Report to:	**Trust Board**	**Agenda item:**	**9**
Date of Meeting:	**8 February 2012**		

Title of Report:	**Patient Safety & Quality Report January 2012**
Status:	**Standing Item**
Board Sponsor:	**Francesca Thompson, Director of Nursing**
Author:	**Jo Miller, Assistant Director of Nursing, Patient Safety** **Sharon Manhi, Head of Quality Improvement**
Appendices	

1. Purpose of Report (Including link to objectives)

The RUH is committed to improving the quality of care and experience for patients and this report gives an update on progress in January 2012.

As a member of the NHS South Quality and Patient Safety improvement programme the patient safety culture is widely embedded in the Trust and forms a key part of the Quality Improvement work.

2. Summary of Key Issues for Discussion

Summary of progress against NHS South Quality and Patient Safety improvement programme. The Patient Safety programme is aligned to the RUH Strategic direction of putting patient care and safety at the forefront of business.

This report includes a focus on:

- A benchmarking analysis against other participating Trusts within the South West
- Aggregation of data to support quality improvement

3. Recommendations (Note, Approve, Discuss etc)

To update and inform the Board on progress to improve quality and patient safety at the RUH.

To note the mandatory requirement (linked to CQUIN) from April 2012 to submit data to the National Safety Thermometer tool.

4. Care Quality Commission Outcomes (which apply)

Outcome 1: Respecting and involving people who use services
Outcome 2: Consent to Care and Treatment
Outcome 6: Cooperating with other providers
Outcome 4: Care & Welfare of people who use services.
Outcome 5: Meeting Nutritional Needs
Outcome 7: Safeguarding people who use services form abuse

Outcome 8: Cleanliness and Infection Control Outcome 9: Management of medicines Outcome 11: Safety availability and suitability of equipment Outcome 13: Staffing Outcome 14: Supporting workers Outcome 16: Assessing and monitoring the quality of service provision

5.	Legal / Regulatory Implications (NHSLA / Value for Money Conclusion etc)
Care Quality Commission (CQC) Registration 2011/12	

6.	NHS Constitution
This report demonstrates compliance with the following principle; 3. The NHS aspires to the highest standards of excellence and professionalism	

7.	Risk (Threats or opportunities link to risk on register etc)
Risk 180 Lack of sufficient and appropriate isolation facilities.	

8.	Resources Implications (Financial / staffing)
None identified.	

9.	Equality and Diversity
None identified.	

10.	Communication
Patient safety campaign: " Safety Matters" RUH Quality Improvement Strategy will play a key role in both internal and external communications.	

11.	References to previous reports
Routine monthly quality and patient safety reports.	

12.	Freedom of Information
Public.	

Patient safety and quality report

1. Introduction

The patient safety and quality report this month includes benchmarking analysis against other Trusts participating in the South West Patient Safety programme and how we use data to improve patient care.

From February 2012, the monthly quality and safety report will integrate with patient experience.

2. Patient Safety work overview

2.1 The Trust continues to provide a progress report on each of the 5 workstreams - Leadership, General Ward, Critical Care, Perioperative and Medicines Management. This progress is uploaded on a monthly basis through the Institute of Healthcare Improvement (IHI) extranet.

2.2 A regional celebration event in February is to include all 3 Quality and Patient Safety Improvement programmes (acute, mental health and community). 4 Trusts have been asked to take part in a short film to be shown at the event and the RUH will be demonstrating how the use of the Situation, Background, Assessment, Requirement (SBAR) tool has made a difference in the handover of patients. The Critical care lead has been asked to present a patient story on the work they have completed in daily goal setting for patients. The medicines management workstream have been asked to present their work on the reduction of INR's greater than 6. Feedback from this event will be included in the next report.

2.3 The initial scoping stage is underway in the safer clinical systems Parkinson's disease medication pathway. On January 12th the final process mapping event for the elective patient pathway was held in the Qulturum. This event was attended by RUH staff, patients and carers.

2.3.1 The safety culture index survey has been distributed to 125 members of staff involved in the specific pathway as part of the initial stage of the Safer Clinical Systems. The results of this will be presented at the 3-day project launch event at Warwick in January and reported to Management Board in February.

