Sherwood Forest Hospitals NHS
NHS Foundation Trust

Quarterly Patient Safety & Quality Report

Quarter 2 summary 2015/16

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Executive Summary

Within the 2015/16 Quality Account, the Trust agreed a number of key Quality and Safety targets these are identified within the trusts Patient Quality and Safety Strategy. This report gives an assessment and future plans against those priorities.

Quality Priority 1: A joint Mortality Action Plan has been developed between Sherwood Forest Hospital Trust and the Mid-Nottinghamshire CCGs. Our aim is to achieve a sustained HSMR at, or below 100. The plan sets out in detail a number of clinical and administrative areas where work is focused; sepsis, pneumonia, pathways of care including acute kidney injury, end of life care including ceilings of care and supporting documentation. The Dr Foster Data Intelligence data is now reported up to June 2015. This shows a reduction in our HSMR. The HSMR for May 2015 was 103 and is currently showing at 89 for June 2015.

Quality Priority 2: This priority focuses on improving the management of sepsis and reducing sepsis related mortality. An audit of patients with Bacteraemia and Sepsis is carried out monthly. In addition to the Trust Sepsis group, a Task & Finish group has been set up (with Executive chair) to review and monitor in Sepsis screening and compliance with the Sepsis pathway. The Sepsis Task Force continues to oversee the Sepsis Action Plan which was created to accelerate the improvement of sepsis care and achieve compliance with the Sepsis Six Bundle. The target is Trust wide compliance >90% by November 2015. The CQUIN target for Quarter 2 was to achieve 60% compliance with sepsis screening within our admission areas. We have exceeded this target with compliance of 94.8%

Quality Priority 3: The falls priority is to reduce the number of inpatients falling in hospital, with harm, and reduce the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital. The focus of the falls work programme is to work with the nursing and clinical teams to understand the perceived barriers that prevent the outcome of risk assessment being transacted into practice. The number of falls with harm shows a reduction against the mean for September; confirmation of the CQUIN target remains to be agreed. The number of falls with severe harm for quarter 2 shows no improvement, work continues to target support on specific wards and areas with a higher incidence of falls with harm to promote sustained interventions.

Clostridium Difficile 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 is disappointing that we failed to meet the venous thromboembolism (VTE) assessment target for July and August 2015 which we have previously consistently met. The shortfall was on average 2.2%. Compliance improved during September to 95.09%.

HSMR - Quality Priority 1

Mortality targets for 2015/16 are:

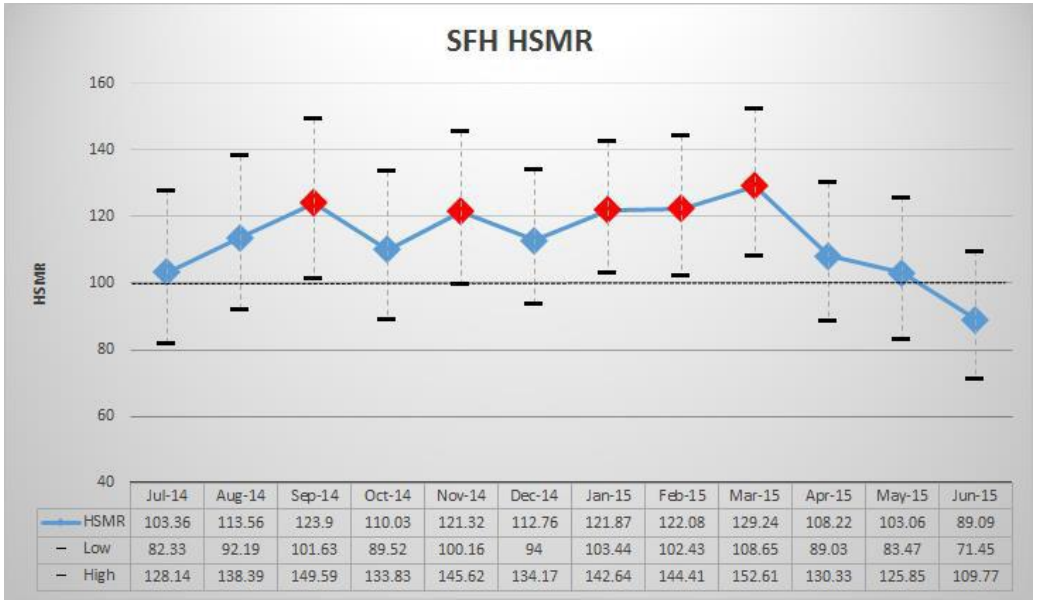
1. To reduce mortality as measured by HSMR to within the expected range

2. To implement a robust mortality reporting system that is visible from service to board

To eliminate the variation between weekend and weekday HSMR

How are we performing against this target?

Graph 1



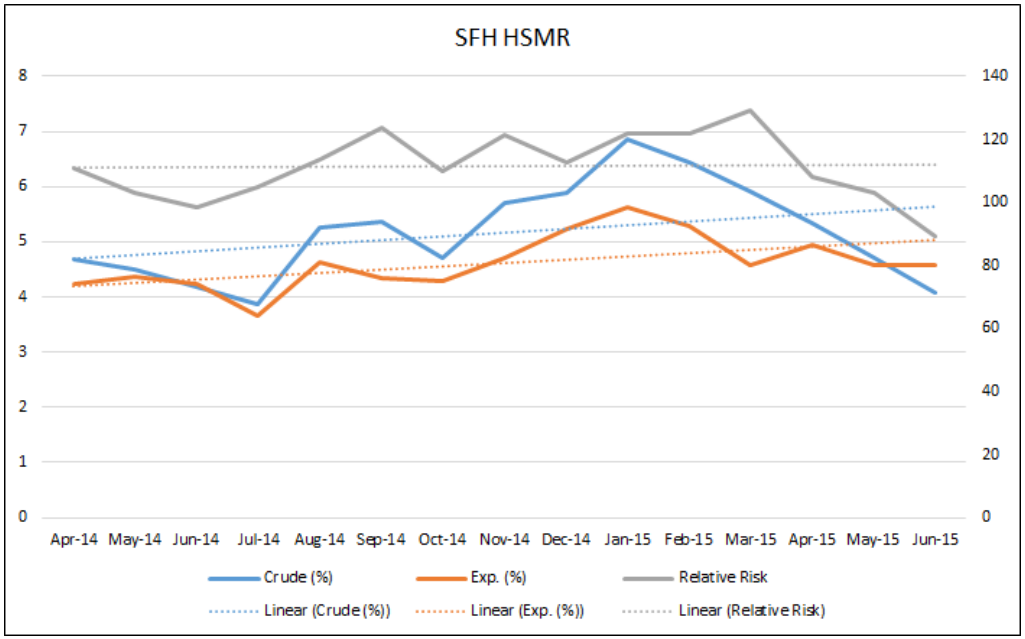
	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
HSMR	103.36	113.56	123.9	110.03	121.32	112.76	121.87	122.08	129.24	108.22	103.06	89.09
Low	82.33	92.19	101.63	89.52	100.16	94	103.44	102.43	108.65	89.03	83.47	71.45
High	128.14	138.39	149.59	133.83	145.62	134.17	142.64	144.41	152.61	130.33	125.85	109.77

Graph 1

The Dr Foster Data Intelligence data is now reported up to June 2015. This shows an encouraging reduction in our HSMR. The HSMR for May was 103 and is currently showing at 89 for June, although this may change slightly. It coincides with the reduced crude mortality that we see over the summer months, but the reduced HSMR also reflects all the improvements that have been made in terms of pathways of care, record keeping and coding.

As the crude mortality rises going into the winter months, a pattern that is repeated nationally every year, we need to ensure that we continue with the same standards of care and attention to record keeping that we have seen since the improvements were introduced.

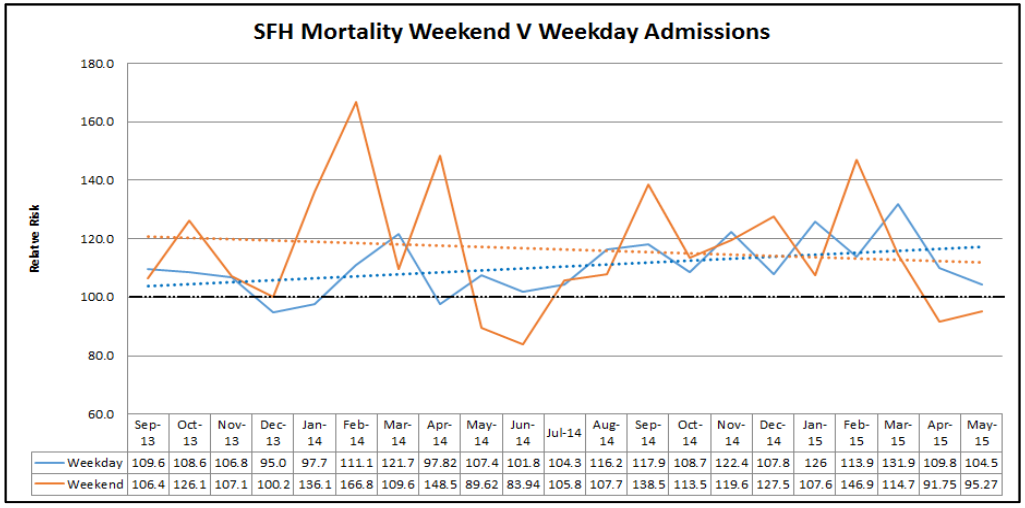
Graph 2



Graph 2

This graph shows the pattern of Crude mortality over the last year alongside the pattern of our expected mortality and our overall HSMR. The expected mortality is a calculated based upon the patient cohort, primary diagnosis and comorbidities, age and other factors such as the level of deprivation. An HSMR of 100 represents a crude mortality and an expected mortality that are the same. The improvements that we have made show that in June, our expected mortality was actually higher than our crude mortality. This shows an improvement inpatient care, record keeping and coding.

