TRUST BOARD OF DIRECTORS – 26th November 2015

QUALITY & SAFETY REPORT (REPORTING PERIOD OCTOBER 2015)

1. INTRODUCTION

The monthly Quality & Safety report to the Board of Directors provides an overview of performance / achievement against our key quality priorities for 2015/16 as described within the Quality Report & Accounts (2014/15), in addition highlighting and referencing a range of other quality (including patient experience) and safety indicators. This report complements the quarterly Quality and Safety report which provides a more detailed and comprehensive review of progress against the Trust's quality and safety priorities. This report concentrates on the Key priorities.

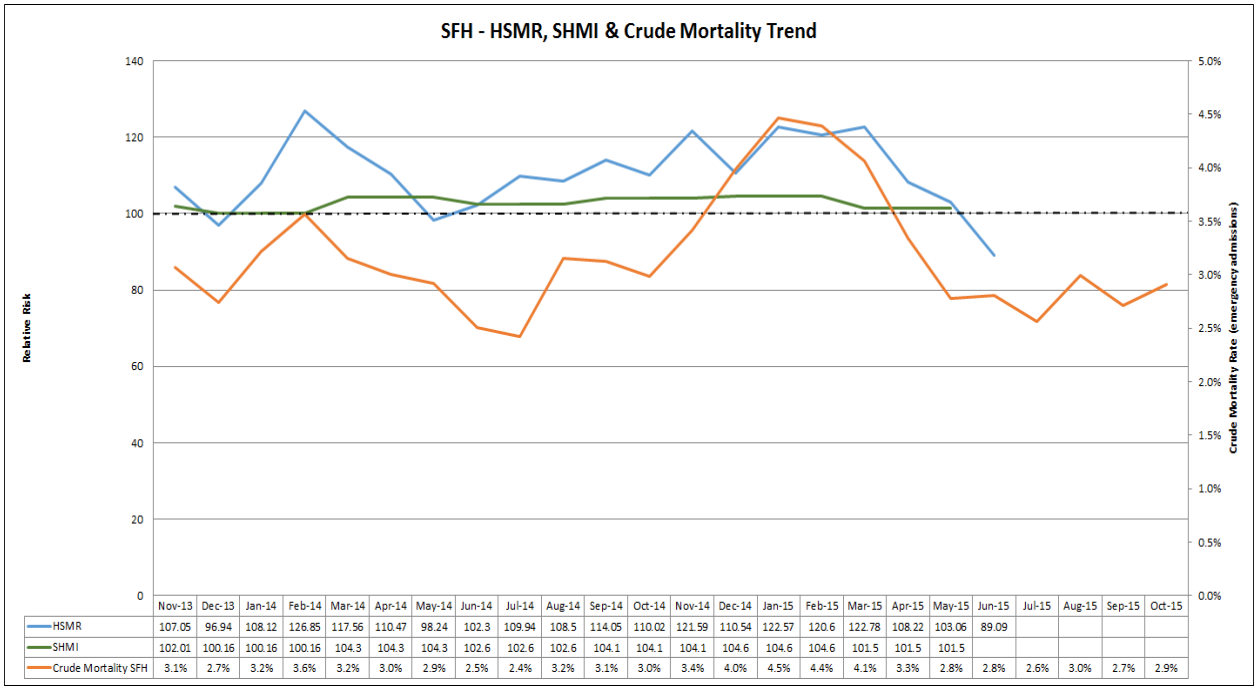
The following section provides an overview of our agreed key quality and safety priorities for 2015/16, they include;

Key Priority 1	Reduce mortality as measured by HSMR	Headline & specific HSMR within the expected range To have an embedded mortality reporting system visible from service to board To eliminate the difference in weekend and weekday mortality as measured by HSMR
Key Priority 2	Reduce mortality from sepsis	Implementation of a recognised local protocol / screening tool within Emergency Department / other units that directly admit emergency patients Administration of intravenous antibiotics to patients presenting with sepsis within one hour of presentation
Key Priority 3	Reduce harm from falls	Reduce the number of inpatients 'falling in hospital with harm' from Q2 onwards. Reduce the number of inpatients reporting severe or catastrophic harm as a result of a fall in hospital' from Q2 onwards. To deliver a safety improvement programme, utilising best practice both from a local and national perspective.

