Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors

Subject:	Advancing Quality Programme Update	**Date:** 30/11/17	
Prepared By:	Elaine Jeffers, Deputy Director of Governance & Quality Improvements		
Approved By:	Paul Moore, Director of Governance & Quality Improvements		
Presented By:	Paul Moore, Director of Governance & Quality Improvements		
Purpose			
To provide the quarterly update on the Advancing Quality Programme to the Board of Directors		**Decision**	
		Approval	
		Assurance	x

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
x	**x**	**x**	**x**	**x**

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	There may be some financial cost associated with the delivery of programme actions – will be identified and seek approval as required
Patient Impact	Delivery of the programme will have a positive impact on the safety and quality of care delivered to patients
Staff Impact	Delivery of the programme will have a positive impact on the experience of staff to deliver high quality, safe care to patients
Services	Delivery of the programme may impact on service delivery and may necessitate service re-design and reconfiguration
Reputational	Delivery of the programme will significantly improve the internal and external reputation of the Trust

Committees/groups where this item has been presented before

N/A

1. Executive Summary:

1.1 The Advancing Quality Programme Report provides the Board of Directors with an update on the progress being made and identifies key risks and issues.

1.2 The Board of Directors are invited to:

- Consider the content of the Report and progress to date
- To note the position with regards to Programme 6 – Safe Transfers of Care and advise accordingly
- To acknowledge the plans to provide opportunities for staff across all 3 sites of the Trust to have an opportunity to contribute ideas for inclusion in the 2018/19 Advancing Quality programme
- To consider our proposal to establish a closer alignment between Quality Improvement, Service Improvement and Cost Improvement for 2018/19; and advise on the benefits of developing such an approach across the organisation for 2018/19.

2. Background:

2.1 The Advancing Quality Programme is now half way through the first year cycle (month 7). Overall the individual workstreams are making progress against their agreed problem statement with actions in place to address any shortfall or where a workstream is off track.
2.2 The AQP Board meets on the first Tuesday of the month where each Executive Sponsor supported by Workstream Leads discusses in-depth progress to date, including key milestones and risks to delivery.
2.3 A challenge for AQP has been the development of a 'success measure' dashboard to demonstrate the progress being made as many of the initiatives do not yet lend themselves to illustrate their progress in a graphical form. Not all outcomes are easily measurable. It may not be possible in the current financial year to demonstrate a benefit of implementing the workstream as such benefit is likely to manifest through staff surveys, audits and external validation. These processes have a longer lead time.
2.4 The AQP is comprised of 2 sections:

- The CQC Regulatory Requirements following the 2016 CQC Inspection
- The Advancing Quality Programme Workstreams (8)

3. The CQC Regulatory Action Plan

3.1 The Board of Director's Report of August 2017 indicated that there were 3 'Amber' Actions identified on the CQC Action Plan. Confirmation was received through the AQP Board meeting on 06/11/17 that 2 actions have since been completed with the outstanding item relating to the implementation of an electronic solution to record DoLs orders. Details are highlighted below.

Reference	Action	Comments
2M.1.5	To develop an electronic method of recording Deprivation of Liberty orders to replace the current paper-based process	An electronic portal has been developed to allow access to required information in relation to Safeguarding and Deprivation of Liberty Orders (DoLs). Access to the Portal is dependent on the full roll out of the NHS.Net System. Once NHS.Net is implemented all staff will be able to access and share information through the Portal. In light of the timescale for NHS.Net implementation the completed by date has been amended accordingly

4. Advancing Quality Programme Workstream Progress

4.1 Following the 'Confirm and Challenge' meetings a Highlight Report, per programme, setting out progress to date, risks and key milestones is presented at the AQP Board for further scrutiny, support, advice and challenge.
4.2 AQP Board have agreed to adopt a process to demonstrate embedeness in line with that undertaken in the QIP. i.e. the completion of the 'Blue Form' with formal presentation of evidence to the AQP Board for challenge and validation.
4.3 Appendix 1 provides a summary of progress for each workstream that also illustrates the current mechanisms to demonstrate the progress to date.
4.4 Programme 6 – 'Safe Transfers of Care' - it was recognised that there was a lot of overlap and potential duplication of effort between the AQP and the wider 'Patient Flow' Programme. It has been decided to suspend further work within the AQP pending a decision to focus on safe transfers of care through the Patient Flow Programme. Subject to the Board's satisfaction we intend to migrate AQP activity on transfers to the Patient Flow Programme henceforth.

5. Advancing Quality Programme 2018/19

5.1 The AQP is now well established across the organisation. An explanatory presentation outlining the drivers and rationale for the AQP continues to be delivered in a variety of forums. This has given staff a deeper understanding of the programme and the opportunity for them to engage, contribute and get involved.

