Sherwood Forest Hospitals NHS
NHS Foundation Trust

Agenda Item:

Board of Directors Meeting Report

Subject: **Quarterly Quality & Safety Report**
Date: **Thursday 30th January 2014**
Lead Author: **Amanda Callow – Deputy Director of Nursing & Quality**
Lead Director: **Susan Bowler – Executive Director of Nursing & Quality**

Executive Summary

This quarterly report provides the Board with a summary of important quality and safety items and our key quality priorities. This report covers the period quarter 3; specifically October, November & December 2013. In summary, the paper highlights the following key points:

- There has been significant progress made to continue to implement the actions in our improvement plan, in readiness for the Keogh and CQC review visit which took place in December 2013. This includes work to strengthen care and comfort rounding and communicate effectively with our patients via ward communication boards.

- Improvements in HSMR mean that Sherwood Forest Hospitals Foundation Trust is no longer an outlier for mortality and good progress is being achieved against the mortality action plan.

- Pressure ulcer prevention - there has been a continued reduction in avoidable grade 2 and 3 pressure ulcers during Quarter 3 2013. There have been no grade 4 pressure ulcers for 12 months.

- The Trust is on target to achieve all of the CQUIN quality targets in Quarter 3, with the exception falls with harm (part 1) which is at moderate risk of non-delivery due to an increase during Quarter 3. Final analysis of the data is being undertaken prior to the quarterly review meeting with commissioners in February 2014.

- There has been an increase in the number of serious incidents reported during Quarter 3 compared to Quarter 2. We are currently running a project to cleanse and upgrade our DATIX system which is being led by the Governance Support Unit.

- Infection control - there were no further cases of Trust acquired MRSA during Quarter 3 and our year to date total is 3. In terms of *C Diff* performance, at the end of December 2013 there had been 28 *C Diff* cases against a trajectory of 19. At this point, we have therefore exceeded our annual target to have no more than 25 cases.

- The nutrition and hydration projects are demonstrating positive impact in our recent audits. Further work is now being done to embed the principles and drive additional initiatives around hydration.

- The CQC announced their new approach to inspections and monitoring and Sherwood Forest Hospitals Foundation Trust is rated as a level 1 organisation. We are currently reviewing out internal assurance framework so it keeps pace with the needs of the evolving organisation.

Recommendation
To note the content of the report and progress / position to date

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	Achieve financial sustainability
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	BAF 1.3, 2.1, 2.2 2.3, 5.3, 5.5 Mortality, C Diff & Complaints on corporate risk register
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Failure to meet the Monitor regulatory requirements for governance - remain in significant breach. Risk of being assessed as non-compliant against the CQC essential standards of Quality and Safety Failure to meet 2013/14 infection control trajectories – impacts on governance risk rating
Links to NHS Constitution	Principle 2, 3, 4 & 7
Financial Implications/Impact	Potential contractual penalties for C Difficile, Pressure Ulcers, Never Event and MRSA
Legal Implications/Impact	Reputational implications of delivering sub-standard safety and care
Partnership working & Public Engagement Implications/Impact	This paper will be shared with the CCG Performance and Quality Group and the Patient Quality and Experience Committee
Committees/groups where this item has been presented before	A number of specific items have been discussed at Infection Prevention & Control Committee, Pressure Ulcer Strategy Group, Nursing Care Forum, Clinical Management Team and Clinical Governance & Quality Committee
Monitoring and Review	Monitoring via the quality contract, CCG Performance and Quality Committee & internal processes, e.g. Clinical management Team & relevant committees/forums
Is a QIA required/been completed? If yes provide brief details	No

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Patient Safety & Quality Report

Trust Board of Directors Meeting
30th January 2014

Quarter 3 - October, November & December 2013

Contents – Patient Safety & Quality Report Quarter 3

Q3 – Introduction & Summary

This report is presented by the Executive Director of Nursing & Quality and has been prepared with the support of the Deputy Director of Nursing & Quality and the relevant clinical and staff leads. This third 'new look' report covers the period quarter 3; specifically October, November and December 2013.

This report contains summary accounts, aimed at updating the Board of Directors and the public on the Trust's progress against its key quality and safety priorities. It should also be read in conjunction with the Patient Experience report which outlines performance and learning as a result of patient feedback. The report contains information on our 3 top quality priorities, our CQUIN schemes and other key quality and safety indicators.

Quarter 3 has been characterised by the drive to implement the improvement work to deliver the recommendations following the Keogh and CQC reviews. The Trust was re-visited by the Keogh review team and CQC on December 4th 2013, who assessed us against the delivery of the action plan. This was a successful visit and the teams highlighted the considerable progress that had been made since the first visit in June 2013. The organisation is now focusing upon sustaining and embedding the positive changes that have been made over the last 6 months.

A key part of our 'improvement journey' during Quarter 3 has been the extensive patient, carer and staff engagement programme we initiated, 'Quality for All'. Following our 'In Your Shoes' and 'In Our Shoes' events we have developed our Patient Experience and Involvement and Organisational Development Strategies, which we will be implementing throughout 2014. This represents a new approach to patient and staff engagement that marks our commitment **to giving the best possible care to our patients; safely, respectfully and efficiently.**

Q3 – Key National Developments

NHS England's Sir Bruce Keogh sets out plan to drive seven-day services across the NHS

In December 2013, NHS England's National Medical Director Sir Bruce Keogh set out a plan to drive seven day services across the NHS over the next three years, starting with urgent care services and supporting diagnostics. He has published the findings of his Forum on NHS Services:Seven Days a Week, set up in February this year, together with a series of recommendations that have been considered by NHS England.

The Forum points to significant variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England. This is seen in mortality rates, patient experience, the length of hospital stays and readmission rates. For example, the increased risk of mortality at the weekend could be as high as 11per cent on a Saturday and 16 per cent on a Sunday, according to an analysis of over 14 million hospital admissions in 2009/10.

Causes include: variable staffing levels in hospitals at the weekend; fewer decision makers of consultant level and experience; a lack of consistent support services such as diagnostics and a lack of community and primary care services that could prevent some unnecessary admissions and support timely discharge.

Sir Bruce Keogh sets out ten new clinical standards that describe the standard of urgent and emergency care all patients should expect seven days a week, each supported by clinical evidence and developed in partnership with the Academy of Medical Royal Colleges. The ten new clinical standards that all patients should expect 7 days a week describe, for example, how quickly people admitted to hospital should be assessed by a consultant, the diagnostic and scientific services that should always be available, and the process for handovers between clinical teams. The link to further information is:

http://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/

Q3 – Key National Developments

Safe Nurse Staffing

In November 2013, the NHS Quality Board and NHS England published *'How to ensure the right people, with the right skills, are in the right place at the right time'. (2013)* This provides long-awaited guidance in relation to nursing, midwifery and care staffing capacity and capability. The guidance considers the extensive evidence linking safe staffing to patient outcomes, which is further reinforced in the recent Mid-Staffordshire Foundation NHS Trust Public Inquiry, the Keogh reviews and Don Berwick's review into patient safety. The guidance sets out 10 expectations, which include the following:

1. Boards to take full responsibility for the quality of care provided to patients
2. Evidence based tools, in conjunction with professional judgement, to be used to inform staffing requirements
3. Clinical and managerial leaders to foster a culture of professionalism and responsiveness, where staff feel able to raise concerns
4. Directors of Nursing to lead the process of reviewing staffing requirements alongside sisters, charge nurses and team leaders. They should also work closely with Director colleagues to recognise interdependencies between staffing and other organisational elements.
5. Staffing establishments should take into account the needs for nurses, midwives and care staff to undertake continued professional development, undertake mentorship and supervision. Ward sisters and charge nurses should assume supervisory status.
6. Boards to receive monthly workforce information and every 6 months to review nursing, midwifery and care staffing capacity and capability. This information should be in the public domain.
7. NHS providers to clearly display information about the number of nurses, midwives and care staff on duty, each shift.
8. NHS providers to ensure they have plans to actively manage their workforce and have robust plans to recruit, retain and develop all staff.

The guidance clearly articulates individual Board member's responsibilities in relation to ensuring safe staffing levels. The expectations are outlined to support providers in taking complex and difficult decisions to secure safe staffing. The National Institute for Health and Care Excellence (NICE) will shortly begin work to develop evidence-based guidance to inform the practical tools that are available to calculate staffing capacity and capability. A copy of the report can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/11/ngb-how-to-guid.pdf

This guidance has been thoroughly reviewed and informs the current nurse staffing action plan which is being implemented at SFH. Following the agreement to invest in nurse staffing levels across the general wards, the senior nursing team are driving a number of key actions around recruitment (including pursuing opportunities internationally), retention and improving systems.

Q3 – Key Quality Improvement Initiatives

Giving us Feedback

We have developed a poster (above) which shows our visitors who the ward sister/charge nurse is and what to do if thy have any concerns.

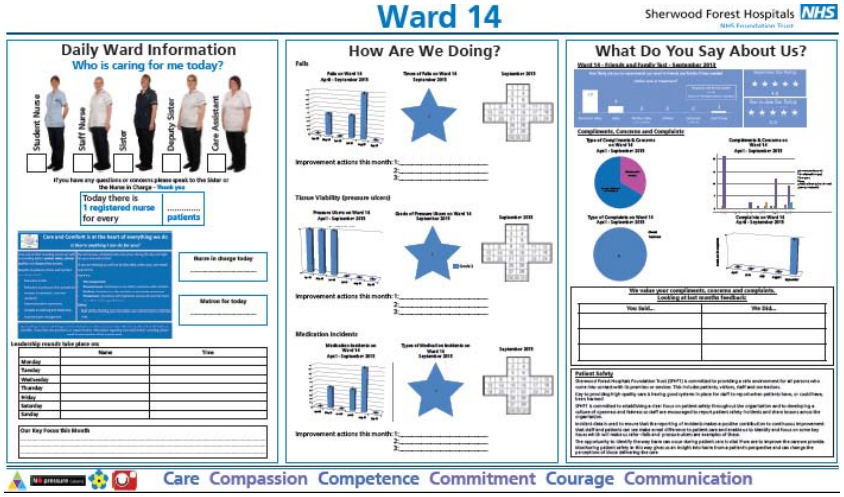
Knowing How we are Doing & Communicating this with Patients & Staff

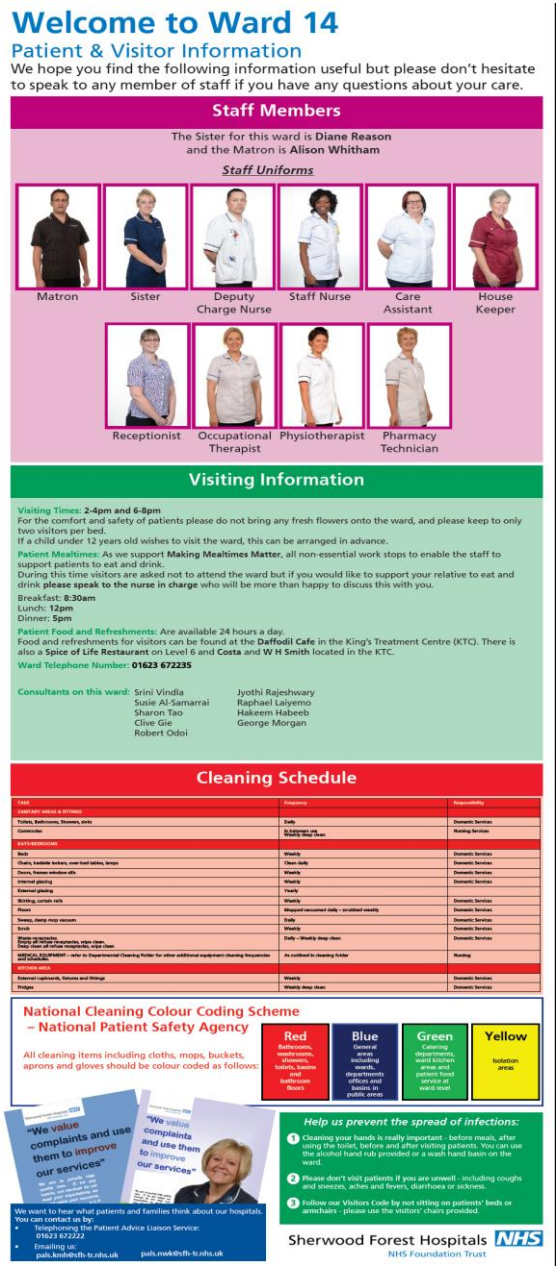
The 'knowing how we are doing' and ward assurance work is a key project across nursing and midwifery. We have refined this standardised approach to displaying important information to patients and staff via the ward boards during Quarter 3.

All wards now have a visual communication board which displays staffing levels, leadership rounding information and tells staff and patients how the ward is doing.

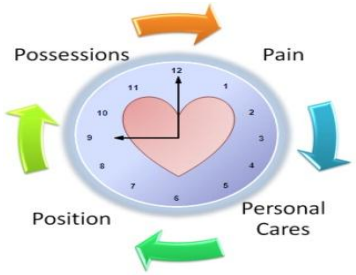
We are also displaying a welcome poster outside each ward which tells our visitors who's who and some of the ward routines.

We will continue to make refinements to these during the next quarter following patient and staff feedback.





Care and Comfort Rounds



How are we doing?

Care and comfort rounds are now fully implemented across all of the trusts three sites. The implementation of care and comfort rounds has gathered momentum and enabled us to engage with staff and patient. Ward leaders and Matrons are now working hard to embed care and comfort into everyday practice and ensure sustainability.

Next steps

- We have undertaken an audit to identify which areas need specific support so we can sustain this new approach which is being led by our Ward Leaders and Matrons
- Our audit has shown that leadership rounds and reward and recognition need strengthening further and we are devising an assurance framework that sets our clear expectations and monitoring
- We continue to gather evidence on the impact of care and comfort rounds on quality and safety. We are able to monitor the impact on quality outcomes, using the ward assurance matrix which is monitored monthly by the Director of Nursing and senior team & divisional management teams

What the staff are saying

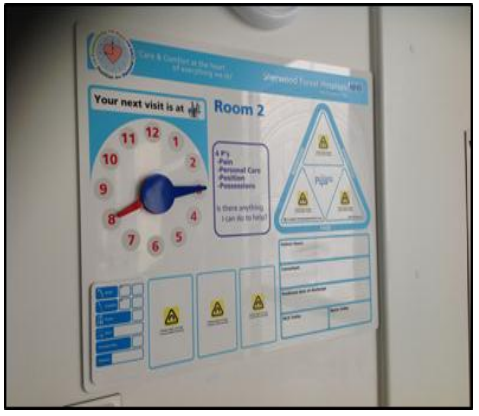
- When the ward is busy it helps you to remember fluids and re –positioning
- Rounding is making a difference as far as keeping charts up to date
- Patients know we will come to them regularly and feel reassured
- Patients in side rooms will not be forgotten
- Improved Communication with all patients
- It's like going back to basics

What the Patients are saying

- Staff check on me and that makes me feel safe
- All staff are good I cannot choose one to stand out they are all excellent
- It stops me having to ring the bell all the time I know they will be back
- Its nice to see a nurse more often
- It's a good idea but they cannot always get back when they are busy

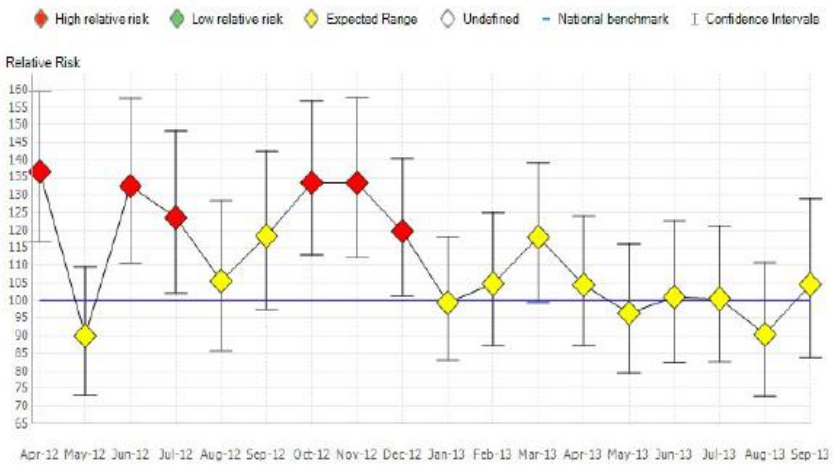
Bedside Boards Pilot

New magnetic boards are currently on trial in the Health care of the older persons wards which comprise of magnetic clocks for care and comfort rounding. They also give staff and patients valuable information to help us meet nutrition, and hydration needs, reduce falls and show the predicated date of discharge. (see right)

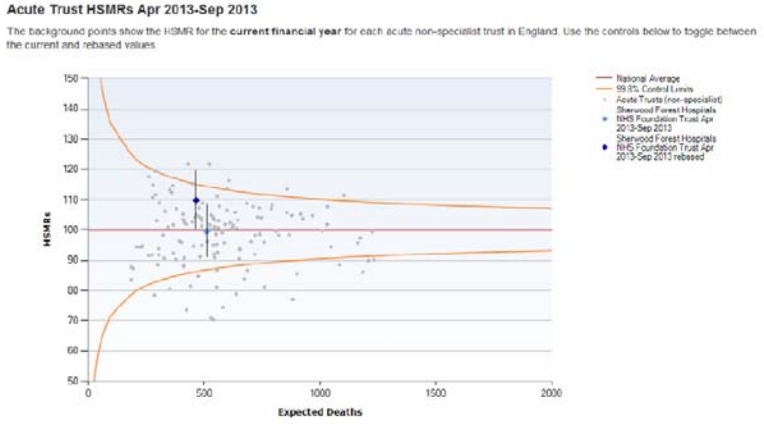


Q3 – Mortality Summary (Quality Priority 1)

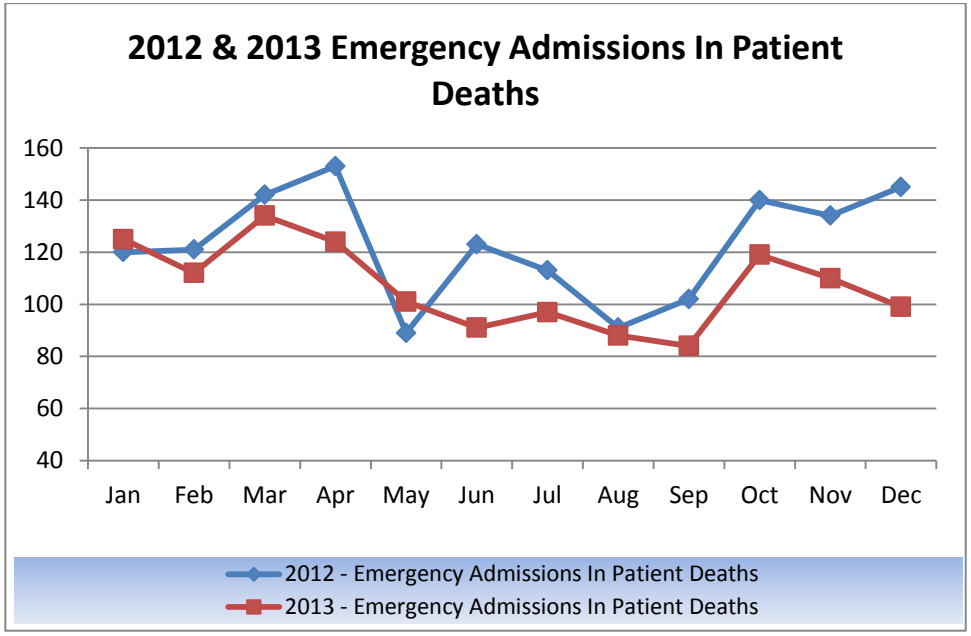
1. Hospital standardised mortality ratio (HSMR) has continued to be stable up to September, the last month for which data is validated.



2. Improvements in HSMR mean that for Apr-Sep 2013, SFHT is no longer an outlier for mortality.



3. There was an increase in deaths at the trust in October but the crude mortality rate has fallen in November and December such that for the same level of activity, the rate fell from 3.46 to 3.02% 2012 to 2013 which represents 189 fewer deaths across the year.



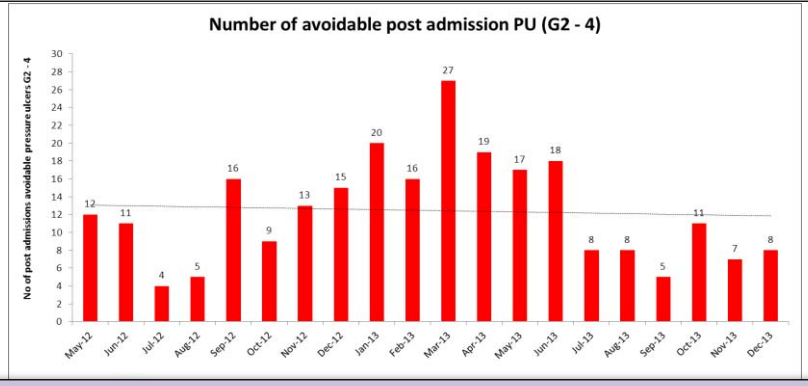
4. We continue to work with the Patient Safety and Mortality groups to monitor performance through the winter pressures and track weekend mortality. On-going work to look at mortality amongst outliers is at the analysis stage and a report will be presented to the Board once complete.

Q3 – Pressure Ulcer Summary (Quality Priority 2)

Hospital acquired pressure ulcers – all targets were achieved for Quarter 3, with the exception of 2 additional grade 2 pressure ulcers (see table below). Quarter 4 targets are to achieve zero grade 4's and a 30% reduction in grade 2's. The ambition is to eliminate grade 3 pressure ulcers by April 14.

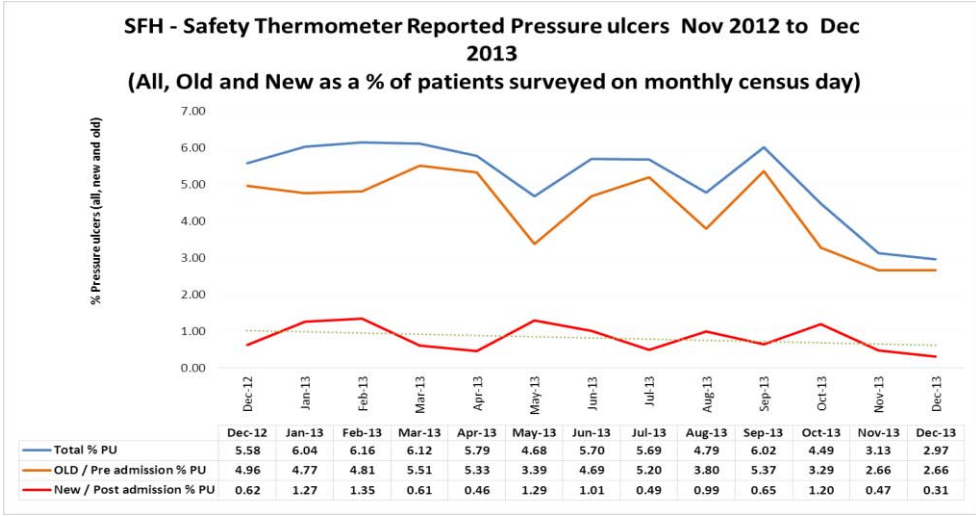
Avoidable grade 2,3 and 4 PU's 72 hours post admission

	Nos.	Q1 Total	Q2 Total	Oct	Nov	Dec	Q3 Total
Grade 4	Target	0	0	0	0	0	0
	Actual	0	0	0	0	0	0
Grade 3	Target	8	6	2	1	1	4
	Actual	11	1	2	1	1	4
Grade 2	Target	45	20	6	7	7	20
	Actual	43	20	9	6	7	22



The Safety Thermometer

The national safety thermometer demonstrates the point prevalence figures i.e. all PU's (whether hospital acquired or not) on a set census day. The graph demonstrates the overall downward trajectory for all Pressure Ulcer's within the Trust. We envisage we will continue to meet this in Q4.



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Total % PU	5.58	6.04	6.16	6.12	5.79	4.68	5.70	5.69	4.79	6.02	4.49	3.13	2.97
OLD / Pre admission % PU	4.96	4.77	4.81	5.51	5.33	3.39	4.69	5.20	3.80	5.37	3.29	2.66	2.66
New / Post admission % PU	0.62	1.27	1.35	0.61	0.46	1.29	1.01	0.49	0.99	0.65	1.20	0.47	0.31

Themes & Trends

Device related pressure ulcers appear to be increasing both within the Trust and nationally, probably due to increased awareness and reporting. The anatomy of the soft tissue affected also means skin damage occurs quickly and is often deep. Heels remain a theme however the depth is less severe.

Spotlight on device related pressure ulcers

- Planning for an evaluation of new oxygen is underway
- Focused teaching to all ward leaders
- Weekly teaching to ward staff and AHP's
- Review of ICU pressure ulcer prevention documentation

Targets achieved for Quarter 3 reduction of grade 3 and 4 pressure ulcers

Q3 – Patient Flow Summary (Quality Priority 3)

Flow within the Hospital

The length of stay was 6.73 in Q1, 6.4 days in Q2 and 6.5 in Q3, against a Trust target of 6 days. These figures exclude zero length of stay for all patients and well babies. Statistical analysis of the data shows there is no significant trend but there is variation around the mean and this is being investigated further. Progress and actions include:

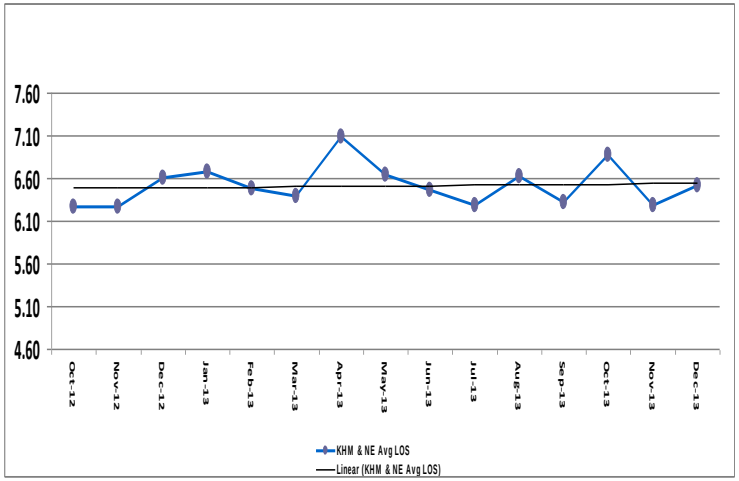
- We have reorganised how the Integrated Discharge Team works. They are now concentrating resources on the wards with the most complicated discharges.
- We have developed a risk assessment tool to identify the complexity of discharge which will be piloted in Q4.
- We have looked at increasing patient information about discharge available on the wards which will be piloted in Q4.
- We are focussing attention on the treatment of patients with fractured neck of femur and planning to revitalise the enhanced recovery care pathway to improve quality and reduce length of discharge.
- We have met with ward leaders to identify constraints on discharge and identified further actions in terms of staffing and processes.

Flow within ED

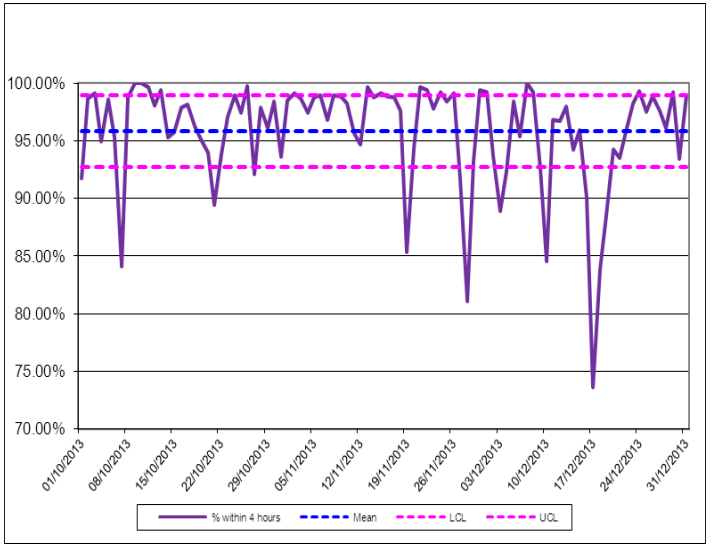
The Trust level 4 hour performance for Q3 was 95.74%, with monthly performance in December dipping just below 95%. The primary cause was the lack of a ward beds to admit emergency patients to. There have been more episodes of high demand. For example, on 17th December there were 270 presenters (average for KMH is 241), with 13 patients requiring resus, (average for KMH is 8). Key progress and actions include:

- There is daily reporting detailing the position, longest wait themes and actions.
- We are working to make ED board rounds more consistent and undertaken regularly.
- We want to highlight to ward staff the predicted demand for beds at the morning JONAH Live meeting and for those ward staff to take that information back to their ward, to try and increase understanding of the pressure on beds and increasing patient flow.

Q3 Length of Stay



Q3 SFHFT ED 4 Hour Waits



Q3 – Patient Flow Summary cnt

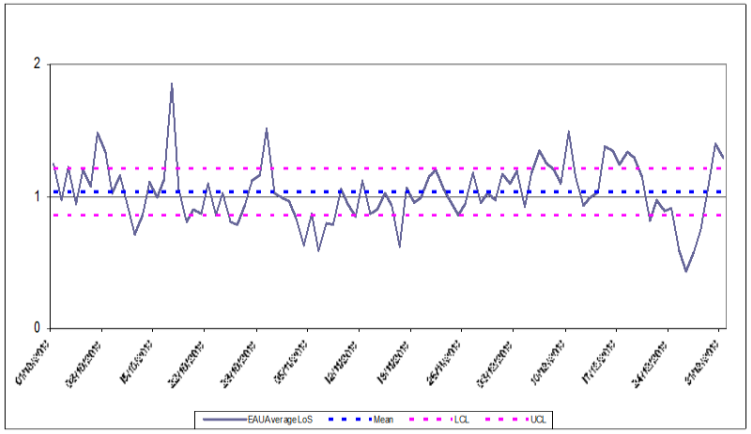
Flow within EAU

The length of stay data presented opposite is the length of stay patients spend on EAU. The data does not illustrate a significant trend upwards or downwards. Additional capacity within EAU has been used at times to increase flow.