2. QUALITY & SAFETY PRIORITIES

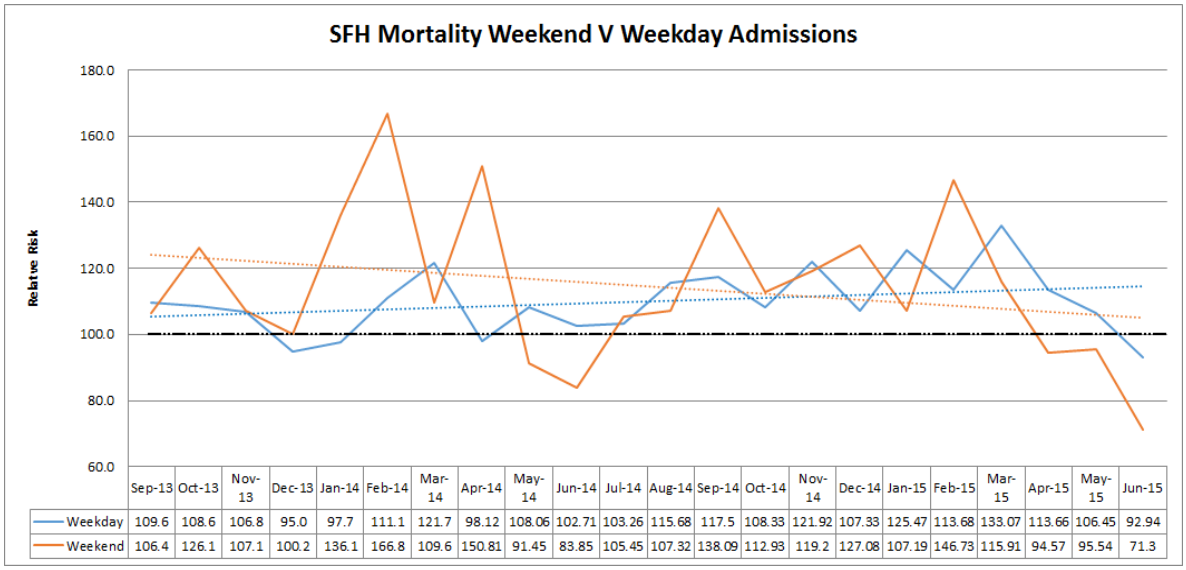
2.1 Priority 1 - Reduce mortality as measured by Hospital Standardised Mortality Ratio (HSMR)

The most up to date information from Dr Foster provides us with an HSMR up to and including June 2015. Our June HSMR is showing as below 100 at 89. Whilst this may change slightly as Dr Foster Intelligence make adjustments against national figures, this is lower than we have seen in the past and reflects the work that has been going on over the past months. This work includes improving our care pathways as highlighted by our mortality review process and improving our record keeping, particularly in the area of co-morbidities, allowing improved accuracy of coding.



	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	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
HSMR	107.05	96.94	108.12	126.85	117.56	110.47	98.24	102.3	109.94	108.5	114.05	110.02	121.59	110.54	122.57	120.6	122.78	108.22	103.06	89.09				
SHMI	102.01	100.16	100.16	100.16	104.3	104.3	104.3	102.6	102.6	102.6	104.1	104.1	104.1	104.6	104.6	104.6	101.5	101.5	101.5					
Crude Mortality SFH	3.1%	2.7%	3.2%	3.6%	3.2%	3.0%	2.9%	2.5%	2.4%	3.2%	3.1%	3.0%	3.4%	4.0%	4.5%	4.4%	4.1%	3.3%	2.8%	2.8%	2.6%	3.0%	2.7%	2.9%