Graph 3



	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	Mar-15	Apr-15	May-15
Weekday	109.6	108.6	106.8	95.0	97.7	111.1	121.7	97.82	107.4	101.8	104.3	116.2	117.9	108.7	122.4	107.8	126	113.9	131.9	109.8	104.5
Weekend	106.4	126.1	107.1	100.2	136.1	166.8	109.6	148.5	89.62	83.94	105.8	107.7	138.5	113.5	119.6	127.5	107.6	146.9	114.7	91.75	95.27

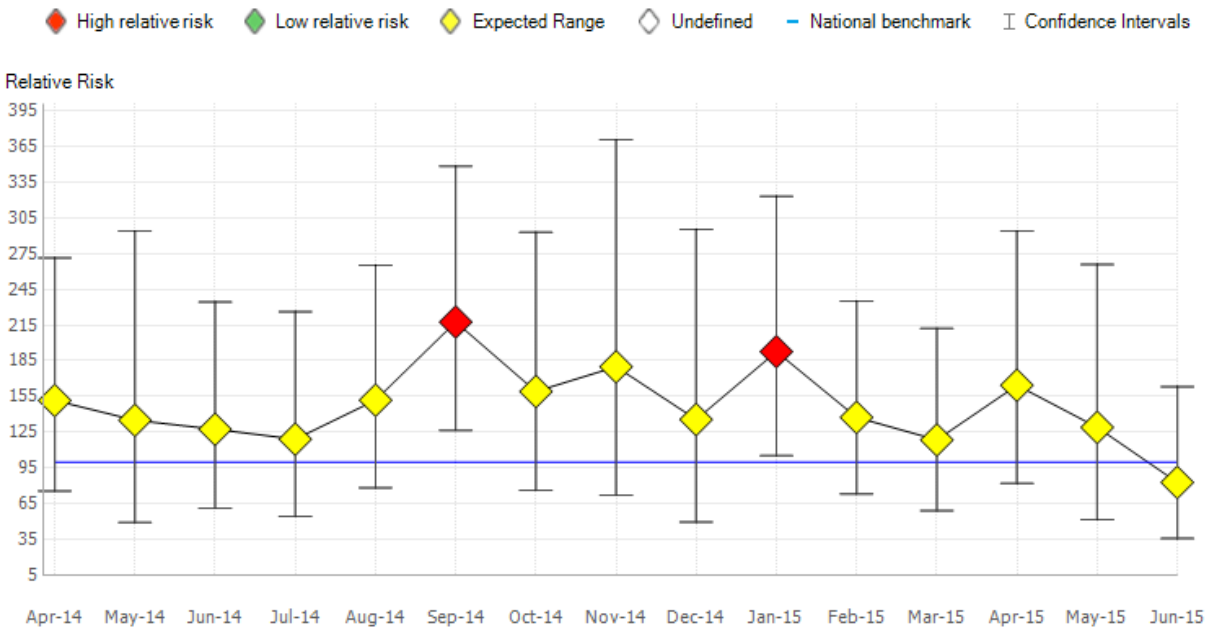
Graph 3

This graph tracks the deaths by day of admission. This varies from month to month. In both April and May of 2015, the weekend admissions have been lower than the weekday admissions. There are senior decision makers available at weekends and tests and results are available supporting the clinical judgments and helping to inform diagnoses and treatment plans.

There are approximately 30 deaths per week at SFHFT. The numbers shown on this graph are the relative risk which is why they are in the hundreds.

Mitigation plan (actions to date and future planning)

- The Joint Mortality Action Plan with the CCGs remains behind the work that is being carried out around mortality across the trust and we continue to receive their input.
- Sepsis remains the area with the highest HSMR above expected, although this is improving. There is considerable work going on in this area. There has been a programme since July to raise awareness of Sepsis and the importance of screening for it, recognising it and treating it promptly as per national guidelines. There has also been an increase in emphasis on Sepsis training in the mandatory training received by both nursing and medical staff at the trust. Weekly and monthly audits of compliance with screening and with treatment show an improvement in prompt recognition and management of Sepsis which is reassuring. Work is continuing to embed this as a normal part of patient care.



Sepsis - Quality Priority 2 (National CQUIN)

Sepsis targets for 2015/16 are:

Our priority is to improve the management of sepsis and reduce sepsis related mortality

1. To implement a recognised local protocol / screening tool within emergency department / other units that directly admit emergency patients
2. To administer intravenous antibiotics to patients presenting with severe sepsis within one hour of presentation

How are we performing against this target?

1. The CQUIN target for Quarter 2 was to achieve 60% compliance with sepsis screening within our admission areas. We have exceeded this target with compliance of 94.8%
2. This element of the CQUIN focuses on antibiotic administration in severe sepsis and data collection commenced in July. Our Quarter 2 objective was to establish baseline data collection which has been completed. 75% of eligible patients received antibiotics within 1 hour of arrival to hospital.

Mitigation plan (actions to date and future planning)

- The Sepsis Task Force oversees the Sepsis Action Plan which was created to accelerate the improvement of sepsis care and achieve compliance with the Sepsis Six Bundle. The target is Trust wide compliance >90% by November 2015. This group will escalate weekly to Divisional teams and report monthly to Clinical Quality and Governance Committee.
- Reporting to governance meetings of the bacteraemia audit results has been increased from quarterly to monthly.
- The monthly sepsis related HSMR mortality reviews continue.
- A new sepsis screening tool has been implemented on the wards and audit was commenced in October 2015.
- The Critical Care Outreach Team is exploring new ways of working in order to incorporate surveillance for possible sepsis patients.
- There is a drive to increase the numbers of staff who are able to perform cannulation and nursing staff that can administer sodium chloride infusion under a Patient Group Directive (PGD)
- The Trust is implementing a new version of the paediatric sepsis screening tool for paediatric emergency admissions.
- A sepsis resource area is now available on the intranet. This contains local policies and information as well as links to external agencies.

None of the deaths reviewed this quarter were avoidable. The Sepsis Lead Nurse is now providing support to the coding department where they need clarity or advice on sepsis cases.

Falls - Quality Priority 3 (National CQUIN)

Falls targets for 2015/16 are:

1. Reduce the number of inpatients falling in hospital with harm from Q2 onwards.
2. Reduce the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital' from Q2 onwards.
3. Delivery of safety improvement programme which has been developed through learning from the best and linking with local and national organisations, notable for their innovation/best practice

How are we performing against this target?

1. Below is a graph (Graph 1) which plots the cumulative number of falls with harm (levels 2, 3 and 4) over the past 18 months.

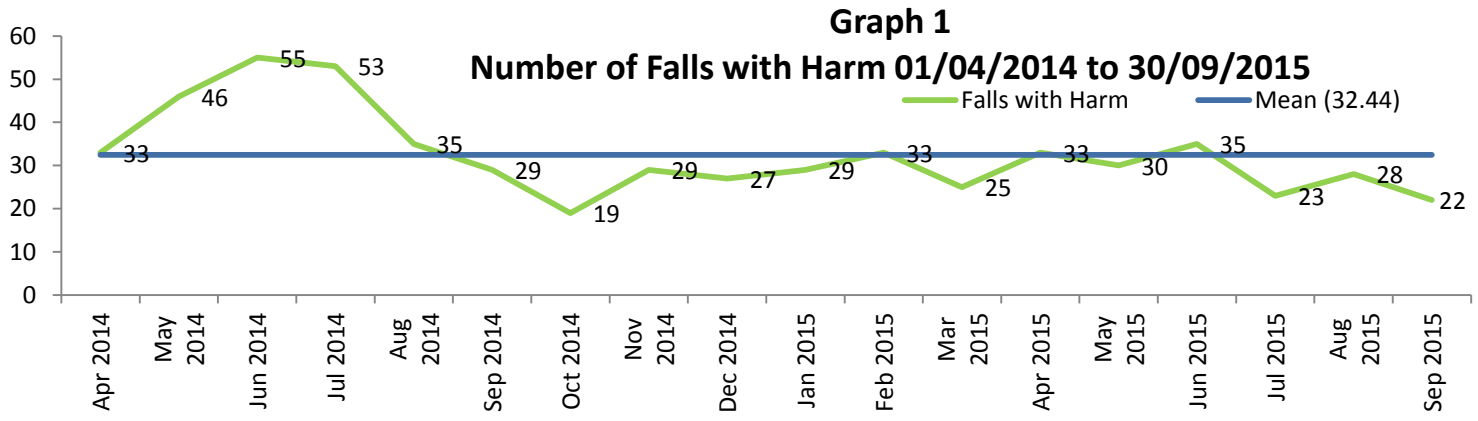


Table 1 below shows the actual number of falls with harm split by level over the past 18 months.

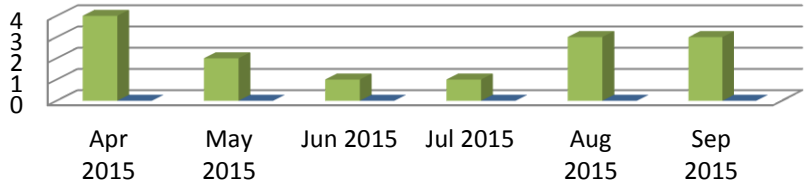
Table 1.

	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015
(Grade 2) Low - Minimal Harm: Patient required extra observation or minor treatment	29	38	52	50	31	29	18	24	20	25	30	19	29	27	31	20	24	16
(Grade 3) Moderate - Short term harm: patient required further treatment or procedures	4	8	3	3	4	0	1	5	7	4	3	6	0	1	2	3	2	3
(Grade 4) Severe - Permanent or long term harm	0	0	0	0	0	0	0	0	0	0	0	0	4	2	2	0	2	3
Total Falls	33	46	55	53	35	29	19	29	27	29	33	25	33	30	35	23	28	22

2. Table 2 below shows the number of falls incidents that have been initially graded as severe and catastrophic. These incidents are subject to investigation and on completion of the investigation the severity coding is reviewed and confirmed or amended.

Table 2.

Incidents by Severity and Incident date 01/04/2015 - 30/09/2015



	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015
(Grade 4) Severe - Permanent or long term harm	4	2	1	1	3	3
(Grade 5) Catastrophic - Death	0	0	0	0	0	0

During Quarter 2 we have had a total of 7 patients who sustained a severe harm following a fall as an inpatient. This is the same number as Quarter1. Work continues to target support on the wards and areas with a higher incidence of fall with harm to promote sustained interventions. For example: ensuring that if a patient has been seen by the Comprehensive Geriatric Assessment team on EAU and then transferred to the wards have the management plan adhered to. Ensuring patients at risk of falls are being referred early to the appropriate services, such as physiotherapy and occupational therapy and pharmacy for early medication review, looking particularly for medications that are likely to increase the risk of falls.

The Lead Nurses for Falls are working with the Ward Leaders, Matrons and the Practice Development Matrons for those ward areas that have a higher number of falls with harm. To ensure lessons learnt are embedded within the team and for those patients at risk from falls they are receiving appropriate interventions which are communicated to all members of the multidisciplinary team.

The local picture in relation to the number of people over 65 in Mansfield, Ashfield and Newark is expected to rise by 9.8% over the next 5 years. The growth in numbers of older people will be associated with a corresponding increase in the number of falls particularly in those aged over 80.

3. To progress the delivery of safety improvement programme which has been developed through learning from the best and linking with local and national organisations, notable for their innovation/best practice. The Trust took part in the Royal College of Physicians 'National Audit of inpatient falls' in August 2015 and the published report highlight the following: *"inpatient falls are common and remain a great challenge for the NHS. Falls in hospital remain the most commonly reported safety incident. There is no single or easily defined intervention, when done on their own, are shown to reduce falls. However research has shown that multiple interventions performed by the multidisciplinary team and tailored to the individual patient can reduce falls by 20-30%. These interventions are particularly important for patients with dementia and delirium, who are at high risk of falls in hospital."*

In response to this the Falls Nurses are working in collaboration with the Dementia Lead and are holding an event called 'Linking the Thinking' which will look at the steps we can take to improve care and patient safety. This event is open to the community teams also and will be the first shared learning experience of this sort. The day is already fully booked with 50 people and following the evaluation of this day further events are planned to bring the multidisciplinary teams together. The day will explore the local picture on falls and dementia and have presentations from a variety of speakers. The afternoon will focus on small workshops supporting staff in the understanding the role of the Frailty Intervention Team, the immediate response following a fall and the incident investigation process in hospital.

The Falls team and Dementia lead will also be working with the front door team to identify patients at high risk of falls at the earliest opportunity and following these patients up on transfer to the ward areas.