5.2 The presentation will now include a focus on potential Quality Improvement initiatives for 2018/19. It is planned to hold a series of focus groups to capture the thoughts and contributions from across a wide range of staff groups. The first set of focus groups will take place over the following 6 weeks and will cover all 3 hospital sites reaching as many different staff groups as possible. An opportunity to join a focus group will be offered to members of the Trust Board and Council of Governors.

5.3 The 2018/19 AQP needs to identify and agree quality improvements that can be clearly defined and measured; improvements that have a high impact on the overall delivery of patient care and generate value for service users.

5.4 For 2018/19 the AQP Board would like to propose increased alignment with the Cost Improvement Programme and the Service Improvement agenda to reduce the potential for duplication of work, maximise the use of resources and importantly ensure that the benefits gained from all work programmes are optimised, both from a patient quality and financial viability perspective.

6. Programme Governance

6.1 Appendix 2 illustrates the governance and reporting arrangements. The cyclical nature of confirm and challenge at workstream level, progress reporting and internal oversight by the Advancing Quality Programme Board continues to be robustly managed. The monthly assurance report to the Quality Committee and the quarterly achievement report to the Board of Directors remain in place.

7. Recommendations:

7.1 The Board of Directors is asked to consider the progress made to date and advise on any further action required over and above those that are set out in the AQP.

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Appendix 1

Advancing Quality Programme

Programme	Problem Statement	Delivery to Date	Success Measure	Workstream Rating Overall
Patient Safety Culture		**Building our safety culture to advance Patient Safety Management:**		
	Improvements required to foster a safety culture where staff across the multi-disciplinary team work together to identify and celebrate good practice and have a constant and active awareness of the potential for things to go wrong. To work towards an 'open culture' where all staff understand the connection between what they do, how that impacts patient safety, and in which staff feel empowered to learn and initiate improvements from incidents and near misses.	• The programme continues to make progress but faces challenges around the resource available to support individual components impacting on the pace of change. It is hoped that this will be addressed as the Patient Safety Culture team expands following the appointment of the Associate Director of Service Improvement. • East Midlands Health Science Network have agreed to support funding of additional surveys to facilitate inviting all staff to take part within ED & Maternity. • Schwartz Rounds training dates have been confirmed and 4 x clinical staff identified to attend • Sign up to Safety Campaign - Pledges have been shared across the organisation with a plan to match identified improvement work against each pledge. • Kitchen table conversations continue to gather momentum • Associate Director of Service Improvement for Patient Safety Culture appointed.	Success of this programme will be measured through improvements in Pascal Patient Safety Culture results identified at the point of re-audit (planned for 2018). The initial domains for improvement are: • Perception of Senior management by staff • Non-punitive response to errors	**A**
Nervecentre	**Problem Statement:**	**Deliver and realise the benefits of Nervecentre to further enhance care and minimise risk associated with sudden an unexpected clinical deterioration**		**Rating**
	Delays in escalation of deteriorating patients through both recognition and communications have been identified as a common theme contributing to actual/potential harm, unplanned admissions to ITU and increased length of stay.	• The overall programme continues to make good progress with some actions delivered ahead of agreed timescales • The Task management module to support the Hospital Out of Hours Team has been implemented and all relevant staff fully trained in its application • The timeline for the implementation of the paediatric Module is awaiting supplier confirmation with the interim work continuing to not only deliver but embed current Nervecentre functionality and device usage.	• Early indicators are that there has been a positive improvement in a number of factors within the Digital Maturity Index (DMI) • To date the % of staff we expected to train in the application of	**G**

			Nervecentre is 99%. • To date the number of hand held devices (iphones/ipods) we expected to issue is 99% • The Implementation have instigated processes for new starters and Doctor rotations	
Mortality	**Problem Statement:**	**Identify and eliminate avoidable factors associated with inpatient mortality**		**Rating**
	We need to implement systems, policies and processes that support the effective and timely review of all deaths that occur in hospital to maximise learning opportunities.	• The use of the electronic Mortality Review Tool remains sporadic, although it is clear that clinical teams are carrying out mortality reviews. • Q3 will focus on the learning from the Structured Judgement (Case Record) Reviews that are presented at Divisional level to elicit learning and optimise improvement opportunities. • Supporting bereaved families will be a focus for Q4. Head of Patient Experience has attended the NHSI Conference in preparation for the publication of further guidance due January 2018. • Self-assessment against the 2015/16 End of Life QIP actions should have commenced w/c 2/10/17, with the implementation Plan for ResPECT Tool developed through October 2017. This has been delayed due to availability of key individuals – a revised start date is proposed for 20/11/17.	• Q2 saw an increase of 19% in the review of all deaths from the Q1 performance of 65% to 84% in Q2. • Of the 547 deaths reviewed year to date 0.18% (14) were considered to have contributory or avoidable factors	**A**
Safe Medicine Prescribing	**Problem Statement:**	**Reduce risk associated with medications by focusing on senior review and controls for managing high risk medicines**		**Rating**
	We do not have assurance that all medication incidents are reported in the Trust and improvements are required to ensure learning from incidents is shared appropriately and in a timely fashion. Antimicrobial	• Pharmaceutical Profile Record Profile roll out commenced on 18th September, all new patients now receive the new profile. • Local renegotiation of the CQUIN target has not been successful. The CCG are liaising with NHSE for a national review of the current targets in light of the global		**G**