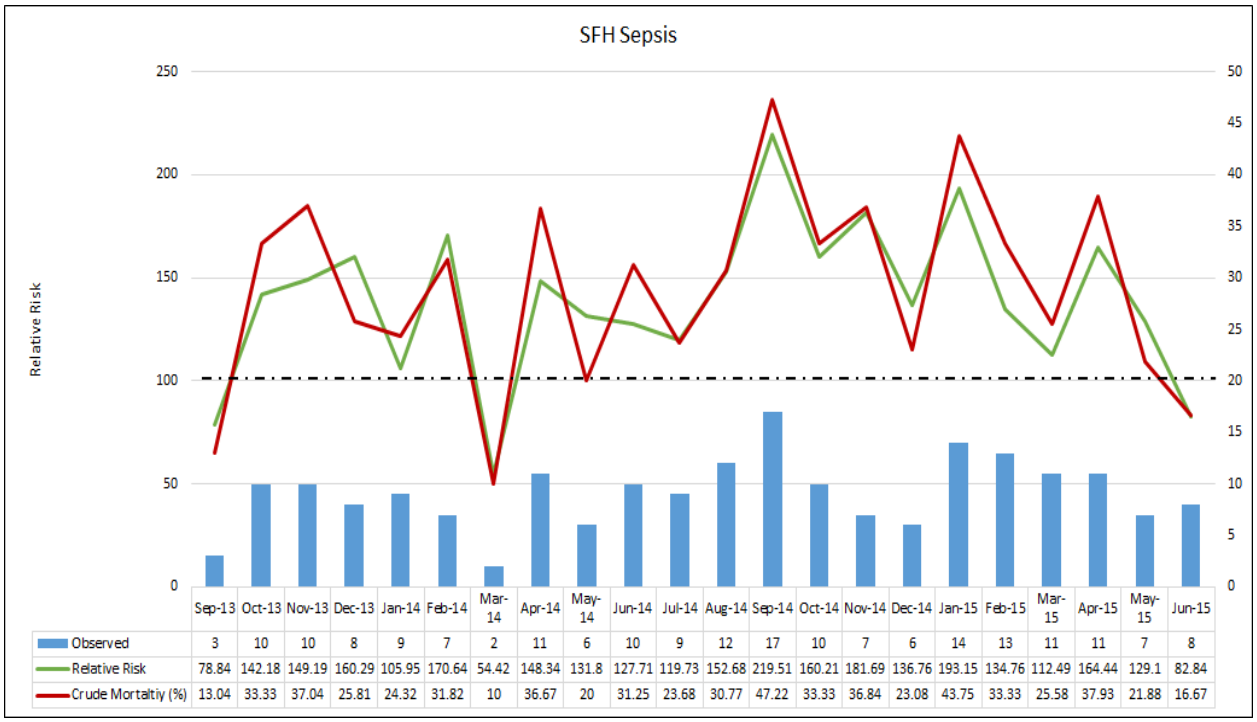
As a trust we also carefully monitor our HSMR around day of admission, in particular whether there is a trend around weekend or weekday admission.



	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	Jun-15
Weekday	109.6	108.6	106.8	95.0	97.7	111.1	121.7	98.12	108.06	102.71	103.26	115.68	117.5	108.33	121.92	107.33	125.47	113.68	133.07	113.66	106.45	92.94
Weekend	106.4	126.1	107.1	100.2	136.1	166.8	109.6	150.81	91.45	83.85	105.45	107.32	138.09	112.93	119.2	127.08	107.19	146.73	115.91	94.57	95.54	71.3

The variation between HSMR for weekday and weekend admission has settled down over the last year following the more marked differences seen in the early part of 2014. The numbers presented as HSMR appear high because it is a ratio. At SFH we see a crude mortality of around 30 deaths per week. At weekends, we have consultant ward rounds across the trust, speciality consultant reviews in admission areas, junior doctor teams covering the wards and the admission areas nursing staff in all areas. We also have radiographers, reporting radiologists available and many pathology results available, all of which provide the detail to allow informed decisions about treatment and get the right treatment started what ever the day of the week.