There currently is no system in place that allows these patients to be flagged on the computer system as high risk of falls and the falls team are meeting with the Infection Prevention and Control team to explore the feasibility of requesting a similar alert system on Medway Pas.

The recommendations in the National Audit of inpatient falls will be shared at the next Falls and Safety Improvement Group and the overall performance in relation to the rest of the East Midlands explored.

Mitigation plan (actions to date and future planning)

- The Falls and Safety Group membership will be reviewed at the next meeting with a view to disbanding the current membership and re-instating the group with representation from Physiotherapy, Occupational Therapy, Radiology, Pharmacy and an appointed Clinical Lead.
- The first draft of the Falls Strategy has been completed and will be circulated for discussion with the Falls and Safety Group at the next meeting.
- In response to lessons learnt from the themes and trends of incident reporting. A bid has been submitted through charitable funds for anti-slip mats that can be used at the side of the patients beds; to reduce the risk of slipping when moving off pressure mattresses in particular. Anti-slip mats that can also be used on patient chairs to reduce the risk of patients slipping from chairs.
- 'Falls Grab boxes' have been requested for all ward areas to centralise the immediate equipment required in the event of a fall. This is to be stored with other emergency equipment.
- Networking with other Trusts continues and the Falls team have arranged to visit Birmingham University Hospitals in November to explore a shared learning opportunity. Education and training sessions for newly appointed staff and ward specific training sessions are also on-going. In addition to this the Library is exploring the options of setting up an E-Learning programme for Nurses and Doctors.

Infection Control (Quality Schedule and Internal target)

Infection Control targets for 2015/16 are:

1. Zero tolerance Hospital Acquired MRSA
2. Minimise rates of Clostridium Difficile – No more than 48 cases per annum
3. No more than 5 Urinary Catheter Related bacteraemia

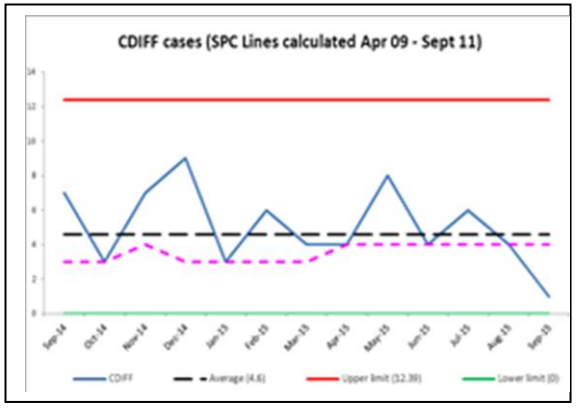
How are we performing against this target?

1. MRSA bacteraemia: This quarter there has been 1 case of a MRSA bacteraemia being attributed to the Trust during 2015/16, the specimen was taken on admission, however it was identified as a contaminated sample therefore it is assigned to the organisation responsible for taking the culture.

2. Clostridium Difficile: There have been 11 incidents of Clostridium Difficile toxin during Q2.

   This is within our maximum quarterly target of 12 (Graph 1). However, overall yearly running total (total of 27) remains over trajectory. RCA's have been performed, lapses in care have been identified in 6 cases; these relate mainly to delays in sampling and delays in isolating patients.

3. Catheter associated bacteraemia: There have been 4 cases of hospital acquired catheter associated bacteraemia during Quarter 2. The RCA's have been completed and prolonged catheterisation and poor documentation continues to be an issue.



Graph 1.

Mitigation plan (actions to date and future planning)

1. MRSA bacteraemia – the recent result identified that contamination was the cause and the patient did not come to any harm. This has led to a drive to improve processes and practice with blood culture taking. The Infection Prevention and Control Team are closely monitoring the contaminated cultures and provide practical sessions for junior doctors on their arrival to the trust.

   Any bacteraemia is reviewed by the Infection Prevention and Control Nurse and a Consultant microbiologist, where identified as Trust acquired and/or device related an investigation is undertaken in order to identify potential lapses in care and facilitate organisational learning.

2. Clostridium Difficile: this remains a high priority across the whole health economy, identifying triggers, practice issues and responding to specific incidents.
   - During Q2, there has been one death attributed to Clostridium Difficile; this has been reported externally and is under full investigation
   - The whole health economy Clostridium Difficile review group; was involved in delivering an educational programme to the G.P's within the local CCG. It was well received and generated discussion specifically around improving anti-microbial prescribing.
   - A high emphasis on clostridium Difficile management is provided in all opportunities
   - The sampling proforma introduced in March 2015 has been strongly promoted during Quarter 2 and compliance has improved from 30% to 69% during that time.

3. Catheter Associated Bacteraemia: The Implementation of the integrated catheter packs continues to be part of the plan to improve practice. A Q2 audit using the *'HOUDINI' standards indicate 3% catheters remain in situ with no known reason.

Audit programme

Audit Total areas 35	ECM% Q1	**ECM% Q2**	PCS% Q1	**PCS Q2**	NWK% Q1	**NWK% Q2**
Hand Hygiene	90	**85**	91	**95**	50	**85**
PPE	100	**86**	91	**100**	75	**100**
Sharps	80	**50**	91	**75**	100	**100**
Linen	85	**66**	75	**58**	88	**100**
Commodes	76	**80**	66	**61**	75	**58**

Programmes of Bi-weekly audits are performed by the Infection Prevention and Control Team in all clinical areas.
Table 1 shows the audit results by division for quarter 1 and 2. To be considered fully compliant the minimum score should sit at 90%, between 80-89% is partially compliant and below 80% urgent actions are required.
Emergency Care and Medicine Hand Hygiene has shown deterioration, with an improvement shown at Newark and in Planned Care and Surgery.
Sharps non-compliance is primarily due to poor use of temporary closure, catheter issues (related to inadequate securing and positioning) and inconsistent documentation. Specific training for link staff has been provided.
Commode cleanliness remains poor during the past quarter. The acting Chief Nurse has reminded all ward leaders and matrons of their responsibility for monitoring commodes daily.
Electronic audit monitoring is now in place and reports are being generated for areas to immediately review.

Education and Training

Table 2

Training	Percentage compliance Q1	Percentage compliance Q2
Infection Control on Mandatory Update	88	87
Hand Hygiene (Total)	86	84
Hand Hygiene (medical staff)	81	72
Hand Hygiene (Clinical Staff -non medics)	91	85
Hand Hygiene Non Clinical (New Mandate)	54	58

The education and training compliance data is monitored continuously. With the exception of hand hygiene for non-clinical staff, at the end of Quarter 2 the compliance with infection related training shows a decrease on the previous quarter. Hand hygiene training for medical staff has shown an decrease of 9% and in non-medical clinical staff the compliance with training has dropped by 6%.

With support from link staff, the Infection Prevention and Control Team have made it a priority to provide additional sessions. The drop is recent and may be associated with annual leave. The data is monitored monthly and will be scrutinised and continues to be escalated to the divisional management teams.

From April 2015 it became a mandatory requirement to formally train non clinician staff in hand hygiene every 3 years. There has been a steady increase in compliance to this requirement and the number of sessions provided by the Infection Prevention and Control Team.

The Link Champions study day in September 2015 combined the issues of sepsis and recognising infections.

*HOUDINI protocol stands for the following:

Hematuria, gross

Obstruction, urinary

Urologic surgery

Decubitus ulcer—open sacral or perineal wound in incontinent patient

Input and output critical for patient management or hemodynamic instability

No code/comfort care/hospice care

Immobility due to physical constraints

Scrutinised to identify any patterns occurring that require interventions.

Improving Patient Flow & Discharge Processes (Quality Schedule)

Improving Patient Flow targets for 2015/16 are:

1. Trust Target - To reduce Length of Stay (excluding 0-1 day LOS) to 7 days

How are we performing against this target?

Length of Stay has reduced from an average of 8.3days for the whole of 14/15 to an average of 6.73 for August 2015.

Mitigation plan (actions to date and future planning)

- Reducing length of stay is a key objective of the Emergency Flow Programme which is part of the PMO (Programme Management Office)
- Internal workshops have taken place to review how discharges are managed in the organisation.
- A workshop for key stakeholders of the health and social care system was held on the 30th Sept. Whilst the aim was to review last winter and the problems that led to 17 patients breaching the 12 hour wait in ED, a number of actions came from the staff who attended that can be implemented ahead of the 1st December that should help to maintain better flow for this winter.
- The Trust has launched the 'There's no place like home' campaign which is planned series of events throughout the winter designed to embed proven, successful changes that enable patients to flow through the hospital in a more timely manner. The first four 4 changes are:
- Increasing the number of patients who are cared for in CDU and who are discharged from CDU
- Some wards to discharge 2 patients a day and have those beds filled by patients from EAU by 10am
- To have 25 empty beds a day on EAU at 8pm
- To have all TTO's written on the day before discharge

Acute Kidney Injury (Local CQUIN)

Acute Kidney Injury CQUIN targets for 2015/16 are:

The targets for Q2 and Q3 were set based upon our starting baseline in Q1 where our figure was 21%.

CQUIN target for Quarter 2 = 35%
CQUIN target for Quarter 3 = 60%
CQUIN target for Quarter 4 = 90%

This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below.

1. Stage of AKI (a key aspect of AKI diagnosis)
2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment)
3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care)
4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care)

How are we performing against this target?

Changes have been made to the Orion Discharge letter during Q2. There is now a mandatory question regarding AKI and a requirement for certain responses where AKI was present during a patient's admission. This change to the discharge letter was introduced on 20th August, just over halfway through Q2. The percentage for Q2 is 46.7% so we have achieved and exceeded the Q2 target of 35%.

Mitigation plan (actions to date and future planning)

- The CQUIN is monitored through the Acute Kidney Injury working group. The AKI group has prepared an audit to be carried out before Christmas. This will be carried out once the data collection process has been set up on the Meridian System.
- The AKI group has been monitoring progress with meeting the new national AKI reporting system that went live in September. Any AKI alerts identified are presented as additional test information to clinicians. In addition, our AKI data will be uploaded to the new Renal Registry and processed to become a part of the HES dataset.

Dementia (National CQUIN)

Dementia target for 2015/16:

1. To improve care for patients with dementia or delirium during episodes of emergency unplanned care.
2. To ensure that appropriate dementia training is available to staff through a locally determined training programme.
3. Ensure carers of people with dementia and delirium feel adequately supported.

How are we performing against these targets?

1. The Dementia CQUIN target has been achieved for quarter 2 with a compliance average of 91.99% for FAIR (Find, Assess, Investigate, Refer).

July	August	September
90.1%	91.6%	94.2%

The Dementia Care Appeal continues to raise money for environmental changes throughout the Trust in order to be a dementia friendly organisation. Examples of changes already implemented are improved signage in key areas, provision of red coloured toilet seats to improve visibility and identification of the toilet, 100 dementia clocks have been installed across the Trust; the design of which changes from day to night which improves orientation of the person with dementia.

"This is Me" document continues to be available in clinical areas and relatives are encouraged to complete the document to inform and enable better understanding by nursing and other staff about the person with dementia, to enable person-centred care planning.

The library at Kings Mill Hospital continues to provide resources for people with dementia in order for staff to facilitate meaningful activity.