Actions

- To evaluate use of discharge lounge to ensure right capacity in terms of demand
- To revitalise Board rounds on wards to create pull.
- Review ambulatory clinics run from EAU in terms of processes, and capacity and demand.

Q3 EAU Length of Stay

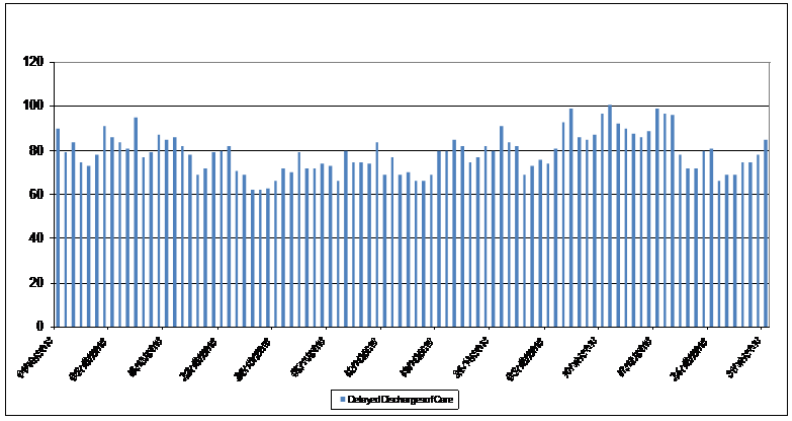


Delayed Discharges

Delayed discharges have remained at a steady state over this quarter. We need to work at reducing this. In Quarter 3 we have made the following progress:

- We have been involved in developing a “transfer to assess” beds scheme, which is managed by Social Services, however the impact is not as expected and it is being reviewed.
- A referral form has been created and the process developed for more timely transfers to Newark. We plan to extend the use of this form to MCH and Ward 41.
- A Jonah top twenty meeting has been established to look at the longest staying patients and whether actions can be taken to address their delays.
- Following the ECIST visit on 3rd January, they have offered to support a review of patients with length of stay over 14 days which we are accepting.

Q3 Delayed Discharges



Q3 – Patient Flow Summary cnt

30 Day Re-admission Rates

This re-admission rate is based on 30 days, which equates to the time difference between the original discharge date and re-admission date. For Q 3 this is 8.6%, this is an improvement on the rate for Q2 which was 9.9% and indicates that our discharge processes may be improving.

Operations cancelled on the day of surgery for non - clinical reasons

The number of cancellations in Q3 was 83, this was more than Q2 which was 45, however this is an improvement on 2012/2013 Q3 when the number of cancelled operations was 107. Principal reasons for cancellation remain lists overrunning however not all the coding for December data has been carried out. We are slightly above the National target of 0.5% at 0.6%. Actions we are taking include:

- Theatre staff are carrying out monthly reviews of the Ormis data.
- Newton Europe are currently working closely with the theatre departments looking at scheduling.

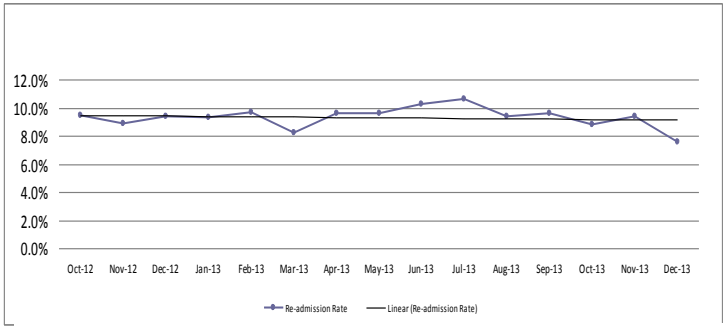
Patient Journey

There has been no significant trend over the last quarter in percentage of patients with four or more movements during their hospital stay. For some patients 4 moves will be their normal patient journey as it involves admission to EAU, then their base ward, internal treatment and a move at the end of the pathway to rehab or to an outlier ward to accommodate acute medicine.

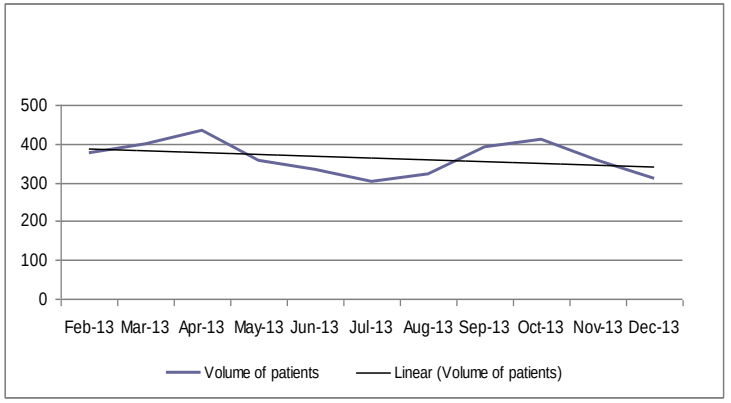
However, the number of medical outliers has increased towards the end of Q3 as winter pressures start to impact. While outlying is generally avoided, with increased demand at the front door there is an impact on the location of patients who no longer require their specialist bed. Actions we are taking include:

- Outliers are discussed at the Flow and Capacity meetings.
- There is an emphasis on minimising transfers but to adhere to the outlier policy when needed, a risk assessment is used.
- We are reviewing the causes of internal waits.

Q3 30 Day re-admission rates



Q3 Volume of patients with 4 or more ward moves



Q3 - 2013/14 CQUIN Indicators

The Commissioning for Quality and Innovation (CQUIN) payment framework was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. The table below gives an overview of the schemes within the acute contract for 2013/14 and a forecast of delivery. Evidence for Quarter 3 is currently being finalised and performance against the targets will be reviewed by the commissioners on the 17th February 2014.

Summary of Acute Schemes		Risk Assessment of Delivery			
CQUIN Scheme	**Requirement**	**Q1 Actual**	**Q2 Actual**	**Q3 Forecast**	**Q4 Forecast**
1 VTE assessment	95% of patients screened for venous thromboembolism (VTE) & 100% root cause analyses carried out on cases of hospital associated thrombosis (HAT)	£112,000	£112,000	£112,000	£112,000
2.1 Dementia Screening (Find, Assess, Investigate & Refer)	90% of emergency admission patients aged 75 & over screened, assessed and referred on to specialist services (during 3 consecutive months)				£968,000
2.2 Dementia – clinical leadership	Named lead clinician for dementia and appropriate training for staff	£13.455	£13.455	£13.455	£13.455
2.3 Dementia – supporting carers	Improve the support available for carers	£13,455	£13.455	£13.455	£13.455
3 Friends and Family Test	Phased expansion to ED & maternity, increased response rate & improved performance	£168,187	£168,187	£168,187	£168,187
4.1 Safety Thermometer	Submit monthly harms data for Safety thermometer	£56,063	£56,063	£56,063	£56,063
4.2 Safety Thermometer	Reduction in the prevalence of 'all' pressure ulcers		£112,000		£112,000
5.1 Think Glucose	Maintaining reduced Length of Stay for Patients with Diabetes	£44,850	£44,850	£44,850	£44,850
5.2 Think Glucose	Reduction of errors resulting in harm relating to insulin prescribing and / or administration	£44,850	£44,850	£44,850	£44,850
6.1 Reducing mortality	Implementation of sepsis bundle	£56,063	£56,063	£56,063	£56,063
6.2 Reducing mortality	Failure to Rescue – reduce the number of cardiac arrests	£56,063	£56,063	£56,063	£56,063
7 End of Life	Local action plan to improve care for end of life patients	£100,913	£100,913	£100,913	£100,913
8 Smoking at Time of Delivery	3 year target. 3% reduction in smoking at time of delivery by Q4. 11% reduction by 2015.	£56,063	£56,063	£56,063	£56,063
9 Falls	Reduction in the number of falls resulting in harm (part 1) & 95% patients to be risk assessed for falls (part 2)	£100,913	£100,913	£100,913	£100,913

There are a number of schemes that are currently RAG rated as amber/red:

- Safety Thermometer pressure ulcer improvement target – we have achieved Q1-2 but there is a moderate risk against meeting the reduction target for Q3-4, principally as it includes all pressure ulcers (hospital & non-hospital acquired).
- Reduction in the number of insulin errors resulting in harm – although we look likely to achieve this for Q3, there is a moderate risk for quarter 4. This is being mitigated through focused improvement work in line with the medicine safety project. Analysis is undertaken on each error that occurs to inform the improvement work and this is fed back to commissioners.
- Reduction in cardiac arrests – the risk rating for Q4 has now reduced to moderate based on Q1, 2 & 3 improvements. The targets for Q4 still remain challenging and is therefore risk rated accordingly.
- Smoking at time of delivery – this public health scheme requires a reduction of 3% within 1 year which is a short timescale to achieve this based on benchmarking data. The maternity service has made good progress particularly to ensure data capture is as accurate as possible and further initiatives are planned for year 2 and 3 where a further 8% reduction is required.
- Reduction in the number of falls (part 1) – although we met Q1 and Q2 targets, there is a risk in achieving the level of reduction required by Q4 due to an increase in the number of patient falls (with harm) in Q3. Payment is incremental based on the % achievement of the final year target and this is high risk of full delivery. For part 2, however (number of patients with falls risk assessment), we are on track to achieve. Actions are in place to mitigate these risks and are described within the falls report later.

As a result of the new processes and structure for Dementia screening, we now envisage we will meet this CQUIN. The requirement is to assess 90% patients over 75 years in 3 consecutive months and we have achieved this so far for November and December.

Q3 - 2013/14 Specialist CQUIN Indicators

There are 4 additional schemes set by East Midlands Specialist Commissioning Group. As above, the table highlights the forecast position for Quarter 1 and the risk assessment of delivery for Quarters 3-4.

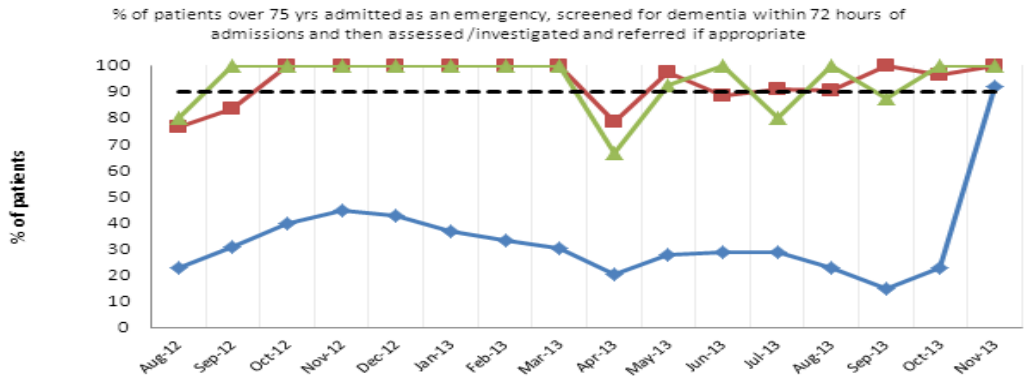
Summary of Specialist CQUIN Schemes		Q 1 & 2 Actual & Q's 3-4 Forecast			
CQUIN Scheme	**Requirement**	**Q1 Actual**	**Q2 Actual**	**Q3 Forecast**	**Q4 Forecast**
1 Clinical Dashboards	To embed and demonstrate routine use of specialised services clinical dashboards (Cystic Fibrosis, Cardiology, Trauma, Immunoglobulin, HIV, Neonates)	£18,825	£18,825	£18,825	£18,825
2 Paediatric High Dependency	To prevent and reduce the number of patients re-admitted onto PHDU on an unplanned basis within 48hrs of original discharge	£12,550	£12,550	£12,550	£12,550
3 Neonatal Care	Improved access to breast milk in preterm infants	£12,500	£12,550	£12,550	£12,550
4 Neonatal Care	Timely simple discharge for neonates	£6,275	£6,275	£6,275	£6,275

Q3 - Dementia CQUIN Summary

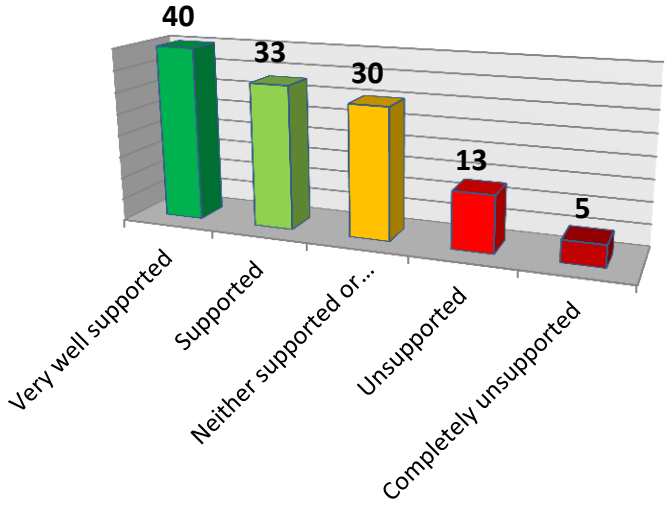
1. Dementia Assessment, Referral & Treatment

During Quarter 3, screening rates for finding new cases of dementia have increased significantly. Screening has increased from 22% in October to **91% in November,** meaning 431 patients were screened for signs of dementia on admission to the Trust during November. 95% patients were screened in December.

This increase is due in part to the new screening forms and method of audit but is largely due to the employment of our two CQUIN support workers. Based in EAU 7 days a week, they work with the medical teams to ensure all patients aged over 75 years are assessed.



	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
C1 Screen	22.7	30.9	39.9	44.5	42.5	36.5	33.1	30.4	20.2	27.9	28.5	28.5	22.7	14.81	22.71	91.7
C2 Asses	76.5	83.3	100	100	100	100	100	100	78.6	97.4	88.24	90.9	90.5	100	96.3	100
C3 Refer	80	100	100	100	100	100	100	100	66.7	92.3	100	80	100	87.5	100	100
Target	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Dementia Carers Survey - Total 2013

2. Carers Survey

60% of those surveyed reported feeling supported or very well supported. As well as the on-going work to engage and learn from those who felt unsupported our future priority needs to be to target the 24% of carers who felt indifferent (neither supported or unsupported). Current work outlined below is designed to address this.

3. Ward Based Training

Ward based dementia, delirium and family interventions training, provided by our colleagues in Liaison Psychiatry has commenced, with initial feedback from both staff and leaders in pilot areas being very positive. Being ward based and delivered by specialist services enables front line staff to access tailored training in their work environment without the need to release staff for whole shifts.

Q3 - Dementia CQUIN Summary cnt

The Trust's inaugural Dementia Link day was held on December 5th and was a resounding success with 62 staff attending from a variety of specialities across all Trust sites. Various topics were covered during the day with very positive feedback from all those who attended (evaluating at 4.9 / 5). Dementia Link Staff are in the process of implementing 'This is Me' documentation in all areas in order to improve patient and carer experience for people living with dementia. Further link days are being planned for 2014 where we hope to see even more interest.

A successful bid to the Nottinghamshire Local Education and Training Council has enabled us to commission specialist 'Meaningful Activity' training for some 250 front-line staff. This training supports our Activities to Share resource and will enable the embedment of our Guideline for Enhanced Patient Support.

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Reminiscence Pods

Further funding from Hardwick CCG has enabled us to purchase two RemPod's. These portable reminiscence 'rooms' have a 1950's theme and will enable reminiscence activity to take place close to the bedside, brining therapeutic engagement to our most vulnerable patients whom may benefit the most even if they are unable to leave the immediate care environment

Dementia Projects for 2014/15

Numerous projects are planned for improving dementia services at Sherwood Forest Hospitals. We hope that 2014 will be the year that we put our Trust on the map for excellence in dementia care.

- An ambitious scheme to make all of our inpatient wards more dementia friendly
- Further development of our Dementia Link staff to roll out improvements across the Trust
- Partnership working with local education providers and third sector organisations to develop innovative staff training and carer support
- Continue to support and build our team of dementia befriending volunteers
- Trust sign-up to the national Carers Call to Action
- Public engagement event to review of our Dementia Strategy for which we have gained funding for external facilitation
- Ward based, targeted training for staff to develop their skills in caring for people with dementia

We forecast meeting the dementia CQUIN targets for 2013/14

Q3 – Reducing Mortality – Cardiac Arrest Reduction CQUIN & Improving the Care of the Deteriorating Patient

Reducing cardiac arrests is part of the Reducing Mortality CQUIN. The goal of this CQUIN is to reduce adult in-patient cardiac arrests (outside of ED, ICU, theatres & coronary care) by 15% by the end of March 2014. The work this year continues to build on that started in 2012 – 13, and aims to improve recognition of patient deterioration and prevent failure to rescue.

BASELINE: Overall in Quarter 1, we counted a total of 2.6 cardiac arrests per 1000 of our inpatient admissions

Targets

Q2 = 2.4 cardiac arrests per 1000 admissions (5% reduction)

Q3 = 2.3 cardiac arrests per 1000 admissions (10% reduction)

Q4 = 2.2 cardiac arrests per 1000 admissions (15% reduction)

Likelihood of achieving Q4 target is good but the winter is typically a period where pressures may impact upon this.

Our Performance during Quarter 3

Quarter 3 cardiac arrest rate = 2.3 per 1000 hospital admissions

This represents a 10% reduction from baseline, and so the target for Quarter 3 has been achieved.

The overall year to date (YTD) reduction rate = 1.8 cardiac arrests per 1000 hospital admissions against the 2.6 baseline.

We have therefore met the CQUIN requirements for Q3.

Monitoring patients closely, recognising signs of deterioration and getting help from the experts for appropriate and timely treatment is key to quality care for acutely ill patients at SFHT.

We have met the reducing mortality CQUIN targets for Quarter 3

The National Early Warning Score (NEWS) and the Critical Care Outreach Team (CCOT)

Trust-wide implementation of the highly sensitive risk score for identifying and recognising deterioration, NEWS, in February 2013 has resulted in a big increase in the number of calls for help made to the CCOT. This is positive and suggests that more deteriorating patients are being identified sooner, being escalated to those with specialist critical care skills and expertise, providing the opportunity to deliver the urgent treatment required.

In October 2013, using CQUIN funding, we were able to employ three new nurses to help manage the increased volume of calls since February 2013. The team continue to receive a large number of calls for help when patients start to deteriorate.

Escalation calls to CCOT per month	
Before NEWS implementation	150 (average)
March 2013 (after NEWS implementation)	230
October 2013	222
November 2013	172
December 2013	243

Introduction of Vitalpac in 2014

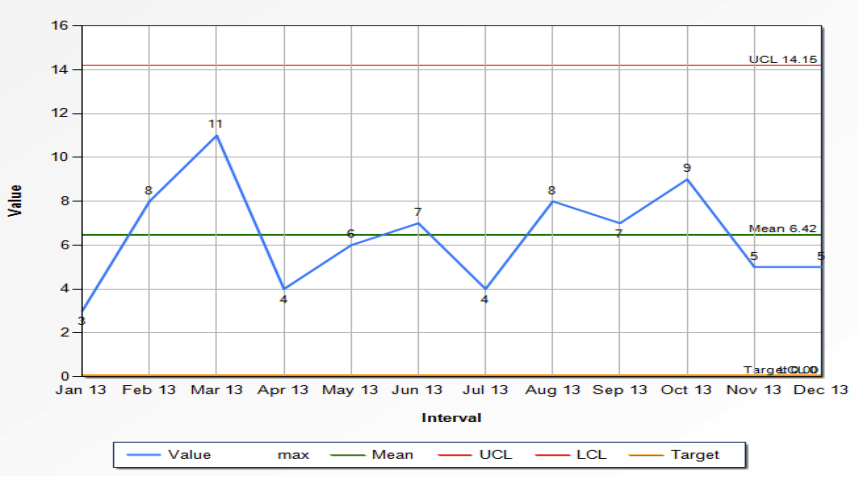
With the implementation VitalPac, a paperless electronic monitoring device, planned to start Spring 2014, we anticipate that calls to CCOT will continue to rise because this device will result in increased patient observation as nurses are provided with frequent reminders when to repeat their observations. The Outreach nurses will be able to pick up details of deteriorating patients in real time, when they are recorded, from their hand-held electronic devices, rather than relying on the nurse to call for help.

The number of calls to CCOT is rising because, as recent audits show, compliance with recording the routine vital signs and NEWS score is increasing. This is another improvement, attributable to additional training in the use of a simplified colour-coded observation chart and further involvement of the Healthcare Support Workers in the observation process. Data analysis from FocusIT, the Trust's monthly metrics audit, showed that for the first time ever in December 2013 all six observations (respiratory rate, oxygen levels, blood pressure, pulse, temperature and level of consciousness) were recorded 100% and the NEWS was documented on 99% of occasions. This represents a big improvement from 89% reported in April 2013. Acute surgical wards 31, 32 and medical ward 44 continue to be the biggest users of the service, and all had an increasing number of visits from CCOT through each quarter in 2013.

In Q3 the enhanced team was able to provide increased coverage across the Kings Mill site (0745-2030hrs seven days per week), with two nurses available during the busiest period, 1000 to 1800hrs. Previously a reduced service was available at weekends and public holidays.

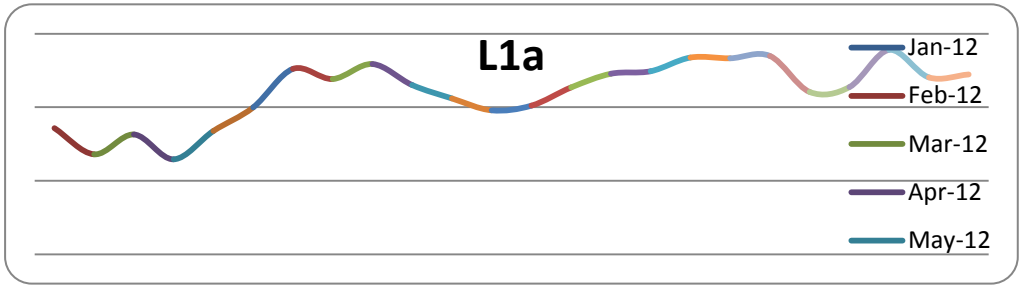
Although only tentative claims can be made at this early stage, increase in CCOT staffing, alongside the other improvements made, may have contributed to a reduction in the number of unexpected admissions to the intensive care unit over the last two consecutive months. The run chart below illustrates this (see the two data points to the far right of the chart below the average green line).

Chart below to illustrate unexpected admissions to ICU (Jan – Dec 2013)



Number of Acutely Ill Patients at the Trust

Our data below shows that the number of acutely ill patients (Level 1a) has increased across the Trust on a monthly basis and this explains the increased number of calls to the CCOT. The AUKUH acuity data, from an on-going monthly audit, shows an increase in raw numbers of acutely ill patients (Level 1a) as illustrated in the run chart below.



In addition to their work in preventing cardiac arrests, CCOT continue to support ward teams identifying patients who require Allow Natural Death (AND) decisions to avoid inappropriate treatment for those patients at the end of life.

Q3 - 2013/2014– Safety Thermometer Summary

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Monthly data is collected on pressure ulcers, falls and urinary tract infection (including indwelling urinary catheters) and blood clots (VTE). On a set day each month the nursing teams collect data on all in-patients wards (excluding paediatrics and Special Baby Unit). Collection of safety thermometer data is a national CQUIN and the targets are described in the table below.

2013/14 CQUIN Targets:	Q1 Apr-June 13 to 14	Q2 July-Sept 13-14	Q3 Oct-Dec 13-14	Plans in place to continue to achieve target for Q4
1. To collect and submit monthly data on the following three elements of the NHS Safety Thermometer : Pressure Ulcers, In-patient Falls and Urinary Tract Infection in patients with a catheter	**Achieved** ☑	**Achieved** ☑	**Achieved** ☑	Safety Thermometer Co-ordinator in place to collate and validate ward data. Ward leaders & Heads of Nursing aware of monthly deadlines and submission dates and have contingency plans in place to ensure data is collected.
2. Reduction in prevalence of reported pressures ulcers (pre-hospital and hospital acquired) within national median	**Achieved** ☑	**Achieved** ☑	**Achieved** ☑	Continued implementation of the Pressure Ulcer reduction strategy.

What do the results tell us?

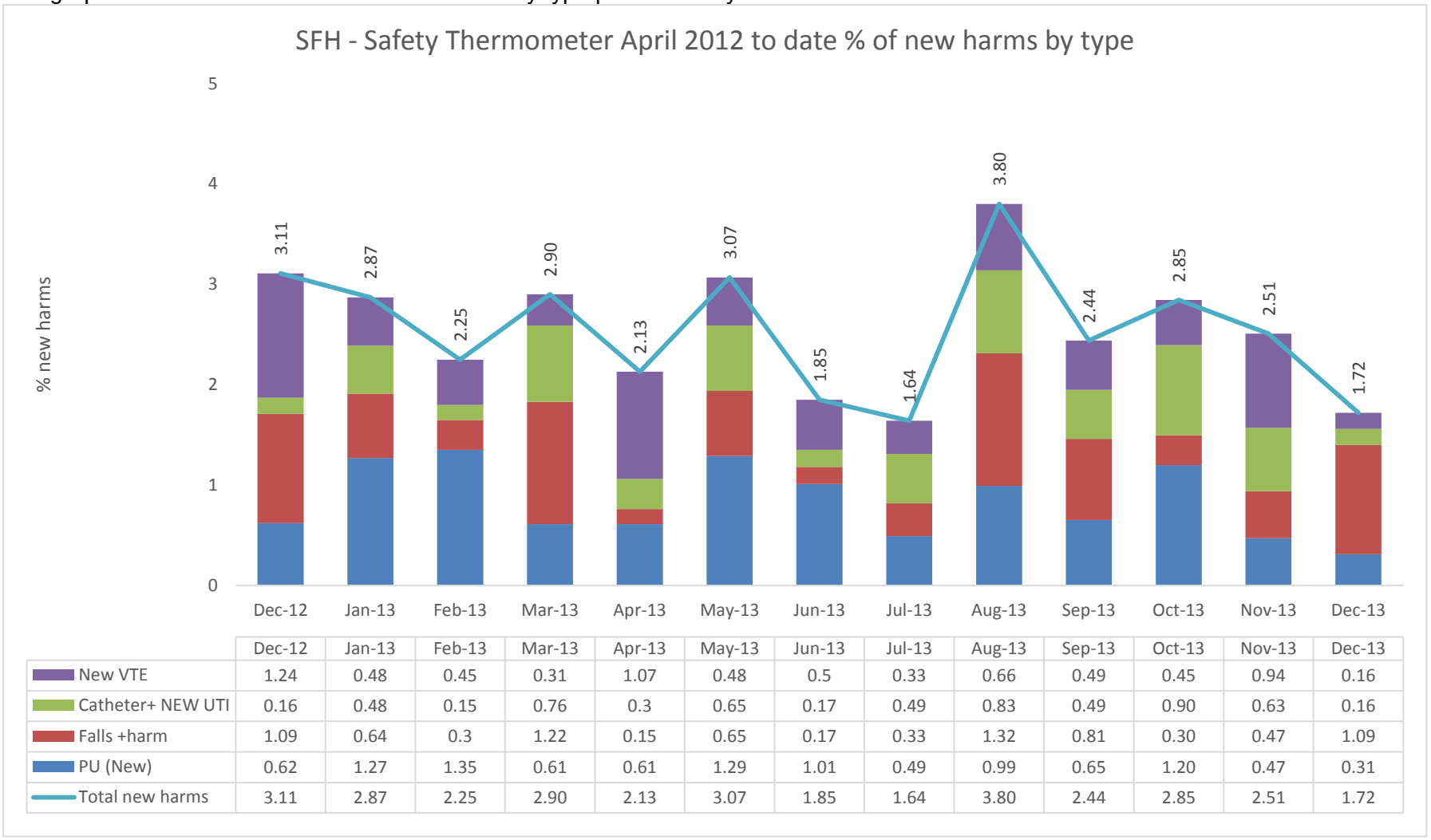
For April-Dec 2013 SFH has had 6 out of 9 months where our reported 'harms' rate was less than the national reported rate - this includes pre-hospital (old) as well as hospital acquired harms (new). Falls represented the greatest number of 'new harms' identified within the safety thermometer during December with 1.09% compared to the total of 1.72%. A new falls nurse has now commenced in post who is looking at causes of this as part of the falls improvement work. When reviewing NEW harms (hospital acquired harms) for 7 out of 9 months we have reported fewer harms when compared to the national results. The National average of NEW pressure ulcers is 1.03% - we have reported fewer at 0.66%.

What will the national requirements be for the Safety Thermometer in 2014/15?

We are currently in discussion with our commissioner colleagues to agree the Safety Thermometer for 2014/15. It will be a national CQUIN scheme and Trusts will still be required to submit data monthly. The focus appears to be on continuing to reduce all pressure ulcers, not only those which are avoidable or non-Trust acquired.