2.4 The mandatory use of the safety thermometer used to measure "harm free care" is included in the NHS Operating Framework for 2012/13. This tool is used to collect data nationally on pressure ulcers, VTE, falls and urinary tract infections (patients with a urinary catheter in situ). The tool and guidance are not yet available at the time of writing this report however it is anticipated that these will be published by the end of January 2012. It is believed data for these 4 areas will be collected on the same day every month on a sample of inpatients from all ward areas, there will be some exceptions to be clarified, but it is presumed that emergency departments will be one of those

exceptions. Data will be submitted to the NHS information centre on a quarterly basis.

2.4.1 The safety thermometer will form part of the mandatory national CQUIN target, however Trusts will not be performance managed against the data during 2012/13.

2.4.2 The Trust did participate in the initial testing of the tool in 2010 however did not continue using due to duplication of effort. This decision was taken as the data was already being collected as part of the NHS South Quality and Patient Safety Improvement programme, and therefore the Trust was confident it could provide the data. As this is now a mandatory requirement the data collection will be linked to work within the general ward workstream. It is to be noted that through participation, organisations agree to the principle of external publication of that data.

2.5 Following the Prime Ministers recent announcement regarding hourly ward rounds by nurses, the Assistant Director of Nursing Patient Safety and the general ward workstream lead have initiated an accelerated roll out programme for all wards to have commenced comfort rounds by the end of April 2012. This work has already commenced within some areas of the Trust, as part of the ongoing patient safety work, with the intention that all wards areas would eventually participate in these rounds. Currently this has not been made mandatory, but it is expected to become a national standard.

2.6 Figure 1 details the number of harm events per 1000 bed days. It is expected that each Trust will have an average of 20-30 harm events per 1000 bed days (Institute of Healthcare Improvement). In November there were 2 harm events found during the notes review.