The role of activity co-ordinator is being piloted on Ward 35. There is firm evidence to support the activity co-ordinator role to improve the patient experience and to reduce distress and anxiety for patients with dementia and cognitive impairment. This role is also to be implemented on Ward 52.

There is now a Project Manager to push forward with the Ward 52 project which will see a complete environmental change. The new unit will be a dedicated Medical Mental Health Unit for patients with the most complex needs. The new environment will incorporate a seated area in the foyer for

patients and relatives, a memory walk, a dedicated end of life care side room with facilities for relatives, colour coded bays, a theme of different seasons along the corridor, cinema style seating along the corridor with projected images on the wall, an activities room and portable nurses stations within the bays. Learning from this will be rolled out to environments across the trust.

A dementia awareness event was held at the Annual General Meeting for members of the public, governors and staff. This further raised the awareness of dementia, and the Trust' commitment to becoming a dementia friendly organisation.

During quarter 2, the Dementia Lead Nurse has become part of the daily Frailty meetings in EAU to case find complex patients with dementia and be a point of contact for advice and support for patients, relatives/carers and staff.

2. Dementia awareness continues to be delivered on the Mandatory Update and on the Orientation Day for all new starters to the trust. During quarter 2 751 staff received dementia awareness training. Overall, 88% of Trust staff have received dementia awareness training within the last 2 years.

3. The Dementia Lead nurse attends EAU each day to case find patients with dementia and to offer support to carers and relatives, the library at Kings Mill Hospital is a resource point for staff and carers to gain resources and advice leaflets, the Trust works in collaboration with the third sector and we have an Age UK advocate on site who is available for advice and support for patients and relatives. The dementia lead nurse is exploring further collaborative arrangements with the third sector.

A small selection of patient carers were surveyed during quarter 2 to gain qualitative feedback. A selection of comments and feedback is identified below:

Positive

"All staff have been supportive; they have looked after me, given me food and drink when I have been visiting my wife. I have been kept informed of my wife's treatment plan".

"I have received explanations from the doctor about the treatment plan for my husband. I feel well informed about dementia".

"I feel well informed and happy with my partner's care. I have felt supported and reassured that he is safe".

Areas for development

"There needs to be more staff on the ward".

"I haven't felt supported or communicated with while my mother has been in hospital. I know I can ask questions if needed but there are often no nurses available to talk to. I had a much better experience at Mansfield Community Hospital- there was always someone available to talk to.

"I wasn't aware that my husband had been admitted until I visited the care home and he wasn't there".

"I like the idea of a Dementia Café for patients and carers to get together and offer support to each other".

Mitigation plan (actions to date and future planning)

- Dementia friendly signage is being implemented in all adult in-patient areas. This will enhance the dementia friendly environment.
- There is to be a re-launch of the dementia screening tool in admission areas and the form is to be modified and changed to a blue colour to make it "stand out"; it is to be completed as part of the clerking process.
- The Dementia Lead Nurse is to have access to a live spread sheet of all emergency admissions of those patients over the age of 75 years to enable follow up of patients who need screening for dementia and to prompt medical staff to complete the relevant documentation.
- Dementia friends training is to be made more widely available at the Trust for all levels of staff and visitors. The Dementia Lead Nurse is undertaking the Dementia Champion training from the Alzheimer's Society in order to facilitate this.
- Work is underway to utilise the carers survey that is currently being collected by colleagues in liaison psychiatry. The plan is to work in collaboration with Nottinghamshire Healthcare Trust to obtain and share information.
- As a Trust we are signed up to the Dementia Friendly Hospitals Charter and we have been matched with another organisation, Mid Yorkshire Hospitals NHS Trust. The purpose of this is to offer peer to peer support and share examples of good practice within our hospitals and to support each other with the implementation of the Dementia Friendly Hospital Charter.
- A study day called "Linking the Thinking" has been planned for 4th December 2015. The study day will involve dementia awareness training and falls prevention, including all the multifactorial and multi-professional elements that contribute to person centred care. The study day has been made available for both internal and external staff.
- A dementia group is to be reformed, including stakeholders and partners internal and external to the trust. The aim is to review and update the dementia strategy and associated workstreams.

Safeguarding Adults (Quality Schedule)

Safeguarding Adults targets for 2015/16 are:

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

How are we performing against this target?

1. The self-assessment has been reviewed for 2015/16 and submitted to the Trusts Safeguarding Adult's Board and the Clinical Governance and Quality Committee (CGQC). The output of the self-assessment forms the basis of the safeguarding adult's work plan.

   The work plan for 15/16 has been developed and is line with the Nottinghamshire Safeguarding Adults Board (NSAB) strategy and work programme. This will be tabled at Q2 Safeguarding Board.

   The main work in quarter 2 has been to:

   Continue to embed Mental Capacity Assessment (MCA) and best interest systems and processes within clinical practice:

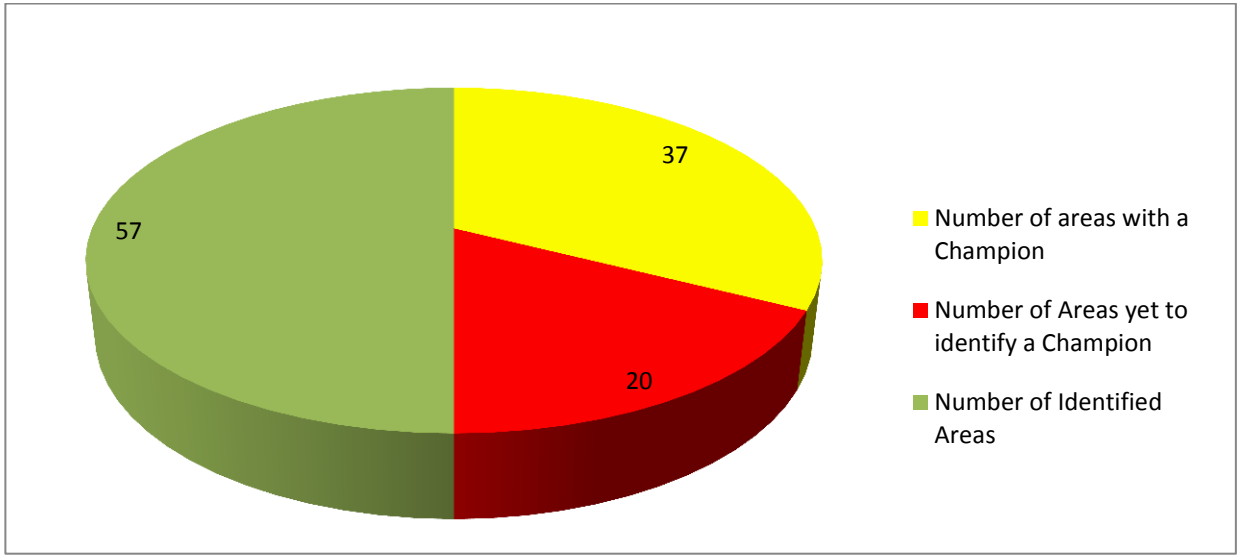
   A full day's scenario based training is offered to staff which gives them opportunity to practice the application of Mental Capacity Act and Deprivation of Liberty. This course runs monthly, the numbers of senior staff attending has been low. This was taken to the nursing and midwifery weekly business meeting in July; the Director of Nursing advised all Matrons and Ward Leaders must attend. As a result of this the numbers of Matrons and Ward Leaders enrolling for full training are now rising. An additional study day has been offered by the Safeguarding team. Mental Capacity Act is also taught on nursing induction and mandatory. Training is also available on request or if identified.

   Work has been untaken to further embed the Vulnerable Adult Champion model, 57 areas within the Trust were identified to need a Vulnerable Adults Champion. Five vulnerable adult study days were arranged to provide in-depth training for nominated Vulnerable Adult Champions and a series of bi monthly support meeting were also arranged.

From the 5 arranged study days, 37 areas have sent a total of 51 staff (some areas have more than 1 Champion), 1 study day has been cancelled due to low numbers, a further day has been arranged for 15th January 2016. To date there are 2 people booked on the study day in January 2016. All Wards / Department Leaders, Matrons and Divisional Matrons have been advised of the dates and asked for nominees.

Commencing in April 2015 monthly support sessions have been made available for staff and information regarding these has been distributed through the same network.

Chart below is the number of Areas Identified and Allocated a Champion



The NHS England Prevent Training and Competencies Framework has been reviewed and a meeting has taken place with the Children's, Adults safeguarding teams and Training and development regarding implementation across the Trust, a plan detailing how the Trust will meet this has been developed.

On-going work is taking place to develop a new tool to audit MCA in practice.

2. Implement the National Capability framework Training figures

Safeguarding training is in line with the national Capability framework. The figures below are the percentage of staff who have completed mandatory training.

Type of training	Quarter 1	Quarter 2
Mental Capacity	95%	96%
Safeguarding Adults	77%	82%

Mental Capacity (full day) attendance is as follows: Quarter 1, 11 staff attended and during Quarter 2, 23 staff attended.

3. Actively participate in the Multiagency Safeguarding Hub (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.

There have been 128 referrals to the safeguarding team in quarter 2, 17 of these referrals were referred to MASH for investigation.

The same themes continue to be identified from safeguarding concerns regarding the Trust. These themes are: staff not following MCA and communication with other healthcare providers particularly on discharge.

Mitigation plan (actions to date and future planning)

- The Foundation Trust has commissioned a development programme relating to safeguarding activities. An action plan was compiled and was received at the July Safeguarding Board meeting. A further report has been written by Professor Amanda Ashton and will be submitted to the Safeguarding Board in October. The heading below identifies the themes within the plan.
- Leadership development programme - The safeguarding team leadership development programme continues within the Sherwood Forest Hospitals with two further sessions completed.
- Training - There has been a review of all training materials used in the Trust relating to adult safeguarding.
- Leadership at the Board - The trust solicitors have agreed to attend the Board (either September or October 2015) to refresh Trust Board members of their legal obligations in relation to safeguarding.
- Safeguarding governance - There is also an on-going review of the Governance process in relation to Safeguarding Adults

Safeguarding Children (Quality Schedule and Internal target)

Safeguarding Children targets for 2015/16 are:

1. Trust to continue to assess and report to Clinical Commissioning Group against the Local Safeguarding Children's Board (LSCB) self-assessment and accountability frameworks (NSCB Markers of Good Practice)

2. Trust to implement Safeguarding Children & Young People: Roles & Competences for Health Care Staff Intercollegiate Document, RCPCH (2014)

3. Active participation in MASH (Multi Agency Safeguarding Hub)

How are we performing against this target?

