Sherwood Forest Hospitals NHS
NHS Foundation Trust

Trust Board March 2015.

Quality & Safety Report

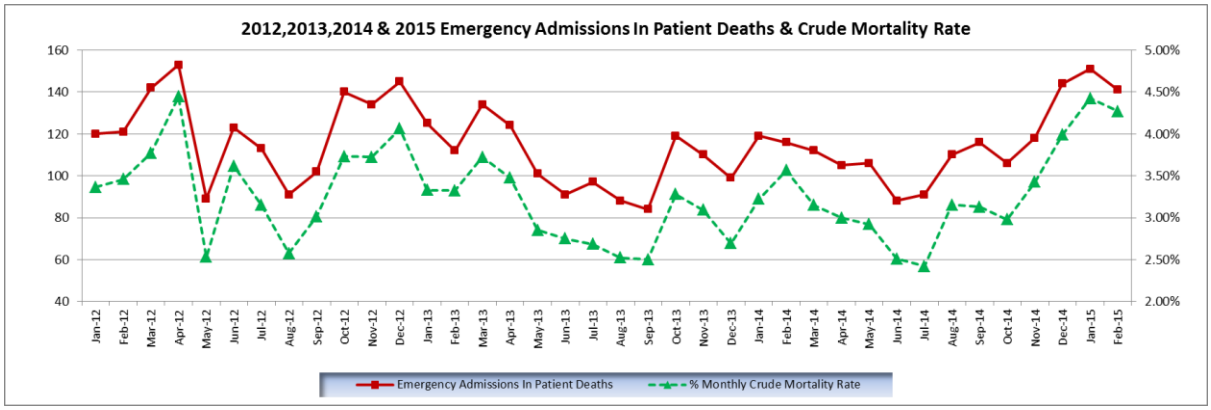
1. INTRODUCTION

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

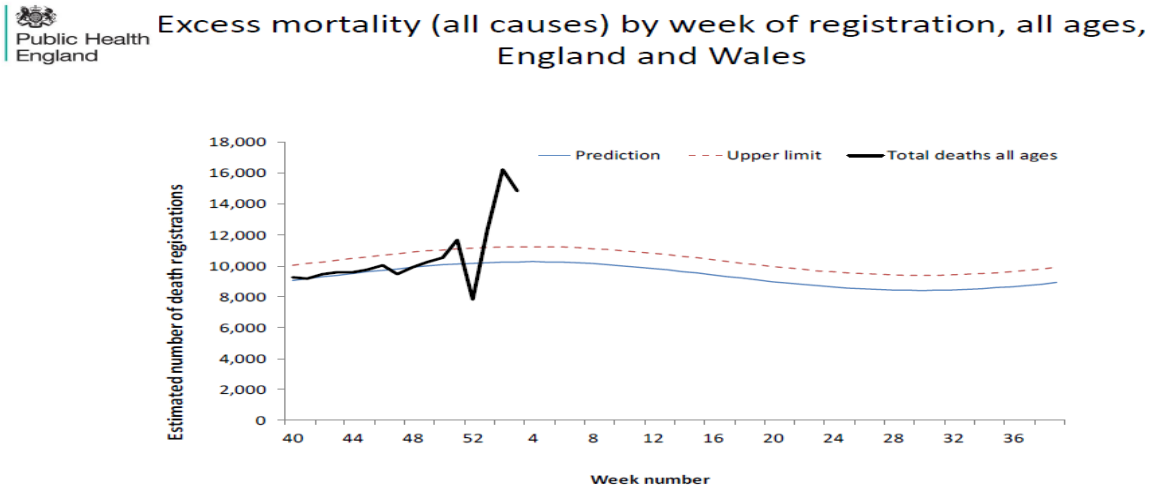
Key Priority 1	**Reduce mortality as measured by HSMR**	Headline & specific **HSMR within the expected range** To have an embedded mortality reporting system visible from service to board **Eliminate** the difference in weekend and weekday HSMR
Key Priority 2	**Reduce harm from falls**	Falls resulting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

2. KEY PRIORITY 1: REDUCE MORTALITY AS MEASURED BY HSMR

2.1 Crude Mortality



The number of deaths per month had been stable between 90 -120 but a significant rise was seen in December to over 140 with a rise in crude mortality. This has been reported in other trusts across the country with crude mortality falling outside upper control limits and increases in the number of deaths by 50% in December and January. The Health Protection Agency (HPA) flu surveillance report showed an increase in deaths over this time period