Q3 - 2013/2014– Safety Thermometer Summary cnt

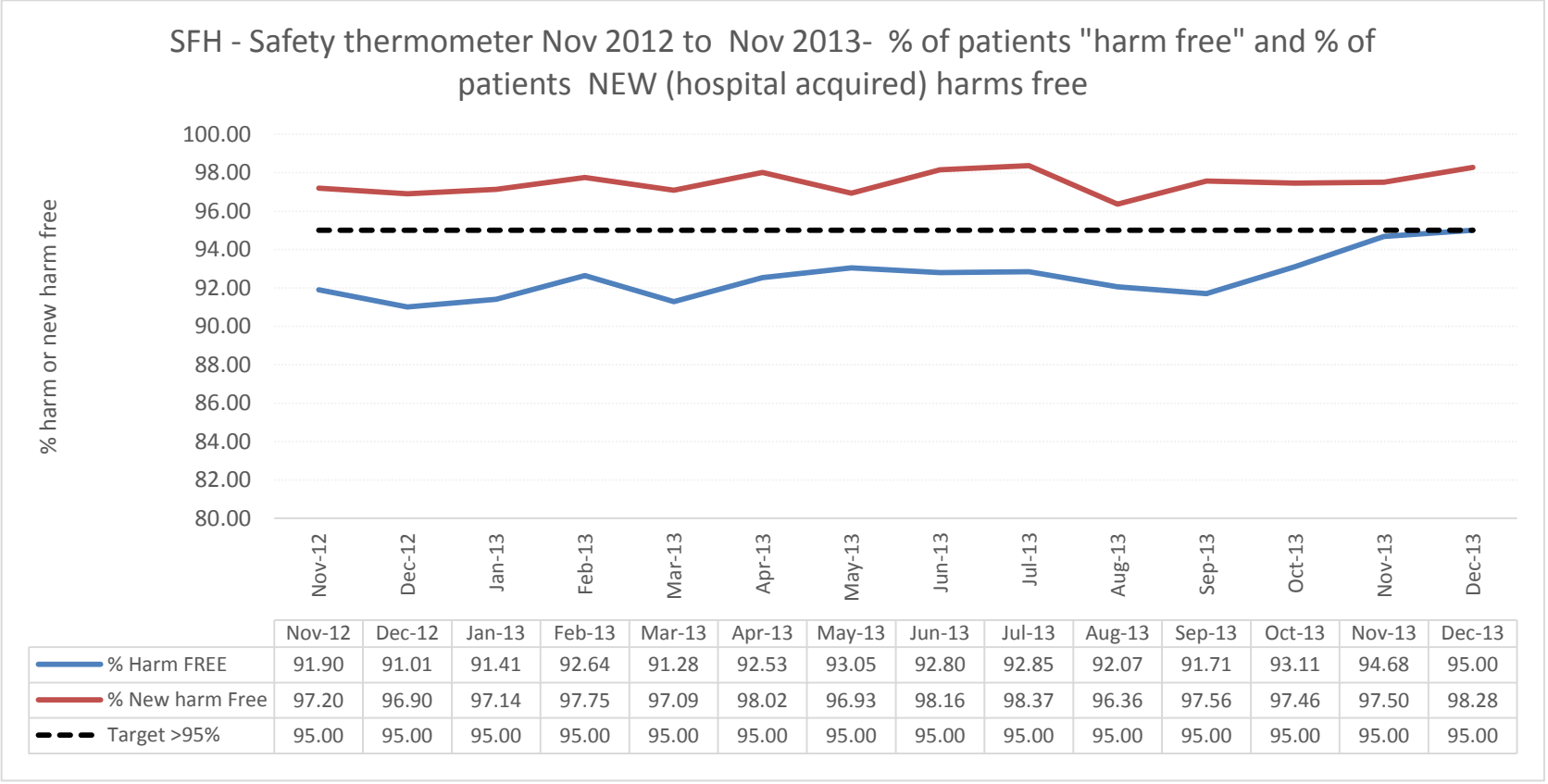
The graph below shows our rate of 'NEW' harms by type per the safety thermometer data.



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
New VTE	1.24	0.48	0.45	0.31	1.07	0.48	0.5	0.33	0.66	0.49	0.45	0.94	0.16
Catheter+ NEW UTI	0.16	0.48	0.15	0.76	0.3	0.65	0.17	0.49	0.83	0.49	0.90	0.63	0.16
Falls +harm	1.09	0.64	0.3	1.22	0.15	0.65	0.17	0.33	1.32	0.81	0.30	0.47	1.09
PU (New)	0.62	1.27	1.35	0.61	0.61	1.29	1.01	0.49	0.99	0.65	1.20	0.47	0.31
Total new harms	3.11	2.87	2.25	2.90	2.13	3.07	1.85	1.64	3.80	2.44	2.85	2.51	1.72

Q3 - 2013/2014– Safety Thermometer Summary cnt

The graph below shows the % of patients classified as 'NEW' harms free by month and indicates that in December we achieved the 95% target for the first time during the past 12 months.

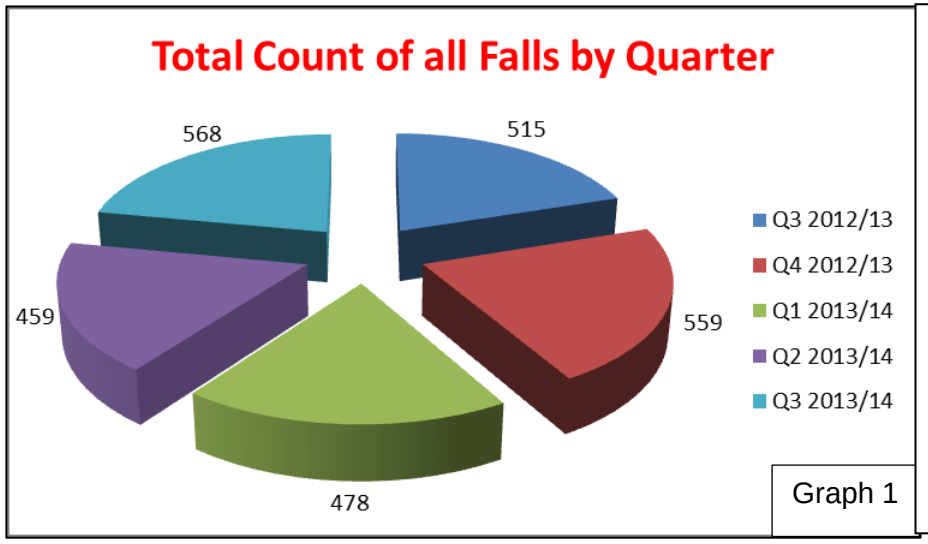


	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
% Harm FREE	91.90	91.01	91.41	92.64	91.28	92.53	93.05	92.80	92.85	92.07	91.71	93.11	94.68	95.00
% New harm Free	97.20	96.90	97.14	97.75	97.09	98.02	96.93	98.16	98.37	96.36	97.56	97.46	97.50	98.28
Target >95%	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00	95.00

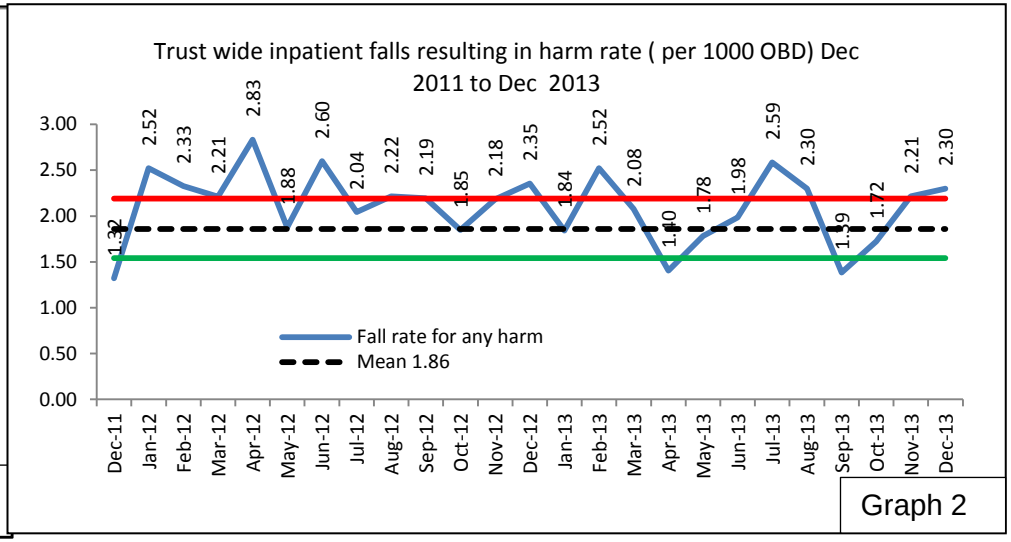
The Trust expects to achieve the Safety Thermometer CQUIN for Q3

Q3 – Falls CQUIN Summary

The overall incidence of falls in Quarter 3 was 568 (graph 1), which is an increase from Quarter 2 when there were 459 falls in total. Overall the falls per 1000 occupied bed days that result in any harm is 2.30, which has increased above the mean in November and December. The falls data has recently been through a cleansing exercise as part of the DATIX reporting project. It now incorporates some of the unclassified incidents, which is why we have had to re-base the data since the previous report (Chart 2). We have highlighted to commissioners that our data has been cleansed in year and will discuss the impact this has on the agreed CQUIN target. Part 1 of our CQUIN this year is to achieve the mean by March 2014. Based on the increase of falls with harm in Quarter 3, this is at high risk of non-achievement. In November, we instigated a monthly ward assurance meeting led by the Director of Nursing, where performance is monitored and actions agreed. This data is available by ward and also monitored at monthly divisional governance meetings. It is proposed that falls prevention is a key priority for 14/15.



Graph 1



Graph 2

Falls Improvement Project – Focus for Quarter 4

The newly appointed Lead Nurse for Falls is working closely with those ward areas where there is a heightened risk, to ensure that the appropriate interventions are put in place in a timely manner. Work is also being undertaken to improve the quality of incident reporting and provide appropriate guidance to ensure accurate information is submitted. As an example, the falls nurse is working directly with the Ward Leader on ward 22 (ortho-geriatrics) to establish a responsive system for when patients have sustained a fall to reduce the chances of recurrence. This work will focus on improving communication, ensuring medication reviews and looking at the patients environment and equipment.

Hospital Falls & Harm

In quarter 3, out of 568 falls, 428 falls resulted in no harm and 131 resulted in low harm (see Graph 3).

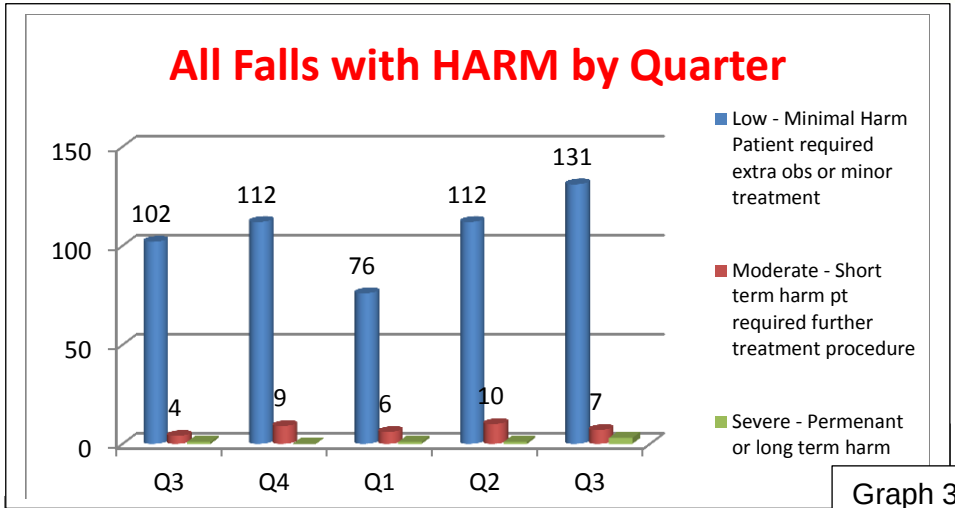
During quarter 3, 7 patients sustained moderate harm following falls and 3 patients sustained severe harm. Of these patients, 5 resulted in a fracture compared with 6 patients in Quarter 2. This is not acceptable and our falls action plan has been implemented to address this.

Graph 4 shows compliance with falls assessment and care plans. Part 2 of the falls CQUIN requires us to ensure 95% of our patients are risk assessed, which we are achieving.

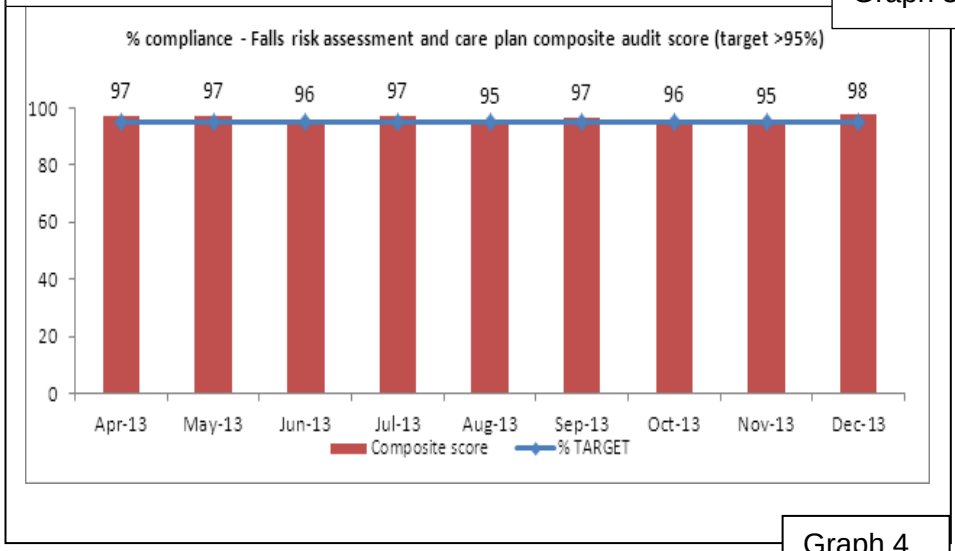
Over the next quarter one particular focus will be in ensuring identified risk factors are addressed and interventions put in place with emphasis on who is responsible for ensuring actions are done in order to give assurance that work identified in action plans is actually being embedded into practices within the Trust.

The falls nurse will be visible to the wards, be available for advice and support and have active involvement in reinvigorating education on the wards and also in ensuring all members of staff have a clear understanding of The Head Injury Policy.

Work is also being undertaken to look at introducing a booklet/leaflet for patients in relation to falls prevention interventions.



Graph 3



Graph 4

The Trust has seen an increase in falls with harm in Q3. Over 95% patients have been risk assessed for falls

Q3 - End of Life CQUIN Summary

Our Aim

We continue to strive to deliver quality and compassionate care to patients nearing the end of their lives, and are making progress in delivering on the five key enablers within the Acute Hospitals Transform Programme below, which aims to enable more people to be supported to live and die in their preferred place.

Our Medical Lead and Lead Nurse for End of Life Care & Cancer continue to drive improvements in outcomes and patient carer experience with the support of members of the Hospital End of Life Care Multi-Disciplinary Team.

Cross Boundary Working & EPaCCS

Work is on-going to improve effective methods of cross-boundary communication between ourselves and our primary care colleagues. Particularly on flagging patients when admitted to hospital and developing methods and systems of sharing information to ensure continuity and co-ordination of care is provided irrespective of which care setting the patient is in.

the gold standards framework in acute hospitals

Progress is being made on the implementation of the GSF Acute Hospitals Programme on Wards 42 & 51. This is a two year programme designed to facilitate the introduction of GSF components, and especially Advance Care Planning (ACP) in hospital. We are approaching the end of the first year. To date a baseline audit has been completed on both Wards, Key Ward members and the End of Life Care Team have attended a 3rd Workshop and staff training on identification of patients for the GSF Register and ACP is now underway. It is anticipated that staff on both Wards will have received training over the next 4-6 months.

the AMBER care bundle

Progress is being made on the implementation of AMBER Care Bundle on Wards 43 and 44. A pilot multi-professional communication skills course was delivered by our End of Life Care Team and Specialist Palliative Care colleagues from John Eastwood Hospice on 19th December 2013, which evaluated very positively, generating a number of suggested improvements to End of Life Care, some of which are possible 'quick wins'. The workshops enabled information learnt to be put into practice. The course will be fully evaluated after all staff from both wards have been trained with a view to training all SFHFT ward staff in the future (Q3 & 4 CQUIN target).

We anticipate achieving this CQUIN for Q3

Q3 - End of Life CQUIN Summary

Fast Track & Rapid Discharge Home to Die

One of the 5 key enablers within the Transform Programme is Rapid Discharge Home to Die. This has become an integral part of the Integrated Discharge Advisory Team's (IDAT) practice. The IDAT support the process of enabling those in the last days/hours of life to die in their Preferred Place of Care (PPC) by co-ordinating and effectively managing the discharge process.

PPC data is being captured on a monthly basis as part of the audit data which reports on the number of referrals made to the IDAT. Quarterly figures are illustrated below:

Qrt 1 – 129 patients
Qrt 2 – 89 patients
Qrt 3 – 138 patients

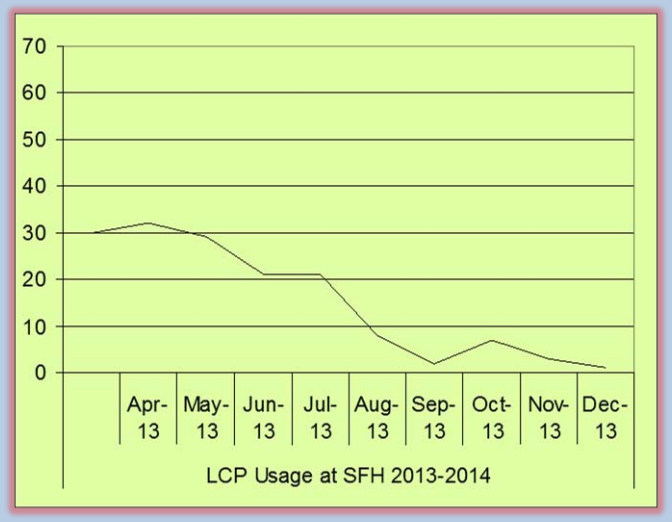
In Q3 there were 6 patients rapidly discharged home to die. It is anticipated that these figures will increase due to the implementation of AMBER Care Bundle & Gold Standards Framework in Acute Hospitals.

At one of the workshops on the pilot multi-professional communication skills course which looked at Rapid Discharge Home to Die, staff discussed ways of improving support for patients and carers following discharge and preventing unnecessary re-admissions. One suggestion they came up with was for the wards to provide follow up calls 2 hours post discharge, to ensure that everything arranged was in place and there were no problems. This will be implemented by the wards implementing the AMBER care bundle

Care of the Dying - Last Days of Life

As the table below illustrates the use of the Liverpool Care Pathway (LCP) continues to have reduced considerably since the government announcement that the LCP is to be phased out over the next 12 months. Therefore while we await further direction and recommendations from the Leadership Alliance for Care of Dying People, the End of Life Care Team have developed Guidance and Care Plans based on the principles of best practice in the last days of life, to support staff reluctant to use the LCP documentation.

The latest data available on usage for 2013 is summarized graphically below.

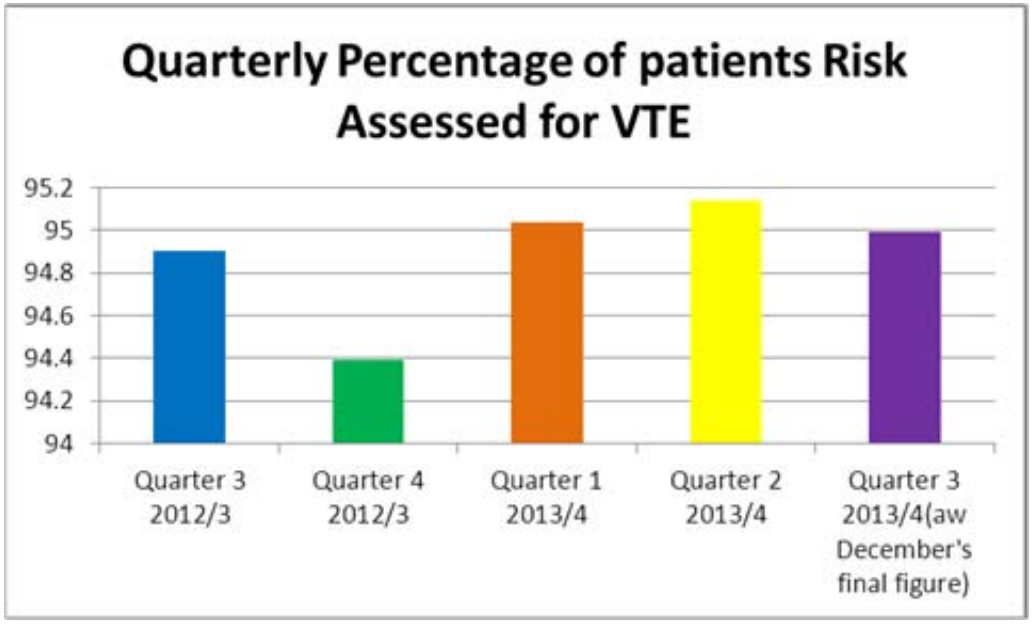


We have participated in the National Care of the Dying Audit in Hospitals, which is a clinical case notes review that measures the standard of care delivered to patients nearing the end of life. Following the publication of these results, the End of Life Care Team will provide an action plan in Spring 2014 to further improve delivery of care to patients in the last days of life.

Q3 - Venous Thromboembolism (VTE) CQUIN Summary

Our aim

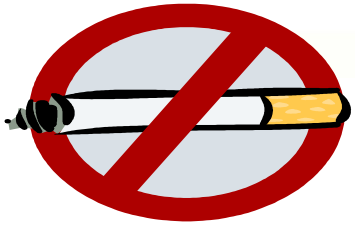
- To assess 95% of patients for their risk of VTE
- To ensure 100% patient identified at risk receive preventive treatment
- To ensure all patients developing a hospital acquired VTE have a full investigation



How are we doing?

- For Quarter 3 we are predicting that we will achieve this CQUIN target. We met the CQUIN target in Quarter 2 and look set to achieve the quarterly average of 95% for Quarter 3.
- 100% of root cause analyses have been carried out on cases of hospital associated thrombosis (HAT).
- > 95% patients receive appropriate thromboprophylaxis on the wards.
- Data collection to support this CQUIN is currently centred upon manual practices. The implementation of Vitalpac later this year is anticipated to streamline this process and give us improved reporting. However in the meantime we are linking with the dementia data collection process on EAU so we can ensure both these key assessments occur.
- We continue to work closely with colleagues at the front door to ensure consistent compliance with this quality target and ensure performance is maintained throughout times of increased pressures or changes in medical staff.

The VTE CQUIN is forecast to be achieved for Quarter 3, ensuring 95% patients are risk assessed for blood clots.



Q3 – Smoking in Pregnancy CQUIN Summary

Capturing Accurate Data on Smoking During Pregnancy

When we embarked upon this CQUIN in April 2013, we started to do considerable work to improve the accuracy of the data we were collecting. To help achieve this, the recording of smoking at the time of delivery (SATOD) became a mandatory item on the electronic Maternity Pathway at the Orion update in early December 2013. Therefore complete data will be available for most of the month of Dec 2013 & then complete for every month onwards, whereby every single lady we care for in maternity will have their smoking details recorded electronically. Key initiatives for 2014 are highlighted in pink below.

What is the CQUIN?

- Our baseline smoking at time of delivery rate is 26% (2013/14)
- Our reduction target for 2013/14 is 3% to 23%
- Our reduction target for 2014-16 is a further 8% to 15%

How are we doing?

- Q1 figures show: SATOD = 25.3%
- Q2 figures show:- SATOD = 22.5%
- Figures for Q3 are due anytime now

Nicotine Replacement Therapy (NRT)

From April 2014, we plan to introduce the use of NRT for women when they attend Maternity Services in early labour or are admitted as an antenatal patient. This will support women when attending the Trust and provide them with therapy that will help them to give up smoking.
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Carbon Dioxide Monitoring at 34 weeks Gestation

Public Health England have supported this initiative by purchasing CO Monitors for the Community Midwives. Colleagues in New Leaf are facilitating training for the Midwives at the team meetings in late Jan 14. From then on every pregnant woman, who continues to smoke in pregnancy, will have a CO reading alongside the existing offer of referral to Smoking Cessation services.

The Rotherham Model

Women who disclose that they smoke will receive an intensive, face to face, stop smoking intervention, adopting a prescriptive medical model, which explicitly outlines the dangers to the pregnancy and the fetus of continuing to smoke. This is to be delivered by a Midwife, in uniform, with specialised training, in the hospital setting, at the time of the woman's dating scan.

This evidence based model is being evaluated and funding secured to start this pilot during 2014/15.

The Trust expects to meet this CQUIN for Quarter 3

Q3 Serious Incidents & Never Events Summary

There were 23 Serious Incidents uploaded onto STEIS (Strategic Executive Information System) during Quarter 3. This compares to 17 incidents reported during quarter 2 of this year and 38 in Quarter 1. The numbers of Serious Incidents reported per month can be seen in the table below.

Quarter 2 and 3 - 2013/2014	July	August	September	October	November	December
Number of Serious Incidents	9	3	5	10	7	6

As at 6th January 2014 there were a total of 23 serious incidents open on Strategic Executive Information System (STEIS). Of these:

- Twelve are within timescales and still being investigated
- Eleven have been submitted for closure to the CCG but remain open on STEIS.

All serious incidents during Q3 were submitted within the timescales agreed with commissioners. The commissioners have requested further information for the eleven that remain open on STEIS following submission for closure. The request for information is being facilitated.

There was one Never Event reported at the end of quarter 3 relating to the Opioid overdose of an opioid-naïve patient.

Serious Incidents by Division

	October 2013	November 2013	December 2013
Emergency Care Medicine	7	5	0
Planned Care & Surgery	3	2	6
Diagnostics & Rehab	0	0	0

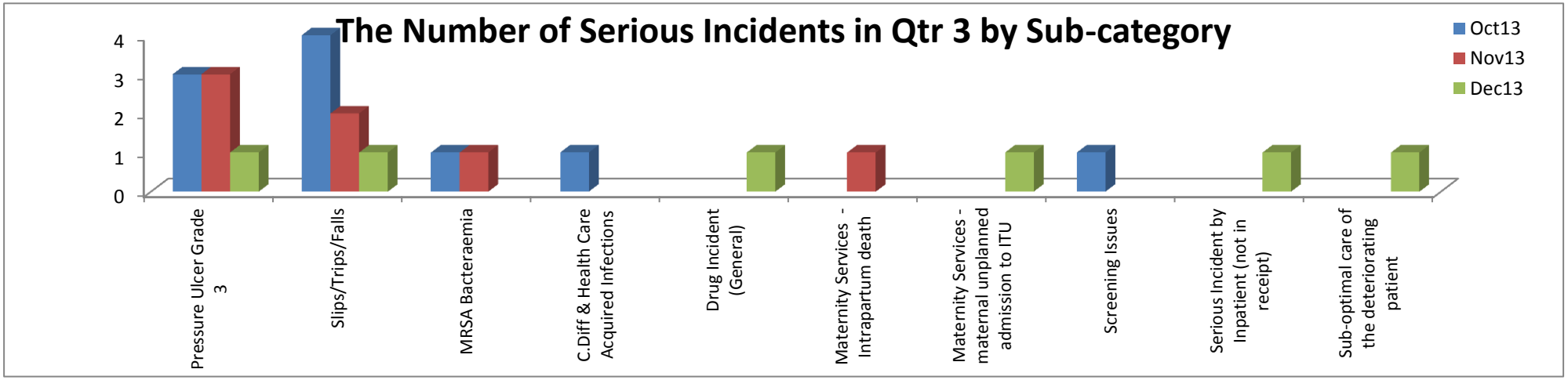
DATIX Project

A specialist has been employed to configure and project plan the changes required to allow full utilisation of the Datix system. Once complete this will ensure the Trust has aggregated quality data available to the Trust Board, Board Sub-Committees and external partners and regulators.

The project plan will also consider the training requirements for reporters and handlers/investigators of incidents in particular relating to the identification and descriptions of patient harms.

Q3 Serious Incidents & Never Events Summary cnt

The categories of serious incidents are shown in the graph below. Pressure ulcers and falls continue to be the top reported incidents during Q 3.



Key Findings – Pressure Ulcers

There were seven grade 3 pressure ulcers reported in Quarter 3 (4 avoidable). Compared to quarter one where 16 were reported, this demonstrates a marked reduction. Key findings and future developments are articulated within the pressure ulcer summary of this report.

Key Findings - Sub-optimal care of the deteriorating patient

This incident is under investigation.

Key Findings – Slips, Trips & Falls

There were 7 serious falls reported on the Strategic Executive Information System (STEIS) during quarter three. This included 3 which occurred in quarter two. Actions to improve immediate reporting have been addressed with the nursing teams. The Governance Support Unit will work closely with the newly appointed Falls Nurse in quarter four to identify with the clinical teams the patient safety concerns which may lead to a serious Injury.

From the serious falls investigations in quarter three, there were apparent delays in instigating x-rays to exclude fractures in patients post fall. This is part of the falls action plan and being monitored at the falls steering group.

Q3 Serious Incidents & Never Events Summary cnt

Key Findings – Serious Inpatient Incident

This incident is under investigation and no immediate risks have been identified.

Key Findings - The Drug Incident (never event)

The Drug Incident (general) as reported on the Strategic Executive Information System (STEIS) relates to the Never Event - Opioid overdose of an opioid- naïve patient.

Immediate actions to reduce the risk for future patients have been implemented whilst the investigation is being undertaken. These actions include a risk assessment in conjunction with pharmacy of the wards storage facilities for morphine and to display the Neonatal induction schedule in all areas where intubations may take place.

Key Findings – Maternity Services Unplanned admission to ITU

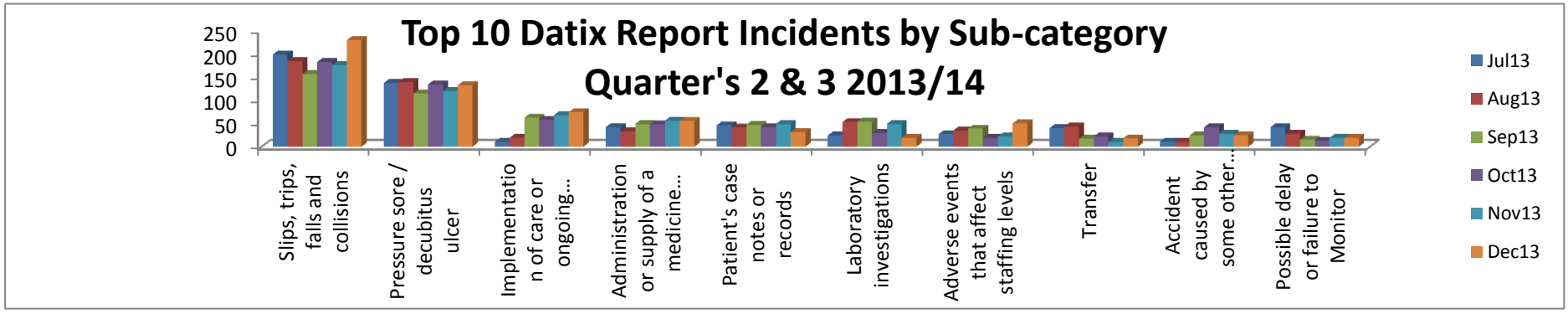
This incident is under investigation and no immediate risks have been identified.