	resistance is a national NHS issue and so within the Trust we need better assurance that our antimicrobial prescribing is being reviewed in a timely fashion by the senior medical team and actions are taken. We must ensure patients receive the correct medication when admitted to hospital by ensuring timely and accurate medicines reconciliation.	Tazocin problem. • Tazocin target met due to shortage and the figures suggest the use of Meropenem is also reducing in line with expectation. • The Medicines Safety Group has approved their work schedule and are focussing on improving medication safety across the Trust. The initial work will look at high risk medication such as Insulin, Parkinson's medication and Warfarin. • The reporting of medication-related harm incidents is discussed on a monthly basis. There is an on-going review and tracking of the number of incidents reported. An Incident reporting campaign will begin with a survey monkey to gather intelligence and understanding around medication incidents from a wide number of staff. This will then direct the campaign with 3-4 key messages. This will be included in the 'Road to Outstanding' Trust campaign.	A number of measures have been put in place to increase the incidence of medication incidents across the organisation. Ward 25 (Paediatrics) in particular are being held up as exemplar practice due to the progress and improvements they have made. The improvement metrics to date are indicated at Appendix 2	
Hospital 24	**Problem Statement:**	**Reduce variability in outcomes for patients admitted to hospital as an emergency regardless of day of the week**		**Rating**
	To reduce variation in outcomes (mortality, patient experience, length of stay and readmission rates) for patients admitted to hospital as an emergency.	• The Trust continues to implement the National Clinical 7 Day Standards and submit the required Audit information. The Trust is performing better than other Trusts in the East Midlands. The Trust submitted the required Self-Assessment Documentation to NHS England and is awaiting feedback. • There has been a continued focus on Hospital Out Of Hours with all Qualified staff in place. • Hospital Out of Hours Policy was ratified by the Deteriorating Patient Group in October 2017 and is published on the Trust Intranet site. • The Task Management module of Nervecentre was launched on 16th October to support the Out of Hours teams. The implementation team in conjunction with the skilled HOOH team has led to excellent adoption by wards.	The implementation of the Nervecentre Task Management for the Hospital Out of Hours team has seen an immediate increase in the number of escalation alerts The Hospital Out of Hours team are working closely with the Nervecentre Implementation team to understand the detail under the alerts and develop a mechanism to ensure that the team are directed to and can prioritise the most appropriate	**G**