29 January 2015

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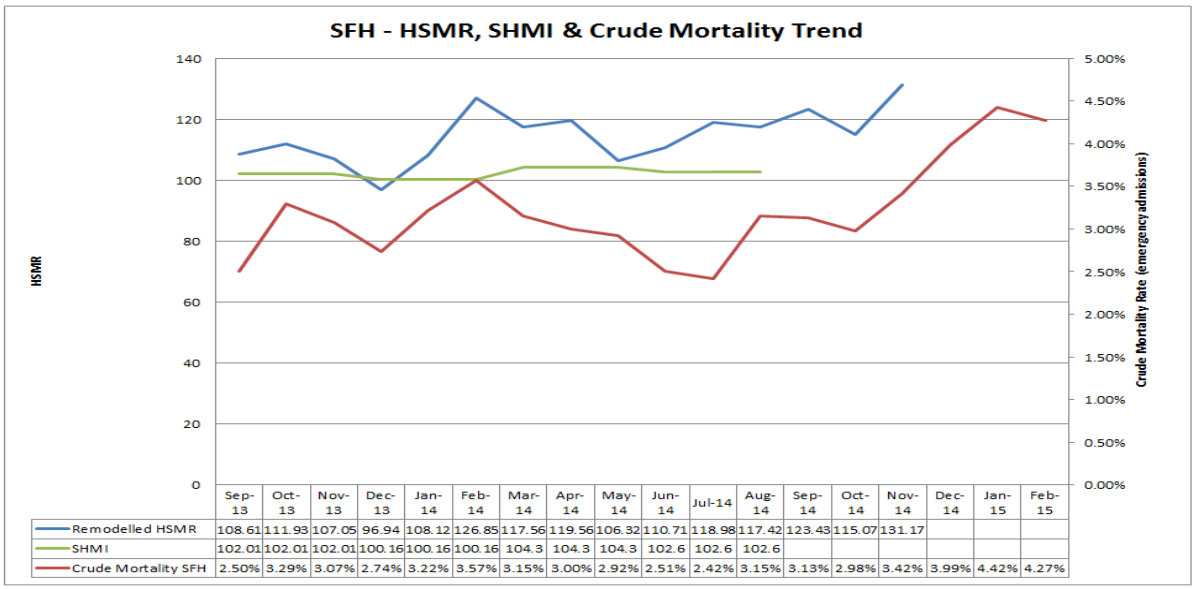
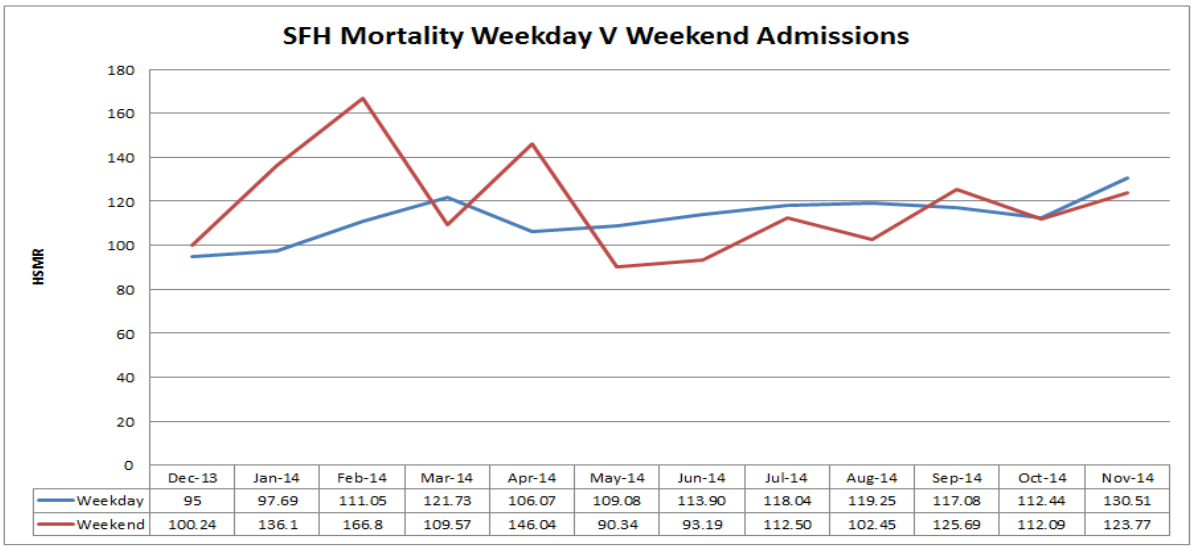
2.2 HSMR

Data from Dr Foster is available to November 2014. The monthly HSMR is shown. This reflects seasonal change with an increase in the winter months however the figures for this year show a rising trend. Mortality reviews for July (n=88) and Dec-Jan (n=86) have not indicated lapses in care or avoidable deaths. A review of November deaths has been initiated and will be externally verified. We are also investigating with Dr Foster a coding issue introduced with the new Medway PAS system in October which may impact on our HSMR. These issues have been discussed in a deep dive at the March Quality Committee.



	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	Jan-15	Feb-15
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	123.43	115.07	131.17			
SHMI	102.01	102.01	102.01	100.16	100.16	100.16	104.3	104.3	104.3	102.6	102.6	102.6						
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%	2.98%	3.42%	3.99%	4.42%	4.27%

