Grade 3 or 4 pressure ulcers reported during December 2014.

Of the pressure ulcer reported on STEIS during quarter 3 a rapid review by the Tissue Viability team and supported by members of the Clinical and Managerial teams , found that these pressure ulcers were unavoidable.

Top 10 Incidents - Category by Severity

	(Grade 1) No Harm	(Grade 2) Low - Minimal Harm Patient required extra obs or minor treatment	(Grade 3) Moderate - Short term harm pt required further treatment procedure	(Grade 4) Severe - Permanent or long term harm	(Grade 5) Catastrophic - Death	Total
Falls	432	104	12	0	0	548
Pressure Ulcers	223	150	4	0	0	377
Medication	226	36	2	0	0	264
Delays in Care	116	24	9	0	0	149
Skin Damage	72	47	2	0	0	121
Treatment	62	34	11	0	0	107
Security or unacceptable behaviour	70	9	1	0	0	80
Health and Safety	45	24	3	0	0	72
Pathology / Specimen related	63	9	0	0	0	72
Staff injuries / illness at work	44	17	5	0	0	66

The majority of incidents are reported by the nursing workforce and further work is required to encourage reporting from all Professions.

Incident, Serious Incidents & Never Events: Serious Incident summary

Graph 1

In the period of Q3 14/15, there was a total of 18 STEIS reportable Serious Incidents. The number of STEIS reportable SI's reported during Q3 14/15 **is fewer** than those reported in Q3 13/14 & Q3 12/13

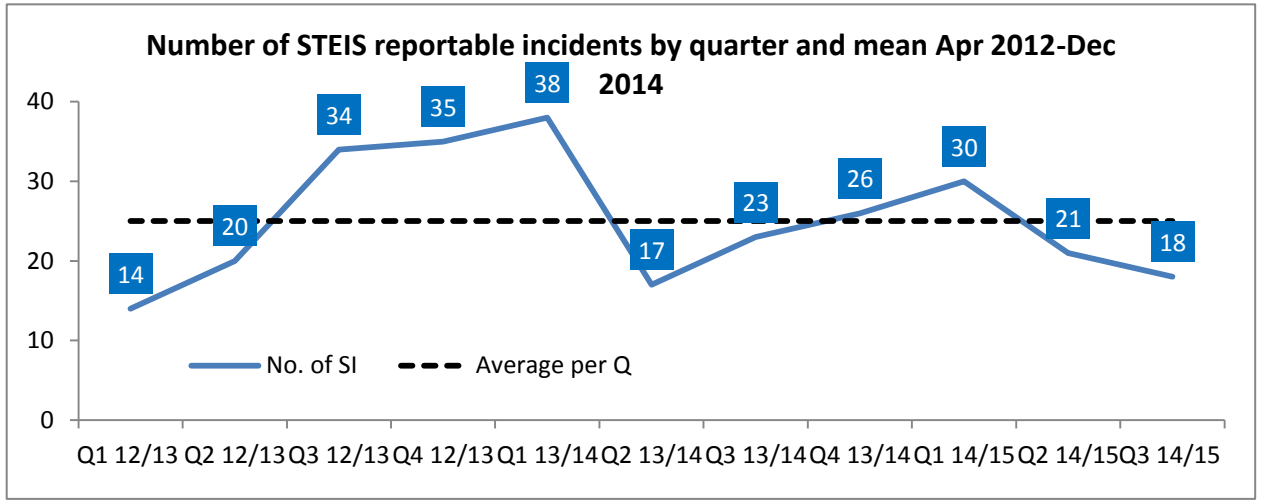


Table 2:

Table 2 shows the number of STEIS reportable Serious Incidents (SI) by Division and reporting category

Table 2: Number of Serious Incidents by Division and Serious Incident reporting category.

No. of SI	Emergency Care and Medicine	No. of SI	Planned Care and Surgery	No. of SI	Newark
5	Slips/Trips/Falls	2	Slips/Trips/Falls	1	Delayed Diagnosis
1	Pressure ulcer grade 3 - unavoidable	1	Pressure ulcer grade 3 - unavoidable	1	Slips/Trips/Falls
1	Pressure ulcer grade 4 unavoidable	1	Confidential Information Leak		
1	Other-Unstageable suspected Deep Tissue Injury	1	Maternity services IUFD		
1	Other-# NOF ? cause				
1	Suboptimal care of the deteriorating patient				
1	Safeguarding Adult				

Incidents, Serious Incident & Never Events

Learning from serious incidents

The Patient Safety Boards being introduced across ward and departments will incorporate Serious Incident Learning at a glance. This will be key messages taken from the recently closed Serious Incidents or in response to immediate risks that may have been identified.