The area that has consistently shown our highest HSMR above expected is the area of Sepsis. However, this is also showing an improvement with an HSMR that is now below 100. There has been a considerable amount of work in this area over this year, both clincally in recognition and management, and in the correct recording of Sepsis and related infective causes. This aim is to maintain a lower Sepsis HSMR moving forward.

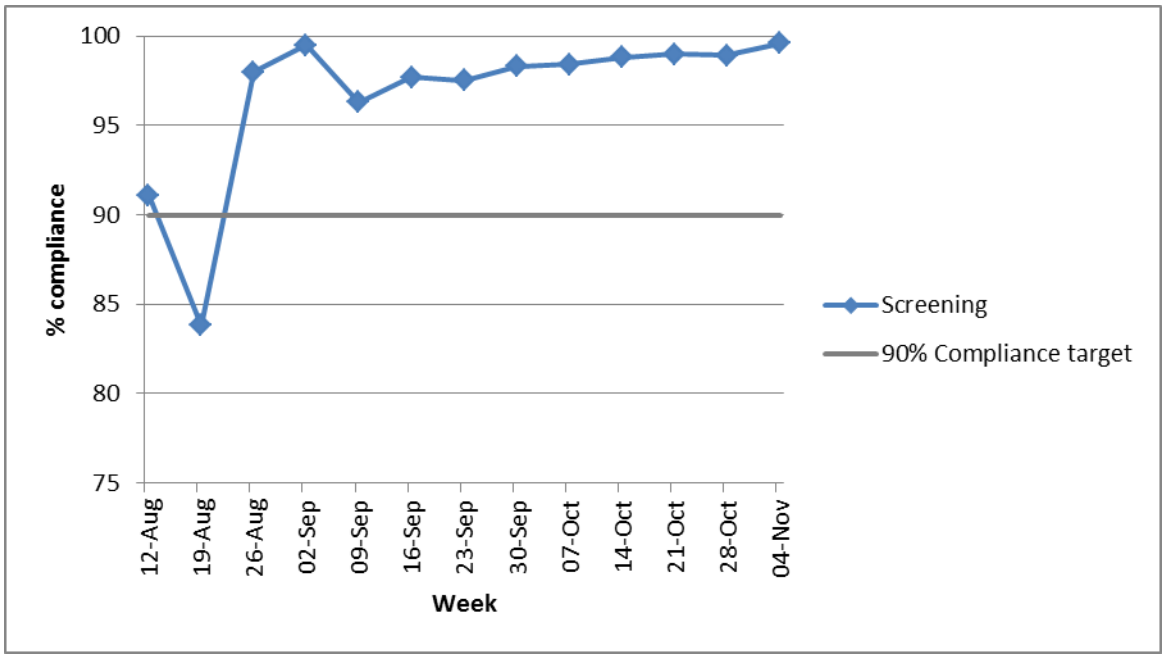


	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Observed	3	10	10	8	9	7	2	11	6	10	9	12	17	10	7	6	14	13	11	11	7	8
Relative Risk	78.84	142.18	149.19	160.29	105.95	170.64	54.42	148.34	131.8	127.71	119.73	152.68	219.51	160.21	181.69	136.76	193.15	134.76	112.49	164.44	129.1	82.84
Crude Mortaltiy (%)	13.04	33.33	37.04	25.81	24.32	31.82	10	36.67	20	31.25	23.68	30.77	47.22	33.33	36.84	23.08	43.75	33.33	25.58	37.93	21.88	16.67

2.2 Priority 2 – To improve the management of sepsis and reduce sepsis related mortality

Use of the sepsis screening tool, for emergency admissions has been audited daily for the last three months. Compliance is now consistently above 90%.