2.3 Weekend Mortality



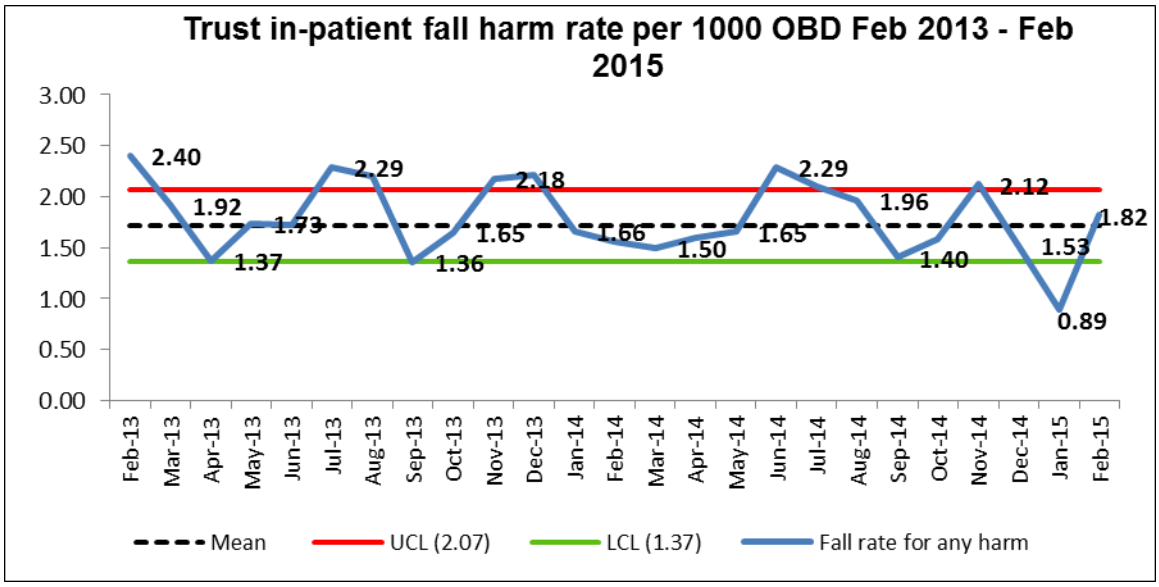
	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14
Weekday	95	97.69	111.05	121.73	106.07	109.08	113.90	118.04	119.25	117.08	112.44	130.51
Weekend	100.24	136.1	166.8	109.57	146.04	90.34	93.19	112.50	102.45	125.69	112.09	123.77

The gap between weekday and weekend mortality has been significantly reduced in the last year reflecting the changes made with access to speciality consultants at weekends. The rise in HSMR in November is reflected in this data.

3. KEY PRIORITY 2: REDUCE HARM FROM FALLS

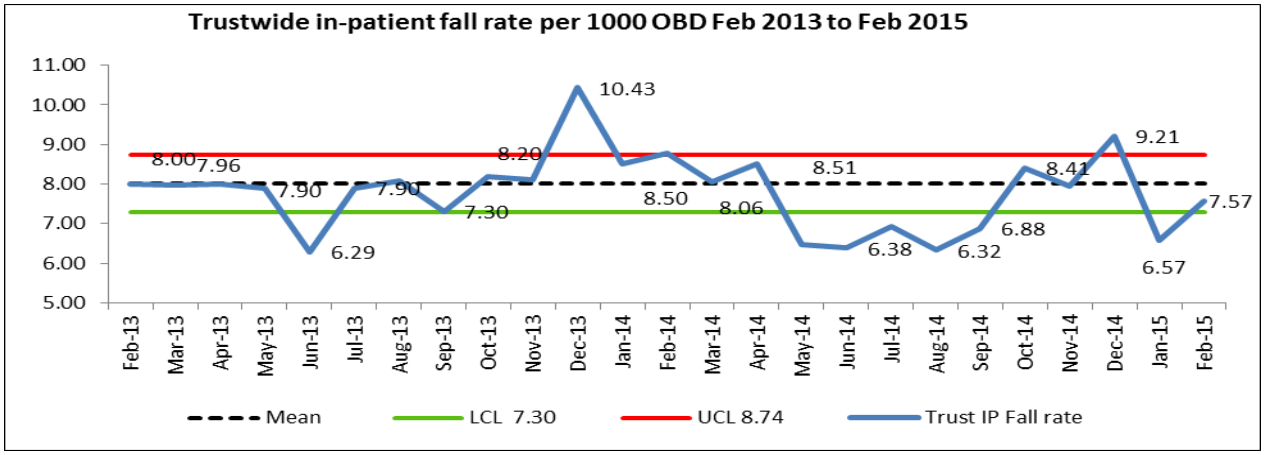
All patients over the age of 65 years presenting to the Emergency Department / Emergency Assessment Unit are systematically screened in order to ascertain whether they have presented with a fall related injury or have suffered a fall within the previous 12 months. Such information enables the clinical and wider multi – disciplinary team to provide support and advice / refer patients onto specialist services in order to mitigate future risk. In addition to the preliminary screening undertaken the CQUIN Workers equally ensure that lying and standing blood pressure checks are undertaken on patients identified as being at risk of a fall, whereby any deficit detected are reported and escalated to the responsible clinical team.

3.1 Reduce the number of patients who fall resulting in harm to <1.7 per 1000 occupied bed days by quarter 4



As evidenced within the above graph the number of falls reported in February resulting in harm was recorded as 1.82, of which is slightly higher than trajectory. Of those recorded there were 3 moderate harms reported.