1. NSCB Markers of Good Practice - Self-assessment against the NSCB Markers of Good Practice took place in September 2015, and showed that as a Trust, we are green against 52 of the 56 outcomes. There were no 'red' areas. 4 Amber areas below were highlighted - (the actions for which are detailed overleaf)

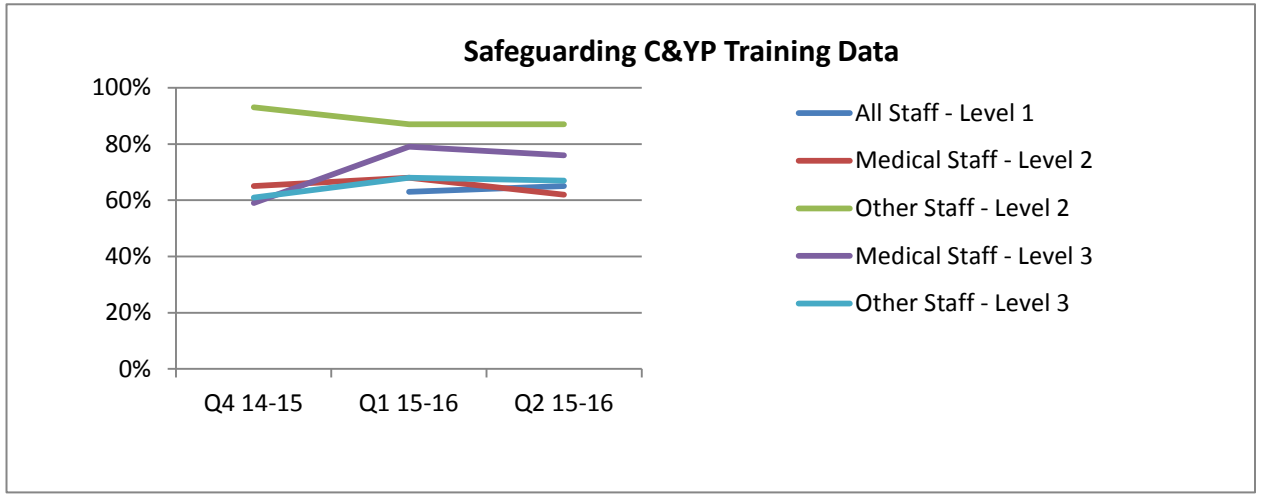
    - 100% attendance by Trust Lead Director (or named deputy) at quarterly NSCB Board meetings.
    - All new starters to the organisation attend a safeguarding children awareness session within an induction programme or within 6 weeks of taking up post within a new organisation.
    - All staff, including those with specialist roles, are provided with safeguarding children training updates appropriate to their role and responsibilities.
    - Professionals involved in day to day work with children and families should have child protection supervision on a minimum of a quarterly basis.

2. Safeguarding Children & Young People: Roles and competences for Health Care Staff Intercollegiate Document – From a minimum staffing standard the trust has a Specialist Nurse for Safeguarding Children (1.0 WTE), however we continue to fail to meet the national standard for a Named Nurse, having only 0.5 WTE organisational wide Named Nurse for safeguarding children and young people (the National Standard is 1.0 WTE), which means there is insufficient capacity within the team to meet both strategic and operational demands. This shortfall was highlighted at the recent CQC Inspection of Safeguarding Children and has been submitted as a risk to be added to the Trust risk register.

    The trust received in October 2015 the report from an externally commissioned review of the Safeguarding service and team structure. The proposals are being considered by the Medical Director and Acting Chief Nurse.

Training compliance continues to present a significant challenge:

	Q4 14-15	Q1 15-16	Q2 15-16	Q3 15-16
All Staff - Level 1		63%	65%	
Medical Staff - Level 2	65%	68%	62%	
Other Staff - Level 2	93%	87%	87%	
Medical Staff - Level 3	59%	79%	76%	
Other Staff - Level 3	61%	68%	67%	



3. 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)

1. NSCB Markers of Good Practice

- Every attempt is made to ensure representation, currently the NSCB Board Meetings conflict with the Trust Board Meeting.

- Monthly reports are produced by Training, Education and Development (TED) and sent to all managers, in addition TED write to all non-compliant staff. Managers must target individual the staff members identified in their reports. Compliance with training has been raised with all matrons and ward managers by the Acting Chief Nurse.

- A safeguarding children's pathway has been developed, this offers a menu of training choices for staff – multi-agency, e-learning and in-house training is available, and has been disseminated to all managers to support them in ensuring their staff are compliant. This pathway is also issued to all new starters to the Trust.

- All staff requiring 1-1 supervision are 100% compliant, however where group supervision is offered attendance at advertised sessions fluctuates. There are now safeguarding children champions in all areas where children and young people are seen and these champions, once trained, will be able to offer front-line supervision to their teams.

2. Safeguarding Children & Young People: Roles & Competences for Health Care Staff

- Compliance of staff in attending training remains an issue across the Trust, particularly for those staff requiring level 3 competency. A new pathway has been developed explaining the range of options for staff requiring training which has been shared with managers and staff across the organisation. Managers should target individual staff within their teams.

- The option of inclusion of training compliance within appraisals will be explored with Human Resources.

Learning Disability (Quality Schedule)

Learning Disability targets for 2015/16 are:

1. To deliver Learning Disability awareness training on the trust induction and mandatory training programme.
2. To facilitate a Learning Disability steering group meeting on a quarterly basis in order to drive this agenda forward within the trust, involving patients with a Learning Disability and involving their family and carers.
3. To provide support and expertise to patients with a learning disability and their family and carers during an acute hospital admission and / or attendance at an outpatient clinic appointment
4. To continue to fulfil the requirements of the annual Safeguarding Adults and Learning Disability work plan.
5. The Trust to be compliant in the 6 Learning Disability Standards.

How are we performing against this target?

1. There are 2181 in the Staff Group requiring the training of which 1713 are compliant which equates to 79%. Learning Disability training is advisory (but not mandatory) for medical staff, with 10 medical staff this quarter attending.
2. The Trust held a Learning disability steering group meeting on the 29th September, main topics discussed were:

    - Transitions pathway – Consultant paediatrician, Complex Disability nurse for children and Learning Disability nurse specialist for adults are devising a policy to follow for young adults moving into adults services. This should ensure that young adults with complex needs have planned care for transitioning into adult services. This should make the transition period better supported for the young adult and their families. This work is progressing well and is expected to be completed by March 2016.

    - Health Buddies project update – 8 people with Learning Disability have received training to enable them (with support) to recieve feedback from their peers about health services. 43 people have provided feedback about using our service; we also have some comments from paid carers. During quarter 3 the feedback will be analysed and this will be discussed at Safeguarding Board and Patient Experience Committee.

- Newark Hospital Changing Places toilet – The steering group have identified aview that this facility is needed. A case of need is being written and put forward for consideration.

- The group have completed the easier read 'How to make a comment or complaint' leaflet.

3. 57 people have been supported this quarter during their hospital admission/outpatient attendance. Referrals continue to be made at a steady rate by both Hospital staff and colleagues in the community. Examples of some of the referrals for individuals have been for support in outpatient clinic to help suggest and arrange reasonable adjustments to make it easier for patients to tolerate certain procedures, support for staff in applying the mental capacity act in practice and best interests planning, supporting staff to manage complex patients in a ward setting.

4. The annual safeguarding adults & learning disability work plan is on-going, this has been tabled at the safeguarding adults board. The main drive on the plan for learning disability is to establish a transitions pathway (as discussed above) as new guidance for the hospital in supporting younger adults and to embed the Learning disability risk assessment in practice.

5. The trust continues to be compliant in the 6 monitor standards. A progress report was submitted to the Quality committee in September, a further detailed plan is being developed with the Acting Chief Nurse.

Mitigation plan (actions to date and future planning)

- An audit on the use of the Learning Disability Risk Assessment showed that hospital staff nurses were not completing the risk assessment for all patients the audit showed 40% compliance. This concern was added to the trust risk register and an action plan was developed to embed the assessments use. During quarter 3 another audit will take place now that the work on the action plan has been completed.

- A summary of the audit went to the Clinical Quality & Governance Committee for their information (September). Details of the areas failing to complete the assessment will be sent to divisional matrons.

CQUIN Summary

Overview of Achievement of CQUIN Targets 2015/16

Table 1 below shows the agreed national, local and specialist CQUIN's agreed for 2015/16.

Summary of Acute Schemes for 2015/16				Q1	Q2
CQUIN Scheme		**Requirement**	**Approx CQUIN Value**		
1	Acute Kidney Injury (Aki)	Improving the provision of information to GPs at the time of discharge	£459,000		
2a	Sepsis Screening	Screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics	£229,000		
2b	Sepsis Antibiotic Administration	Administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis	£229,000		
3a	Dementia And Delirium (Fair)	Improve care for patients with dementia or delirium during episodes of emergency unplanned care	£183,000		
3b		To ensure that appropriate dementia training is available to staff through a locally determined training programme	£46,000		
3c		Ensure carers of people with dementia and delirium feel adequately supported	£138,000		
4	Reducing The Proportion Of Avoidable Emergency Admissions To Hospital (UEC)	Reducing the proportion of avoidable emergency admissions to hospital	£459,000		
5a	Falls Prevention	Reduce the number of inpatients falling in hospital	£92,000		
5b		Reduce the number of inpatients sustaining a fracture as a result of a fall in hospital	£92,000		
5c		Delivery of safety improvement programme which has been developed through learning from the best and linking with local and national organisations, notable for their innovation/best practice	£92,000		
6a	Information Sharing CQUIN 2015/16	Avoiding unnecessary admissions and in achieving the Gold Standard of Care for End of Life Patients	£294,000		
6b	Record Sharing Refinement	Information will be collected and fed back on the usefulness of the information contained within the GP record	£73,000		

Summary of Acute Schemes for 2015/16				Q1	Q2
CQUIN Scheme		**Requirement**	**Approx CQUIN Value**		
7	Improving care at end of life	Reduce the proportion of deaths that occur in hospital	£642,000		
8a	Assessment, Care Planning and Communication with GP - Sharing information and improving cancer care planning and delivery	Systematic assessment, care planning and information sharing to provide proactive care for people with cancer	£459,000		
8b	Cancer Pathway Redesign	Review and plan improvement programme for other tumour pathways delivered at SFHT	£183,000		
9	Better Together: Working in partnership to improve outcomes for our population	To ensure that the population of Mid-Nottinghamshire receives the best possible care	£917,000		
SFH - B2	HIV - Reducing unnecessary CD4 monitoring	To embed evidence based approach to monitoring CD4 counts for management of HIV treatment	£130,680		
SFH - C6	Eligible patients receiving a NICEG10 compliant test with provision of monitoring data	To help patients, who cannot be categorised as low or high risk by existing clinical practice, make more informed choices about whether to undergo chemotherapy through greater insight into their likelihood to benefit	£27,000		
SFH - WC3	Neonatal Critical Care – Reducing Clinical Variation and Identifying Service Improvement Requirements by ensuring data completeness in the 4 NNAP Audit Questions identified.	Where data are complete for an individual child and for a whole unit for these four questions, clinical quality will be improved through identification of areas for improvement and reduced clinical variation	Value to be agreed by specialist		

How are we performing against this target?

Risk rating for CQUIN's

CQUIN evidence reports for the quarter 2 actions will be submitted to CCG and NHS England in November 2015.

The Trust is currently confirming the risk rating forecast for all CQUIN's for quarter two, three and four.

The following CQUIN is risk rated as red:

Further discussion and negotiation is needed for the Better Together CQUIN; a joint meeting with commissioners is being planned for early November. It is anticipated that this meeting will refocus the work and reduce the risk of not achieving the quality initiative.