Key Findings - Maternity Service intrapartum death

The case is to be presented at local perinatal mortality meeting highlighting lack of availability of local neonatal cots, the impact of sub-optimal planning and the need for more multidisciplinary input at a consultant level. In response to the learning from the incident a proforma has been developed, for use when women are admitted before 28 weeks gestation. There are plans for all registrars to complete their basic scanning modules allowing them to detect fetal viability.

Key Findings - MRSA bacteraemia, Clostridium Difficile/Health Care Acquired Infections and Screening issues

The above categories of Serious Incidents are investigated in partnership with the clinical teams and the Infection, Prevention and Control (IPC) team. Key findings are articulated within the IPC summary of this report.



Q3 Serious Incidents & Never Events Summary cnt - Ensuring Data Robustness and Learning from Incidents

Top 10 Datix incidents by sub-category

The sub-categories for the top 10 incidents reported remain primarily the same across both quarter two and three. There has been an overall increase in the implementation of care or on-going monitoring categories; this is due to much greater scrutiny of incident grading/validation that has taken place over Quarter 3 within the Governance Support Unit. We have introduced a new process whereby the Tissue Viability team validate all skin damage reports to ensure they are classified as accurately as possible. This has been agreed via the Pressure Ulcer Strategy Group as will help give more accurate information and help to ensure we are implementing the right improvements for our patients.

During Quarter 4 the Governance Support team will review any previously rejected incidents over the last financial year and re classify. Once reclassified any patient harms will be up loaded to the National Reporting Learning System. This forms part of the DATIX cleansing work we are doing and we will continue to provide an overview of this for our Clinical Management Team and report any impact this may have on Trust data.

During the cleansing of DATIX we have identified an administrative error in terms of our uploading link to the national reporting system. During Quarter 3 we were submitting data to the national system but it was not being recorded. This has now been rectified and key stakeholders informed (CQC and CCG). There has been no impact to how we manage our patients; however, our external bodies would not have received our serious incident information during this period. We do have a relationship with both parties where they were informed of the incidents (e.g. never event) at the time of the time of occurrence.

All Moderate Incidents comparison Quarter two and three

During the last two quarters of 2013/14 there has been daily review of incidents by the Clinical Governance Lead, the Patient Safety Lead and Datix Project Support officer. This review has led to an increase in the number of incidents that are now being reported as patient harms to the NRLS and an increase in the number of incidents graded at moderate.

In Quarter 2, 105 incidents were graded as moderate incidents and in Quarter three 164. This led to an increase in the following sub-categories: Implementation of care or on-going monitoring – other and Pressure sore / decubitus ulcer.

Learning from incidents

Throughout quarter 3 extensive work has been undertaken to ensure that the Trust meets it obligation to report patient safety incidents to the National Reporting Learning System (NRLS)

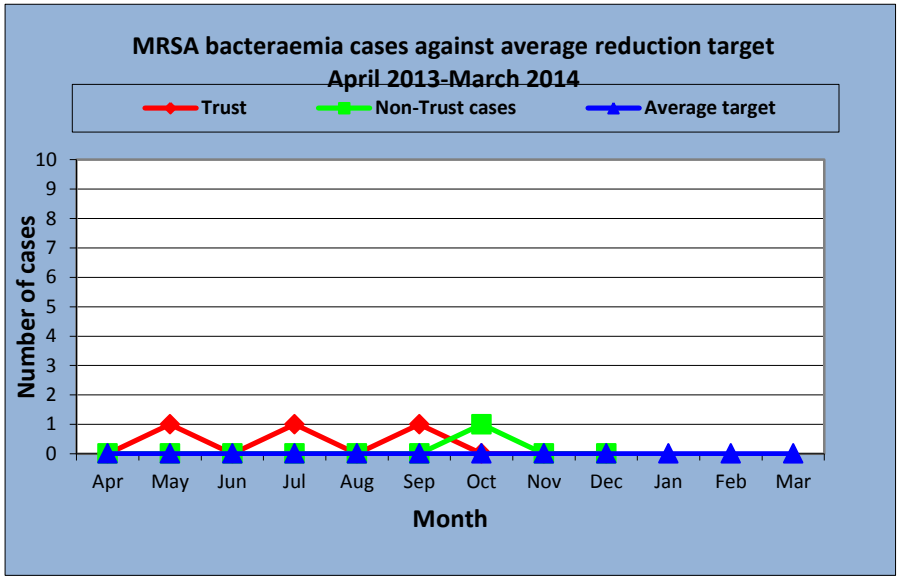
The main focus has been to initially grade the incidents on an on-going basis then validate the moderate graded incidents at the end of each month, before they are uploaded to NRLS. The rational for validating the moderate incidents is to ensure that if the outcome of investigation changes the level of reporting the Trust does not inadvertently miss reporting a Serious Incident.

Q3 – Infection, Prevention & Control Summary

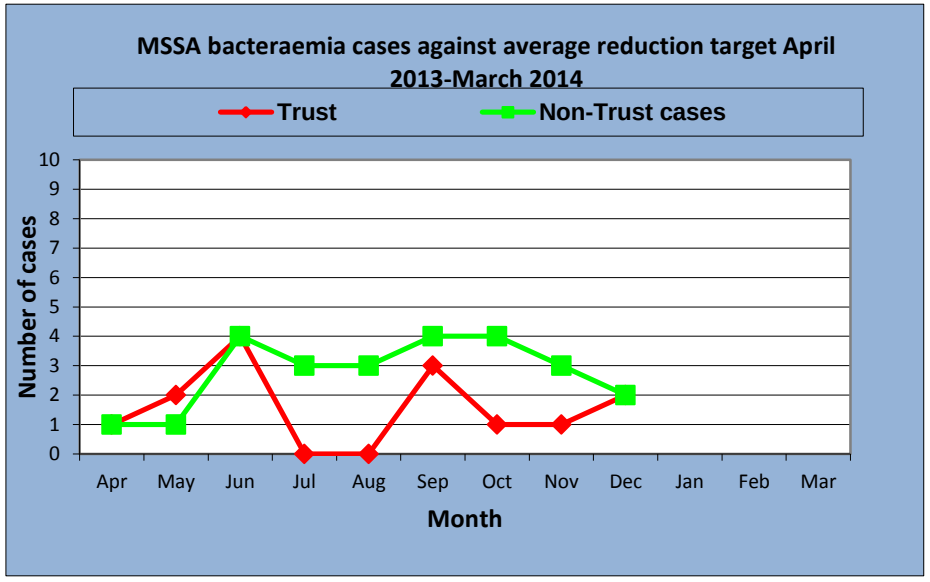
Healthcare Associated Infection Rates

Sherwood Forest Trust continues to work very hard to tackle health care associated infections, but Hospital-associated infections (HCAI) still present us with a great challenge. With a strong commitment to maintain the previously excellent track record and to achieve zero tolerance, we continue to benchmark well in comparison with other local providers. However, we have seen an increase in incidences of *C diff* in Quarter 3. The Infection Prevention and Control Team continue to implement a targeted programme of work, alongside the hospital acquired bacteraemia and *C. difficile* infection action plan. Both of these are updated to include lessons learnt from recent investigations.

MRSA bacteraemia: There have been 0 further cases of hospital acquired MRSA (trajectory 0). This brings the total for 2013-14 to 3 hospital acquired cases. A programme of improvements is currently underway.

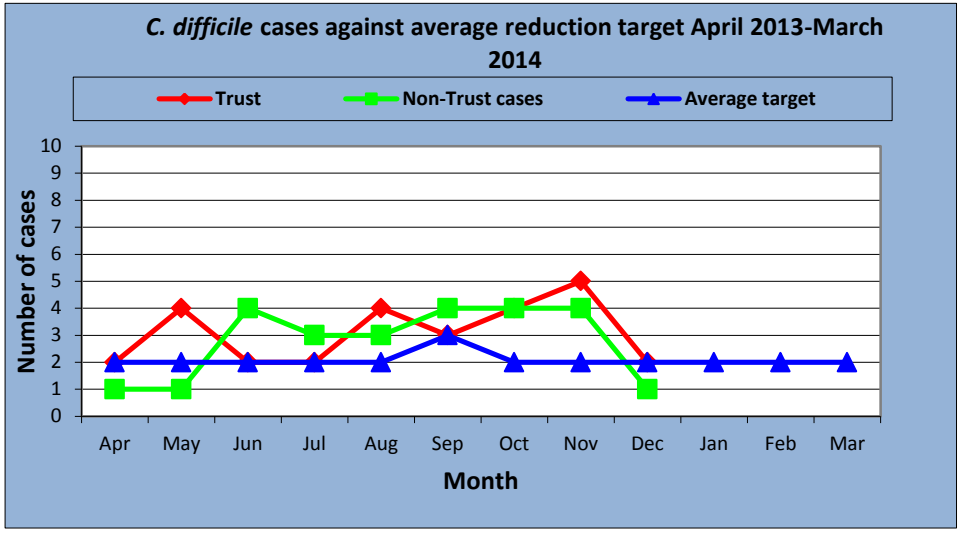


MSSA bacteraemia: There have been 4 cases of hospital acquired MSSA bacteraemia. This brings the total to 14 hospital and 25 community acquired cases. There are no set targets for MSSA.

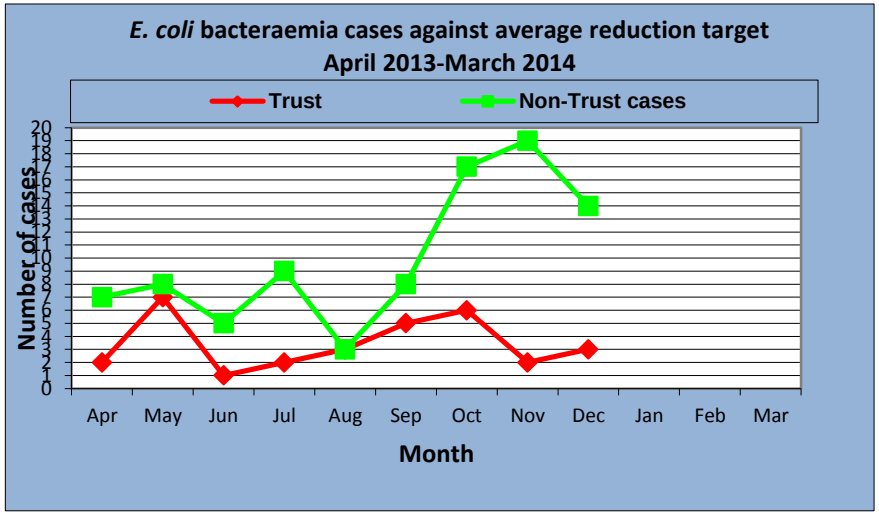


Q3 – Infection, Prevention & Control Summary cnt

C. difficile: There have been 11 cases of hospital acquired (quarter trajectory 6), and 9 community acquired *C. difficile* infections for Q3. The trajectory was breached in October and November: 9 cases against a trajectory of 4. This brings the total to 28 hospital and 25 community acquired cases.



***E. coli* bacteraemia:** There have been 9 cases of hospital acquired *E. coli* bacteraemia for Q3. This brings the total to 32. All bacteraemia are now discussed by the IPC team and Consultant Microbiologist to determine whether a full root cause analysis is required. Any related to indwelling devices are automatically referred for full root cause analysis. These are all to be reported back to the bi-weekly HCAI meeting.



C Diff Route Cause Analysis

Investigation of all these cases hasn't suggested any issue with cross-infection. Most of these are sporadic cases. Review of the Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audit has not highlighted any concerning issues regarding the inappropriate antibiotic usage of antibiotics. We are planning to undertake further investigation. We have implemented twice weekly *CDiff* ward rounds to review patients who have a *CDiff*/GDH positive result or are suspected as having *CDiff*. This is carried out by the Consultant Microbiologist, Consultant Gastroenterologist, Infection Prevention, Control Nurse and ward teams.

E.Coli Mandatory Surveillance and IT Failure

It has been identified that some results from WinPath (Laboratory Results system) are not feeding over to ICNet (used by IPCT to obtain results), especially E. coli which is one of our mandatory surveillance areas. This came to light when the team were looking into WinPath for another result. ICNet is used to do the mandatory surveillance which has to be put into a MESS national database.

All of the results that did not feed over to ICNet had been clinically dealt with by the Consultant Microbiologists who informed the Medics at the time of the result and appropriate medical treatment started. A new interim system has been put in place using WinPath which now has an infection control alert list to which all blood culture results are added and this alerts the IPCT

Q3 – Infection, Prevention & Control Summary

MRSA colonisation Figures

62 patients during Q3 were identified as new MRSA colonisation across the health economy. This brings the total to 181 cases (43 post 48hrs, 138 pre 48hrs).

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
post 48hrs	3	4	9	9	6	4
pre 48hrs	18	14	18	16	15	12
TOTAL	21	18	27	25	21	16

Catheter associated bacteraemia

There have been 5 cases of catheter associated bacteraemia that were hospital acquired, against an internal target of 1 for Q3. This brings the total to 10 cases for 2013-14. Each bacteraemia has been reviewed by the Infection Prevention and Control Team (IPCT) and a Route Cause Analysis has been completed. We are implementing a patient held record (Catheter Passport) which all patients who have a urinary catheter inserted will have completed and this will hold a full suite of information.

We audit catheter care monthly and saw a reduction in compliance with catheter documentation and care during Quarter 3. The full results of this audit are being reviewed by the Nursing Care and Infection Control Forums in January to identify immediate actions to improve this prior to a re-audit.

Surgical Site Infections

There has been no total hip replacement and total knee replacement surgical site infections reported for quarter 3 (October – December), and two C-section surgical site infections reported for the same time period. Although no surgical site infections were reported for quarter 1 (April – June), since then 1 case has been identified against a total hip replacement, which was undertaken in April 2013. In total this brings the number of surgical site infections to 10 cases. It is important to note that surgical site infection rates may change as orthopaedic implant procedures are reviewed for a year and C-section for up to 30 days post discharge.

Policy Review/Development

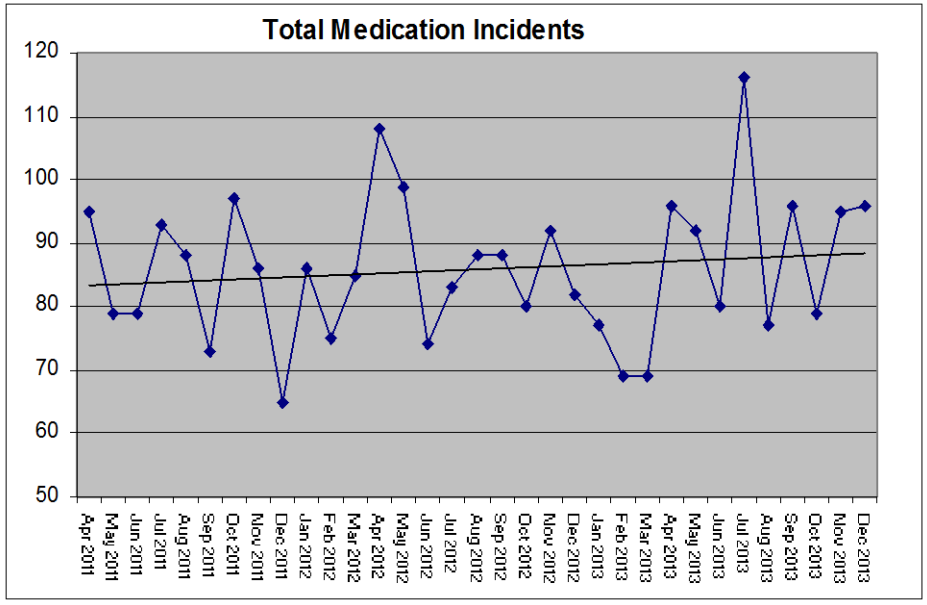
Final versions of the risk assessment tool, Chickenpox and Shingles, Animals in Hospital, PPE and Venepunture policies will be ratified at the January Infection Prevention & Control Committee (IPCC). Further policies have been reviewed or developed and are in the process of peer review these include: Respiratory infection and blood cultures.

Q3 – Medicines Safety Summary

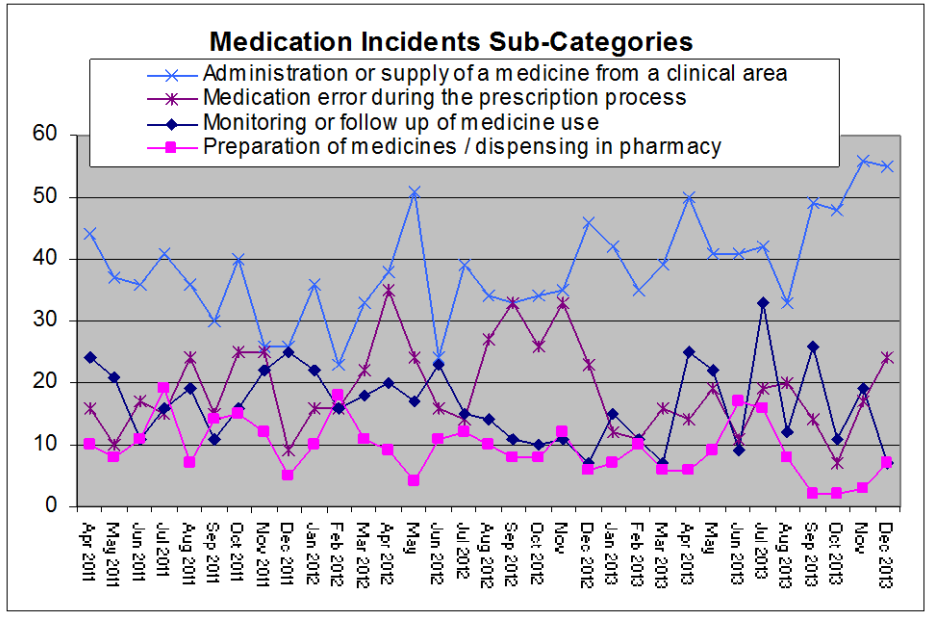
Executive Summary

The total number of medication-related incidents reported on Datix has remained consistent since 2011, with a total of 1001 reported in 2011/12 and 1009 in 2012/13 (see Graph 1). There have been 827 reported by the end of Q3 2013/14 (compared to 794 by Q3 in 2012/13). Of these, most relate to medicine administration/supply (44.9%,↑), prescribing (22%,↔), monitoring and follow-up (19.2%,↓), and pharmacy (11%,↓). The most commonly reported adverse event since April 2011 continues to relate to medication non-administration (18%,↔) (see Graph 2). The recent increase is likely to be due to a greater awareness of the need to report delayed or omitted critical medicines since the corresponding NPSA alert, and work in the Trust to raise the profile of this issue. 95% of reported medication incidents since April 2011 result in no directly attributable reported harm. The recent increase in any harm reporting is likely to be due to an improved completion rate of this field in Datix®. The vast majority of 'harm' is classified as 'low/minimal' but any 'harm' classification should be viewed with caution as it is often subjective and sensitive to potential bias from either the incident reporter or investigator/handler, with inconsistent interpretation between individuals.

Graph 1:



Graph 2:



Q3 – Medicines Safety Summary cnt

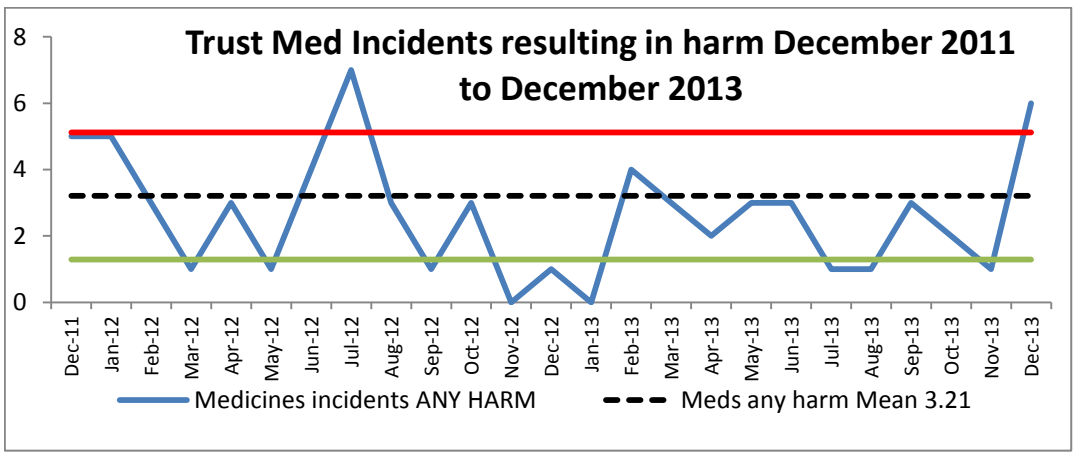
Medication Incidents this quarter

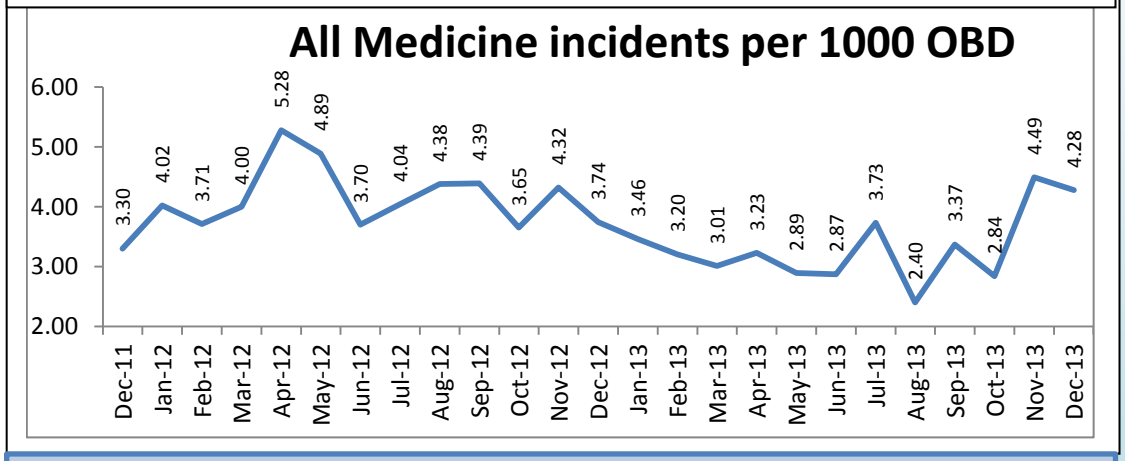
The number of medication incidents reported in 2013/14 Q3 is consistent with quarterly totals over the last 2 years, and demonstrates a consistently higher level of reporting with Datix® compared to the final year of paper reporting in 2005/6 (which produced approximately 550 medication-related incidents in the full year).

Medication-related harm events this quarter

Graph 3 below indicates that the number of medication incidents resulting in any harm events remains very low since 2011. However, the increase in reporting of any harm since September has been maintained, and as indicated above is likely to be due to improved completion rates of this field in Datix®. Approximately 18% of medicines-related incidents reported in Q3 of 2013/14 (48/270) were reported as resulting in patient harm ('low - minimal harm' (42) and 'moderate - short term harm' (6)); there were no 'severe' or 'catastrophic' harm outcomes reported. **There was ONE medication 'Never-Event' relating to opioid overdose of an opioid naïve patient reported in December**; this has been reported externally as a Serious Untoward Incident, and is being investigated within the Planned Care & Surgical Division. Graph 4 shows the overall trend numbers of medication incidents per 1000 occupied bed days.

Graphs 3 & 4:





Improving Medicines Safety Awareness

Nursing staff from the Trust have had the opportunity to undertake some joint training with colleagues at NUH that was dedicated to Medicines safety.

The Trust delivered a new development day for student nurses who were approaching the end oft heir nurse training which incorporated specific training related to medicines safety awareness.

Medicines Safety Messages

- The Trust multidisciplinary Medicines Safety Group has been re-established in order to provide a focal point for the review, analysis and learning from medicines safety incidents and near-misses. Terms of reference have been approved by the Drug and Therapeutics/Medicines Management Committee, and will be able to provide an oversight on 'harm' interpretation.
- This group will lead the development of a Medicines Safety Strategy, which will form part of a broader Medicines Management Strategy being developed by the Chief Pharmacist.
- All Trust staff (including medical staff) need to be encouraged and supported to report medicines-related incidents and near-misses (especially those relating to medication 'Never Events' and other high-risk medicines).
- A key principle of medicines optimisation (helping patients to make the most of medicines) is ensuring that medicines use is as safe as possible.
- Improving the safe use of medicines and minimising the potential for harm is the responsibility of all Trust staff.
- Improving medicines safety has been identified as a significant issue for the Trust; the recent publication of a draft Patient Safety Alert by NHS England proposes that all NHS organisations identify a Medication Safety Officer to be a member of a proposed National Medication Safety Network.

Q3- Nutrition Summary

Meeting our patient's nutritional and hydration needs is a fundamental priority at the Trust and an area that is carefully monitored through monthly nursing metrics and observational visits. Through the Trust's own internal quality monitoring processes we have acknowledged the need to strengthen and reenergise the importance that these elements of care play in the overall wellbeing of patients. Since the Care Quality Commission inspected the Trust in July and found a concern with nutrition, an intensive improvement programme has been delivered.

CQC Report Findings	Key Actions During Quarter 3
Patients were not fully supported to be able to eat and drink sufficient to meet their needs	• Following the launch Of 'Making Mealtimes Matter' across the Trust work is now being done to ensure the standards are embedded into practice There have been 2 further point prevalence audits undertaken in order to review progress. The results are being used in conjunction with nursing metrics, PLACE audit findings and outcome guardian visits to identify areas of good practice and highlight areas requiring further support. • The completion of nutritional intake charts and nutrition care plans are areas of particular focus. • The task and finish group is now being replaced by a monthly Nutrition Steering Group to ensure plans for the future are sustained.
Strengthen guidance for staff/patients	• The Nutrition and Hydration Policy has been revised and implemented. • Adherence to the red tray and red lid jug guidance is being monitored through the regular mealtime observation audits. • Redesigned resources that inform both patients, their carer's/relatives and staff of the support available to them in ensuring individual needs of patients are met have been distributed
Nutrition and Hydration training for staff to be reviewed and developed	• A comprehensive nutrition training plan for all staff has been developed and commenced. Funding has been granted to strengthen training for non-registered staff. • We are continuing to work in partnership with catering colleagues to ensure that all staff involved with the meal time initiatives work together proactively • The Nutritional Link nurses are now actively involved in regular mealtime auditing. This role will continue to be strengthened to support the principles of nutrition

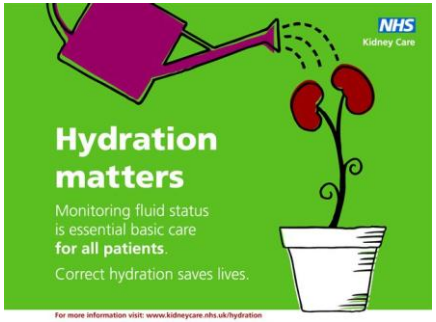
All staff have a responsibility to support the nutritional needs of our patients. By strengthening and sharing best practice, we will ensure the very best outcomes are achieved.

– Executive Director of Nursing and Quality

Q3 –Hydration Summary

An accurate intake and output record provides valuable information for assessing and evaluating a patient's condition. Fluid balance assessment and documentation has been identified as an area of care that we need to improve in.

In August 2013 a hydration workshop was held, this was attended by a multi-professional group of staff who contributed ideas which have been developed into a plan to improve the way we support patients with their hydration needs. A multi-professional Hydration Improvement Group has been established.



A trust-wide mandatory joint training programme for all registered nurses and healthcare support workers commenced in September 2013 , providing an update on all patients' hydration needs and some of the service improvement projects currently underway.

Hydration training will now be included during induction for new clinical staff.

KEY ACTION PLAN

- Development of a new Hydration risk assessment tool to identify when patients require more support to maintain their hydration and to direct health professionals' on the appropriate care actions to be undertaken.
- Development of a new Hydration chart in addition to existing Fluid Balance chart.
- Development of a designated set of hydration quality measures to be incorporated into the FOCUS IT care metrics from October 2013.
- Development of new hydration information for patients and staff.

Fundamental Standards for Hydration Care

- All patients will have immediate access to fresh water at their bedside unless restricted or inhibited by their clinical condition. This will be within the patient's reach.
- Water will be served fresh from clean, intact, drinking vessels suitable for individual patient dependency needs.
- Patients will be provided with a hot drink several times per day by the ward hostess service, but should feel able to ask for additional drinks at any time of the day or night.
- For those patients requiring fluid balance monitoring there will be a consistent approach to the measurement of oral intake.
- Where fluid balance charts are required they will be completed correctly.
- Red-lidded jugs will be used for those deemed to be at high risk of fluid imbalance.

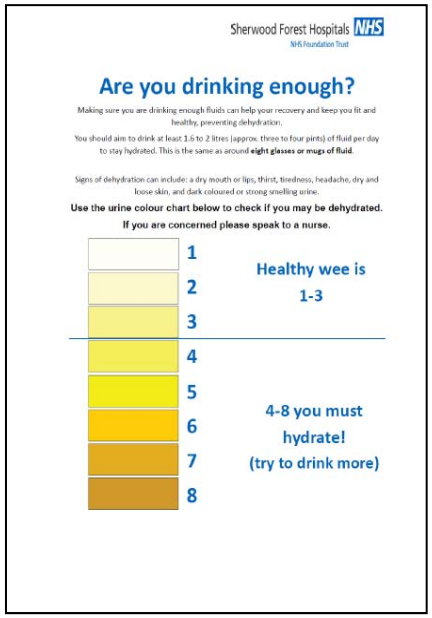
Q3- Hydration Summary cnt

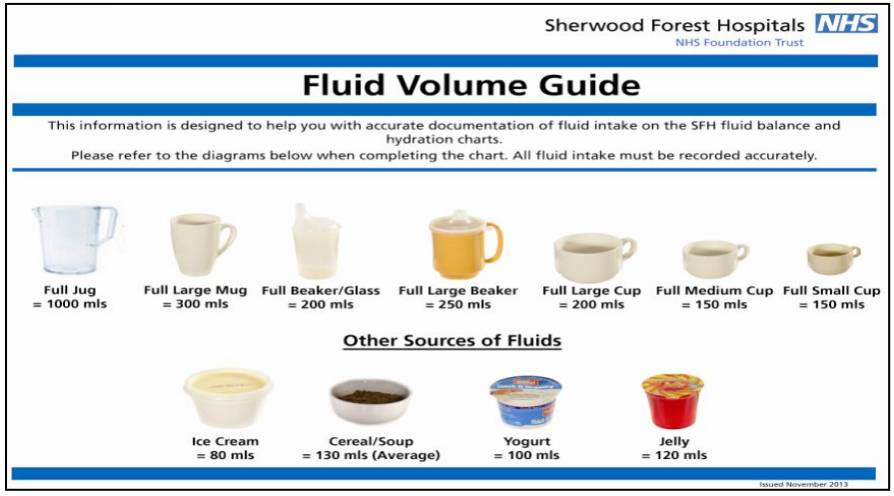
Improvement Work

A programme of service improvements and education has been implemented over the last three months, including a hydration risk assessment tool, a hydration chart for those at low risk of fluid imbalance issues and the 'Are you drinking enough ' colour chart for monitoring urine; all of which help ward teams to promote patients' oral intake.