3.2 Reduce the number of patients who fall to < 7 per 1000 occupied bed days by quarter 4

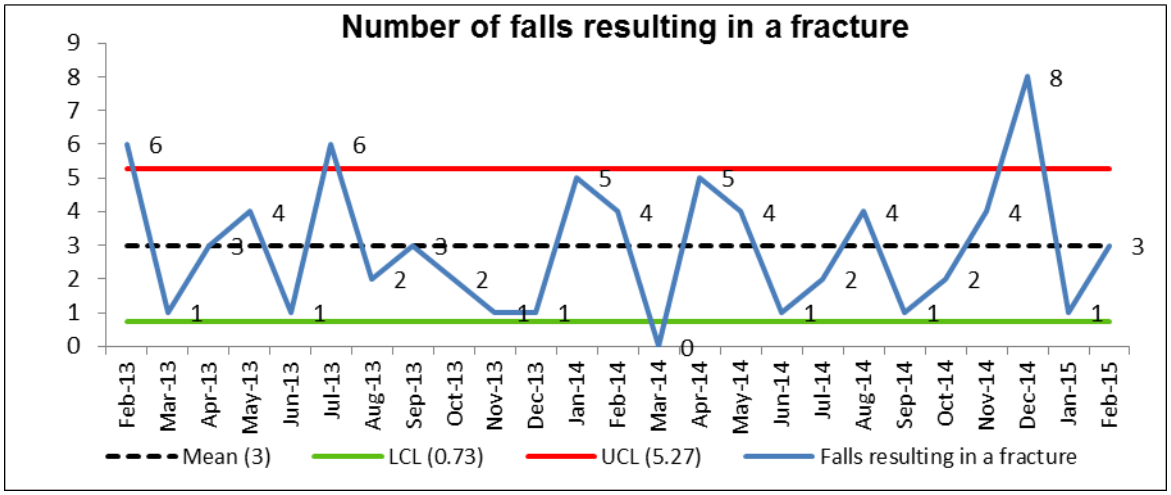


As evidenced within the above graph the number of falls recorded in February was reported as 7.57 per 1000 occupied bed days, this again is above trajectory. During February the overall number of in-patient falls was recorded as 172. These incident reports have been severity coded and validated by the Lead Nurses for Falls. It would appear there has been a slight increase in the overall fall rate for February but this may be reflective of the fact that some of January's incidents were severity coded at the beginning of February. This is being addressed by the Lead Nurse for Falls.

3.3 To reduce the number of patients who fall more than twice in hospital (baseline Q1 14/15 – to be reported each quarter

During February 1 patient was recorded as falling more than twice during their inpatient stay, this is reflective of the high level of intervention by the Lead Nurse for Falls in terms of mitigating future risk for such vulnerable patients.

3.4 Reduce the number of fractures from falls to <25 for 2014/15



During February a total of 3 patients sustained a fracture following a fall, this has bought the trust total to 32 from a year to date perspective. In 2013/14 there were a total of 35 falls resulting in fracture

3.5 Actions to reduce falls

The following section provides an overview of a range of initiatives currently being implemented across the organisation.

The Falls Lead Nurse has developed an established risk assessment tool that enables the clinical team to identify at risk patients. This approach is further supported by the recent implementation of lying and standing blood pressure monitoring and routine urine analysis as part of initial screening. In addition to this a Pharmacist, who is a member of the Falls Group has produced a training guide for medical and non-medical prescribers in order to highlight a range of high risk medications found to increase falls risks. .

Recent improvements to the Accountability Handover and Board Round processes have improved overall communication between the multi-disciplinary team and have raised overall awareness of at risk patients, particularly in relation to where they are located and nursed within the clinical ward environment.

The Falls Lead Nurse has continued to provide advice and support to clinical staff regarding the implementation and application of the Enhanced Care Tool and in ensuring that appropriate decisions are made regarding the need for additional nursing resource to

support individual / several patients deemed to be at high risk of falls. Information regarding enhanced care has been distributed across all clinical ward areas and is prominently displayed at respective nurse stations.

The Falls Lead Nurse is currently in the process of implementing a range of products across clinical ward areas including: a trial of radio controlled nurse call bells, non-slip mats, relocation of toilet roll holders, hip protectors and non-slip anti embolic stockings to further reduce the incidence of falls across the Trust. We are designing a patient information leaflet in order to raise overall awareness and understanding of the importance of appropriate footwear, use of correct mobility aids and importance of using the nurse call bell to seek assistance. The Falls Lead Nurse is developing and implementing the concept of a 'Falls Grab Box', similar to the recent implementation of Sepsis Boxes; such boxes will be located within the resus bay in each clinical ward area and contain essential equipment including:

- Gloves
- Swabs
- Pen Torch
- Relevant documentation
- Guidance regarding the subsequent moving and handling of a patient with a suspected neck or back injury
- Lifting blanket
- RED Gripper socks
- Falls signage

To ensure the correct actions are taken for a patient who has fallen, we have devised a flow chart to raise overall understanding regarding the escalation process to be followed after a patient has suffered a serious fall, including correct categorisation and severity coding. The Serious Falls SI Group has been reinstated to support organisational learning from the falls serious incidents. This has previously been undertaken by the Trust SI group but it was felt additional focus on falls could be supported with reinstating a Serious Falls SI group.