The following CQUIN's are risk rated as amber:

The Dementia CQUIN has been ragged as amber due to Q4 uncertainty with regards to the improvements in electronic communication of care plans with GP's.

Falls: Reducing falls continues to be a challenge for the Trust. The paper included in this report sets out the identified actions being taken to reduce falls.

Eligible patients receiving a NICEG10 compliant test with provision of monitoring data is ragged amber as the data is not yet available to confirm the quarter 2 position.

Mitigation plan (actions to date and future planning)

- Monthly meetings are held with the SFHFT leads to help with the early identification of and removal of barriers for achieving the CQUIN requirements.

End of Life Care (National CQUIN)

End of Life Care targets for 2015/16 are:

1. End of Life (EoL) clinical champions to be in place.

2. Increase in the number of inpatients who die in their place of preference, as evidenced through audit and a reduction in the number of hospital deaths.

3. Ensuring patients are discharged safely and effectively

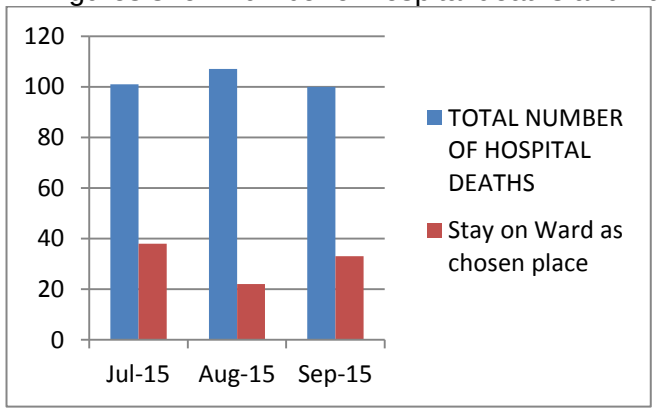
4. Evidence of improved rates of staff training in end of life care

How are we performing against this target?

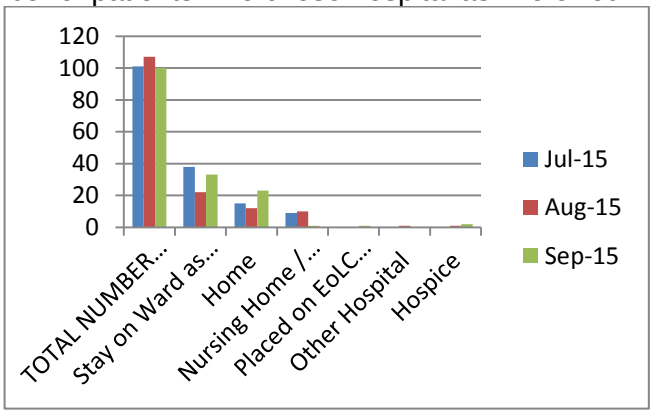
1. The Trust appointed Dr Ben Lobo (Locum Consultant Physician /Geriatrician) to this role April 2015

2. We continue to monitor the number of hospital deaths and measure Preferred Place of Care (PPC). The data shows there were a total of 308 deaths in hospital in Q2. Of those deaths we attempted to achieve Preferred Place of Care for 189 (61%) of patients. We actually achieved Preferred Place of Care for 175 (57%) of patients; 53% of patients choosing hospital as their preferred place of care/death. Data presented in this summary is for those who were known to the Integrated Discharge Advisory Team and met the criteria for Fast Track Continuing Care / Rapid Discharge Home to Die. 47% achieving Fast Track Continuing Care / Rapid Discharge Home to Die. Significant changes in performance might be hard to achieve as factors beyond the Trust's control influence patient choice.

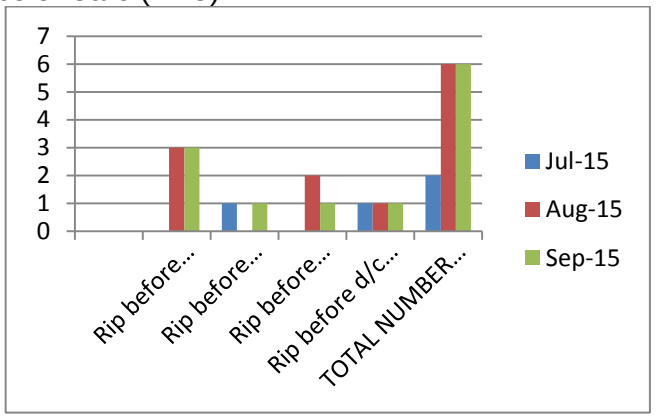
   Figures show number of hospital deaths and number of patients who chose hospital as Preferred Place of Care (PPC)



Number of hospital deaths and number of



Number who achieved PPC

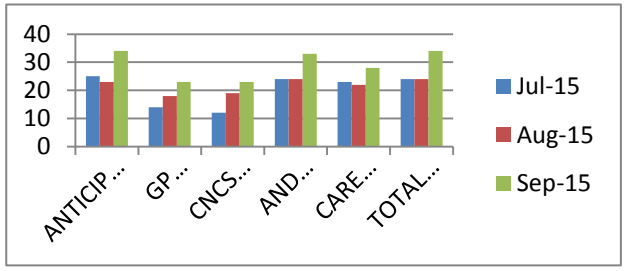


Figures of the number of non-achieved PPC

patients who chose hospital as PPC

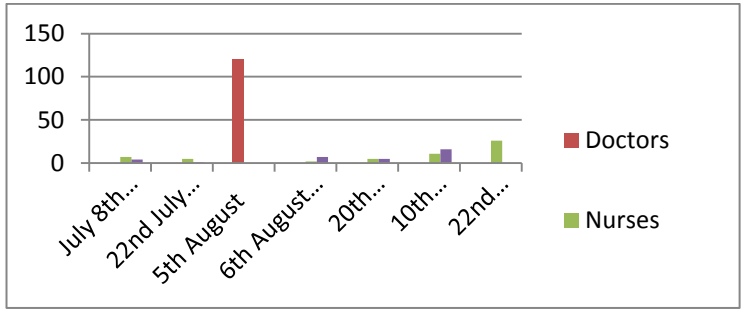
In the last few months the End of Life Care team has been heavily committed to the CQC inspection and Trust response to the inspection. We continue to lead on improving end of life care through the Trust end of life care strategy and are identifying further improvements in the improvement plan. In this quarter the two parts of the national audit for End of Life Care, data entry and validation, were completed through the on line system.

3. We continue to monitor the quality of discharges against the parameters on the CQUIN.



4. Good progress is being made with training and is on schedule to achieve the planned training within the annual Training Programme. Evidence of improved rates of staff training in end of life care: The figures show an increase in uptake of training in a number of different areas compared to 2014-15 performance.

This Quarter the following numbers of staff have attended the following end of life care training:



422 non-medical staff have completed the mandatory workbook in Quarter 2.

Mitigation plan (actions to date and future planning)

- The current and emerging risks have planned review dates and are supported by the corporate team (Executive Leads: Medical Director and Acting Chief Nurse). There is quality and financial risks involved which the End of Life Care Team has already escalated.

Maternity (Quality Schedule)

Maternity targets for 2015/16 are:

Midwife to birth ration of 1:28

How are we performing against this target?

The workforce tool of choice for maternity staffing is birth rate Plus which gives an overarching view of staffing and a suggested optimum ratio of 1:28.

On a day to day basis the acute staffing needs take into consideration elective activity and inpatients, with a proxy marker of being able to provide 1:1 care for all women in established labour. Community staffing is predominately based on clinic cover and there are no minimum staffing levels.

We trust continues to monitor the 'midwife to birth' ratio and now reports this monthly. During Quarter 2 there has been an increase in births of 4.1% on last year delivering 898 women during this time. Based on the funded establishment the 'midwife to birth' ratio for this quarter is 1:30 and 1:32 for staff in post.

This has ranged from 1:28 to 1:33.5 against funded establishment and 1:28.3 to 1:35 in post.

Mitigation plan (actions to date and future planning)

- The service is currently appointing 6 new members of staff to the acute service and actively recruiting for community posts where there is a significant gap of 5 whole time equivalents. The service is reviewing different models of care that may help with this gap and has managed to maintain safe staffing levels without the use of bank or agency staff.
- A midwifery workforce report has been produced from human resources for the board in relation to the age profile of the current midwifery work force.
- The nation survey on Women's Experience of Maternity Care 2015 has recently been received by the trust. Women who gave birth at Sherwood Forest in February 2015 were surveyed about all aspects of their maternity care. The trusts response rate was 36% compared against an average of 41%. The trust has received the initial report and is currently analysing the results which will be reviewed by Maternity Governance and the Maternity Improvement Group.
- Staff Survey; In June and July the trust surveyed all staff within the maternity team. Maternity service received 111 responses out of 230 and all staff groups were represented. 99.1% of our staff identified they were satisfied with the quality of care they gave, 98.2% would recommend the standard of care we provide to a friend or relative and 96.4% would recommend the maternity service as a place to work.
- A Maternity Improvement Group has been established with an initial meeting held in October 2015. The group will be supported in its focus and additional scrutiny and challenge will be achieved through membership on the group of a number of external partners including Fiona Wise who was the Improvement Director at Morecambe Bay.

Safety Thermometer (Quality Schedule)

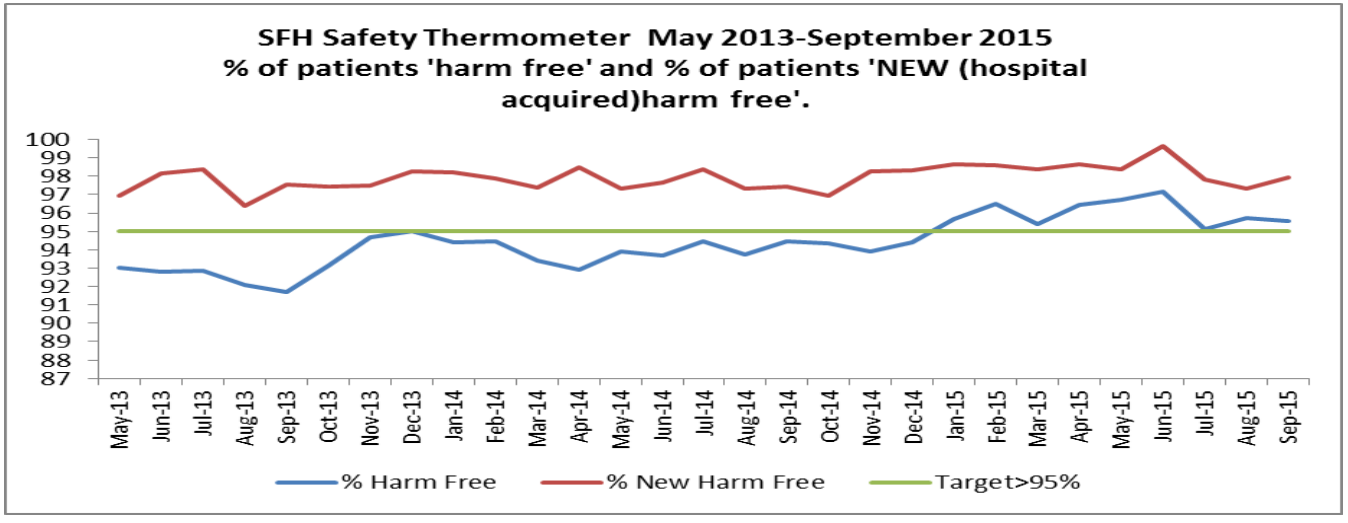
Safety Thermometer targets for 2015/16 are:

1. Ensure harm free care for patients (>95%), as measured monthly by the Safety Thermometer. A national tool to measure local improvement and enable comparative benchmarking between trusts and within the trust over time.