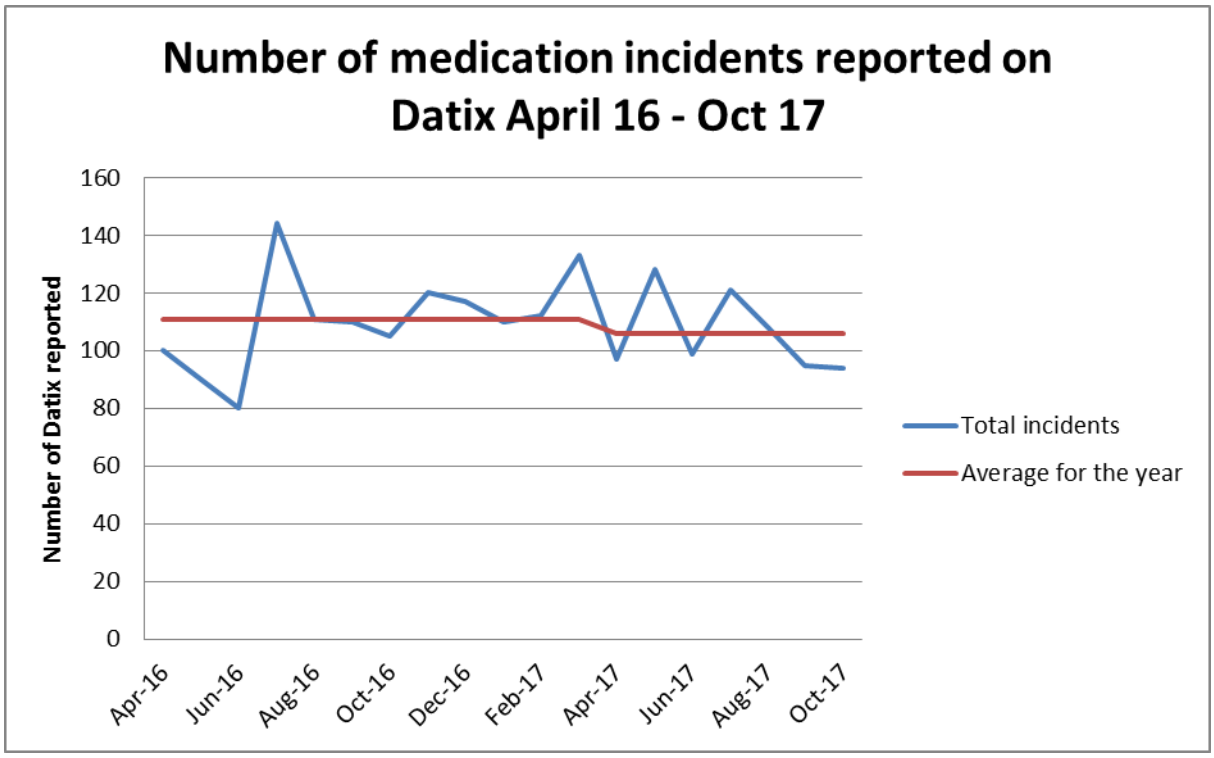
		• A Medical Lead has been identified to assist with the integration and development of collaborative working out of hours. Work on going to look at integrated handover for all specialties using electronic handover - Derby has been approached as theirs has been held up as good practice. • Weekend 24 hour working has commenced and has evaluated well – further discussion is being held around additional support required for cover for twilight which has been agreed in principle but requires further work to operationalise.	patient	
Safe Transfers of Care	**Problem Statement:**	**Improve the safety, quality and experience for service users when being transferred between care providers - both internally and externally**		**Rating**
	To reduce the risk to patient harm when transferring care across care providers.	The Safe Transfers of Care Programme has stalled due to the synergies with the wider 'Patient Flow' Programme. Discussions have been held as to whether this programme should be formally incorporated into Patient Flow to minimise duplication and ensure resources are allocated appropriately.		**R**
Safeguarding & Mental Health	**Problem Statement:**	**Deliver safe, seamless care for those admitted to hospital as an emergency who are learning disabled or have ongoing mental health needs**		**Rating**
	We need to implement systems, policies and processes that support and enable staff to identify and respond to the care needs of patients with Safeguarding and Mental Health problems or Learning disabilities.	• The workstream and supporting action plans to underpin and further develop this work have been implemented. • The 'Must Do' Actions from the CQC Inspection Report 2016 have been addressed but now require further developments to ensure they incorporate additional requirements both nationally and locally. These are identified within the highlight and Workstream reports and plans. • The Training Strategy is in place and underpins training provided • Further developments around the recording and processing of DOLS is established. The DOLS recording processes will now be via the Nottinghamshire Safeguarding Board DOLS Portal. Work is ongoing to ensure that this is implemented and services are aware of its use. Therefore there is a revised timescale of 30th	A key feature of both the 2015 and 2016 CQC Inspection reports was the training compliance and associated understanding of front-line staff with the Mental Health Act (MHA), Mental Capacity Act (MCA) and application of DoLs. The Safeguarding Team provide comprehensive training to support this requirement and current compliance can be found at Appendix 3.	**A**

		November 2017. The Portal roll out Programme is being developed. • Safeguarding Quality Dashboard has been developed and assured through the Safeguarding Steering Group. PSQB gave approval and sign off in July 2017; we are working to align this to the quarterly reporting mechanism. We are working to identify someone to develop the spread sheet formulas to allow us to demonstrate effective and accurate data from the dashboard reports/results. This work remains on going and a revised timescale of 30th November 2017. • John's Campaign was launched on October 5th. Work is now underway to publicise this within the Trust.		
Patient Information	**Problem Statement:**	**Empower and engage service users by improving the quality of and access to patient information**		**Rating**
	How can we provide accurate accessible information to patients at the right time?	• Paediatric leaflets are in the process of being updated. A resource of Learning Disability Leaflets have been identified following the LD review and will be incorporated into the Master Log. • SharePoint training for the Patient Information Officer and Head of Communications was completed at the end of October and existing leaflets will now be added onto the new system. • The first Patient Involvement Forum took place on October 30th. 47 people responded to take part of which 20 attended the first informal meeting to discuss the meeting aims. A further discussion with the Trust's LD nurse has identified some LD service users to include in this going forward.	343 Patient Information leaflets have now been reviewed and are available to access through the Trust SharePoint Site	**G**