The Falls Lead Nurse has in addition begun to establish networks across the wider health community in order to seek out and share best practice regarding falls prevention.

4. KEY PRIORITY 3: TO IMPROVE FAMILY & FRIENDS (FFT) RESPONSE RATES (PATEINT)

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The Trust have implemented the following actions to increase the response rates and capture the qualitative data provide by patients to shape and improve services:

1. During February 2015 a CQUIN Support Worker was redeployed to support the uptake of FFT across the Trust. This has resulted in data now being collated on a

daily basis, providing wards and departments with real time updates on their feedback, highlighting any potential concerns, and sharing good practice.

2. The Trust is currently exploring the option of upgrading the provider package for the duration of the contract (January 2016) to provide additional modes of collection of data, in particular in the Outpatient and Day Case Unit from April 2015. This will therefore provide real time feedback for staff to shape service improvements, and influence patient experience at that time.

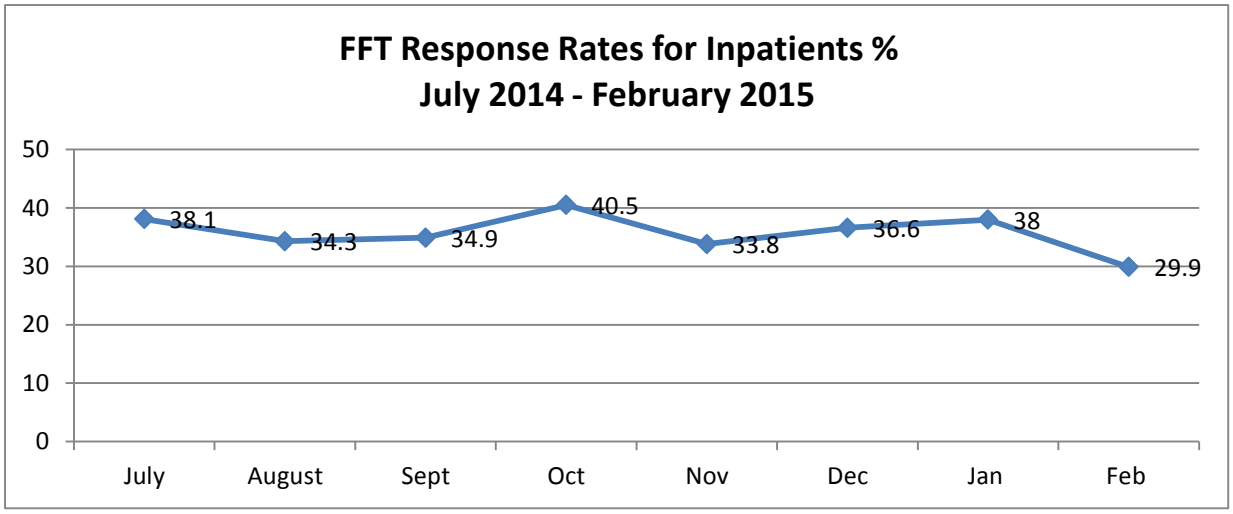
3. A recent review of the Trusts FFT response rates (RR) compared nationally with NHS Acute Trusts highlighted that although the Trust are currently not achieving our internal target of a 50% response rate, the Trust response rates are on par with the National response rates for the inpatient and Emergency Department Friends and Family test (national maternity RR is currently not available to compare)

4.1 Outpatient and Day Case Unit FFT Response Rates

A total of 536 FFT responses were received and submitted during February. Of those received 121 responses were received from the Day Case Unit and 415 responses received from across the Out Patient Departments. Further work is on-going with Information Services colleagues in order to calculate % response rates.

4.2 In Patient FFT Response Rate

Friends & Family (FFT) Response Rate July 2014 – February 2015.