We understand that it is essential that the care we provide for our patients is free from harm. The Safety Thermometer allows healthcare professionals to measure a snapshot (or prevalence) of harm backdated over a 72 hour period and the proportion of patients that are 'harm free' in relation to Grade 2, 3 and 4 pressure ulcers, Catheter associated urinary tract infections (CAUTI), Falls, and Venous thrombo-embolism (VTE).

The Safety Thermometer was fully implemented across our Hospitals in April 2012 and harms data is now collected for every adult patient on the same day, once a month with the exception of patients in theatres, emergency department and outpatients.

How are we performing against this target?



The graph above shows the % patients classified as "harms free" and "new (hospital acquired) harms free' by month and indicates that for Quarter 2 we have achieved the 95% target and consistently remain above 95% for patients who have acquired new harms.

Q2 Safety Thermometer

The Trust continues to collect and upload data to the NHS information centre within the defined period each month.

A total of 1743 patients were assessed using the Safety Thermometer during Q2. In Q2 the result for harm free care is an average of **95.46%**, this is an improvement on the average of 94.20**%** in Q2 2014/15 and exceeds the national goal of **95%**. This includes patients who have been admitted with a degree of harm.

Q2 Monthly breakdown of harm free care by %

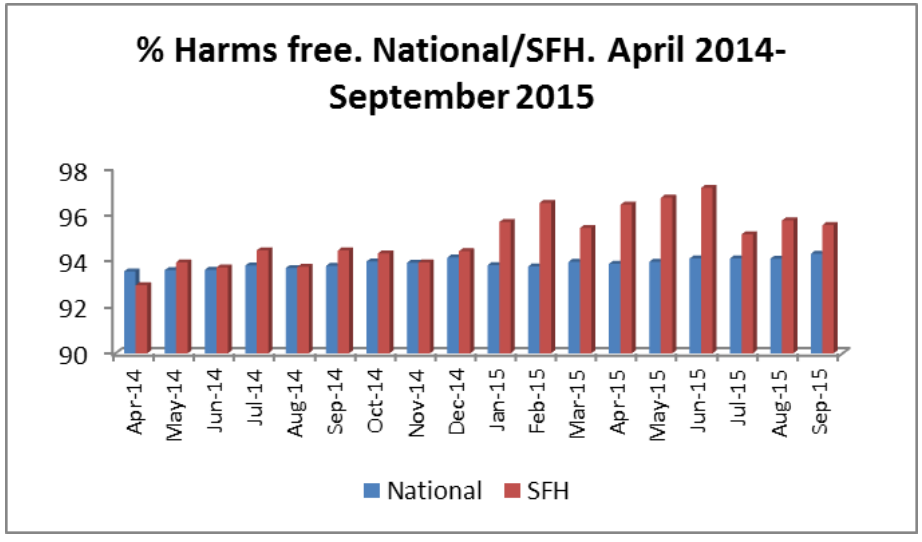
July
95.14%* -harm free care
97.82% - new harm free care
2.18% of our patients suffered a new harm
New CAUTI – 2 New Fall with harm - 3
New Pressure ulcer PU – 5

August
95.74%* -harm free care
97.34% - new harm free care
2.66% of our patients suffered a new harm
New CAUTI – 6 New Fall with harm - 0
New Pressure ulcer PU – 5

September
95.54%* -harm free care
97.94% - new harm free care
2.06% of our patients suffered a new harm
New CAUTI – 4 New Fall with harm - 1
New Pressure ulcer PU– 3

96.76% Harm Free Care in Q1

95.46% Harm Free Care in



The graph above illustrates the Trust position of harm free care alongside the national average performance

What do the results tell us?
Since May 2014 our reported 'harms' rate has been less than the national average reported rate this includes pre-hospital

**Please note that the percentage shown is the overall percentage of harm free care, this includes patients admitted into the Trust with pre - existing pressure ulcers, 'old' UTIs in patients with catheters. Old UTIs are defined as those where treatment had started outside of the Trust.*

Mitigation Plans (actions to date and future planning)

- The falls specialist nurses analyses the data from reported incidents on a monthly basis. This information is used to identify any clinical areas with an increased number of falls, repeat falls and/or falls with harm. The falls nurse specialists met with staff, Ward Leaders and Matrons from these areas to support development of action plans to drive local improvement and deliver additional education and training.

- The Infection Prevention and Control team have also commenced collaborative working with the Falls team to help reduce the number of falls due to catheter urometer / measurement bags by promoting staff to change to leg bags as soon as possible.

Medicine Safety (Patient Safety and Quality Strategy)

Medicine Safety targets for 2015/16 are:

1. Zero medication-related 'Never Events' as per NHS England Never Events List 2015/16
2. To increase the number of reported medication-related incidents and near-misses reported on Datix® and improve learning from the incidents.
3. To increase the number of patients whose medicines are reconciled by pharmacy staff within 24 hours of admission to hospital.
4. To ensure all patients have a documented allergy status on prescription.
5. To reduce the number of patients with omitted doses of critical medicines (e.g. antibiotics, insulin etc.).
6. To reduce the number of medication-related incidents resulting in moderate / severe harm by **25%** (compared to 2014/15 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation etc.

How are we performing against these targets?

1. No medication-related 'never events' reported during 2015/16 Q2. One significant insulin overdose incident reported which was a prescribing error (50 units rather than intended 10 units for treatment of hyperkalaemia) but not specifically never-event related.
2. 18.7% fewer incidents reported Q2 2015/16 vs. 2014/15; 23.6% fewer incidents reported YTD 2015/16 vs. 2014/15. This is against a reduction in Trust activity described by occupied bed days (OBD) of 13.4% for Q2 recognising admissions have increased by 2.2%. Nursing, midwifery and pharmacy staff continue to report the majority of medicines-related incidents (94% of incidents for Q2), medical staff reported 2% and 4% reported 'job role' was not stated.
3. Data collected monthly for the Medicines Safety Thermometer (MST) indicates an average of 89% of patients in Q2 receiving medicines reconciliation by Pharmacy within 24 hours of admission, compared to 87% for Q1. This data is only to the end of August 2015 as September data not yet available.
4. Data collected monthly for the MST indicates >98% of patients have a documented allergy status in Q2 (to end of August), continuing the performance in Q1. Further assurance is obtained from HAPPI data collected over the same period indicating a continued rate of 100% in Q2.
5. Data collected monthly for the MST indicate 17% of patients had an omitted dose in Q2 (this includes both valid and invalid reasons for omissions), to end-August. This represents 17% deterioration in performance compared to Q1. For critical medicines, the omission rate is 3%, again indicating a slight deterioration on Q1. MST data does, however, continue to indicate better performance than the national average.
6. Medicines incidents resulting in ANY harm are down by 10% in Q2 compared to 2014/15. Moderate harm incidents are up by 66% for the same period but numbers remain low; there were no incidents in Q2 reported with higher severity. Most reported incidents continue to have no attributable harm (>80%). High-risk medicines incidents are well reported, with a significant focus on insulin and opioids.

Mitigation plan (actions to date and future planning)

1. Near-misses relating to never-events are actively followed-up with internal SI investigations. Incident report content is reviewed to avoid the use of 'never-event' as specific terminology for such near-misses, as this would flag on the NRLS despite no such event occurring. Never-events continue to be promoted at new staff induction, mandatory updates to maintain awareness, and are flagged on the 'Be Safe with Medicines' leaflet available on the intranet.
2. The importance and value of medicines incident reporting continue to be promoted at new staff induction, mandatory updates, Trust Shared Learning events etc.; increased reporting by medical staff remains a challenge.
3. Medicines reconciliation continues to be a priority for Pharmacy, with significant resources being applied to admissions areas, 7-days/week.
4. Allergy status documentation continues to be a priority for all clinical staff to complete; gaps/omissions are actively challenged and investigated when drug administration has occurred. Revisions to the Trust drug chart have improved space available allergy status on the documentation.
5. Medicine omission remains a high priority; significant work continues through the Trust Medicines Safety Task/Finish Group and Medicines Champions in clinical areas. Red 'Do Not Disturb' tabards are now routinely used by nursing staff during periods of medicine administration, and ward-specific missed dose data is now available and fed back to staff in clinical areas. This is to be continued during 2015/16, in addition to monthly MST data collection. A flowchart to help staff minimise missed doses has been designed and is available on the intranet.
6. Medicines-related incident 'harm' measures are closely monitored by the Medicines Safety Officer; those incidents suggesting significant harm, or significant near-misses with no attributable harm (e.g. recent insulin near-misses) are actively investigated, and learning identified where possible. Medicines Safety bulletins continue to be published by the Trust Medicines Safety Group.

Pressure Ulcers (Quality Schedule)

Pressure Ulcers targets for 2015/16 are:

1. Less than 3 grade 2 avoidable pressure ulcers per month with a yearly trajectory of no more than 36.
2. Zero grade 3 and 4 avoidable pressure ulcers.

How are we performing against this target?

Avoidable Hospital Acquired Pressure Ulcers 2015/2016								
		Apr	May	Jun	Jul	Aug	Sept	Total
Grade 2	Target	3	3	3	3	3	3	18
	Actual	1	2	1	3	2	2	11
Grade 3	Target	0	0	0	0	0	0	0
	Actual	0	0	0*	2	1	0	3
Grade 4	Target	0	0	0	0	0	0	0
	Actual	0	0	1	0	0	0	1

**Following a thorough investigation of a patient with a grade 3 PU on Ward 32 in June, it was deemed an unavoidable PU. Therefore June's Grade 3 pressure ulcers have been changed from 1 to zero.*

Following investigation of the grade 4 pressure ulcer from June 2015, the findings highlighted concerns in the care of a patient with complex care needs. Additionally that the Waterlow risk assessment tool was not specific enough to capture the personal care and equipment needs and the nursing staff did not use their professional judgement in ensuring the patient had the appropriate dynamic pressure relieving mattress in place when transferred from intensive

care to the surgical ward. Post operatively there was also an assumption made that this fit young man would mobilise and eat quickly post operatively, and so therefore did not require pressure relieving equipment or a high protein/calorie diet. The care and incident review identified the young man had nutritional requirement above what was identified and he was malnourished and had an undiagnosed neuropathic illness that severely hindered his recovery. This patient story will be shared at the trust Board Meeting, and the Nursing and Midwifery Board meeting on 23rd October 2015. Nursing 'Proud to Care' study days scheduled throughout the following year will include this patient story to ensure trust wide learning and support nurses to think widely about their responsibilities to deliver personalised care.

Mitigation plan (actions to date and future planning)

- Individual ward reviews have occurred during the week commencing 12th October, by named Tissue Viability Nurses to identify specific training and support needs within the entire nursing and allied health professionals team. The Tissue Viability Nurse Consultat will lead the programme of learning and development for the trust.