CCOT have supported the delivery of specific hydration improvements and education to ward nursing teams to ensure all frontline staff receive this training. In addition Hydration training has been delivered to 450+ staff.

The Trust delivered a new development day for Student Nurses who were approaching the end of their nurse training, which incorporated specific training related to hydration care.





Knowing how we are Doing

Ten patients and their nursing records were reviewed on every ward across all three hospital sites, commencing October 2013, by a senior nurse from a group trained to evaluate care using the Focus IT metrics system. The sample was monitored for compliance with the fundamental standards.

The results of this audit are very encouraging. Access to oral fluids was consistently good.

- All individual patients had access to oral fluids at the bedside (100%). The jug, with fresh water and a drinking vessel were found to be within the patients' reach on all but two occasions.
- If patients wanted additional fluids, those questioned felt able to ask for supplementary drinks.
- All patients who were deemed to be at risk of fluid volume imbalance were served from a red-lidded jug in 100% of occasions.

Areas of hydration care that are working well are access to oral fluids and use of the red-lidded jug system. But the key area for improvement continues to be completion of fluid balance chart. A further deep dive audit will highlight specifically what further changes need to be made.

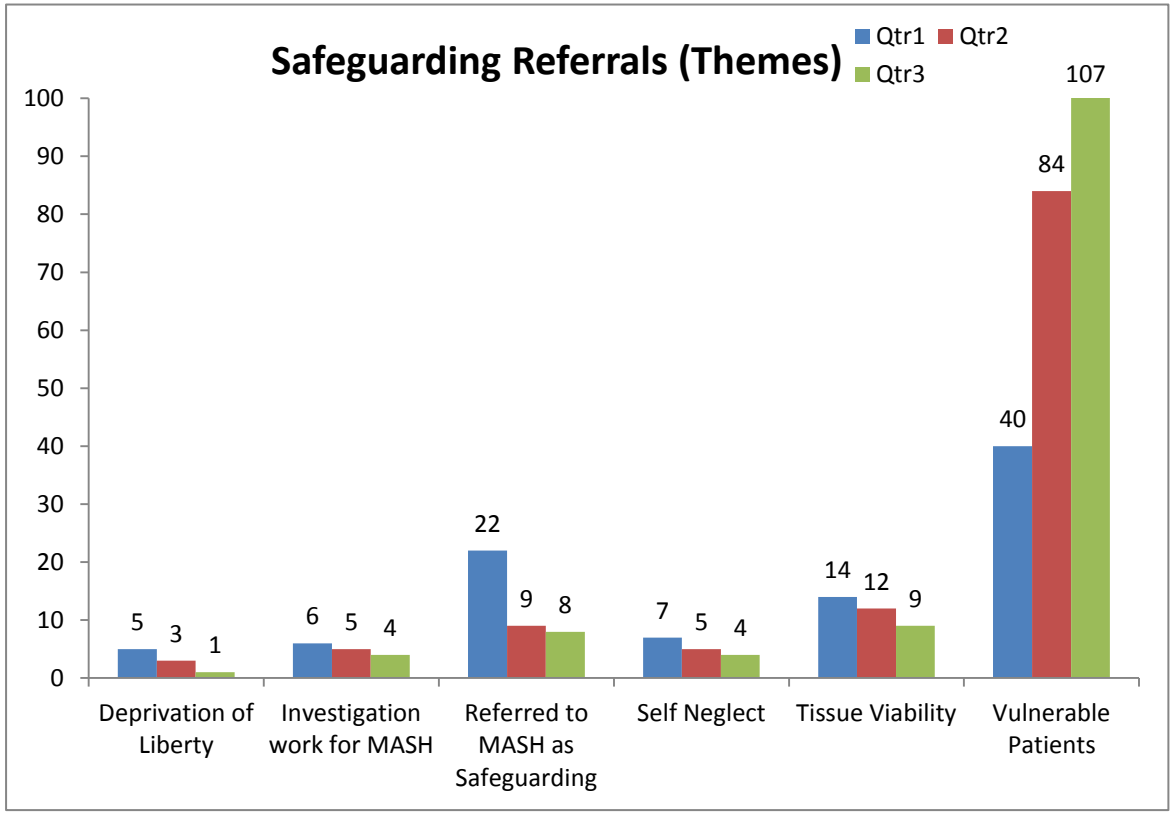
Posters depicting a range of drinking vessels found across the Trust, labelled with their specific volume content, were disseminated to all wards. The audit showed that in November and December there was a more consistent approach measuring volumes of fluid consumed by patients.

Q3 – Safeguarding Adults Summary

There have been 165 referrals to the Trust's Safeguarding adults team which is an increase from Q2 when 152 referrals were made. In Q3 16 of the 165 patients referred necessitated a referral to the Nottinghamshire Multiagency Safeguarding Team (MASH). This is a slight increase in the amount of referrals made Q2 when 9 were made to MASH. We have found no special causes for this.

During Q3 an Independent Management review (IMR) has been completed and submitted to the Nottinghamshire Safeguarding Adults Board (NSAB), for the current Serious Case Review (SCR). A Transfer letter from Emergency department (ED) to other care settings has been developed and is being piloted in ED.

In Q3 there has been another significant rise in the number patients in the vulnerable patient's category to 107 see graph below. The contributing factors are increased staff awareness due to staff attendance at the vulnerable Adults and mental capacity study days and discharge planning complexities.

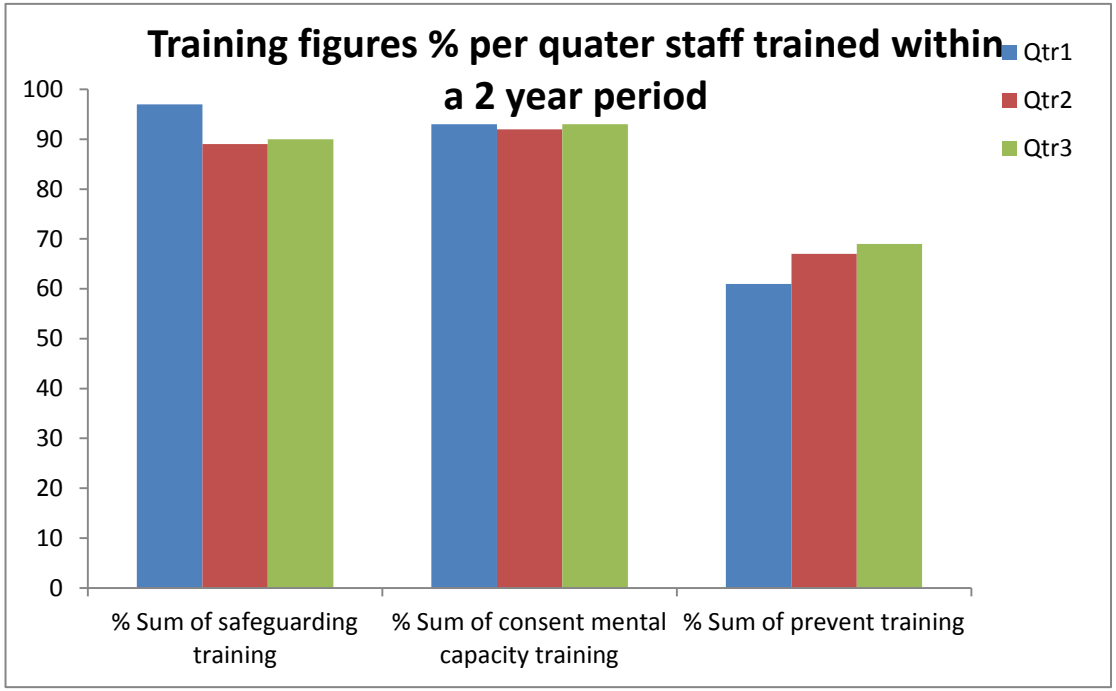


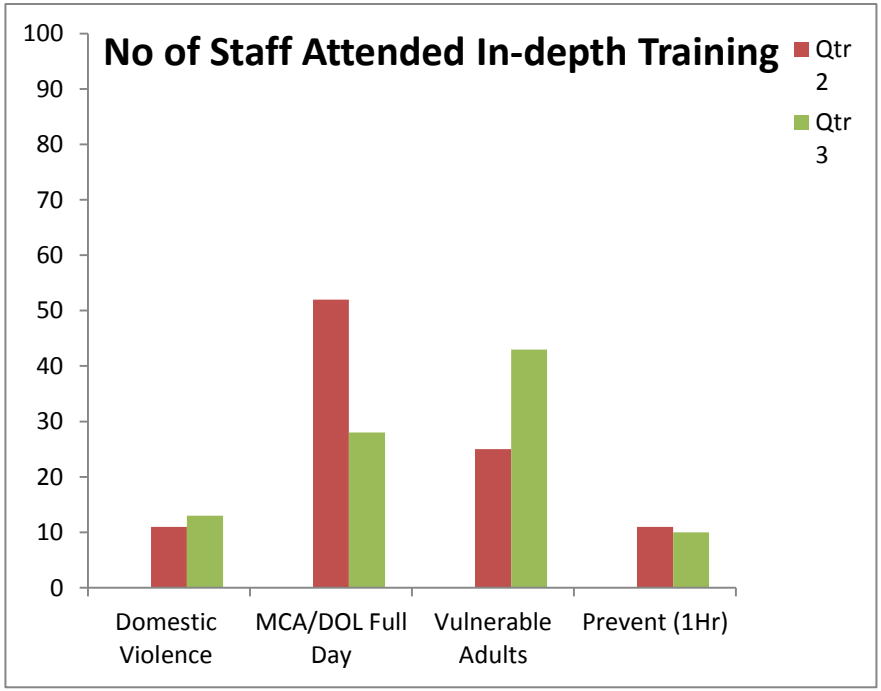
The Safeguarding Adults Steering group

The Trusts steering group meets bi – monthly. To date, it is chaired by the Executive Director for nursing and quality or her deputy. The Dementia, Learning Disability and Domestic Violence work streams report to this group.

- This group reviews the training and referral data on a quarterly basis any exceptions are actioned.
- The vulnerable adults work is reviewed and updated.
- Any relevant policies are discussed and updated.
- In Q3 the Trusts Safeguarding Adults and Deprivation of liberty policies have been reviewed in line with the updated Nottinghamshire Multiagency polices.

Q3 – Safeguarding Adults Summary cnt





Training

Mental Capacity Act (MCA)
The programme of MCA training for Consultants by solicitors has been complete. Training sessions regarding MCA in practice are being requested by individual medical specialties. The programme of Mental Capacity Act and Deprivation of Liberty Training has been reviewed for 2014.

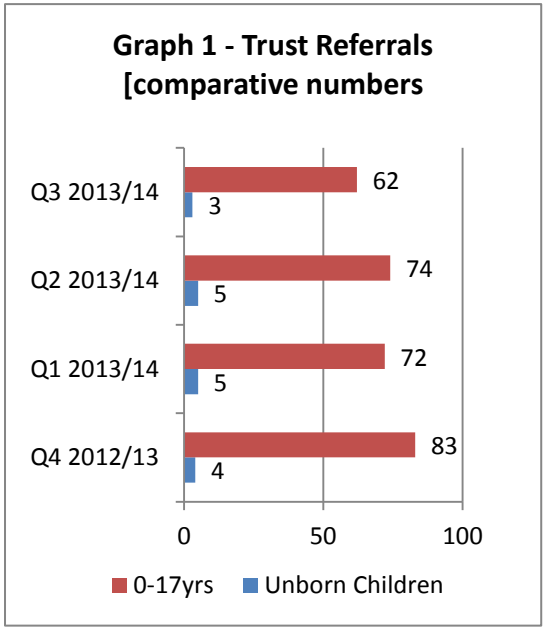
Vulnerable Adults
A new programme of vulnerable Study day days have been opened up outside organisations in Nottinghamshire. These training days have been reviewed and deigned to accommodate both internal and external participants to enhance staff learning of vulnerable adults across all agencies.

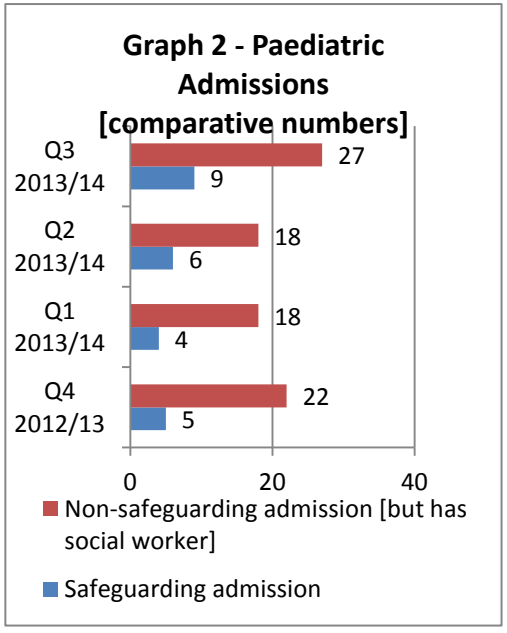
Prevent
Prevent is part of the Government's counter-terrorism strategy. Prevent is about recognising when vulnerable individuals are being exploited for terrorist-related activities. It is high on the Government's agenda. The Trust lead is the Safeguarding Adults Advisor. The training needs of staff have been risk assessed, awareness sessions are included in the mandatory training programme and staff in certain roles receive the hour long 'Health WRAP' training.

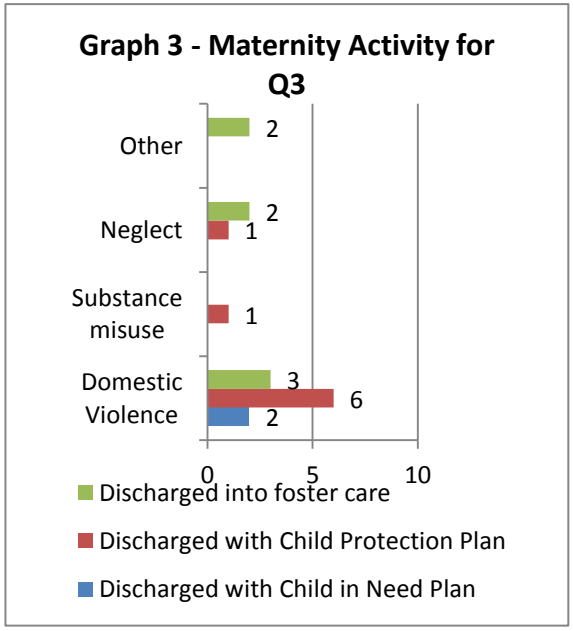
Q3 – Safeguarding Children & Young People Summary

Safeguarding Children and Young People Summary

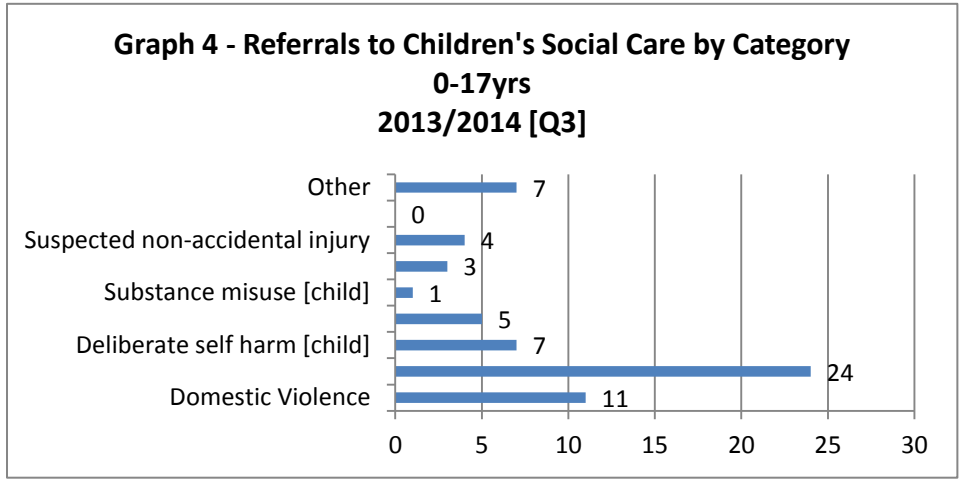
During Q3 Trust **r**eferrals to Children's Social Care for 0-17 year olds and unborn children decreased slightly [graph 1]. Paediatric safeguarding admissions and paediatric admission of children who were already under the care of a social worker increased [graph 2]. There were no obvious reasons for either change. Maternity activity for Q3 [graph 3] remained comparable with Q2 as were the reasons referrals were made [graphs 4 and 5].
Due to its success the system put in place in ED during Q2 to ensure that all children requiring additional paediatric liaison were correctly identified was implemented in MIU & UCC in Q3. The development of the electronic safeguarding alert for ED which would automatically notify staff if a presenting child was subject to child protection plan is currently awaiting development by TPP. Concerns that the development has not progressed have been escalated by the Safeguarding Children and Young people Governance Meeting. Training compliance continues to remain challenging despite additional training sessions being offered in Q2; compliance concerns have been escalated to Divisional Governance Meetings.
A Serious Case Review involving the Trust was also initiated in Q3; the required chronology and report are currently being prepared.

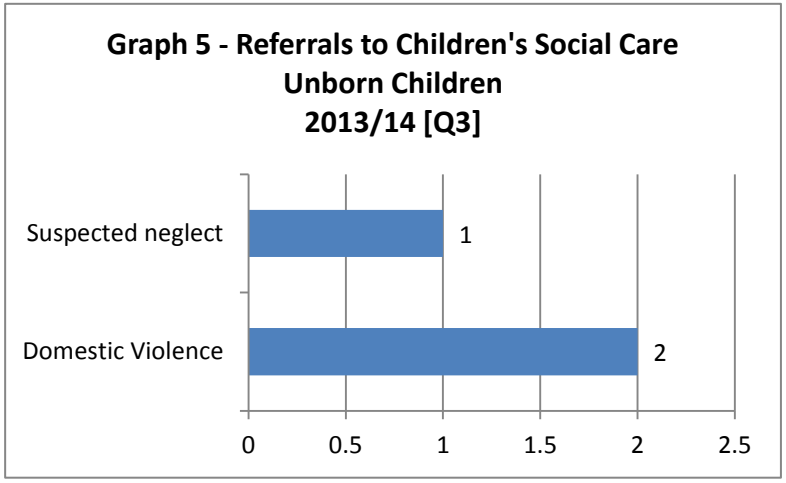


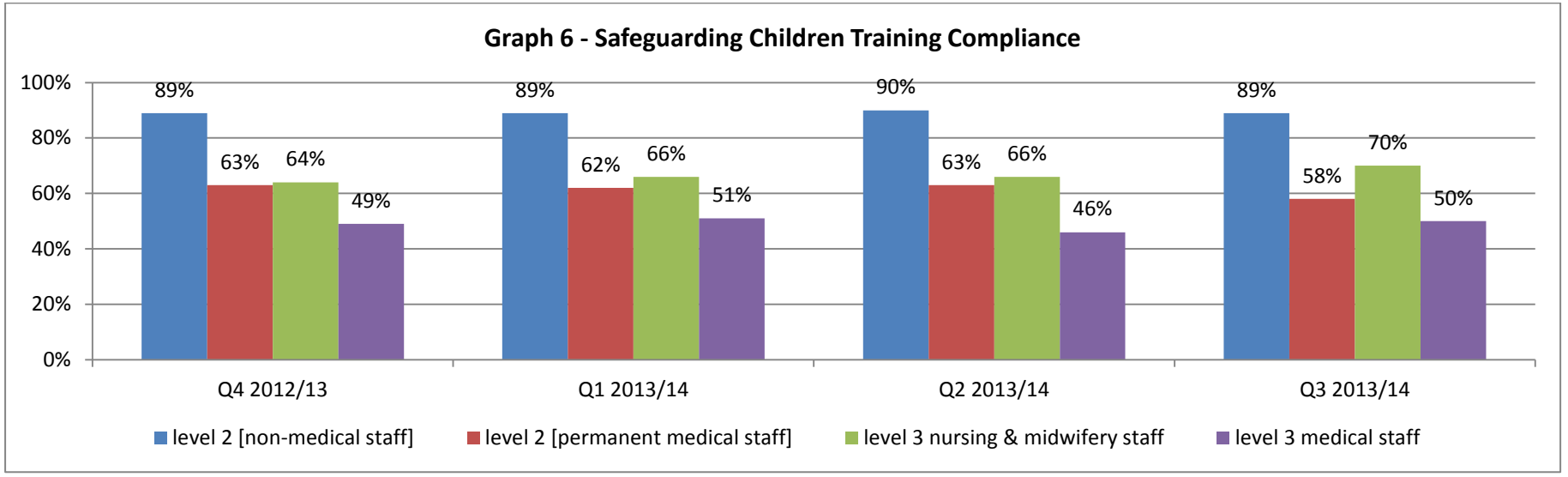




Q3 – Safeguarding Children & Young People Summary cnt







Sherwood Forest Hospitals NHS
NHS Foundation Trust

Q3 - Learning Disability Summary

During Q3 there have been 111 referrals to the LD nurse to support with complex patients. The Hospital's Learning Disability Steering Group met in November 2013 (see photo) and discussed how the group feeds back to Healthwatch, adult changing places possibilities for SFHFT sites, how to involve patients in the Guardian audits for safeguarding and consent.

You Said

1. **Family Carer: 'There needs to be an adult changing places toilet at Kings Mill Hospital as currently people visiting the outpatients department do not have equal access to toileting facilities'.**
2. **Patient: Highlighted by a patient that he had not been given meal choices in a way he understood**
3. **Family Carer: The trusts process for electing a governor disadvantaged people that had learning disabilities or people that are unable to write, as a new declaration stated for the vote to count the form needed a signature.**

We Did

1. **The trust has met with the complainant and discussed requirements. The draft drawings have been shared for discussion at the Learning Disability Steering Group. The build is due to be completed by April 2014.**
2. **Picture Menu's made available and training on communication given to medirest staff.**
3. **We checked the constitution; there is a section in there about giving help to voters with disabilities. We met with the Company Secretary and the Trust will make sure all voters have contact information early on in the process to get the help they need, so their vote is counted.**

Joint Learning Disability Health and Social Care Self-Assessment Framework.

The trust contributed towards the Learning Disability Self-Assessment. This year questions included social care and the questions were different from previous years. We were asked to provide evidence of:

- Training undertaken for Mental Capacity Act and Deprivation of Liberty - 93% of staff had undertaken this training.
- The trust was asked to provide data around how many LD patients were admitted to our services (outpatients 230, inpatients 220, and emergency department attendances 398).
- RAG rate maternity services on the ability to recognise ladies with LD and make reasonable adjustments to services to give individualised care –rated Green. From these links with maternity we have now agreed that LD awareness training would be of benefit to midwives and this has been arranged as mandatory training from April 2014.

Q3 – Maternity Summary

Midwife to Birth Ratios

As highlighted already, in November 2013, NHS England produced a document called "How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability". This guidance, seeks to support organisations in making the right decisions and creating a supportive environment where their staff are able to provide compassionate care. It describes Birthrate Plus® as the only national tool available for calculating midwifery staffing levels. It was developed 24 years ago and has now been applied in the majority of NHS Trusts in the UK and Ireland, being modified and developed to reflect changing models of care and working patterns.

At its simplest Birthrate Plus® can provide any given service with a recommended ratio of clinical midwives to births, in order to assure safe staffing levels. The methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period. From these quantifiable needs of women, Birthrate Plus® provides insights and intelligence to inform decisions about staffing numbers, staff deployment, models of care and skill mix.

We last completed this for our CNST assessment and will undertake it twice a year. In quarter 3, we saw a drop of 1.6% births on the same period of last year with a total of 863 births; a lower rate than quarter 1 and 2. This gives a ratio of 1:28.4 against funded establishment, which for the first time includes our newly trained maternity assistants and is satisfactory. However we are experiencing a high natural turn over of staff at the moment and recruitment is challenging, which would make our in post position approximately 1:30.5. We are looking at different recruiting strategies with colleagues in Human Resources.

Forthcoming Visits in Quarter 4

- NMC Local Supervising Authority review 5th and 6th February.
- Local Supervising Authority Annual Audit 26td February
- Baby Friendly Level 3 Accreditation Visit 26th and 27th February

CNST – Maternity standards

Our Level 2 Visit was on 11th and 12th November, at which we were successful in scoring 48 out of 50. The assessors were very complimentary of our preparation for the visit and made a few minor recommendations for the service. An action plan has been developed to monitor progress against these.

National Maternity Survey

At the end of Quarter 3 we received our initial maternity survey results. Out of 38 criteria, we were in the top 20% for 13 and the bottom 20% of Trust for 5. The senior midwives and obstetricians are currently interrogating these results in more detail and developing an action plan to address the key areas where progress is needed.

CQC External Assurance Process

The New Wave of CQC Inspections & Monitoring

The CQC has re-designed its collation of evidence and data streams in regards to preparing for inspections. The 'new wave' is developing its systems to have Key Lines of Enquires (KLOE's). The aim is that these domains of inspection are both more meaningful to inspectors and more importantly to those that are inspected.

Sir Mike Richard's, Chief Inspector of Hospitals, enlisted an 'Army' of inspectors to concentrate on a new set of CQC Indicators. These have been devised to focus attention on the fundamental standards, whilst recognising the essential requirement to prioritise the importance of safety.

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

Historically, the Quality Risk profile (QRP), was prepared monthly by the CQC to reflect the Trusts performance and signposted the CQC prior to an inspection. The information provided in the document tended to be retrospective and Trusts questioned its integrity at times. As part of Behan's (Chief Executive Officer of the CQC) remodelling of the CQC's infrastructure, the QRP has now been disestablished.

The replacement document has a range of key indicators that relate to the five domains. The newly established Intelligent Monitoring Report's (IMR) format will now inform their reviews from October 2013. The IMR will also signpost the CQC to where and when it inspects; importantly the CQC has indicated that they will further develop its indicators during the first wave of inspections; and use them as a basis for enhancing their inspections in the future.

The new set of CQC Indicators have now been devised to maintain attention on the new fundamental indicators. The CQC will be assessing Trusts using a risk-based approach as to whether Trusts are safe, effective, caring, well-led, responsive to people's needs and subsequently the CQC will be allocating an overall score based on their assessment. The IMR risk based scores are identified by:

- No evidence of risk
- Risk
- Elevated risk

Banding has now been established across 161 acute and specialists Trusts. There are six summary bandings. Band 1 represents the highest risk whilst band 6 the lowest. At this time it is the intention of the CQC to review Trusts from each of the banding areas to further develop their new method of inspection and refine their indicators.

The rating system will be similar to that of Ofsted inspections, and although these have not yet officially been announced, it is widely accepted that these will be the ratings set across the five domains of safety in future inspections.

Sherwood Forest's Intelligent Monitoring Report

1. What is CQC's Intelligent Monitoring?

The new Intelligent Monitoring tool has been developed to give our inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust or a specialist NHS trust. The system is built on a set of indicators that look at a range of information including patient experience, staff experience and performance. The indicators relate to the five key questions we will ask of all services:
are they safe, effective, caring, responsive, and well-led?

2. How will CQC use this analysis?

CQC will use the indicators to raise questions about the quality of care, but we will not use them on their own to make final judgements. These judgements will always be based on a combination of what we find at inspection, intelligent monitoring analysis and local information from the trust and other organisations.

3. How have the indicators been selected?

The indicators are those that we consider to be the most important for monitoring risks to the quality of care in acute hospital services. We selected these indicators because they measure things that have a high impact on people and because they can alert us to changes in those areas. We have engaged and consulted, and we tested the indicator set with a wide range of stakeholders.
Our inspection programme will help us to refine the intelligence monitoring tool.

4. How is Sherwood Forest Hospitals Foundation Trust rated?

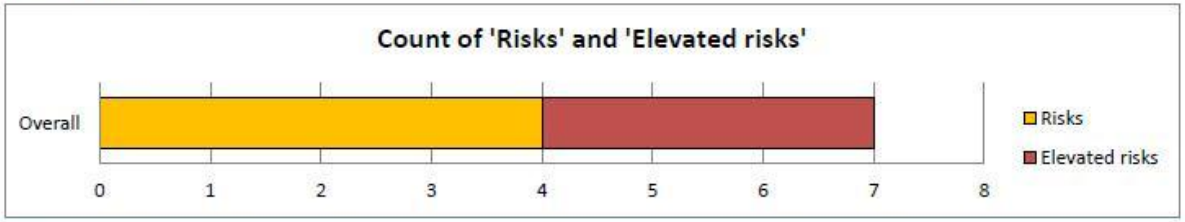
As expected we are shown to have an elevated risk associated with mortality and are rated as a level 1 Trust (see excerpt from our IMR below). The alert associated with cerebrovascular disease has been investigated and should be down graded by the next report. We are also rated as 'elevated risk' for whistleblowing and we are working through how this is measured with our CQC assessors. We are aware of one

whistleblowing alert during Quarter 2 around early morning medications, which we have investigated fully and subsequently communicated our findings with the CQC. Our overall score is also influenced by further risks associated with having a recent never event, governance risk rating and higher than average levels of staff sickness.

We are also working with the CQC to understand the risk identified around under reporting of safety incidents resulting in death or serious harm. Our initial response is that this is associated with the data issues we experienced in Quarter 3 with the National Reporting System (discussed within the serious incidents section of this report).