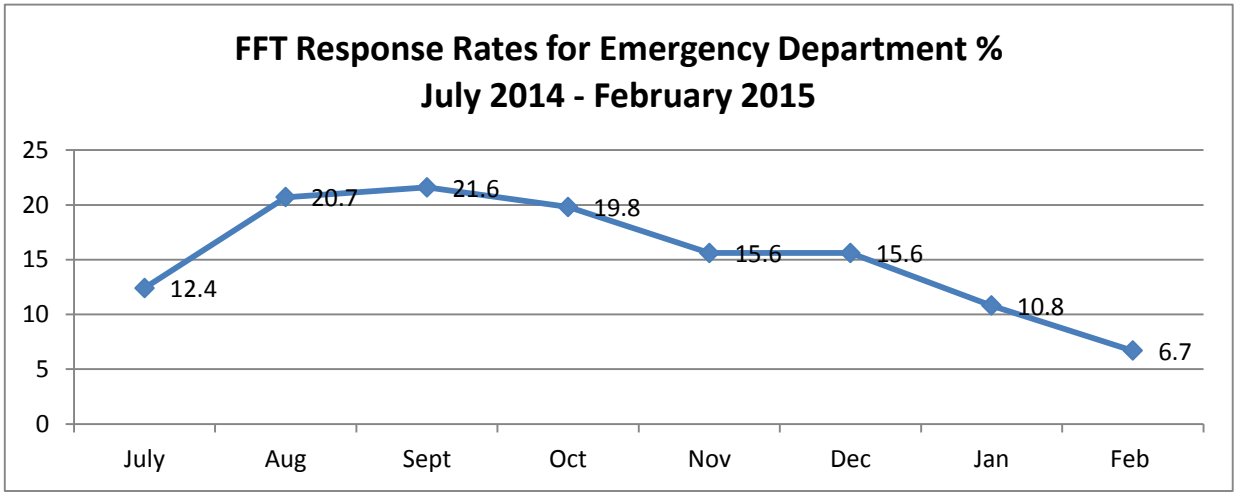


July	August	Sept	Oct	Nov	Dec	Jan	Feb
38.1	34.3	34.9	40.5	33.8	36.6	38	29.9

As evidenced within the above graph and table, the in-patient response rate whilst showing signs of improvement over the year has deteriorated in February. As previously discussed a CQUIN Worker has been redeployed to support the uptake of FFT and in ensuring the eligible patients are being asked to complete and submit their responses. An increase in the collection of FFT

surveys and processing to the external provider is now in place to ensure completed surveys are received for inclusion in the relevant reporting period.

4.3 Emergency Department FFT Response Rates



July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
12.4	20.7	21.6	19.8	15.6	15.6	10.8	6.7

The Emergency Department FFT response rates have significantly deteriorated in month to 6.7%. During February a CQUIN worker has been instrumental in eliciting responses in ED. Each day, these responses are sent by recorded delivery to the company who register our response rates. Our records show that we had 2034 responses sent which equates to 55%. This does not correspond with what our provider says they have received. Discussions are currently underway with the provider in order to sort out this discrepancy. This does question our other results, where wards have been feeding back they have put a lot of energy into this and the response rates do not equate to their understanding. We are seeking assurance from a data quality perspective that both historical and future data is accurate and robust over the remainder of the contract duration. We are currently in contact with our buddy partners, Bath, who utilise an in house solution for F & F as we may wish to progress this option going forward.

4.3 Maternity FFT Response Rates

For Maternity FFT we are mandated to report at four separate touch points during the patients antenatal and postnatal pathway.

	Antenatal Care at 36 Weeks	Sherwood Birthing Unit	Ward Post Natal Care	Community Post Natal Care	Average
Response Rate (%)	61.6	34.2	36.4	12	36

The above table illustrates our combined performance during February of which demonstrates sustained improvement in terms of FFT response rates. This is a great result for this specialty.

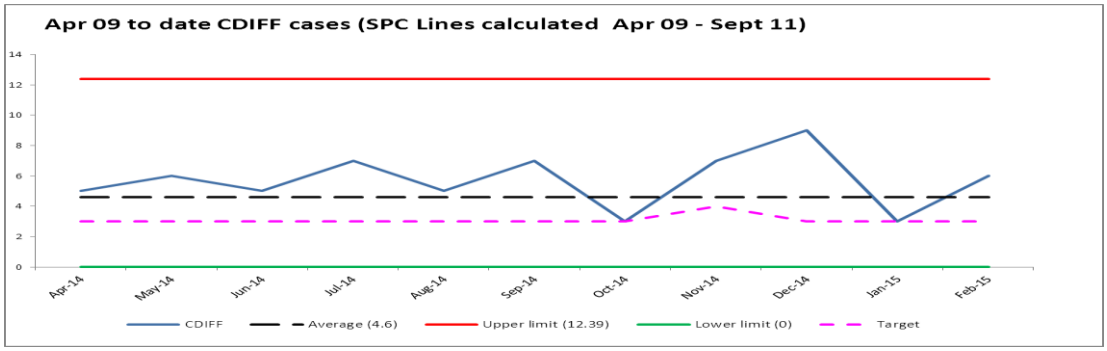
5. INFECTION PREVENTION AND CONTROL UPDATE

Health Care Associated Infection (HCAI) continues to provide major challenges to health provider services across the NHS. This paper provides an overview of current HCAI performance during February 2015 against a range of infection related targets including Clostridium Difficile Toxin (CdT).

5.1 Clostridium Difficile

The Trust reported 6 post 48 hours Clostridium Difficile infections during February. This breached the monthly trajectory; bringing the Trust year to date total to 63 cases. Together with the wider health economy discussions have been held to consider how to improve our current performance and ensure that we meet trajectory over the forthcoming year.

Clostridium Difficile Infection (April 2014 – February 2015)



5.1.2 Root Cause Analyses (RCA)

A Root Cause Analysis (RCA) has been undertaken on all Clostridium Difficile cases reported during the month. Detailed data analysis has identified that all of the patients affected had pre-existing underlying infection, were treated in accordance with the Trust anti-microbial policy and were appropriately isolated.

There was however some evidence to suggest that a number of symptomatic patients were tested for Clostridium Difficile during a period of increased incidence of Noro Virus. In order to address this issue the Infection Control team have developed and implemented a range of literature / algorithms to raise overall understanding and awareness within clinical teams regarding appropriate sampling and bowel assessment on admission.