Aggregated compliance with sepsis screening tool, in emergency admissions.



A new version of the national paediatric sepsis screening tool has been piloted and will be formally adopted for non-trauma paediatric emergency admissions on 19th November

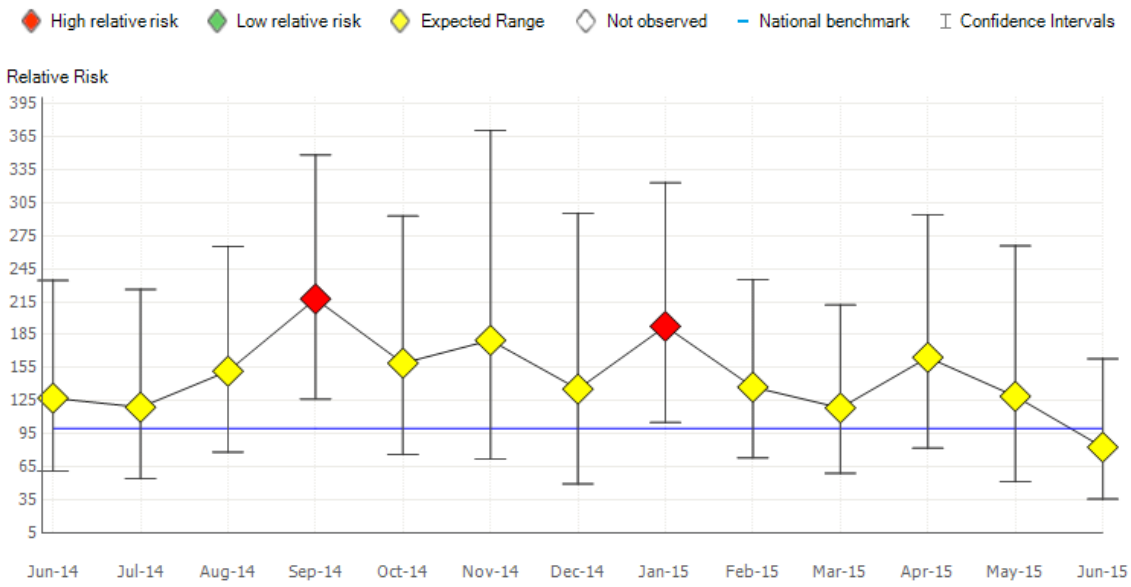
Daily monitoring of compliance with the Sepsis Six treatment bundle, in admission areas, has shown improvements. The crucial element of the bundle that is linked to preventing deaths from sepsis is timely administration of intravenous antibiotics. Our performance with this factor is consistently above 90%.

Initial review of the newly implemented in-patient sepsis screening tool showed variable uptake. Ward Leaders have put actions in place and wards have been supported by the sepsis team and the Practice Development Matrons. Further review of the tool will be completed at the end of November and monitored monthly going forward.

The 2015-16 CQUIN is in two parts. Part A of the CQUIN focuses on screening for sepsis and all the work described above ensures all emergency admissions are screened appropriately. The audit for Part A showed compliance of 94.1% in Q". Part B of the CQUIN focuses on antibiotic administration in patients with severe sepsis. The Part B CQUIN goal is to achieve 90% antibiotic administration within 1 hour of arrival at hospital by the end on the year. Initial data collection in Q2 showed a starting point of 75%.

The mortality data from Dr Foster has been released up to June 2015 and sepsis related HSMR dropped to 82.84.

Sepsis related HSMR for June 2014 – June 2015



Retrospective monitoring of sepsis mortality has been in place since January 2015, going forward this will become prospective review. This will enable timely correction of coding errors and improved feedback to both clinical teams and governance processes.