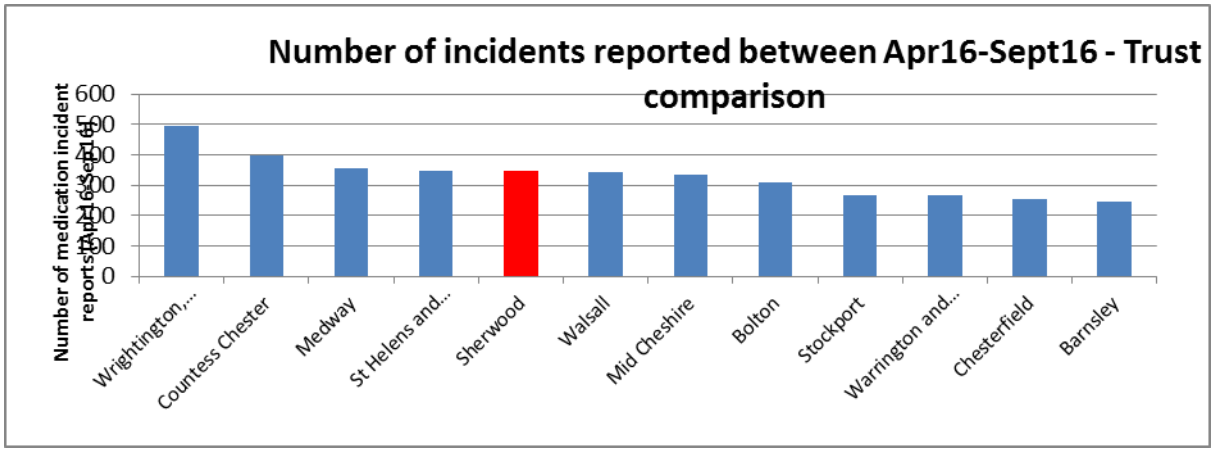
Appendix 2

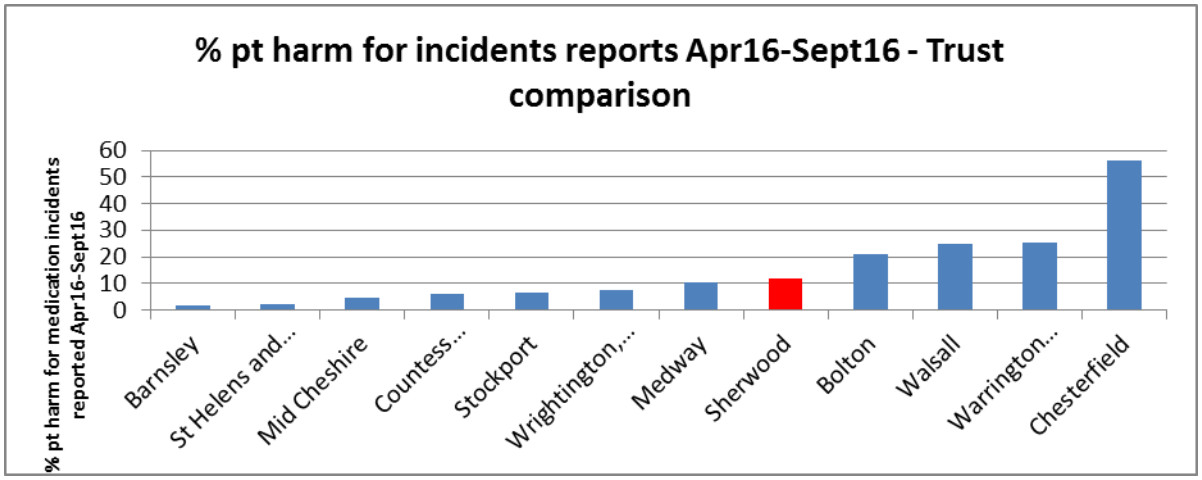
Medication Safety Group - Increasing Incident Reporting

Current situation:



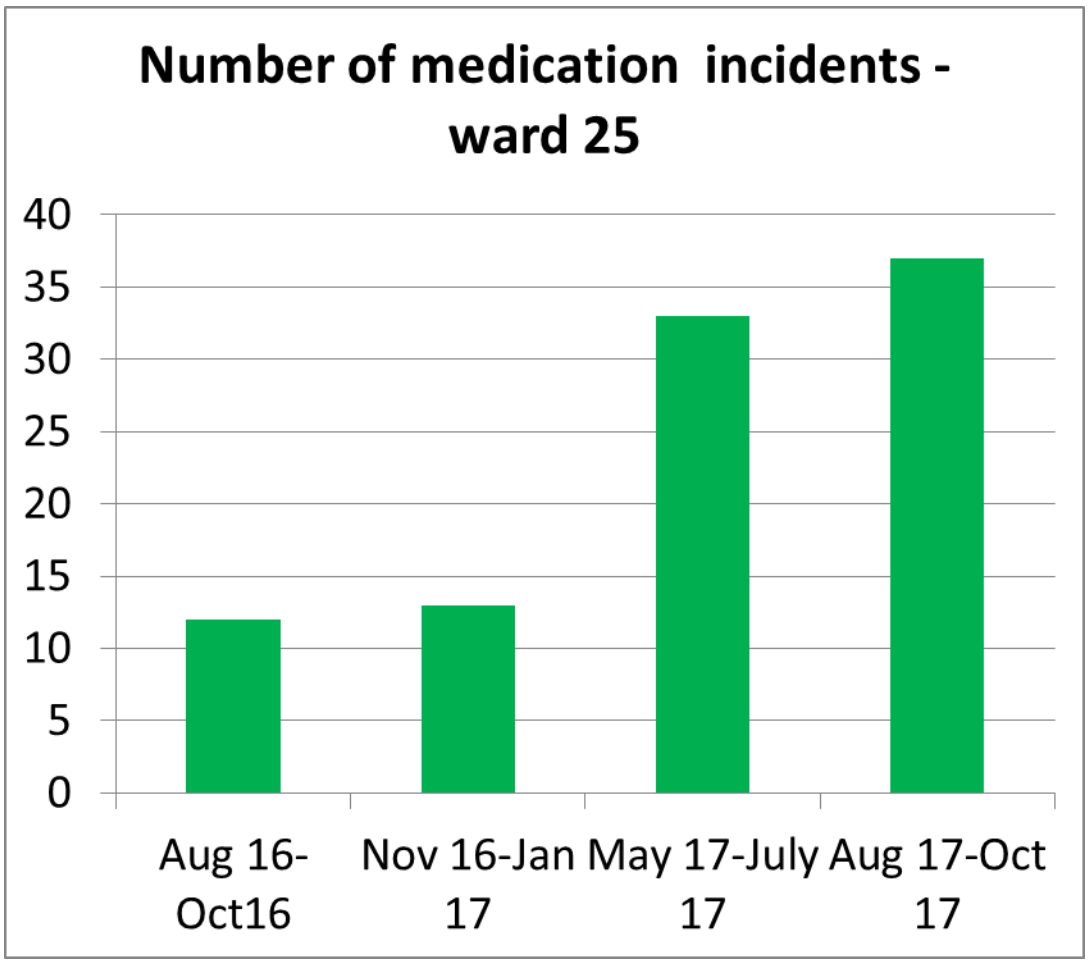
Aim is to increase overall reporting by 30% which will put us in line with well performing Trusts of a similar size. See graph below for recent comparison from medicines optimisation report:





Area of excellence: Ward 25

Ward 25 have put a number of measures in place to improve incident reporting and the learning from incidents.



Responsible person appointed in April 2017 (gap in the graph whilst they made arrangements for a different structure)

A number of initiatives have been employed:

1. Training staff locally on how to report an incident on the Datix systems (many staff did not know how to access the system)
2. Appoint a person from the ward to take responsibility to review all medication incidents (deputy ward leader). (April 2017)
3. Quarterly report produced on medication incidents for the area.
4. Ward forum – where people can come and highlight issues
5. Incident trigger meeting – weekly. Discuss incidents where help is required on the investigation, incidents of significance. The reporter of the incident is invited to attend as required.

Benefits seen / action taken:

1. Prescribing test for all new Drs to the ward area – this must be completed and passed before prescribing can occur unsupervised.
2. Training planned to enable nurses to cannulate
3. Training on the critical medication list – better understanding of what this list means and how it relates to incident reporting
4. Training on how to report an incident on Datix
5. Better engagement from staff and increase incident repotting in the area (staff now see the positive changes that can occur as a result)
6. Learning / Sharing methods:
    a. CHIP – changes in paediatrics. This highlights any changes, new guidelines etc
    b. LIP – Learning in paediatrics. Short summary of incidents and what we have learnt
    c. Bread and butter – highlighting issues commonly seen, routine things people forget.
7. Prescribing room – to decrease interruptions
8. Medicines champion (with two deputies to help with incident work)

Trust wide roll out:

- Meeting in place between Pt Safety Lead and Medication Safety Officer for the trust to begin to facilitate the role out of this way of managing medication incidents to other areas in the trust.
- Survey Monkey written to get general feedback from staff groups on the incident reporting system and barrier to completion of reports.
- Campaign to be launched in the New Year to focus on what we want reporting.
- Electronic tracker to be uploaded to allow staff to see progress to the 30% target over the next 12 months. Goal to see improvements by March 2018 with sustained improvement by Dec 2018.

Expected outcomes:

1. Increase incident reporting in this area
2. More positive feeling towards the incident reporting process.
3. Multidisciplinary buy in and support.
4. Improved prescribing in the clinical area.