5.1.3 Direct Interventions

The Infection Control Team continue to work closely with Medirest colleagues regarding the use and trial of alternative disinfectant products across the clinical ward and department areas. The trial is nearing completion and following evaluation the team will develop revised cleaning standards.

5.1.4 Training & Development

During February the Infection Control Team have proactively increased their presence and profile across a number of high risk / high volume clinical areas namely:

- Emergency Department (ED)
- Emergency Assessment Unit (EAU)
- Critical Care Unit (CCU)

This approach has proven to be effective in terms of proactively addressing and managing infection control related issues including appropriate sampling and prompt isolation.

For mandatory training the Infection Control Team have in addition undertaken the following training:

- Hand Hygiene Training 82% - year to date compliance recorded
- Infection Prevention Training 86% - year to date compliance recorded

5.1.5 Audit

The Infection Control Team have continued to progress with their audit programme of which has included the following monitoring during February:

- Hand Hygiene - 75% compliance recorded
- Personal Protective Equipment (PPE) - 91% compliance recorded

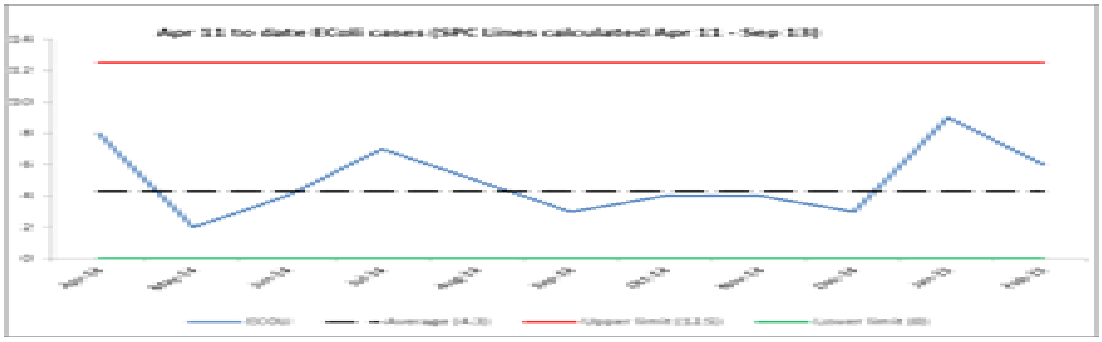
5.2 MRSA Bacteraemia

There were no episodes of MRSA Bacteraemia reported in February

5.3 E Coli

The Trust reported 6 cases of E Coli during February

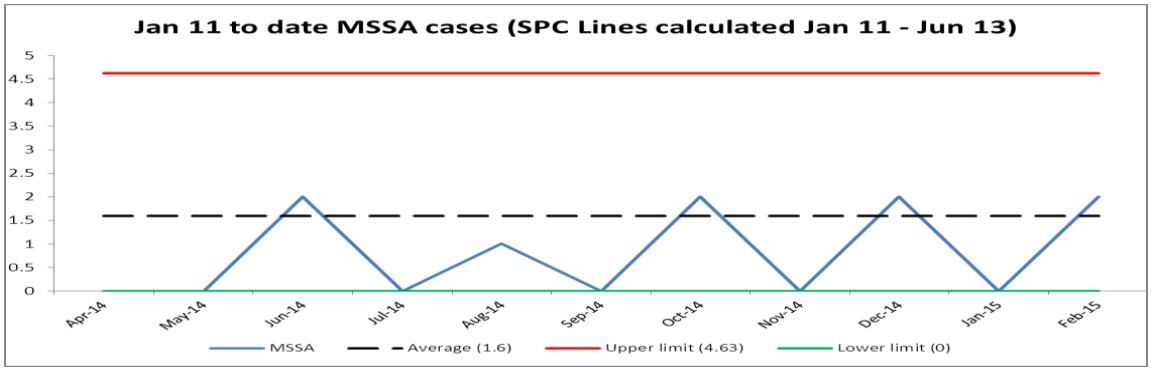
E Coli Infection (April 2014 – February 2015)



5.4 MSSA

During February the Trust reported 2 cases of MSSA.

MSSA Infection (April 2014 – February 2015)



6.0 NURSING REVALIDATION

From Dec 31st 2015, nurses and midwives will be required to revalidate at the point of registration in order to maintain NMC registration. Without successful revalidation, nurses and midwives will no longer remain registered and therefore no longer able to legally practice. Revalidation will be a positive affirmation of an individuals practice based on the New Code of Conduct; revalidation is not about spotting bad practice this will continue to be managed through performance, capability and fitness to practice routes.

The process of revalidation has four elements that are:

- Demonstrate they have undertaken at least 450 hours practice in the last 3 years; 900 hours if registered as nurse and a midwife
- Achieved the requirements of continuing professional development; this is currently set at 40 hours in draft guidance so could be subject to change
- Show they are using practice and service user feedback to improve standards of care by way of reflective practice
- Obtained 3rd party confirmation on their continuing fitness to practice and compliance with the Code

It is important to note that some of the finer detail around revalidation is yet to be confirmed; this will happen when findings are released from the numerous pilot sites up and down the country in multiple settings. However despite this lack of clarity it has been decided to forge ahead with preparation of our registrants.