2.3 Priority 3 – Reduce harm from falls

Reducing the patient's level of harm following a fall in hospital remains a Trust priority. The falls improvement programme includes a CQUIN element. The CQUIN targets have not been formalised and the CCG are preparing a contract variation for consideration and agreement.

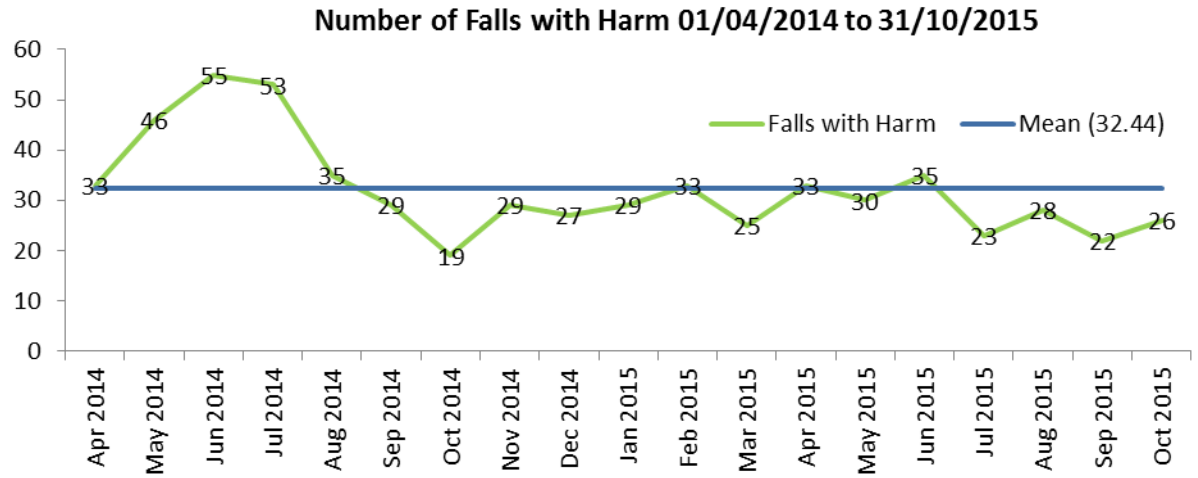
Whilst the number of falls incidents severity coded as no harm has fallen. The number of falls incidents with harm has shown a slight increase during October compared to September.

Tabled below is the number of falls by severity of harm.

In-patient Falls by severity of harm	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
No harm Falls	195	138	151	112	122	127	110	132	123	106
Low harm Falls	25	30	19	29	27	31	20	24	16	22
Moderate harm Falls	4	3	6	0	1	2	3	2	3	3
Severe harm Falls	0	0	0	4	2	2	0	2	3	1
Total	224	171	176	145	152	162	133	160	145	132

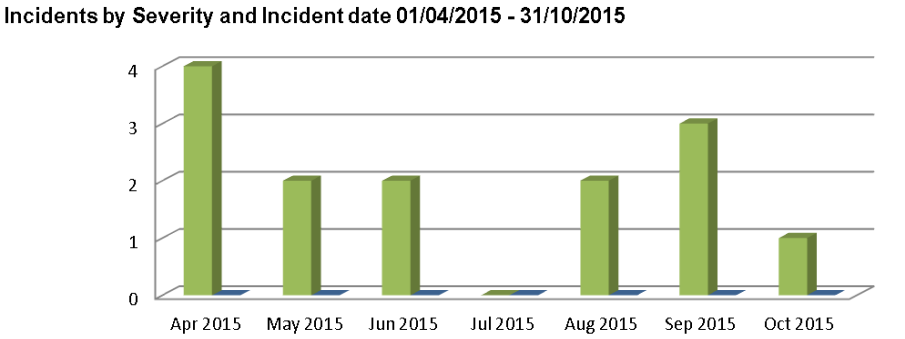
Below is a graph (Graph 1) which plots the number of falls with harm over the past 19 months. The trend is beginning to show a downward improvement especially when compared to the mean for the period. There is a downward trend for Q2 against the mean.