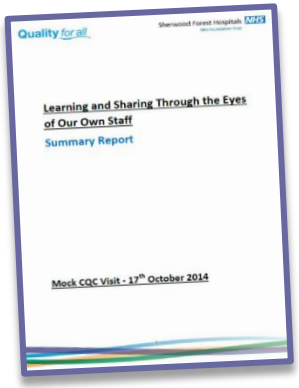
Within the Planned Care & Surgery Division since October 2014 every month a specific speciality has been asked to present a case history of a patient where there has been an Internal investigation, STEIS reportable incident or Coroners case. These presentations have looked at the presenting complaints and the management of the patients, where lessons have been learnt for both medical and nursing personnel and the actions that have come out of these incidents. These presentations have provided excellent opportunities for shared learning within the Division and have provided the team with the opportunity to have open and honest discussions and sharing of experiences. Following the December presentation the division have now developed a “Learning Board” which looks at “What happened? Why did this happen? What did we learn? and Actions. This will be completed after each presentation and then will be disseminated to all the Governance leads to share at the Speciality Governance meetings.

Going forward after the submission of any internal or reportable incidents the author of the report will be asked to share the findings with the Divisional Governance group.

Within the Emergency Care and Medicine division, whenever a serious investigation has been closed by the CCG (or in the case of internal SIs, signed off by the Trust), the investigation report is sent to the author, and to the clinical areas and governance leads to share the learning from the investigation with the clinical and nursing teams, and for inclusion on the agenda at the Specialty Governance meetings. The Speciality Governance leads are also asked to present the findings of the investigation to members of the division at the monthly Emergency Care and Medicine Clinical Governance meeting, to ensure there is learning throughout the division. Any investigation findings and shared learning that is considered to benefit being shared with the other divisions, is requested to be an agenda item on the respective Divisional Clinical Governance meeting (via that division’s Clinical Governance Co-ordinator). Findings and learning from coroner’s inquests are disseminated in the same fashion. Members of the Emergency Care and Medicine Clinical Governance Group have fed back to the Clinical Governance Co-ordinator that they have found this to be a useful and meaningful way of sharing learning across the division, and indeed where appropriate, across the Trust.

CQC Compliance & Quality Assurance

As with all health care providers, Sherwood Forest Hospitals is required to be registered with the CQC and inspection of services is an integral part of this. With a re-inspection of the whole Trust expected in the very near future, preparations are underway so that we are in the best position possible. Progress of our Quality Improvement Plan can be found by following this link:
http://www.nhs.uk/NHSEngland/specialmeasures/Documents/December%202014/sherwood-dec-2014.pdf



Mock CQC 'Inspection'

In October we held a Mock CQC style internal inspection of our services. The intention of this full day was to assess our Trust's position by replicating the CQC inspection process of viewing care through the eyes of our patients as well as develop staff knowledge and skills (how does it feel/what does it mean to me). In order to do this, we gathered a 60 strong team of volunteer 'inspectors' who were placed into 14 teams and sent out across the Trust. We had representatives from a number of disciplines as well as Directors, Non-Executives, HealthWatch, Governors, our commissioners and former patients acting as 'expert by experience'.

- A copy of the final report can be obtained by emailing adam.hayward@sfh-tr.nhs.uk.
- Response to the final report was provided by specialities and service lines in which they were shared their views on what the report told them about their service line as well as to identify what immediate plans they had for addressing any concerns raised.
- Feedback has been helpful in influencing future planning for both improvement work and developing our internal assurance programmes.
- The whole day was deemed to be a huge success with the report and it's findings influencing the development of a detailed assurance dashboard with associated Key Performance Indicators.

Internal Assurance Teams

Guided by various sources of intelligence, our Internal Assurance Teams (IAT) will form a key part of our Quality Assurance processes. Visits are scheduled to commence in January 2015, continuing monthly thereafter.
17 teams from across specialities and professions will give monthly scrutiny to departments across the Trust
Highlighting excellence in practice as well as providing support to wards/departments where they need to further develop or improve Following and reporting utilising the 5 domains followed by the CQC (Safe, Caring, Effective, Responsive, Well-led).
Judgements and recommendations will be provided to individual wards/departments as well as the Trust's governance structures.