Sherwood Forest Hospitals NHS Foundation Trust

Trust Summary



Band	1*
Number of 'Risks'	4
Number of 'Elevated risks'	3
Overall Risk Score	10
Number of Applicable Indicators	85
Proportional Score	5.88%
Maximum Possible Risk Score	170

Elevated risk	Dr. Foster: Composite of Hospital Standardised Mortality Ratio indicators
Elevated risk	Composite indicator: In-hospital mortality - Cerebrovascular conditions
Elevated risk	Whistleblowing alerts
Risk	Never Event incidence
Risk	Potential under-reporting of patient safety incidents resulting in death or severe harm
Risk	Monitor - Governance risk rating
Risk	Composite risk rating of ESR items relating to staff sickness rates

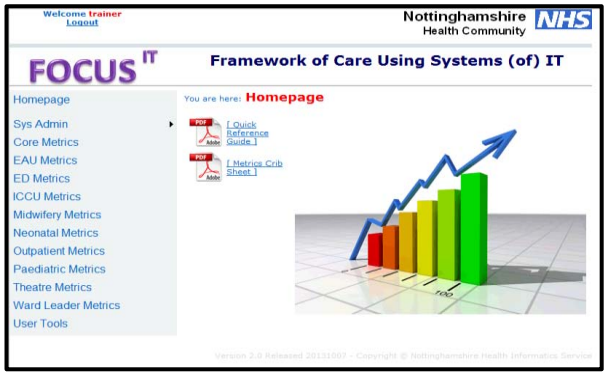
We will continue to actively review any further national guidance around this new monitoring framework, so we can ensure we fully understand the reasons behind our overall rating. We are also attending regional and national events to ensure we fully embrace this new approach and utilise it to improve our compliance with quality and safety outcomes.

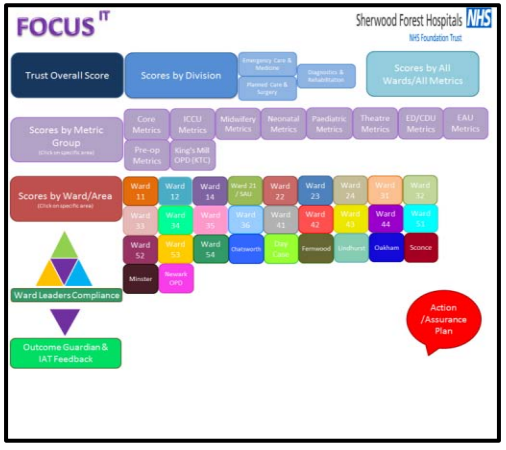
Internal Assurance Process

We are currently reviewing our Guardians of Care model to ensure that our Trust wide assurance framework evolves and meets our needs, it is vital that the trust notes feedback from staff on how it can improve the quality of patient care. The initial re-design meetings have been scheduled and the team is bringing together elements of Governance, safety and assurance to create a clear framework that enables us to sustain the work we have done already in establishing the guardians of care model and the internal assurance team reviews. The aspiration is that the new model will be in place by summer, and whilst this is being developed the present structure will provide the assurance that the Trust requires.

As part of this development work we need to ensure we have an assurance tool that supports this robust framework and we will be building on the work we have done with FOCUS to design a system that supports our staff to monitor care and action plan effectively. Following a successful bid application to the 'Safer Hospitals, Safer Wards Technology Fund' we have secured funding to develop and strengthen this system. We are working with colleagues in IT and clinical teams to design the system over the coming months. We are keen that this tool also incorporates a more interactive and accessible version of the ward assurance matrix.

FOCUS IT





Sherwood Forest Hospitals NHS
NHS Foundation Trust

Agenda Item:

Board of Directors Meeting Report

Subject: **Patient Experience Quarterly Report**
Date: **Thursday 29th January 2014**
Author: **Susan Bowler / Jill Faulkner**
Lead Director: **Susan Bowler – Executive Director of Nursing & Quality**

Executive Summary

The aim of this report is to pull together all of the patient experience data into one report. A number of actions that have been implemented to respond to and improve the patient experience have been referenced within this report, but more detail is provided within the quarterly patient safety and quality report.

Key highlights from the Patient Experience Report are as follows:

- The Customer Services PALS team received 1700 contacts during Q3, 236 of these contacts were 'Compliments' and 870 were 'concerns'. The top two 'concerns' themes received were 'communication' (42.5%) and 'waiting times queries' (18.3%).

- The Trust has received 182 new complaints between October and December, which is a 14% decrease on the previous quarter. The 182 complaints received in this quarter reflects an 18% decrease (218) on the number of complaints received in the same period last year.

- During Q3, 4295 patients chose to respond to the Friends and Family Test. A response rate of 21.8% discharged in-patients and ED patients who were eligible to participate was achieved during the quarter. The Trust continues to demonstrate excellent results with many of our patients choosing to recommend SFH as a place to be cared for. Q3 also saw the introduction of the Friends and Family Test for the Maternity Services Pathway and for one additional ward at King's Mill Hospital.

- In September 2013 the Trust re-introduced an 'In Patient Experience Survey'. This survey captures feedback monthly basis all adult inpatient wards across three hospital sites. During Q3 865 patients took part in this survey. Results suggest that patients are:

    - happy with their care and treatment and with the information provided to them by the clinical teams
    - very happy with the cleanliness of the wards and satisfied with the meals provided to them
    - treated with dignity and respect
    - likely or extremely likely to recommend our hospitals to their friends and family
    - The results also indicate areas where we can make improvements – for example during this quarter a third of the patients surveyed had not been made aware of how they could raise issues and concerns. The survey also provides the opportunity for patients to express any issues and enable 'on the spot' resolution.

Recommendation

The Board is asked to note:

- The continual progress in developing our patient experience agenda.
- The consistent complaints performance that has been maintained since the visit of external regulators
- The development of the patient experience service, with clinicians positively changing the culture towards complaints management.
- The openness that has developed around displaying information to our public and patients on our wards

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	Achieve financial sustainability
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	BAF 1.3, 2.1, 2.2 2.3, 5.3, 5.5
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Failure to deliver the Keogh action Plan and be removed from 'special measures' Risk of being assessed as non-compliant against the CQC essential standards of Quality and Safety, particularly in relation to Outcome 17 Complaints
Links to NHS Constitution	Principle 2, 3, 4 & 7
Financial Implications/Impact	Indirect financial implications – patients not being referred to SFH or not choosing SFH as a consequence of poor patient experience. NHSLA and Ombudsman implications – gratuity payments
Legal Implications/Impact	Reputational implications of delivering sub-standard safety and care
Partnership working & Public Engagement Implications/Impact	This paper will be shared with the CCG Performance and Quality Group, governors, Patient Engagement work and the Patient Quality and Experience Committee
Committees/groups where this item has been presented before	CMT
Monitoring and Review	Complaints performance is monitored daily and assessed weekly
Is a QIA required/been completed? If yes provide brief details	No

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Patient Experience Report
October, November and December 2013

Sherwood Forest NHS Foundation Trust

Trust Board Report

Quarter 3

Introduction

The Patient Experience Report aims to present a rounded picture of patient experience and provide information on all aspects of experience, both good and less positive. Where poor experience is reported and identified, actions are taken to ensure improvements are made and the outcomes will be documented in future reports.

The reports present a wide range of information from different sources. Including the following:

- Compliments
- Friends and Family Test
- SFH Patient Surveys
- Service Improvement Projects
- Complaints
- Patient Advice & Liaison Service (PALS)
- Voluntary Services

It is recognised that each method of feedback provides a rich source of data and information and should not be taken in isolation. Each method has its strengths and weaknesses, therefore, where possible data and information is triangulated to determine if there are patterns emerging and pointing the Trust to particular challenges and concerns which will require addressing. Using all methods of information available enables the Trust to better understand the patient's experience of the services offered and delivered, and is beneficial to assist in prioritising the focus of change and service improvement.

Headlines:

- The Customer Services PALS team received 1700 contacts during Q3; 236 of these were ‘Compliments’ and 870 were ‘Concerns’.
- The Trust has had a further inspection by Keogh and it was acknowledged the complaints backlog had been eliminated.
- The number of complaints received in Q3 was 182.
- The Trust’s performance for replying to complaints within the timeframe given i.e. 20, 40 or 60 working days was 85%.
- During Q3, the Parliamentary Health Service Ombudsman (PHSO) upheld 1 complaint, 6 are being assessed and 4 are under investigation.
- During Q3 6 new cases were referred to the PHSO
- The key concerns identified in complaints across all divisions during this quarter are predominantly attitude and clinical treatment.
- In Q3 865 patients participated in the Trust’s ‘Monthly In Patient Experience Survey’ (referred to as ‘Frequent Feedback Survey’ in Q2 report). The survey is undertaken across the King’s Mill, Newark and Mansfield Community Hospitals sites and provides an ‘on the spot’ reflection of patients views. The questions set are reviewed quarterly.

Executive Summary:

Key highlights from the Patient Experience Report are as follows:

- The Customer Services PALS team received 1700 contacts during Q3; 236 of these contacts were 'Compliments' and 870 were 'concerns'. The top two 'concern' themes received were 'communication' (42.5%) and 'waiting times queries' (18.3%).
- The Trust received 182 new complaints between October and December, which is a 14% decrease on the previous quarter. The 182 complaints received in this quarter reflects an 18% decrease (218) on the number of complaints received in the same period last year.
- During Q3, 4295 patients chose to respond to the Friends and Family Test. A response rate of 21.8% discharged in-patients and ED patients who were eligible to participate.. The Trust continues to demonstrate excellent results with many of our patients choosing to recommend SFH as a place to be cared for. Q3 also saw the introduction of the Friends and Family Test for the Maternity Services Pathway and for one additional ward at King's Mill Hospital.
- In September 2013 the Trust re-introduced an 'In Patient Experience Survey'. This survey captures feedback monthly from all adult inpatient wards across three hospital sites. During Q3 865 patients took part in this survey. Results suggest that patients are:
    - happy with their care and treatment and with the information provided to them by the clinical teams
    - very happy with the cleanliness of the wards and satisfied with the meals provided to them
    - treated with dignity and respect
    - likely or extremely likely to recommend our hospitals to their friends and family

  The results also indicate areas where we can make improvements – for example during this quarter a third of the patients surveyed had not been made aware of how they could raise issues and concerns. The survey also provides the opportunity for patients to express any issues and enable 'on the spot' resolution.
- The Medirest survey results were not available for this quarter however will be reported on in Quarter 4.

Contents

1.0 Compliments

Whilst complaints are one of the most valuable sources of feedback and learning for the Trust, it is also recognised that compliments provide rich data and information. Where patients and service users have had a good experience, it is helpful to share this learning with other staff groups and Trust clinical and non-clinical departments. Compliments are received through a variety of sources, including those documented in the local press. Whilst most thank you letters and cards are sent directly to wards and departments, the Trust's Customer Services team (PALS) and the Executive Officers, regularly receive letters of praise.

During Quarter 3, 236 compliments were directed to our Customer Services team.

Table 1

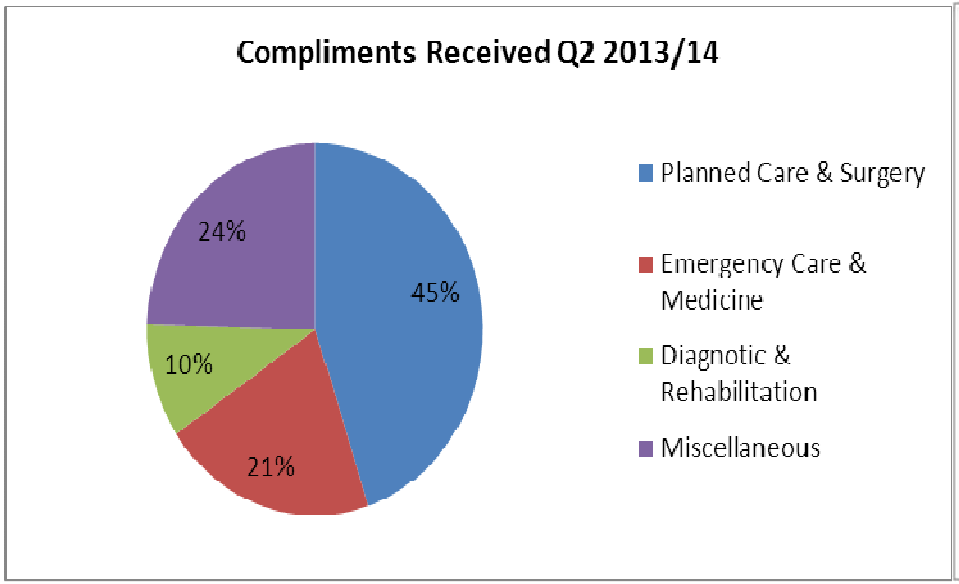
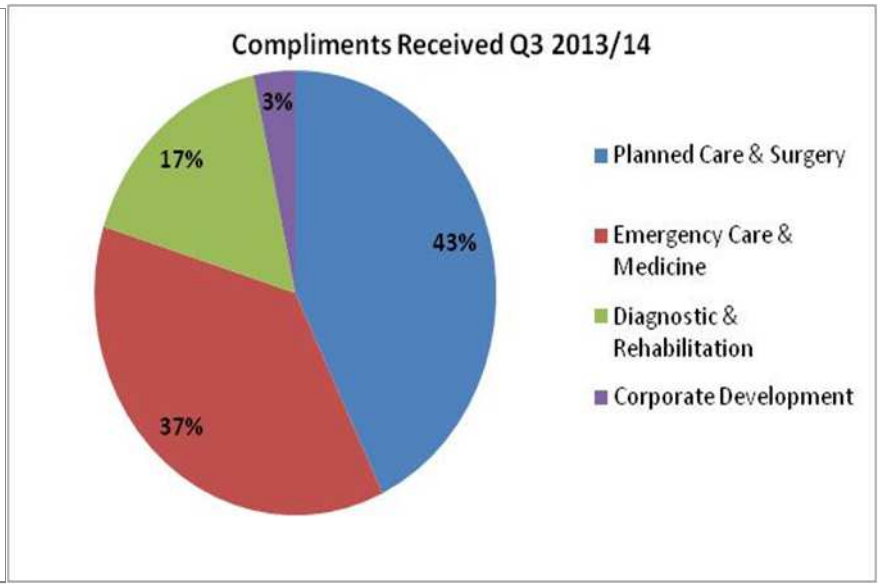


Table 2



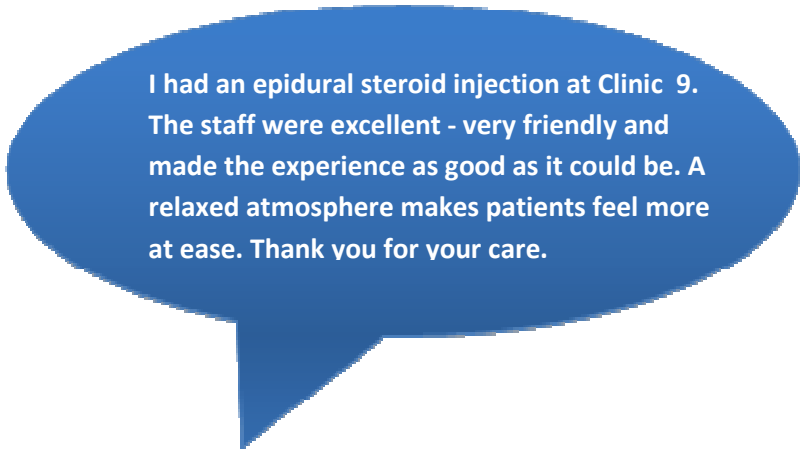
The number of compliments received remains constant throughout the year.

1.2 Patient Compliments

Mansfield Community Hospital, patient admitted to Lindhurst Ward

Newark Hospital, Minor Injuries Unit patient

King's Mill Hospital, patient admitted to Ward 31



Patient attending the Pain Management Out-Patients Department at King's Mill Hospital

2.0 Friends and Family Test

From April 2013 all acute hospital inpatients and emergency department patients have been given the opportunity to rate and review the services provided. Patients are asked to identify if they would recommend our hospital to Friends and Family. The Maternity Service Pathway survey commenced in October 2013.

The outcome of this survey is reported nationally at a Trust level and locally at a ward level. At the point of discharge from adult inpatient wards and from the emergency department a questionnaire and on-line facility are made available to leave a review. Maternity Services patients are also now able to review their care at four key touch-points.

2.1 Data Summary – July to December 2013 (Q2 & Q3)

Table 3

	Number of Respondents	Eligible Response Rate Acute In Patients	Eligible Response Rate A&E	Combined Response Rate for Acute In Patients and A&E	Maternity Services Response Rate	Net Promoter Score (+100 to -100)
July 2013	1087	30.1%	11.7%	16.8%	n/a	60
August 2013	1059	21.8%	15.3%	17.2%	n/a	60
September 2013	906	24.6%	13.5%	16.8%	n/a	60
Q2	**3052**	**25.5%**	**13.5%**	**16.9%**	**n/a**	**n/a**
October 2013	1327	33.1%	19.1%	23.3%	26.3%	64
November 2013	1400	24.6%	20.3%	21.6%	20.4%	62
December 2013	1568	22.6%	21.4%	21.8%	11.9%	62
Q3	**4295**	**26.8%**	**20.2%**	**22.2%**	**19.5%**	**n/a**

The Trust has a Commissioner Quality Initiative to meet at least a 15% response rate of eligible adult discharged inpatients, ED attendance patients and maternity patients (see section 2.6 below) to respond to the Friends and Family Test. Results are available on NHS Choices website.

2.3 Individual Ward Results – October to December 2013 (Q3)

Table 4

Month		EAU	ED	11	12	14	21	22	23	24	31	32	33	34	35	41	42	43	44	51	52	53	54	Min	Sco
Oct	***R**	4.7	4.5	4.9	4.7	4.7	4.7	4.7	4.9	4.6	4.8	4.9	4.7	4.8	4.5	4.5	4.9	4.9	5	4.6	4.3	4.7	5	5	4.7
	NPS	69.8	54.1	91.8	65.5	76.7	71.4	70.6	91.7	58	82.4	90.9	80	77.3	54.6	62.5	87.5	92.9	95.7	57.1	33.3	69.2	100	100	71.4
	RR (%)	15.6	19.1	52.6	50.8	26.5	31.2	22.8	47.1	187.2	21.3	44.9	31.5	27.2	70.8	78.3	47.3	15.6	31.3	43.8	23.8	24.1	46.2	27.6	18.9
Nov	***R**	4.6	4.5	4.7	4.8	4.9	4.9	4.8	4.8	4.8	4.8	4.7	5	4.6	4.5	4.8	4.8	4.8	4.9	4.8	4.9	4.9	5	5	4.6
	NPS	62.5	52.6	71.4	75	84.6	87.5	81.8	87.5	76.9	84.2	71.1	100	55.6	56.9	80	81	81.3	85.2	80	90	85.7	100	100	60
	RR (%)	8.8	20.3	36	35.1	8	25.2	22.9	30	52.8	21.3	33.9	13.2	14.1	119.1	57.7	51.1	15.5	39.7	33.3	26.3	11.7	61.5	21.7	14.3
Dec	***R**	5	4.5	4.7	4.8	4.9	4.5	5	4.7	4.6	4.8	4.7	4.8	4.6	4.5	5	4.9	4.9	4.9	5	4.4	4.9	0	5	4.6
	NPS	100	53.4	70.9	80	91.2	57.1	100	77	75	84	71.9	83.3	57.1	46.2	100	88	92.9	88.2	100	53	93.3	0	100	54.6
	RR (%)	21.4	1.3	38.7	50	20.9	13.9	4.1	25.5	34.7	28.3	34	10.3	16.3	97.1	12.5	43.1	16.9	24.3	10	53.1	30.8	0	28.1	44

***R= Star rating (max. 5 stars) NPS = Net Promoter Score RR= Response Rate**

N.B.: The Response Rate shows the percentage of patients who responded to the survey in relation to the number who met the eligibility criteria.

In Q3 2013/14 the Customer Services team introduced the Friends and Family Test across three wards at Mansfield Community Hospital and Ward 36 at King's Mill Hospital.

The Out Patient and Day Case Patient Friends and Family Test will role out in Q1 2014/15 for patients who attend our outpatient clinics and Day Case Unit. This is one year ahead of the national requirement for implementation.

2.4 Patient Comments from the survey

- Ward 14 – October 2013: 'staff were pleasant, ward clean, couldn't ask for more.'
- Ward 52 – October 2013: 'nursing team good. Negative – food often cool.'
- Accident & Emergency – November 2013: 'staff are friendly and do what they can to help. Try to cut down waiting times as you wait too long even though there are not many people to be seen.'
- Sconce Ward – November 2013: 'food good, care good, nothing to improve.'
- Ward 33 - December 2013: 'all the nurses are lovely and nothing seems to be too much trouble, there's nothing to improve.'
- Minster ward – December 2013: 'everyone friendly and attentive, any calls with the buzzer were answered very quickly, I felt totally treated as an individual, I had total confidence with the medical care at every level. The food was good, fresh and nicely presented.'

2.5 Improvement Actions

From December all wards display their Family and Friends results as part of the new ward performance boards. This new display provides opportunities for wards to state to patients and their carers, actions they are taking in response to feedback. These actions are updated at least monthly. Re-designing the Trust communication boards, we reviewed the presentation of the Family and Friends feedback. It was important that this essential feedback was presented in a format that ward and department leaders felt would be both motivational to their teams, but also importantly, displayed to relatives and patients the experiences of patients on their wards.

The communication boards have re-energised the focus on Family and Friends and give a simplified but informative opportunity for this feedback to be discussed and scrutinised at ward/ department level during team meetings

Actions implemented based upon patient feedback and ward discussions to improve the patient experience include:

- Ward 52 are trailing open visiting following relatives requests to visit more often to help support care, like falls prevention.
- New patient bed head boards are being implemented following numerous patient complaints and comments via friends and family data. It was noted relatives were unclear who was the named consultant or nurse. The magnetic white boards implemented across the geriatric wards have a number of purposes: they incorporate the care and comfort rounding (clocks) and in addition they display key patient safety factors e.g. falls risk, when the patient requires assistance to mobilise and dietary requirements. On the opposite side of the board is the named nurse/named consultant section, along with the predicted discharge date

2.6 Friends and Family Test - Maternity Services

From October 2013 the Friends and Family Test was introduced nationally across Maternity Services. The requirement is that we collect data at four specific touch points of the patient pathway – antenatal care at 36 weeks, care during birth (includes home and hospital births), post-natal care received whilst on the maternity ward and post-natal care received at home.

As a Trust we also wanted to be able to gather valuable data from patients who receive antenatal care on the maternity ward. As this is not a national requirement the score from this feedback is not included in the overall score.

Table 5

Month	Number of patients surveyed		Antenatal Care on the Ward (see above for further information)	Antenatal Care at 36 weeks (touch point 1)	Birth (Sherwood Birthing Unit) (touch point 2)	Home Birth (Community) (touch point 2)	Postnatal care on the Ward (touch point 3)	Postnatal care in the Community (touch point 4)
Oct	203	*R	4.5	4.6	4.8	4.7	4.6	4.7
		NPS	50	59.4	83.3	66.7	58.8	66.7
		RR (%)	n/a	40.2	21.1	30	40.3	6.2
Nov	181	*R	4.5	4.7	4.6	5	4.7	4.7
		NPS	50	64.7	75	100	70.2	72.7
		RR (%)	n/a	26.6	22.2	8.3	29.8	8.7
Dec	117	*R	4.8	4.9	5	5	4.7	4.6
		NPS	79	87.5	100	100	72.7	58.3
		RR (%)	n/a	15.9%	2.3%	12.5%	27.1%	4.9%

***R= Star rating (max. 5 stars)** **NPS = Net Promoter Score** **RR= Response Rate**

3.0 Patient Experience Surveys

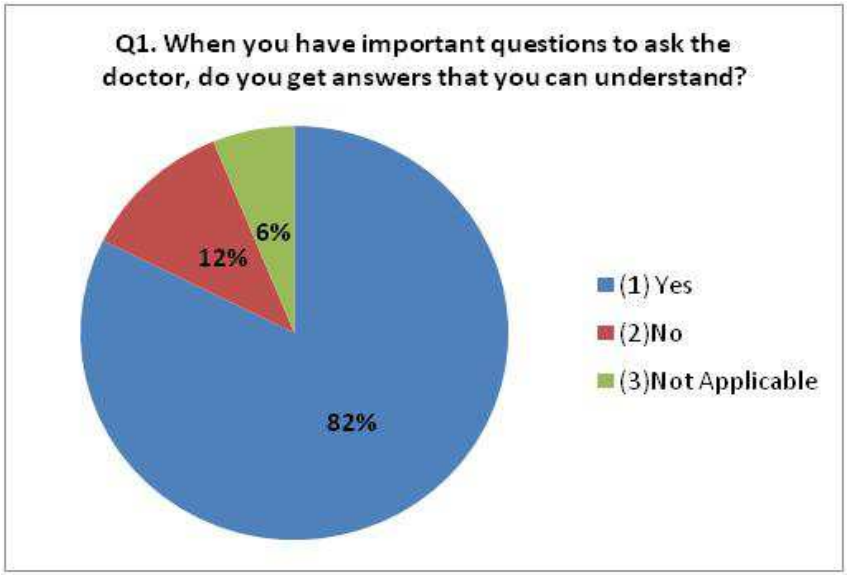
Data and information generated through patient surveys are seen as highly valuable and are used to inform the trust in measuring performance in meeting patient expectation, whilst providing direction for change. Divisional teams receive monthly reports from the patient experience data collected. These are used in conjunction with other tools to inform service change. The Trust is required to participate in national surveys, which are reported annually, the 'Friends and Family Test' which is reported monthly and other local surveys conducted by choice by trust departments. The national in-patient survey for 2012/13 is due to be reported imminently.

3.1 SFHT Inpatient Survey

The Customer Services teams, supported by hospital volunteers, undertake monthly patient feedback surveys across our inpatient services. A sample of inpatients is surveyed each month to give us key information to drive our improvement work.