- The Tissue Viability key performance indicators will also be clearly communicated and monitored with the Matrons and Ward Leaders with the support of the Divisional Matrons.

- Purpose T trial – a new evidenced pressure ulcer risk assessment tool to be piloted on four wards across the Trust from 26th October 2015.

- A new wound care pathway to be piloted by the Tissue Viability Team from week commencing 19th October 2015.

- Dynamic mattresses: a programme of work is being developed to improve effectiveness and ensure the appropriate equipment (dynamic mattresses) are delivered to patients in a timely manner and are safe to use.

Venous Thromboembolism (Quality Schedule)

Venous Thromboembolism (VTE) targets for 2015/16 are:

1. 95% of patients who have been identified as being at risk of venous thromboembolism (VTE) to receive appropriate preventative treatment
2. 100% of cases of hospital acquired thrombosis (HAT) have a root cause analysis performed.

How are we performing against this target?

1. Data for Quarter 2 is shown in the table below: It is disappointing that we failed to meet the target for July and August 2015. For July, even if all 111 notes to be tracked were complete, this would not achieve the target as there are 148 required to be completed. The blank or missing forms allow for more than the downfall for each month therefore; non completion of the risk assessments is the reason the target was not met.

	July	August	September
COMPLETE	**2119**	**2260**	**2701**
Low Risk	**3887**	**2974**	**3141**
Blank/Missing Form	346	230	156
Notes to be tracked/Awaiting data	111	156	149
RIP	52	33	12
Assessed > 24hrs	5	20	43
Total complete/low risk	6002	5254	5884
Notes needed to reach 95%	148	114	-5
	92.60%	**93.00%**	**95.09%**

2. The Clinical Lead for venous thromboembolism has left the Trust and a new lead is required as all hospital acquired thrombosis should be assessed and where appropriate investigated by the Specialty teams. The initiation of new investigations is currently on hold.

Mitigation plan (actions to date and future planning)

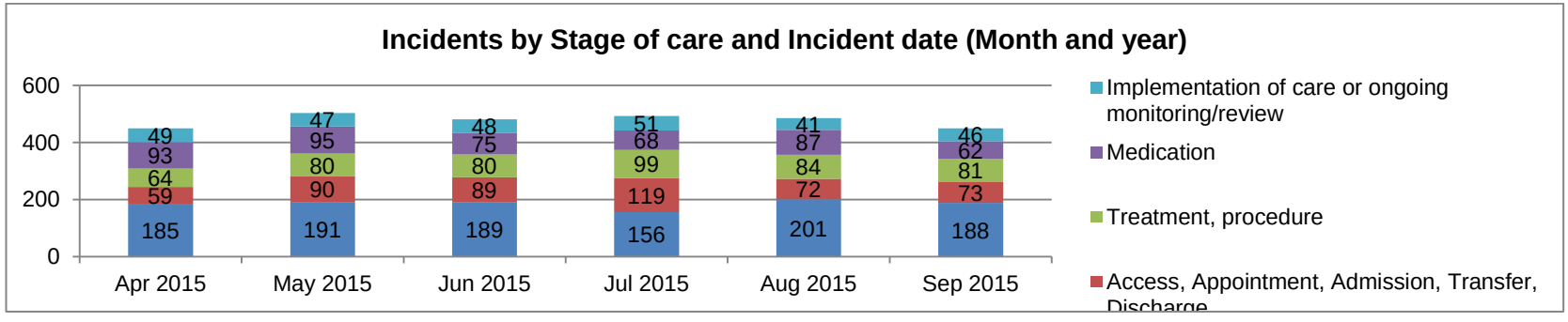
The medical teams requested that the venous thromboembolism risk assessments were attached to the medical clerking document as they felt the drug chart may not be completed until later and this led to an oversight in completing the forms. This may have been a contributory factor in the improvements during September. September also saw an improved method of data collection, to include a rolling monthly list rather than a daily list for collection previously used. The CQUIN support staff has worked closely with the admitting areas to raise awareness and respond to constraints. There was a shortfall in this workforce during July and this was also a significant factor why the target was not met.

Incidents, Serious Incidents and Never Events (Quality Schedule)

Incidents:

Below are the top 5 incidents by stage of care and incident date.

Incidents by stage of care and Incident date (month and year)	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Total
Accident that may result in personal injury	185	191	189	156	201	188	1110
Access, Appointment, Admission, Transfer, Discharge	59	90	89	119	72	73	502
Treatment, procedure	64	80	80	99	84	81	488
Medication	93	95	75	68	87	62	480
Implementation of care or ongoing monitoring/review	49	47	48	51	41	46	282
Total	450	503	481	493	485	450	2862



This data excludes the 700 incidents that require severity grading. To improve compliance with severity grading incidents in line with Trust policy a report with all ungraded incidents was sent to handlers – this included Ward/Dept leads, Heads of Service and copied into Divisional Management Teams. This will be raised by the Clinical Governance Coordinators at the Divisional Governance meetings. The completion of the National Reporting and Learning Systems (NRLS) upload is due for completion by the end of November 2015 therefore members of the Governance Support Unit are also supporting to make sure all severity coding is complete.

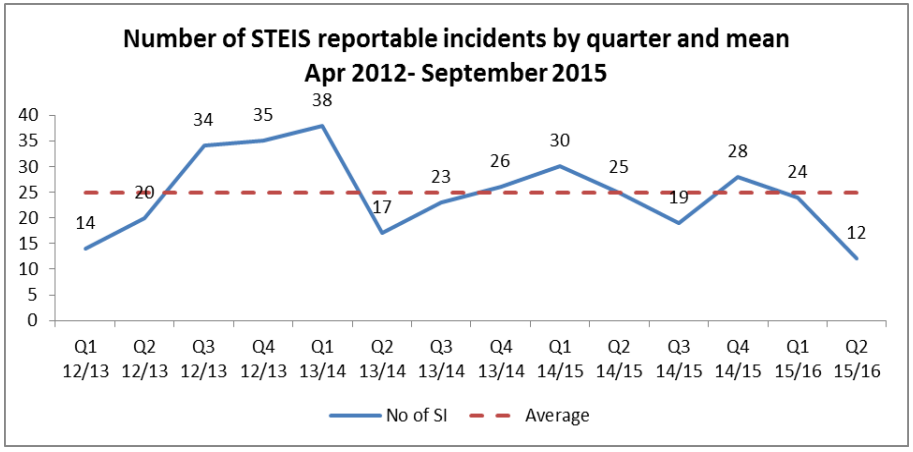
The NRLS report for 01/10/2014 to 31/03/2015 shows that we are below the median of 35.34 recording a rate of 29 per 1000 bed days. More work is required to fully appreciate the data and understand the perceived downward trend. This will also include a review of the process for the management of incidents.

Serious Incidents:

Graph 1 shows quarterly the number of serious incidents raised on the Strategic Executive Information System (STEIS).

Quarter 2 2015/16 shows a reduction in numbers of serious incidents reported on STEIS compared to Quarter 1 2015/16.

There were 18 internal serious incidents initiated during Quarter 2.



Graph 1

An Executive led serious incident scoping meeting takes place weekly to review potential serious incidents. If the incident does not meet the criteria for external reporting on the Strategic Executive Information System, then the incident is either; investigated as an internal serious incident and tracked through to completion in the same manner as a STEIS reported incident. Or on occasions the incident does not require a serious incident investigation the appropriate division and/or specialist team are requested to review the lessons learnt as part of the local governance arrangements and action plan accordingly.

The table below shows the position regarding the progress to completion of serious incident investigations at the end of Quarter 2. Totals: 34 STEIS reports and 27 internal serious incident investigations.

September 2015 overview

Outstanding STEIS reports	STEIS reports under investigation within time scale	Outstanding internal reports	Internal reports under investigation within time scale
21	13	13	14

Serious incident workshops have been introduced from October 2015 and facilitated by the Governance Support Unit. To provide an environment to discuss the incident, agree the root cause and make recommendations for inclusion within the action plans. 2 workshops have been undertaken and 4 more workshops are planned. The investigation lead is provided with the facilities to make the changes and the reports are then progressed to the next Serious Incident review and sign off meeting. It is anticipated that this will support the closure of investigation reports in a timelier manner as currently there are delays in completing the investigation reports.

Listed below are examples of Learning from Serious Incidents:

- Reinforce with all medical staff the Guideline for the Detection and Management of Acute Confusion/Delirium in Adults and when to implement this guidance.
- Reinforce with nursing staff the Post Fall Protocol; in particular, the monitoring of neurological observations in line with the Policy for the Management of Patients Following a Head Injury on Hospital Premises.
- Reinforcing care pathways with nursing and medical staff at medical and surgical divisional governance meeting
- On receipt of new patients nurses will review treatment plans and ensure medication plans are in order.
- Accountability Handover sheets to be completed on all transfers and reviewed by the receiving ward
- Tissue Viability Nurse Consultant to look at revising the pressure ulcer prevention plan.
- Review and revise Unit Guideline 'Fetal Monitoring in Labour' to include action to be taken where there is difficulty interpreting a CTG
- Consultant team to agree and document a clear process of actions to be taken if a clinic is Maternity cancelled to ensure that alternative arrangements are made for scans/assessments to be carried out in timely manner.

Never Events:

There have been no 'Never Events' reported during Quarter 2.

Legal Services Report (Quarter 2 2015/16)

Coroner's Inquests held during Quarter 1

Inquests	Emergency Care & Medicine	Planned Care & Surgery	Diagnostics & Rehab	Number with linked Datix incident	Number investigated via SI process	Total number of Inquests held
Quarter 2	3	4	0	3	3	7
Quarter 1	2	1	0	3	3	3

The table to the left shows the number of CNST claims received by Division and indicates which are linked to an incident recorded on Datix, or an RCA investigation

Clinical Negligence Scheme for Trusts (CNST) Claims received in Quarter 2 by Division

CNST Claims	Emergency Care & Medicine	Planned Care & Surgery	Diagnostics & Rehab	Number with linked Datix incident	Number investigated via SI process	Number with complaint lined	Total number of C N ST claims
Quarter 2	3 (2 linked with incident/ complaint)	10 (4 linked with incident/ complaint)	0 (0 incidents)	2	1	7	13
Quarter 1	6 (1 incident)	10 (1 incidents	0 (0 incidents)	2	1	7	16

This report provides details of Claims made under the Clinical Negligence Scheme for Trusts (CNST) and feedback on Inquests held in Quarter 2 of 2015/16

The above table shows less than half of the Inquests held in Quarter 2 were subject to a full RCA investigation, which were shared with the Coroner. The Duty of Candour was applied and the reports were shared with the family of the deceased.

The Coroner is keen to ensure, and receive evidence to confirm that, where an RCA has been undertaken, the resultant action plans are monitored to ensure that they are fully implemented and learning takes place. The Coroner has also requested that statements prepared by staff for the purposes of the SI investigation are shared with her.

No Prevention of Future Death (PFD) Reports were issued by the Coroner during the Quarter. Three Inquests held were subject to a narrative conclusion, four concluded with a short form verdict. In two of the cases, it was considered that a PFD report could be issued, but in both cases, evidence was heard that assured the Coroner that action to avoid further death had been taken.