CQC Compliance & Quality Assurance

Executive Walk Rounds

Several of the Directors and Non-Executive Directors have been performing assurance 'walk-rounds' in clinical areas. These visits are intended to follow a brief '15 steps' approach to assessing wards and departments. By having first-hand experience of the care we deliver, we can help to paint a clearer picture of how we are preforming at the point of care delivery. A brief summary of the main findings can be found below:

Positive Practice

- Wards/departments were calm
- Care was well organised
- Cleanliness was excellent
- Patients described staff as friendly and caring
- All the visiting teams experienced lots of positive patient feedback
- Departments appeared busy but well controlled
- Several areas of excellent practice were identified in all of the visit reports

Areas of concern

- Inconsistency in practice within wards and departments
- Drug security in some areas
- Fluid balance charts inadequately completed
- Notes security on some wards
- Leadership in the absence of the ward Sister/Charge Nurse
- Poor attitudes of some of our Staff towards visiting teams

Intelligent Monitoring Report

Our latest CQC intelligent monitoring report (IMR) was published 3rd December 2014. Intelligent Monitoring is based on 150 indicators that look at a range of information. The CQC uses this statistical analysis in order to categorise Trusts into one of six summary bands, with band 1 representing highest risk and band 6 the lowest.

- We are currently banded as 'recently inspected'. However, as we are in special measures this would be reflected as 1*
- Our current risk score is 12 (6.90%)
- In the December 2014 report Sherwood Forest Hospitals have 4 "elevated risks" in the red category and 4 "risks" in the amber category

Red risk

- Dr Foster Intelligence: Composite of HSM Ratio Indicators
- Monitor governance risk rating
- Monitor continuity of service rating
- CQC Whistleblowing alert

Amber risk

- In-hospital mortality (gastro and hepatological conditions and procedures)
- Composite of hip related PROMS indicators
- Stroke Audit SSNAP Domain 2
- Consistency of reporting to the National Reporting and Learning Systems (01-Oct-13 to 31-Mar-14)

Risks removed from report (no longer alerting)

- Composite of Central Alerting System (CAS) safety alert indicators
- Composite risk rating of ESR items relating to staff sickness
- rates.

You can view a copy of this current IMR by following this link http://www.cqc.org.uk/sites/default/files/RK5_104v3_WV.pdf

Appendix 2

Quality Account 2015/16 Timetable

Date	Milestone
January 2015	Commence stakeholder engagement period in order to identify quality priorities for 2015/16: • 20 January 2015 Safety & Experience Governors Meeting • 12 February 2015 Discussion with Governor • 18 March 2015 Council of Governors • 23 March 2015 Health Scrutiny Committee
February 2015	Establish Project Plan with clearly identified milestones to achieve required deadlines. Establish Project Team to produce Quality Account 2015/16
3 March 2015	Contact Clinical Leads in order to update respective sections
March 2015	Quality Account priorities developed (First Draft) for approval at internal trust committees
8 April 2015	Quality Account (First Draft) to be presented to Clinical Quality & Governance Committee
March & April 2015	Advise audit team of selected mandatory & local indicators
12 March 2015	Audit Committee to review identified priorities
April 2015	Completion of all external and internal stakeholder meetings
April 2015	Final data for Q4 to be included in report
27 April 2015	Quality Account to be circulated to external stakeholders and external audit
April 2015	Quality Account (First draft) to be presented to Audit Committee
May 2015	External Audit to test local and mandatory indicators
May 2015	Feedback from auditors and confirmation that no material issues identified. Additional evidence / amendments made

21 May 2015	Quality Account (Final Draft) to be presented to Council of Governors
28 May 2015	Quality Account (Final draft) presented to Board of Directors
29 May 2015	Quality Account & Annual Report uploaded to Monitor portal
23 June 2015	Quality Account & Annual Report sent to the Parliamentary Clerks Office
Immediately post June 2015 Board of Directors	Approval of final Quality Account – publication on intranet / hard copies available / trust wide comms / upload onto NHS Choices website / forward to Department of Health