Appendix 3

1) SFH Training Compliance

Mandatory Training Data Overview

Activity	Q2 2016-2017	Q3 2016-2017	Q4 2016-2017	Q1 2017-2018	Q2 2017-2018
SGA	97% ↑	96% ↓	97% ↑	98% ↑	98%
SGC Level 1	96% ↑	97% ↑	98% ↑	97% ↓	98% ↑
SGC Level 2	89% ↑	90% ↑	89% ↓	91% ↑	90% ↓
SGC Level 3	79% ↑	78% ↓	69% ↓	63% ↓	66% ↑
LD Training	83% ↓	84% ↑	87% ↑	85% ↓	88% ↑

Non Mandatory Training

Activity	Q2 2016-2017	Q3 2016-2017	Q4 2016-2017	Q1 2017-2018	Q2 2017-2018
DV Training	3	0	0	32	13
MCA	50	61	58	36	25

(NB. Figures relate to number of attendees)

Summary

Level 1 and 2 Children's safeguarding training has remained at 90% or over, however level 3 even though showing a slight increase still does not fall within the required Trust target of 90%, the probable reason for this is the transition from separate level 3 child training to the Think Family training which incorporates both adult and child safeguarding issues, the impact of this has been more staff requiring this level of training with limited spaces available. To address this risk the safeguarding team have advised staff they must undertake some form of level 3 children safeguarding training to maintain their competency as well as booking onto the next available 'Think Family' session.

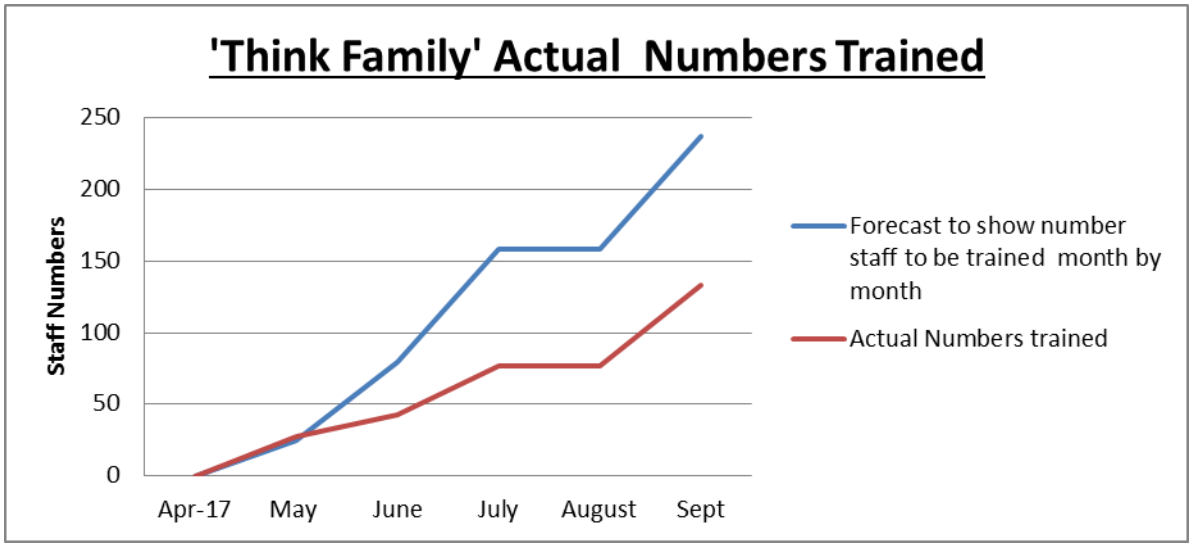
'Think Family' Level 3

From April 2017, all qualified staff are required to evidence they have attended a full day Level 3 safeguarding training session every 3 years. This competency will be achieved via staff attending the full day in house 'Think Family' training, provided by the Safeguarding

team, which will provide staff with a combined adult and children level 3 competency. However compliance can also be achieved by evidencing attendance at an external multi agency Level 3 Safeguarding Adult/Children training.