The graphs illustrate how the 865 patients surveyed in Q3 responded:

Table 6



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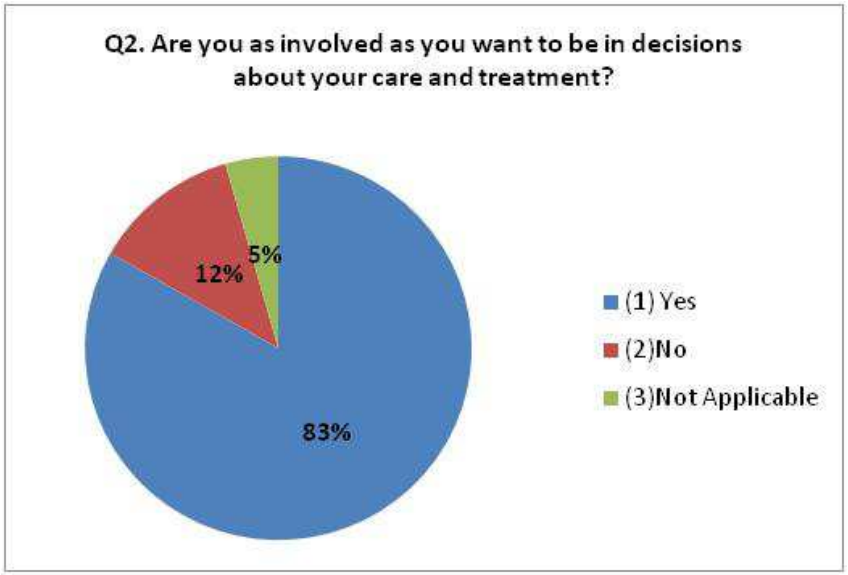

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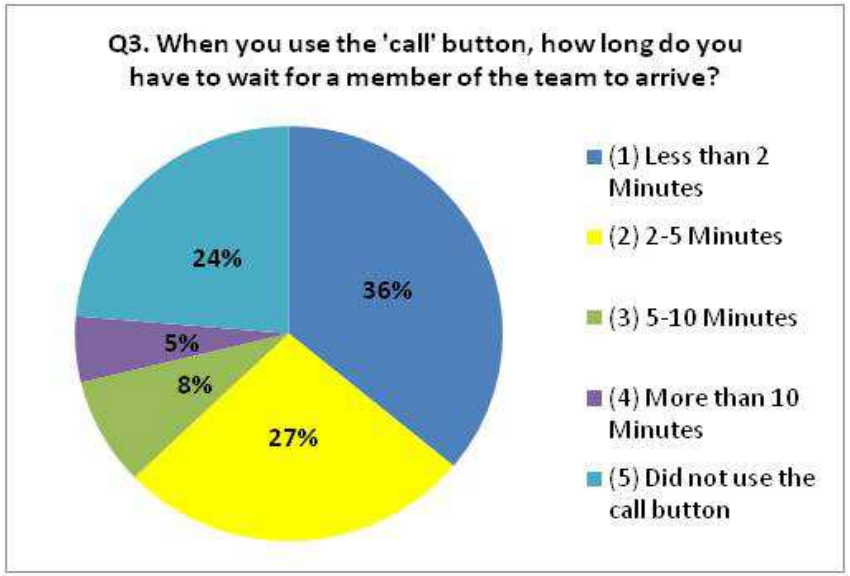

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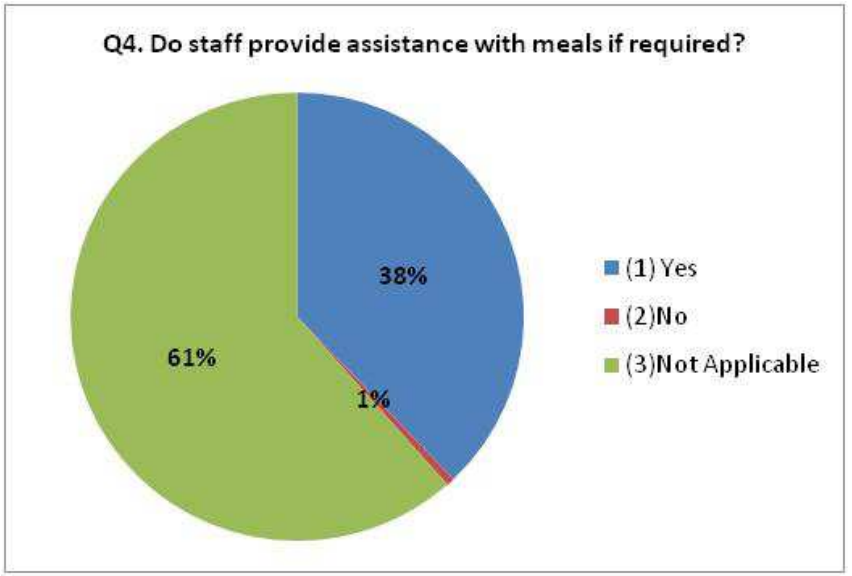
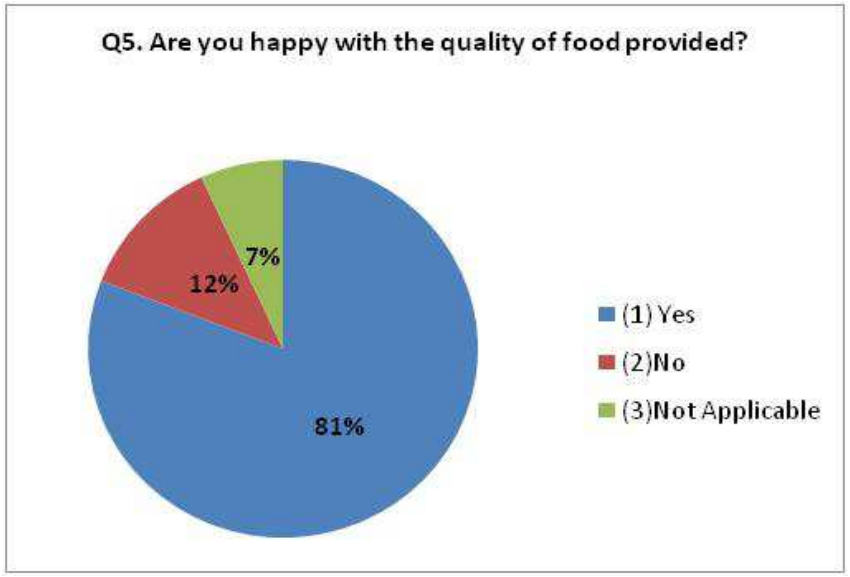


Table 10



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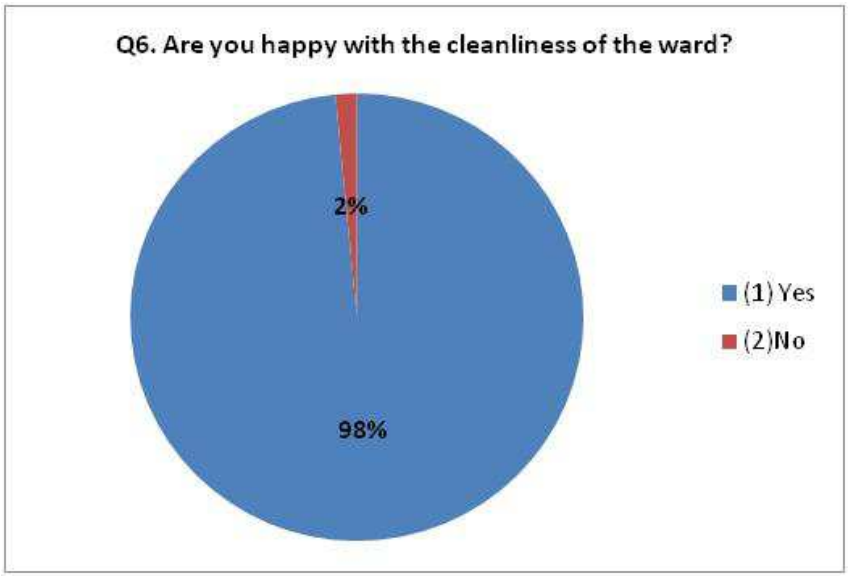

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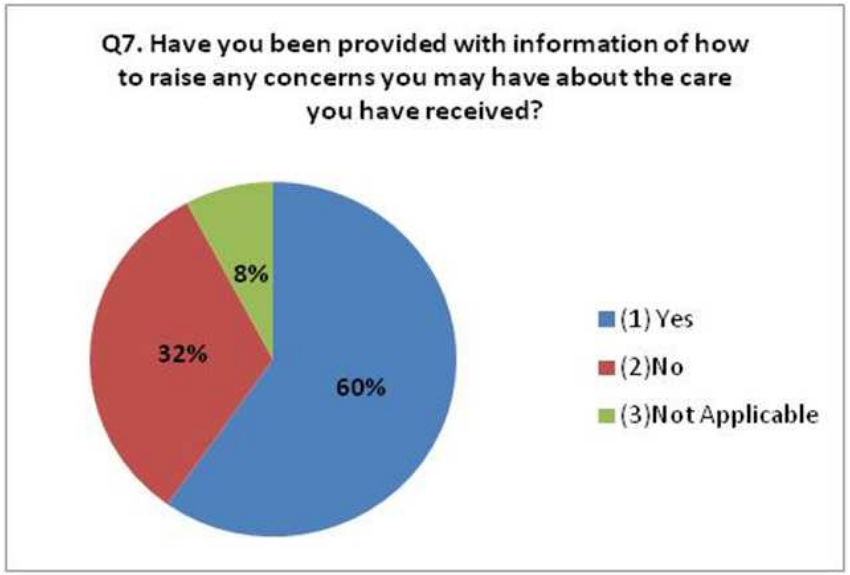
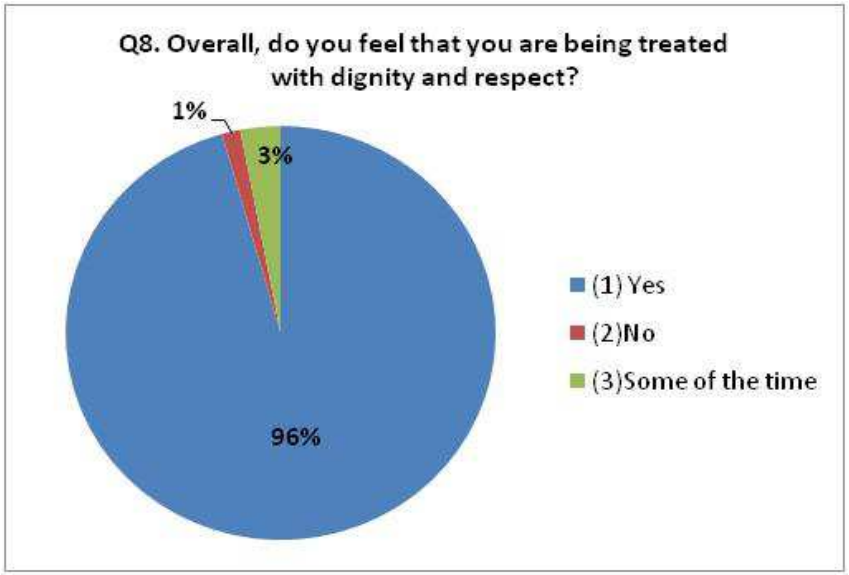


Table 13



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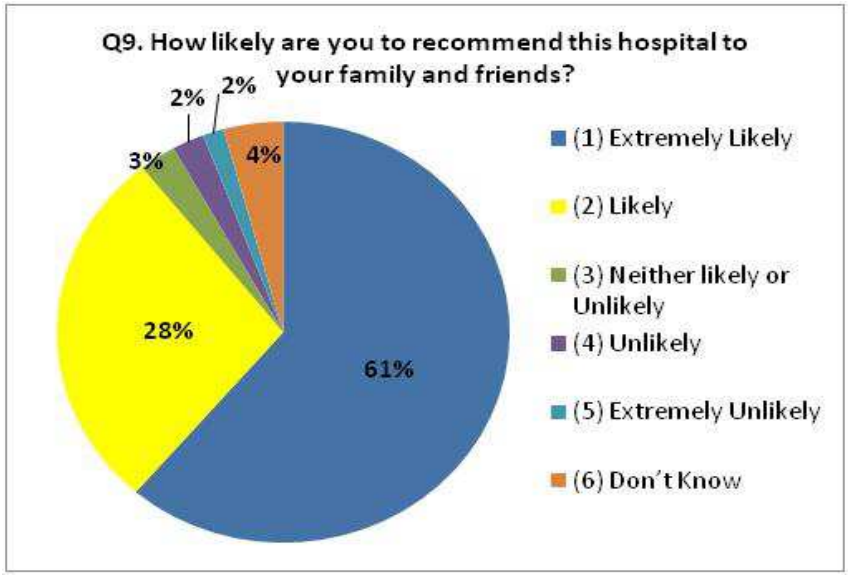


Additional Information re Q9:

Based on the scoring methodology for the current national Friends and Family Test, the Net Promoter Score for this In Patient Survey is: 57

Initiatives that have been implemented which will help address areas of concern include:

- A new A3 sized complaints poster has been designed and displayed on each ward entrance, with a large picture of the ward sister asking for feedback. However, this concentrates on complaints and does not help the patients in knowing how to raise concerns (relatives and carers only tend to see the poster). The Head of Nursing for Health Care of the Elderly and the Dementia Practice Matron are currently reviewing how we improve the communication tools to raise concerns. These will be implemented during Q4
- Implementation of care and comfort rounding should reduce the number of call buttons used, but would not necessarily help with response times. This concern will be discussed within the senior nursing forum in February

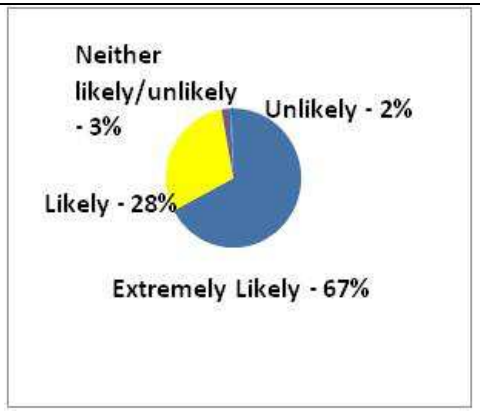
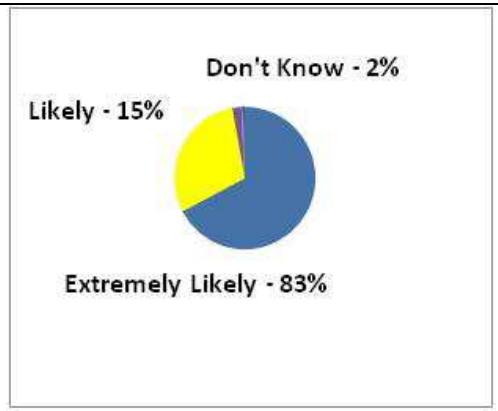
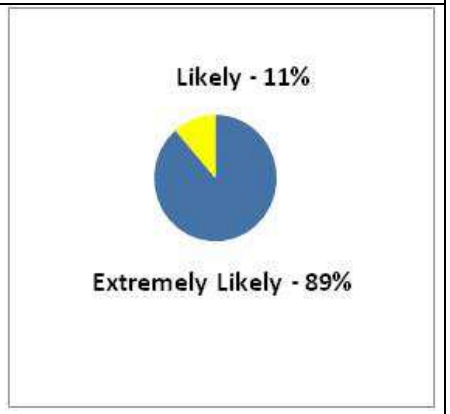
3.2 SFHT Outpatient Surveys – Q3

The Customer Services team supported by our hospital volunteers surveyed 484 King's Mill outpatients, 318 outpatients at Newark and 44 outpatients at Mansfield Community Hospital. Divisional teams receive outpatient survey data in specialty and clinic format.

Results of Outpatient Survey – Q3

Table 15

	King's Mill Hospital	**Newark Hospital**	**Mansfield Community Hospital**
	No. Respondents – 484 (Positive responses shown as a percentage)	**No. Respondents – 318** (Positive responses shown as a percentage)	**No. Respondents – 44** (Positive responses shown as a percentage)
Were our staff courteous and helpful?	100	100	100
Do you feel treated as an individual?	99.5	100	100
Were you given enough privacy during your appointment?	99.5	100	100
Do you feel you were given	98	100	100

enough information?			
Did you find the area clean?	100	100	100
Would you recommend this hospital to family and friends?			
Based on the current Friends and Family Test the **Net Promoter Score** for our Out Patient Services is:	62	85	89

3.3 Medirest Surveys

This will be reported on in Q4.

3.4 Achieving Best Care (ABC) – developments based upon patient feedback

3.4.1 Clinic 8

Service Improvement work continues within Ophthalmology focusing on increasing clinic capacity and patient experience.

3.4.2 Supporting prompt and effective discharge

Following the successful pilot of visually displaying patient's predictive dates of discharge this has now being rolled out throughout the geriatric service lines and continues to have positive patient and carer feedback.

3.4.3 Improving provision for patients with dementia on Sconce Ward Newark

A joint project between the ABC team and medical and nursing staff at Newark Hospital is currently looking at the most effective ways in which to make a positive impact to patients with dementia who require an inpatient stay on Sconce ward. This included adaptation of environment and staff training, education and support.

3.4.4 Improving effective transfer of care to Newark Hospital

Initial investigations and observations have highlighted barriers in the transfers of patients to Newark hospital

Preliminary work has been undertaken to streamline the assessment process to ensure appropriate patients are transferred in a timely manner

A new assessment document has been devised which will be supported by IDAT (Integrated Discharge Advisory Team). This is now out for approval with the Newark team and will be ready to pilot in late January.

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4.0 Complaints

The Trust has experienced significant challenges in effectively managing complaints over the past nine months. The Trust has received a further visit from the Keogh team and the Care Quality Commission (CQC) in December 2013. These visits identified that the backlog had been cleared and the current workload was being sustained, albeit challenging due to the number of complaints received. There are mechanisms in place to avoid a further backlog and new processes and structures are materialising.

We aim at all times to provide local resolution to complaints and take all complaints seriously. We listen carefully, we are open, honest and transparent in our responses and welcome the opportunity to do all that we can to put things right. Our complaints system gives the opportunity for complainants to meet with managers to discuss their concerns and we ensure that staff are made aware if concerns are raised about them and encourage them to look at ways they can change their practice or behaviour's where appropriate.

We are a learning organization and we recognise the importance of lessons that can be learned from complaints and use this invaluable feedback to reflect on our patient care and take immediate actions to improve services as a result of the complaints we receive. We take the lessons learned from complaints to change and improve the services we provide.

Many complaints are resolved locally by front line staff that are able to resolve the client's concerns/issues to their satisfaction, in a timely manner.

The Trust actively encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. This timely intervention can prevent an escalation of the complaint.

4.1 Clwyd-Hart Review

The Clwyd-Hart review undertaken in response to the Francis Report received over 2,500 responses detailing problems members of the public had experienced, not knowing how to complain or identify staff was a barrier for many, but some also reportedly feared the impact of complaining. The report, 'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture', gives the NHS a year to become more accountable.

The report creates specific expectations for various bodies in and around the NHS. Clwyd and Hart were able to secure 'Pledges to Act' from 12 bodies, ranging from the Nursing and Midwifery Council to the Local Government Association and the Care Quality Commission – each will now have a specific role in strengthening complaints procedure, all of which are outlined in the report.

An August report by the Heath Service Ombudsman similarly stressed the need for a more positive and constructive approach to collecting feedback, staff complaints training and clear guidelines on publishing data. It also recommended a national complaints hotline and for NHS

organizations to visibly publish examples of changes made in response to complaints –the latter is a technique that you sometimes see businesses adopt, keenly aware that they cannot simply view their customers as passive recipients. Earlier in the year, former Health Secretary and chair of the patients' service iWantGreatCare.org Alan Milburn argued that patients should be seen as "smoke alarms" in the service and that greater transparency and accountability, rather than more regulation, could empower them to drive improvements in the service.

The Parliamentary and Health Service Ombudsman, has called for a "24/7" complaints service that is more easily accessible to patients, arguing that the "toxic cocktail" of difficulties complaining on the public side and reluctance to respond on the NHS side currently creates major problems.

4.2 Complaints Received

Number of complaints received in Q2 = 205 **Number of complaints received in Q3 = 182**

During Quarter 3 the Trust received an average of 60 complaints each month. Medicine and Emergency Care Division (EMCAM) and Surgical and Planned Care Division (PLANCS) received the greatest number of complaints, however averaging less than one per day. The Divisions are responsible for ensuring relevant investigations are undertaken, responses prepared and that lessons learned are translated into demonstrable practice.

The flow of complaints within each department remains virtually the same, although the number of complaints received in PLANCS and EMCAM remain high, they are slightly lower in numbers compared to the same period last year, whilst Diagnostic and Rehabilitation (D&R) experienced a further reduction for the same period (Table's 15 and 16). Corporate Development has also seen a drop in complaints received although of the complaints received in relation to smoking in the hospital grounds is still an issue.

4.3 Complaints received by month, year and Division for Q3 2012/13 and Q3 13/14

Table 16

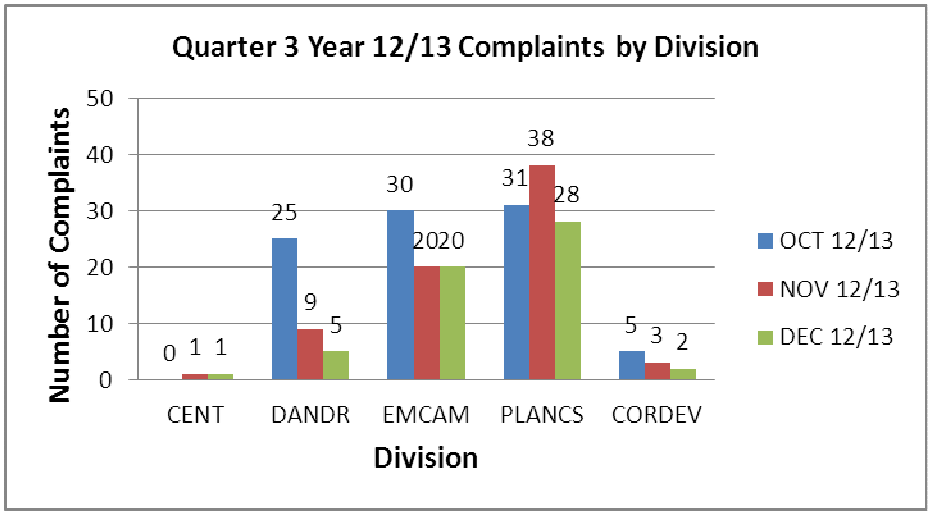
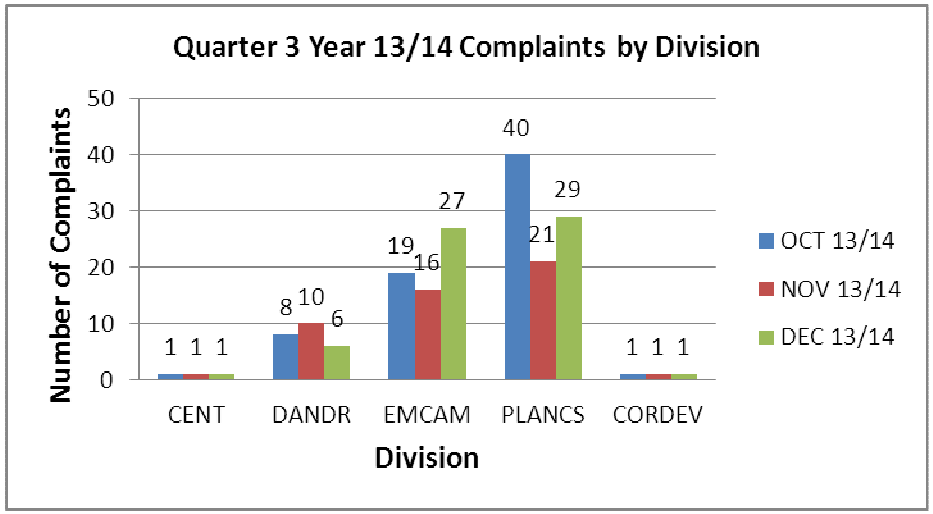


Table 17



It is felt that there was a rise in complaints received in October because of the media interest in the upcoming Keogh visit. There were no trends within complaints received although there has been more than average amount of complaints received in obstetrics/Gynecology.

4.4 Complaints received by specialty and type for Q3 2013/2014

Table 18

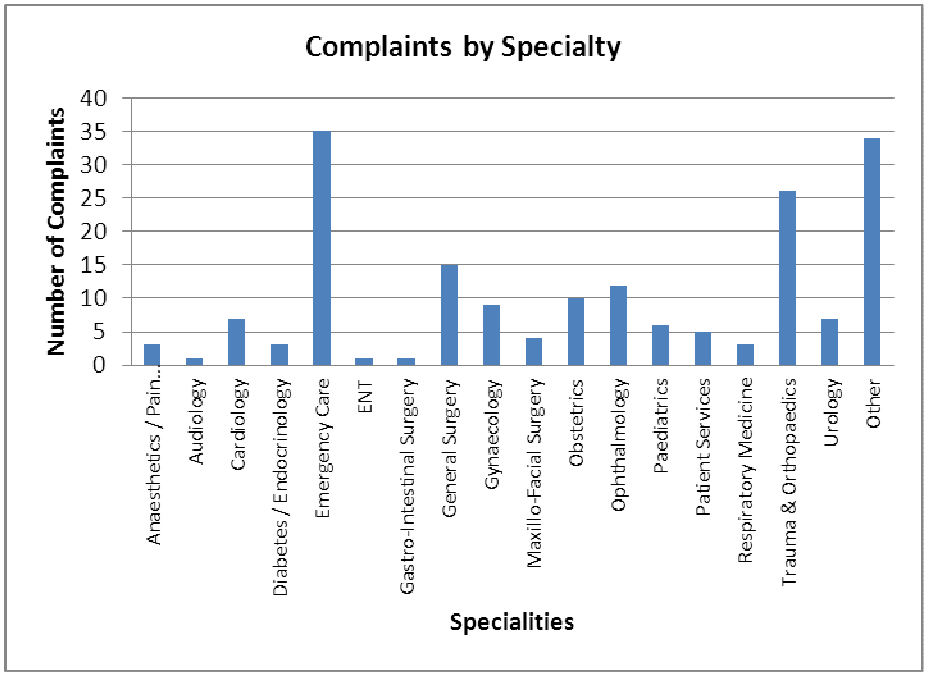
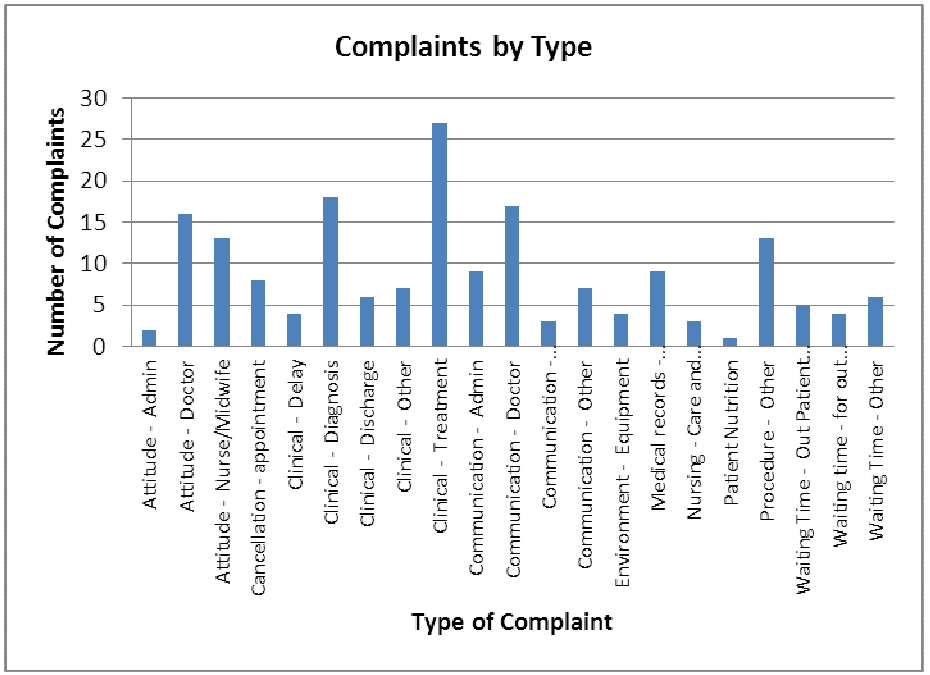


Table 19

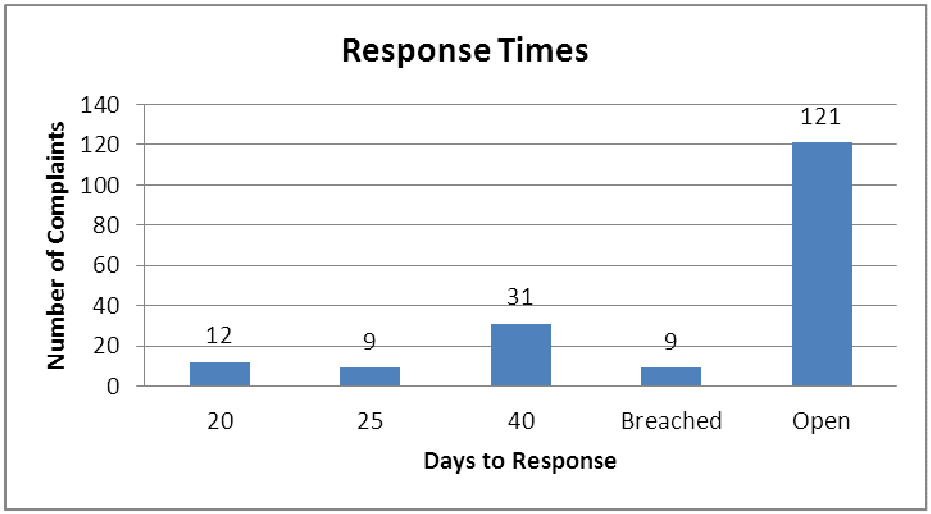


There have been a number of complaints raised around obstetrics/ gynecology during Q3 (9) and 23 since the beginning of the financial year, this has been highlighted within the Planned Care & Surgery Division for review. We are benchmarking ourselves against other Trusts to ascertain whether this number is high in comparison with other Trust's. The complaints received within obstetrics/gynaecology mainly pertain to births, aftercare and clinical treatment.

4.5 Complaint Response Times

Table 20 below shows the time it took the Trust to respond to a complainant during Q3. This information assists the Trust in learning how effective it is at meeting the expectations of those who complain in both a timely and effective manner. Although all complaints are given a timeframe of 40 days we do where possible respond as quickly as possible. Of the 182 complaints received in Q3 121 remain open. The Trust responded to 85% of its complaints within agreed time frames during Q3. Of those that breached the timeframe (15%) complainants were sent letters or telephoned to advise them of the reason for the delay which is more often about the complexity of the complaint. To enable the Trust to generate further learning into how complaints are managed and responded too, satisfaction surveys of complainants are being undertaken in Quarter 4.

Table 20



The current legislation states that all complaints should be acknowledged within 3 working days and this target was met throughout Q3 at 100%. The Trust standard is that all complaints are acknowledged on the day of receipt and a full and final response within the agreed timescale of 20, 40 or 60 days however due to the volume of complaints received a timeframe of 40 days is given . This has been subject to review as part of a change process with the planned intention of reducing this time line to 25 days.

4.6 Reopened complaints

Since the beginning of this financial year (1.4.13 – 31.12.13) 555 complaints have been received and the Trust has reopened 57 complaints (10%) for further investigation and response; however some of these relate to the previous financial year (plus a further 2 that have been withdrawn). In comparison to the same period last year there were 575 complaints received with 71 reopened (12%).

There have been 23 reopened complaints during Q3 which relate to complaints received throughout the year.

As a Trust we are offering every complaint received (new or reopened) a Local Resolution Meeting (LRM) to discuss their complaint with the appropriate members of staff. This has proven to be extremely beneficial to both the complainant and the Trust as this is conducted in an open and honest environment. During Q3 there has been 17 LRM's with 5 being held for reopened complaints.

Table 21

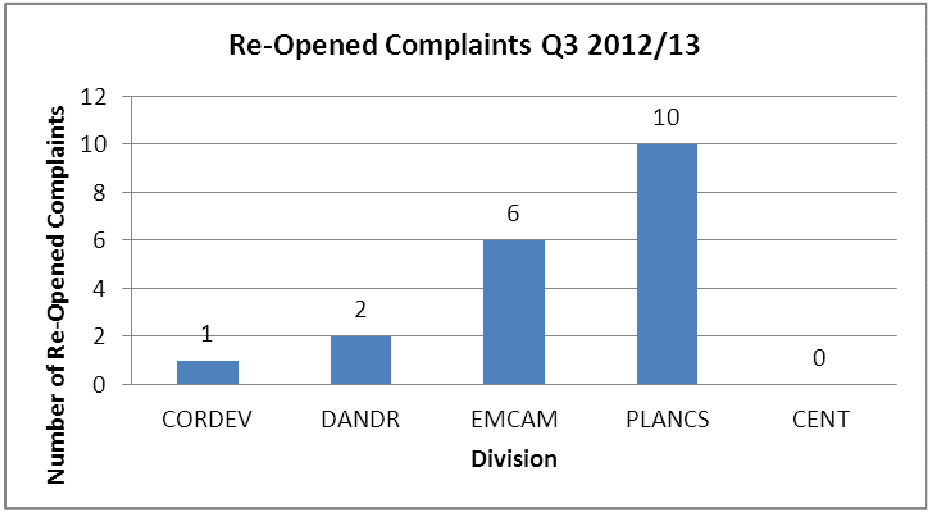
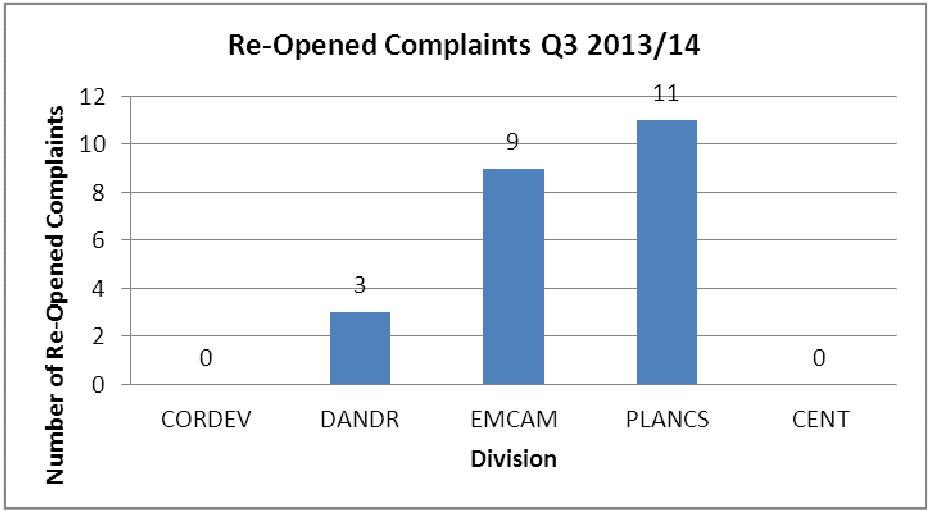


Table 22



4.7 Themes

The Trust actively monitors the key themes identified in complaints and is now working towards triangulating this information with information generated through other sources of feedback such as patient surveys. Each Division is responsible for critically reviewing key themes to identify actions required to improve service delivery and the patient experience. The Trust recognises the importance of lessons that can be learned from complaints, and the Trust wide value in sharing these with appropriate members of staff.