All learning material and resources are triangulated with The Code of Conduct, Quality for All and the Nursing and Midwifery Strategy. This ensures revalidation is not seen as a standalone extra thing to do but an integral part of "being a nurse or midwife at SFH". As a responsible employer we have a duty to provide learning opportunities and support to our registered nurses and midwives so they feel prepared and able to comply with the new requirements, however this must be balanced with maintaining the individual's responsibility to maintain their professional registration

We have also engaged regionally with other organisations to adopt a standardised approach to revalidation processes guidance and paperwork across the region. Sherwood Forest

Hospitals will be required by NHS England to provide assurance of Organisational Readiness for revalidation in the next few months. This briefing paper is to give the board assurance that plans are in place and workforce preparation has started and over the coming months it is anticipated that a task and finish group will give steer to the more strategic elements to revalidation.

6.1 Current Preparatory Work

In order to prepare nurses and midwives for revalidation a number of learning opportunities have been initiated

- Professional update session on the 'Proud to Care' timeout days includes revalidation. Every Nurse and midwife will attend these.
- Weekly revalidation awareness sessions commenced in February 2015 which include support and guidance in undertaking reflective practice/writing and portfolio building. These sessions are also repeated at ward and team level (see appendix 1)
- NMC posters have been displayed throughout the organisation.
- Regular updates in staff bulletin sign posting to learning resources and national updates
- Using the new learning boards as a tool for registrants to demonstrate reflection on practice and incidents
- Early identification of nurses and midwives who are due to revalidate in December 2015 & January 2016 to ensure they are fully prepared

6.2 Future Preparatory Work

- Record awareness session so staff can access through Practice Development website via a podcast.
- Deliver training to ward / dept. sisters and their deputies
- Commence portfolio surgeries in summer so staff can bring along portfolio for advice and feedback
- Identifying individuals in wards and dept. who have good portfolio's to "buddy up" and support others.

6.3 Communication Strategy

- Undertaking a survey using survey monkey to gauge the level of awareness and knowledge around revalidation
- To maintain the current awareness raising at induction, Preceptorship programme, N&M time out days, ward leader meetings and Nursing @ SFH newsletter
- Staff bulletin will have a regular section on revalidation informing staff of next training dates
- Create a web page for revalidation linked to the Practice Development intranet page with the latest information as it is released by the NMC, podcasts of training sessions and also templates for reflective writing and portfolio building.
- Use social media pages to post revalidation information

6.4 Resources

The training sessions will be delivered by the Practice Development Matrons & Midwives. We are trying to undertake revalidation within our current resources.

6.5 Revalidation Steering Group

There are still some outstanding decisions required around the more strategic direction associated to revalidation. It is proposed that a steering group is developed to provide this organisational direction.

Members of the group should include key stakeholders to provide direction in the following areas;

- Third party confirmation who, how, and when will this take place?
- Providing guidance for third party confirmers
- If we use appraisal as a platform for revalidation how will we link to current appraisal framework and documentation?
- How will we support nurses and midwives to use patient and service user feedback to improve practice?
- what will the process be if individual cannot be signed of by 3rd party confirmer as they don't meet the requirements.
- How do we support nurses and midwives who do not report directly to an NMC registrant?
- Will we consider an eportfolio solution?
- How will we use ESR to support the process

6.6 Conclusion

There is a huge opportunity to use the revalidation agenda as a vehicle to drive forward the profession, Quality for All and Nursing and Midwifery Strategy. To achieve this we need to work in partnership with our registered nurses and midwives to provide the support and guidance required for them to feel confident and competent within the new process, using our organisational strategies as the underpinning foundations of practice, whilst maintaining the individual's personal responsibility for revalidation.

Andy Haynes Executive medical Director

Susan Bowler Executive Director of Nursing and Quality

Lisa Dinsdale Deputy Director of Nursing & Quality

Appendix 1

Revalidation Training Plan 2015/16

Course Title	Contact/Lead	Description of Training	Mode of Delivery	Staff Group	notes
Revalidation Preparation (Nurses)	Andrea Clegg/Karen Noseley/ PDM's	Revalidation presentation prep training/info	Presentation Face-to-face 30 minute session	All nursing staff	weekly sessions
Revalidation Preparation(Midwives)	Karen Noseley /Kerry Bosworth	Revalidation presentation info/prep/training	Presentation Face to face 30 minute session	All midwifery staff	Mandatory update from Apr 15
Reflective practice / Portfolio building sessions (Nurses)	Andrea Clegg/Karen Noseley/ PDM's	Info/advice reflective practice	Face-to-Face Available as drop in	All nursing staff	Weekly following
Reflective practice / portfolio building sessions (Midwives)	Karen Noseley/Kerry Bosworth	Info/advice reflective practice	Face-to-Face Available as drop in	All midwifery staff	Monthly
Revalidation Preparation **Reflective practice / portfolio building sessions**	All PDM's Andrea Clegg	Revalidation presentation prep training/info Info/advice reflective practice	Face to face small groups at ward level	All Nurses and Midwives	As required
Revalidation refreshers	Karen Noseley	Revalidation refresher/ reflective practice/portfolio building	Face to face Presentation 30 mins	Community Midwives	Team meetings