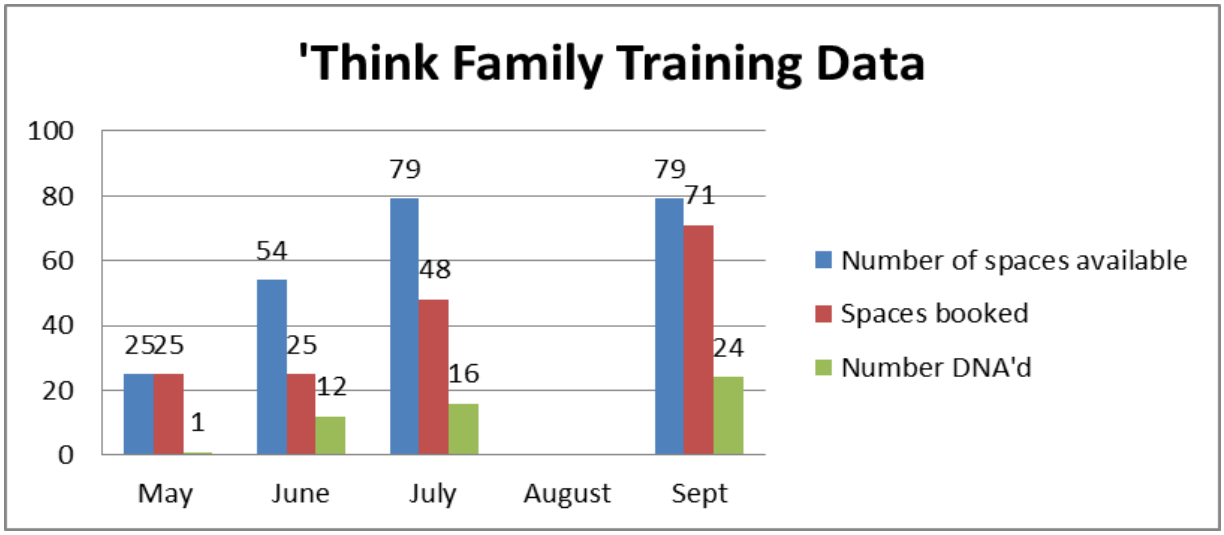
'Think Family' training trajectory

A total of 2500 staff across the Trust require level 3 'Think Family' Training. The trajectory above shows the numbers to be trained over the next 3 years based on the spaces available on each training session.

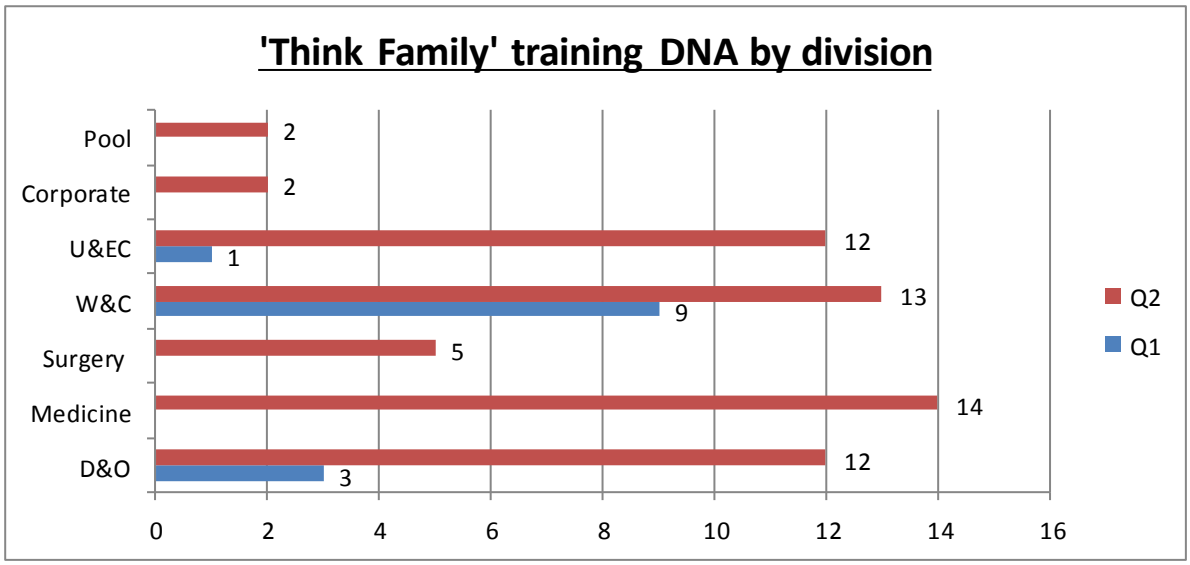


Actual numbers trained are lower than predicted over Q1 & Q2. This has been predominantly due to the number of spaces not being booked and delegates not attending sessions. The graph below shows the proportion of spaces available alongside spaces booked and non-attendance (DNA – Did Not Attend). Training spaces have been limited due

to the room availability within the hospital. Only half the lecture theatre was available for some of the sessions, however even when fully booked there was still a percentage of staff not attending.



In **Q2** the total number of training spaces **lost** to DNA's and unbooked places equates to **50%.** There was a similar picture in Q1 where **53%** of overall spaces were lost. The safeguarding team have attempted to recoup some of these spaces by allowing sessions to be overbooked. There were no sessions booked for August due to the summer holiday period. Moving forward in 2018-2019 the training delivery dates will include August to ensure maximum spaces are available.



Mental Capacity Act (MCA) Training

This training is scenario based and gives staff the opportunity to practice the application of Mental Capacity Act and Deprivation of Liberty.

Six MCA half day (am or pm) sessions took place during Q2. Each half day session has the capacity to accommodate 40 attendees. This equates to an available **480 places per quarter.** The graph below indicates the number of staff booked onto the sessions **(39 attendees in total, 8.1%)** and the number of staff who actually attended the sessions **(24 attendees in total, 5%)**. There is an identified need to further explore the total number of training spaces lost to DNA's and un-booked places. This will be reviewed as part of the MCA development plan being developed as a result of the MCA audit undertaken in this quarter.