Graph 1



At the start of Quarter 3 we are slightly above trajectory with 26 harms reported. All of these harms have been validated and a further breakdown of the findings is provided later in the report.

The table below (Graph 2) 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.



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

There was one patient who fell and sustained a hip fracture from the falls incident in October. Concerns were raised immediately following this incident due to the fact that the patient had been assessed and identified as a high falls risk. Assessed as requiring Level 4 Direct Observation for Enhanced Patient Support (*'within arm's length/close observation')* and this had been implemented and maintained by the ward team up until the morning of this incident. The patient was left unattended by the member of staff who was undertaking this role. A full investigation is underway and as an immediate action information has been sent to the Nurse Bank office to distribute to all bank staff. This information described what the Levels of direct observations for enhanced patient support means and what is expected of the staff member whilst undertaking this role. The Falls Nurses have also spent time on the ward with staff and the Ward Leader examining 6 months of falls data to analyse themes and develop immediate actions plans. For example, a time band analysis showed that between the hours of 1600-1900hrs there were more falls related incidents recorded, discussions

were then held around having staff on different shift patterns with the suggestion to consider a twilight shift. There is a trial of Tabs Bed and Chair Sensor alarm systems being initiated.

During the month of October we have had 3 patients who fell and sustained moderate harms, these injuries were a patient who fell and sustained an ankle fracture, a patient who fell and sustained a rib fracture and a patient who fell and sustained a fracture to the Greater trochanter. All of these patients were treated conservatively and did not require surgery. It should be noted however that there was a slight delay in the detection of the injuries at the time of the falls. There is evidence that all of the patients received a thorough assessment post fall in line with Trust Guidance but their initial pain and discomfort did not resolve and further assessment was undertaken and the fractures detected. All of these incidents were discussed in the Serious Incident Scoping meeting chaired by the Medical Director and internal investigations are underway. There was concern about the number of incidents that had been taken to this forum initially but the reasons around the delays in diagnosing the fractures needed to be explored in the appropriate forum. Lessons learned will be shared at the ward meetings and if wider learning is deemed appropriate will be shared through the governance structures following submission of the reports to the Serious Incident Review and Sign off Meeting.

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 interventions, 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*

Recommendations from the National Audit report has been circulated to Matrons and shared at the Falls and Safety Improvement Group in October. A detailed analysis and comparison of the Trusts performance in relation to last year will be undertaken by the Trusts Clinical Audit and Effectiveness Officer and the Falls Lead Nurses and presented at the Clinical Audit and Effectiveness Committee at the end of January 2016. Any immediate actions and recommendations will be incorporated into the Falls Strategy.

The Falls and Safety Group membership was discussed in the meeting on the 12th November and a final decision will be sought from the Acting Chief Nurse next week due to the poor attendance. It is proposed that going forward and in line with the key recommendations from the National Audit report that there is a '*Falls Multidisciplinary working Group established* 'with representation from Physiotherapy, Occupational Therapy, Radiology, Pharmacy and an appointed Clinical Lead.

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.

3. CONCLUSION

Sherwood Forest Hospitals HSMR for June is showing as below 100 at 89. Whilst this may change slightly as Dr Foster Intelligence make adjustments against national figures, this is lower than we have seen in the past and reflects the work that has been going on over the past months.

The effective management of sepsis continues to be crucial for reducing mortality with a dedicated programme of work designed to meet recommendations from the Care Quality Commission and address the National CQUIN requirement.

Reducing the patient's level of harm following a fall in hospital remains a Trust priority. Whilst the number of falls incidents severity coded as no harm has fallen. The number of falls incidents with harm has shown a slight increase during October compared to September.

4. RECOMMENDATIONS

The Trust Board are asked to discuss the information provided and the actions being taken to mitigate the areas of concern.

Victoria Bagshaw Deputy Chief Nurse

Andy Haynes Executive Medical Director