To ensure organisational learning from complaints, any recommendations made following investigation of a complaint are recorded and monitored.

It can be seen in Table 23 that the Trust continues to see a high level of complaints regarding attitude however there is a decrease from the previous quarter. Clinical treatment has seen a rise in complaints compared to the same period last month.

Table 23

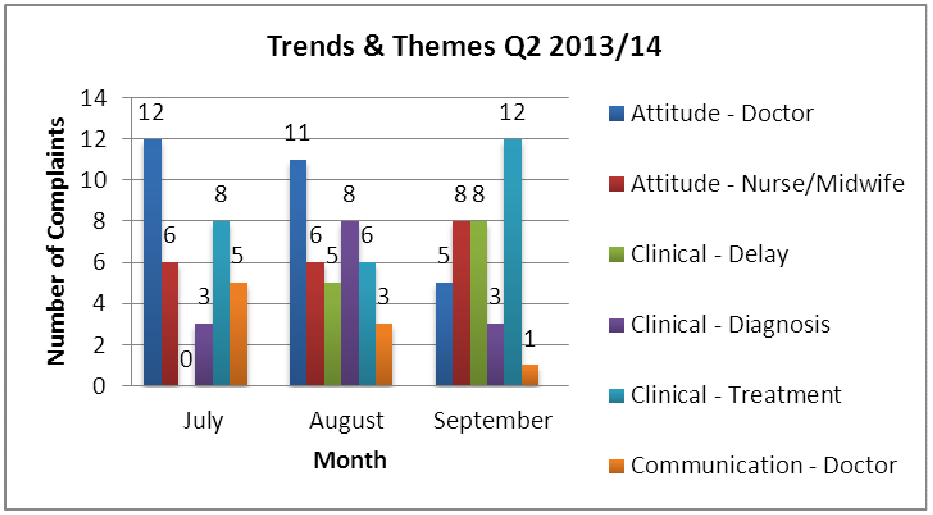
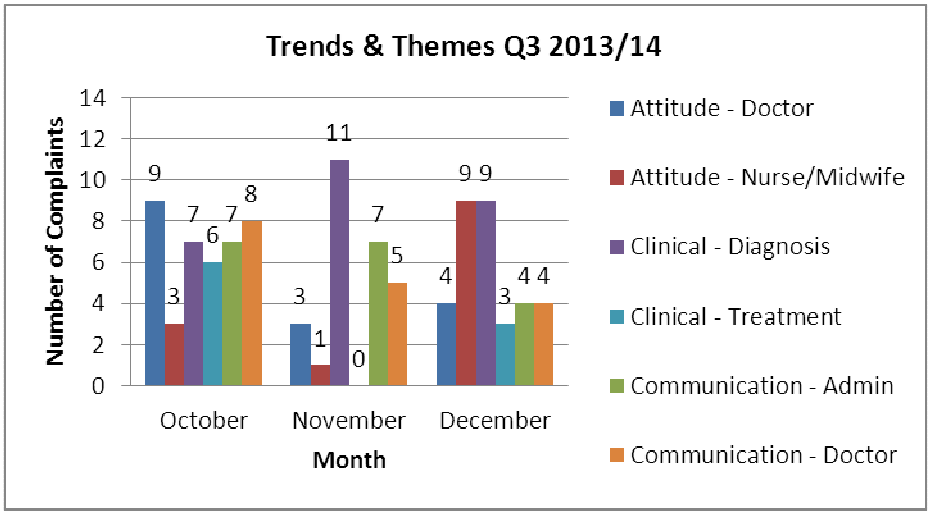


Table 24



It is clear that issues of 'attitude' are frequently commented on by patients and their families which highlights their importance in the overall experience. Staff attitude can often be the complainant's perception of the way they were addressed or treated by staff.

4.8 Parliamentary Health Service Ombudsman (PHSO)

Under the current complaints legislation, Trusts have six months in which to endeavor to resolve a complaint to the complainant's satisfaction. If the complainant remains dissatisfied with the response they receive, they can ask the Ombudsman to independently review their complaint.

The Ombudsman may:

- Refer the complainant back to the Trust to complete 'local resolution'
- Ask the Trust to consider if further local resolution is an option
- Request the case file for screening assessment
- Having assessed the case file, decide not to investigate further
- Having assessed the case file, appoint an Investigating Officer to carry out a review 'on paper'

In Quarter 3, 6 new complaints were referred to the PHSO for review.

A full review into cases referred to the PHSO since 1 April 2013 has been undertaken. A total of 25 complaints have been submitted to the PHSO from the beginning of Q1. One complaint was fully investigated during Q3 which related to a below the knee amputation. The clinical aspects of the complaint were upheld and the Trust was therefore asked to pay the sum of £5000 as compensation to the patient to which has been agreed. The Trust has also been asked to put an action plan together to ensure that this incident does not happen again and submit to the PHSO in 3 month's time.

Tables 24 and 25 below outline the current status of complaints with the PHSO as a whole from this financial year as well as last year.

Table 25

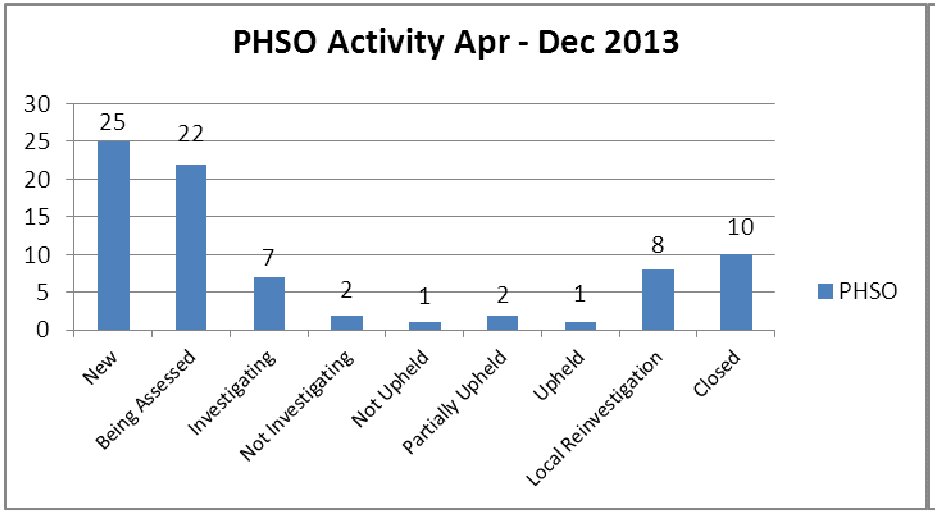
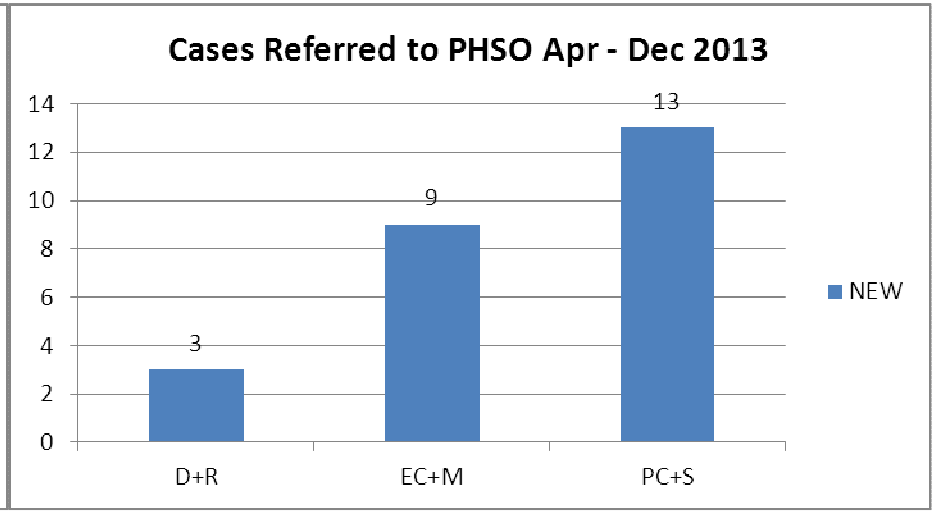


Table 26



4.9 Lessons learned and actions taken:

The following are examples of complaints from each Division during Quarter 3 and actions taken:

4.9.1 Emergency Care & Medicine

Complaint – Patient had a broken toe, but her medical records stated she had a vaginal bleed, soft tissue injury.

We answered…

'In terms of preventing such occurrences in the future I wish to assure you that we take these matters very seriously, this incident will be discussed at our clinical governance meeting and daily communication cell in order to raise overall awareness, understanding and learning within the team.'

4.9.2 Planned Care & Surgery

Complaint - Treatment relating to a third degree tear following birth of baby.

We answered…..

The Maternity Unit is committed to ensuring that the service delivered to all women is improved for the future therefore as part of our programme of education for next year, 'perineal repair' has been included on one of the mandatory study days for all midwives to attend.

4.9.3 Diagnostics & Rehabilitation

Complaint – Unavailability of a patient's medical records when attending a clinic appointment

We answered …….

Work is currently being undertaken to improve the storage and filing within the case note store to prevent reoccurrence of this issue. This was raised to CMT and actions have been implemented to improve this including: a plan that by the end of this year the printing of test results will cease and clinicians will rely on the electronic records for the management of their patients. This will reduce a large bulk of loose filing and eradicate the need for filing and a regular review of filing will be undertaken weekly within both case notes store, Pathway Co-ordinator offices and wards. Any problem will be raised in a timely manner and resolved quickly.

4.10 Compliments

It is important to share positive feedback and all staff are encouraged to send the compliments they or their service receive to be logged and reported to either the PALS office or the Complaints Department. It should be noted that the number of compliments received verbally cannot be realistically logged.

The Complaints Department has received a number of compliments relating to the care received and from the outcome of complaints raised:

'I would like you to pass on my thanks to the staff on duty at the Day Case Unit. Staff were friendly, effective, efficient and most importantly--CARING. This included the two student nurses I dealt with as well. I wish them well for the future. Another thing I noticed was the infection control carried out extremely thorough. I felt safe just watching Well done.'

'All the other staff I had contact with were good too. The porter who pushed my trolley, the anesthetist lady Tracy, smiley, lots of patter and good distraction technique when the anesthetist missed the first vein I still felt totally relaxed.'

'In the recovery room I also felt cared for, thank you!'

'The consultant, Mr Badrinath told me all I needed to know and hopefully he sorted the issue.'

'After the treatment I have personally received, I do not understand how the hospital gets complaints. This was my third visit to the day case unit in 3 years and I highly commend it and recommend anyone to use it if offered.'

Compliment received resulting from a complaint made:

'Just wanted to say thank you to the complaints manager for getting the cancellation appointment for my mum at Clinic 5. We have been this afternoon and have had the best attention anyone could wish for. They were completely professional and explained the situation clearly and I now feel confident that my mum is receiving the best attention possible even though it is not as simple as I (and the care home staff) were led to believe by the GP.'

Compliment received resulting from a complaint made;

'Thank you for your letter dated 11 October 13, regarding the outcome of my father's complaint.'

'My father and I were delighted with outcome with the opening of a discharge lounge for patients to wait in, also the provisions that have been put in place regarding communication. Thank you so much'

We have also received compliments into the complaint response received:

My wife and I would like to say thank you to Jill Faulkner, Complaints Manager for all the help she has given us it has been a tough time dealing with all this it's been good of her to help us the way she has and hopefully we can move forward. Thanks

Would you please pass on my thanks to Mr R Clarkson, Emergency Department Leader and Susan Bowler for their letter dated 10 January in respect of my correspondence of 2 December. I appreciate the time that has been spent on this matter, the findings and the apologies received.

5.0 Patient Advice and Liaison Services (PALS)

The PALS team at King's Mill and Newark Hospitals provide an accessible service 8.30am to 5.00pm Monday to Friday and are based in the main entrance at each site..

The PALS team received 1972 contacts during Quarter 2 2013/14 and 1700 contacts during Q3 2013/14.

5.1 Method of Contact

Table 27 – Method of Contact Q2 2013/14

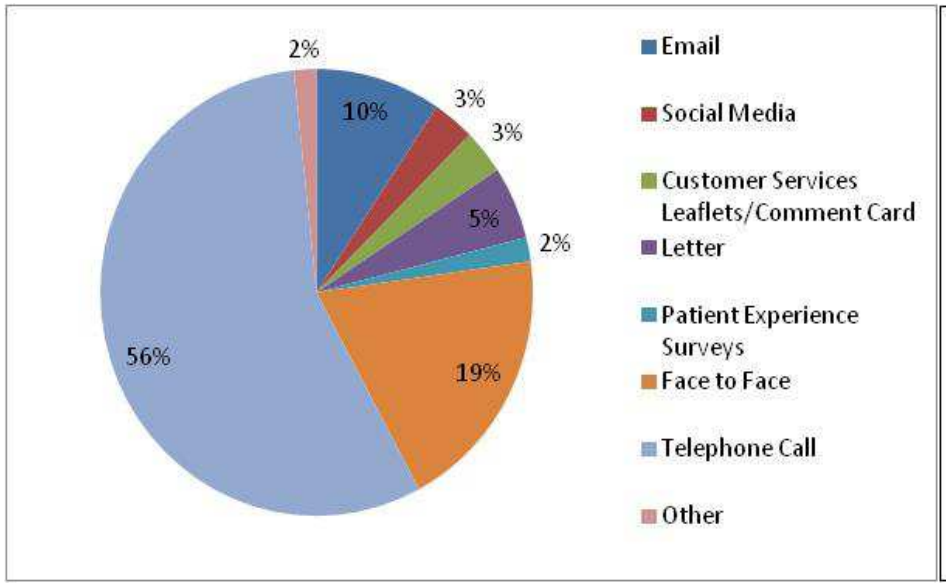
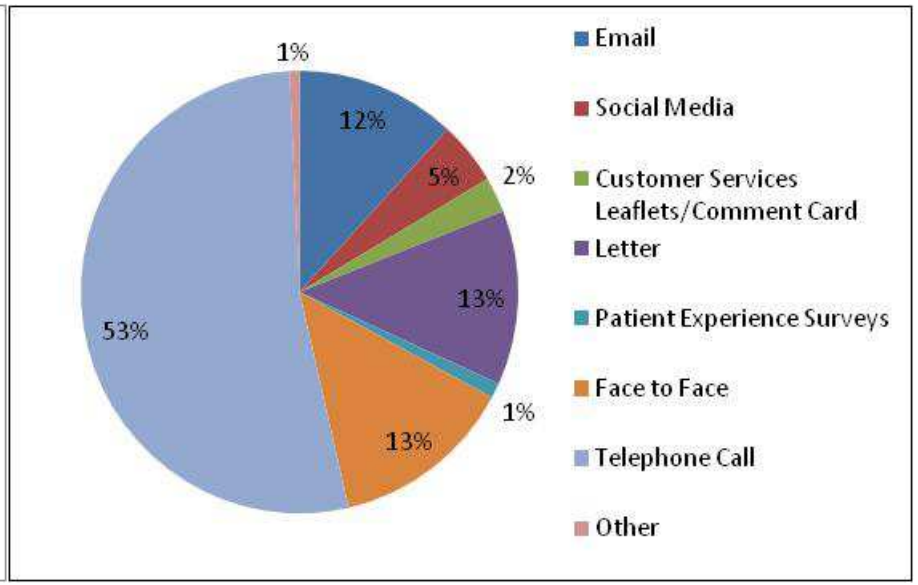


Table 28 – Method of Contact Q3 2013/14



In Q2 there were 718 Comments, 231 Compliments, 40 Complaints (first point of contact) and 1003 Concerns.
In Q3 there were 553 Comments, 236 Compliments, 26 Complaints (first point of contact) and 885 Concerns.

5.2 Q2 & Q3, PALS Contacts

Table 29 – Q2

Divisions	Planned Care & Surgery (n=827) Emergency Care & Medicine (n=478) Diagnostics & Rehabilitation (n=471)
Top 3 Areas	Patient Administration (n=367) Trauma & Orthopaedics (n=129) Gastroenterology (n=128)
Top 3 Subjects	**Communication** • 42.2% lack of or concerns with information provided, information requests, confidentiality **Waiting times** • 19.5% of concerns related to waiting times. Includes: waiting times for appointments, results of examinations, for clinical procedures. **Procedural** • 13% of concerns related to appointment queries. Includes: appointments changed not at the patient's request, lack of capacity.

Table 30 – Q3

Divisions	Planned Care & Surgery (n=722) Emergency Care & Medicine (n=450) Diagnostics & Rehabilitation (n=353)
Top 3 Areas	Patient Administration (n=324) Emergency Care (n=122) Trauma & Orthopaedics (n=118)
Top 3 Subjects	**Communication** • 50.3% lack of/concerns with information provided or information requests, the remainder were confidentiality, interpreting services and medical records information contacts. **Appointment Queries** • 69.4% general queries or requests from patients to change their appointments, 30.6% contacts were unhappy that their appointments had been changed and concerns about lack of outpatient appointment capacity. **Compliments** • As previously stated there were 236 compliments received. The top 3 area's were: A&E at KMH (n=20), Newark Hospital in general, not service specific (n=20) and Ward 42 KMH (n=18).

5.3 **Division Breakdown of Concerns**

Table 31

	Q2 2013/14	Q3 2013/14
Planned Care & Surgery	420	371
Emergency Care & Medicine	278	239
Diagnostic & Rehabilitation	139	182
Central Services	136	34
Corporate Development	96	47

The increase in the number of concerns noted for the Diagnostic and Rehabilitation Division Q2 to Q3 does not demonstrate any particular trend. Small increases in contacts are spread over a number of services, the highest of which is Radiology which received 10 more concerns than Q2. The only theme identified was that a small number of patients (7) requested their appointment location be moved to a different hospital within the trust.

Divisional teams receive monthly reports identifying key themes and trends for triangulation with other sources of data. Each divisional team review and identify actions required to influence service improvement and training needs.

5.4 First point of contact Complaints – during Q3 the PALS team referred 27 contacts to the formal Complaints team, 40 were referred in Q2.

Table 32

Month	No. referred
July	11
August	15
September	14
October	9
November	7
December	11

6.0 Reviews from NHS Choices

The NHS Choices website invites patient and carers to leave feedback on their treatment/care whilst visiting Sherwood Forest Hospitals NHS Foundation Trust. Out of 188 reviews the Trust has been given a score of 3.5 out of 5.

A selection of the reviews are as follows:

'I am a regular patient at kings mill with my asthma and also recently with bowel cancer .I would just like to say on all my appointments, treatments and admissions I cannot fault any of kings mill. Apart from hunting for a parking space .people also moan about the wait in clinics, .but do they moan when the doctor is spending extra time talking to them.'

'I visited the Emergency Department early on a Saturday evening in connection with a cut to my hand. The Department was not busy. I was treated in a friendly but professional way and have nothing but praise for the nurses involved to whom I offer many thanks'.

'Our son was born at home with a rare condition, Scolded Skin Syndrome. This was not evident at birth but started to develop very gradually 3 hours later. My husband and I feel humbled by the care we have received. The attending midwife saved the baby's life by noticing something was wrong and packing us off to the hospital for much needed antibiotics. We had 2 days on the maternity ward and then moved to neonatal ICU for a further 4 days. This was a horrendously difficult time for us, as the symptoms also matched those of a vastly more serious condition, Epidermolysis Bullosa. The hospital not only treated our son quickly and appropriately for his symptoms, but also helped us through the process with a kindness, sensitivity and understanding well beyond their remit. We certainly did not feel like 'just another number', we are in awe of the humanity of every single member of staff. We should especially like to mention our first nurse, one of the most incredible people we have met. We were in need of somebody highly skilled and full of empathy to spend (literally) hours with, in the middle of the night, bandaging up our fragile, poorly and potentially severely disabled new-born. Similarly other nurses helped us through a couple of extremely tough nights. We could not have asked for anybody better. Finally, we should mention that the resources put at our disposal were, similarly, outstanding. We very much felt that all the stops were pulled out to help us, both in terms of physical resources and in terms of allowances made. We shall never stop feeling grateful but shall remain, as mentioned above, feeling humbled by our experience.'

7.0 Voluntary Services Summary

The Customer Services Department continues to develop new voluntary roles in addition to reviewing and improving the valued established volunteer roles that 631 volunteers currently provide across the four hospital sites.

In Q3 Volunteers contributed over 18,000 hours of service across the four sites.

7.1 Q3 Service Developments

- Volunteer assistance is now provided on Ward 54 to support the patients and their carers.
- A service improvement plan is being developed following a review of the internal patient buggy service. The volunteer drivers transport approximately 1,000 patients per week around the King's Mill Hospital site; 26 drivers to provide 120 hours of coverage for the service per week.
- Volunteers at Newark are now trained to assist with the ' In Patient Experience Survey' which was implemented in Q3

7.2 The Chairman's long services awards took place on:

The Chairman hosted events during this period to recognise and reward the work and commitment of our volunteers. Awards ranged from 5 years to 50 years service. The award recipients' service totalled 835 years.

- 70 volunteers received recognition for their service ranging from 5 – 15 years.
- 3 volunteers received 20 year awards and a further 3 volunteers received an award for 25 years service.

An award was presented to Sheila Clutterbuck at Newark Hospital for her dedicated 35 years service. Margaret Thompson from King's Mill Hospital received a 50 year award to recognise her valuable service and commitment to healthcare services.

7.3 2013 Staff Excellence Awards:

Volunteer of the Year award was received by Mavis Keers for her work supporting maternity services and the Daffodil Café at King's Mill Hospital.

The Volunteer Team award was received by the Mercia Doughty Pre-Operative Assessment Volunteers. The team of 15 volunteers support the patients in the Newark assessment unit and provide a meet and greet service.

7.4 Christmas Events held across the Trust:

Hospital volunteers in December supported events to celebrate the Christmas period across the sites. Local children attended both Newark and King's Mill Hospital to sing carols – this was greatly appreciated by visitors and patients.

The Friends Associations provided funds for gifts for inpatients, refreshments and decorations.

Patrick Mercer MP for Newark and the Chairman of the Friends of Newark Hospital visited patients on Christmas morning with the Salvation Army.

The Trust Chairman attended the League of Friends (Mansfield and Ashfield) three charity shops to express thanks to the volunteers for the invaluable support received.

Kirkby Woodhouse Primary School Choir

Lee Ogden decorating the patient garden

Santa pays a visit!

7.5 Patient Experience

Our volunteers collected 1711 patient experience surveys about the quality of our in patient and outpatient services in Q3. The valuable information collected from the patient questionnaires are used to provide monthly data for our service line teams.

The roll out of the Friends and Family test continues and in Q4 the Mansfield Community Hospital volunteers will support the implementation of the programme.

7.6 Voluntary Services Fund Raising

Volunteers continue to fund raise across the four sites for the general charitable fund account or the Friends Associations. The Customer Services team support the activities of the hospital volunteers, individual fundraisers and our autonomous charities.

- A Christmas Fayre at Mansfield Community Hospital raised £814.
- King's Mill Hospital volunteers Christmas raffle raised £917.
- Christmas raffle at Newark raised £1,590.
- The Mansfield Community Hospital Tea Bar volunteers presented a cheque to the League of Friends (Mansfield and Sutton) £18,573 from profits raised.
- Autumn events organised by the League of Hospital Friends for Mansfield and Sutton raised £6,990.

Susan Bowler

Executive Director of Nursing and Quality

Supported by Jill Faulkner Head of Complaints and Tracey Brassington Customer Liason Manager

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Agenda Item:

Board of Directors Meeting Report

Subject: **Medical Appraisal and Revalidation**
Date: **January 2014**
Author: **Nicola Boulding/Nabeel Ali**
Lead Director: **Andy Haynes, Interim Executive Medical Director**

Executive Summary This Report updates the Board on recent developments in revalidation both locally and nationally. It also details the current position of our appraisal uptake. The report highlights areas where progress has been made, and further work that will be required.
Recommendation The Board are asked to **note** the contents of the report.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	Achieve financial sustainability
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	NA
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	None compliance would result in a break of our GMC requirements
Links to NHS Constitution	4b – Staff – your responsibilities
Financial Implications/Impact	None
Legal Implications/Impact	None
Partnership working & Public Engagement Implications/Impact	None
Committees/groups where this item has been presented before	None
Monitoring and Review	Quarterly reporting to Board. Regular monitoring and reporting to Medical Director. Implementation of actions by Medical Director's Office Manager and Responsible Officer.
Is a QIA required/been completed? If yes provide brief details	No

Sherwood Forest Hospitals NHS
NHS Foundation Trust

MEDICAL APPRAISAL & REVALIDATION

January 2014

This Report updates the Board on recent developments in revalidation both locally and nationally. It also details the current position of our appraisal uptake.

The report highlights areas where progress has been made, and further work that will be required.

1. Revalidation

The NHS England Revalidation Support Team recently visited Sherwood Forest Hospitals to sense check our process and procedures in relation to appraisal and revalidation. They reported back that our information pack that we provided to support their visit was gratefully received and that it would be held up as an exemplar at forthcoming network meetings.

As of the 10th January 2014, there are currently **205** doctors under the designated responsibility of Sherwood Forest Hospitals.

Doctors Revalidated	**64**
Revalidation 2014	65
Revalidation 2015	62
Revalidation 2016	14

We have deferred 1 doctor's revalidation date from Dec-13 to Oct-14 pending outcome of a review process. 3 other doctors are currently on hold with the GMC (pending investigation), 1 doctor due for revalidation in 2014 and 1 doctor in 2015. 1 doctor currently under investigation by the GMC has already been revalidated by the GMC in March 2013.

2. MYL2P (my licence to practise)

Sherwood Forest Hospitals has recently gone live with a new electronic system for appraisals. This system allows doctors to complete their appraisal paperwork online and submit their appraisal preparation to their appraiser. Once completed they can submit electronically to their Responsible Officer. This eliminates the paper trail and should increase the speed in which their appraisals are signed off. At each checkpoint the appraisee is aware of where the appraisal is in the system.

Not all doctors are registered on the system, this is likely to complete within the next 4 weeks. Doctors have the option of undertaking a paper appraisal until the 14th February 2014. This was agreed as some doctors had already prepared their appraisal prior to the system going live. Any paper versions will be scanned and uploaded to their profile by the Medical Director's Office Manager.

The Responsible Officer, Head of Appraisal & Revalidation & Medical Director's Office Manager are equipped with Administration rights to monitor the progress of appraisal and revalidation. The full dashboard demonstrates very clearly which doctors have completed and submitted appraisals and also marks appropriately the ones that are due or late. Reminders are automatically sent to the doctor in the latter case.

3. Appraisal Numbers

The Trust is currently **73% compliant** with Medical Appraisal. This is a drop of 23% since our last report. It is however to be recognised that this is the busiest time for our appraisals and the numbers increase on a daily basis. We are aiming for 98% compliant by the end of March 2014.

Appraisal Overview

Month	Number of Appraisals Due	Completed
October 2013	15	10
November 2013	19	16
December 2013	70	23
January 2014	45	
February 2014	19	
March 2014	13	
April 2014	6	
May 2014	6	
June 2014	7	
July 2014	3	
September 2014	2	
Total	**205**	

A total of 150 appraisals are compliant/not due out of 205. We are awaiting paper copies of completed appraisals undertaken and these have not been included in the figures. We currently have only 1 doctor which is not engaged in the appraisal and revalidation process. This has been reported to the Responsible Officer.

We have 21 appraisers which translate to roughly 10 appraisals per appraiser. Each Doctor keeps the same appraiser typically for a period of three years.

4. 360° Colleague & Patient Feedback

The GMC requirement for Colleague & Patient Feedback is that it needs to be performed only once in the five year cycle. The Trust however runs a fresh 360 every 3 years as the Responsible Officer feels that this is more in line with best practice. It also ensures that no doctor is without a valid 360 prior to their revalidation.

Our contract with Equinti 360 ceased on the 31st December 2013. We are conducting our 360 MSF through 360 Res Consortium. This enables additional 360 profiles to be undertaken for example a 360 MSF can be undertaken for clinical work and a separate one for their management roles.

5. Progress and Planning for 2014

1. To maintain and improve the appraisal uptake. As the electronic system roll-outs over the next four weeks it will provide the necessary reminders to doctor to remain within their required appraisal date.

2. A review of all appraisers will take place in March 2014. The majority of the appraisals will have taken place by this time and will provide an excellent opportunity of reviewing the quality of our appraisals per appraiser. This will be fed back to our appraisers at the quarterly forum.

3. All doctors have been issued with their Mandatory and Statutory Training profiles. Where they are out of date, there is a requirement to annotate the matrix and return to the Medical Director's Office Manager for updating. There is also a requirement for certificates to be submitted to the Training & Education Department for uploading to the OLM system. We would expect to see a significant improvement in mandatory and statutory training records now that doctors have received their profiles. With the introduction of this matrix it has put extra measures in place to ensure doctors are up to date prior to receiving pay progression. The matrix will be reissued on a yearly basis.

For approval

The Board are asked to support the **progress and planning for 2014** required to support revalidation

Dr Nabeel Ali
Responsible Officer