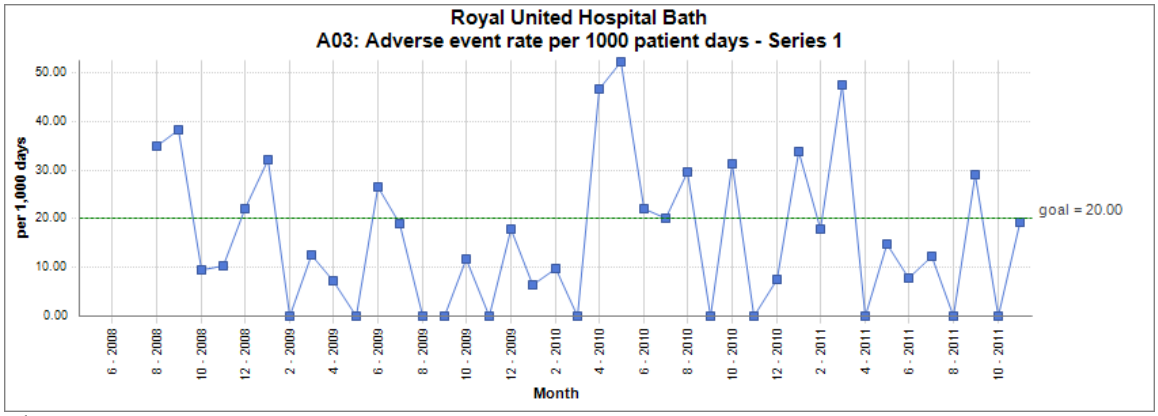

Figure 1

2.6.1 Figure 2 illustrates the baseline median and the trajectory for us to achieve a 30% reduction over the 5 years.

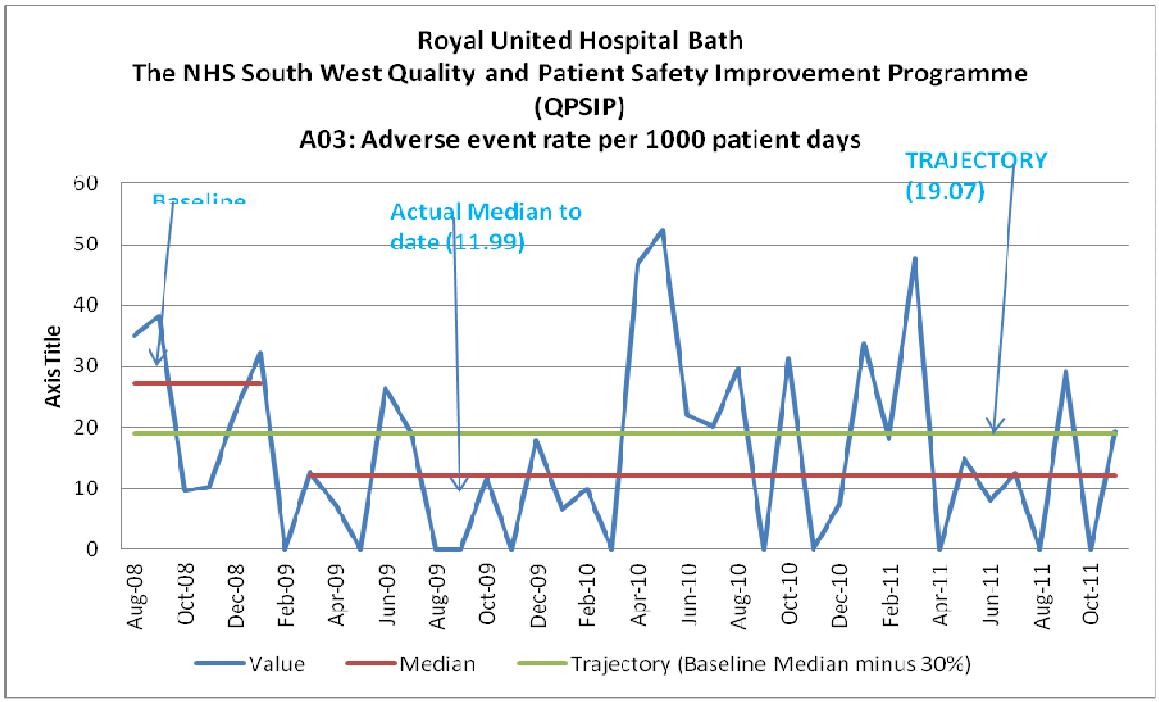

Figure 2

2.7 There have been several requests for the patient safety work to be benchmarked against the other participating Trusts. Below is a selection of data to illustrate the Trusts position in relation to the other hospitals.

2.7.1 Figure 3 is the adverse event rate per 1000 bed days for all Trusts within the South West. The RUH has been above the average harm events per 1000 beds days on 12 occasions.

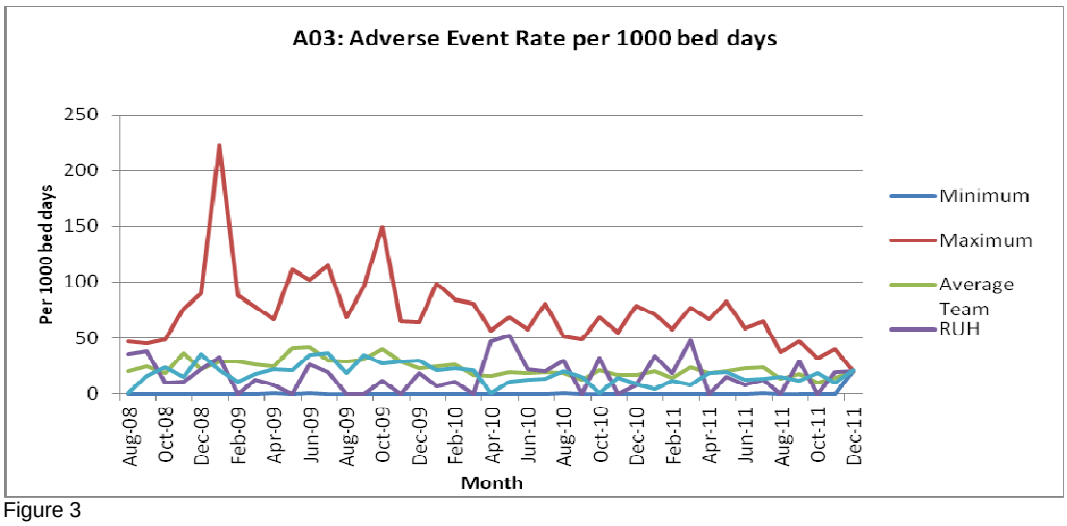

Figure 3

2.7.2 Figure 4 illistrates the number of VTE risk assessments completed on admission to the wards. The RUH has remained above average since October 2010; however there was a drop in September following the installation of millennium.

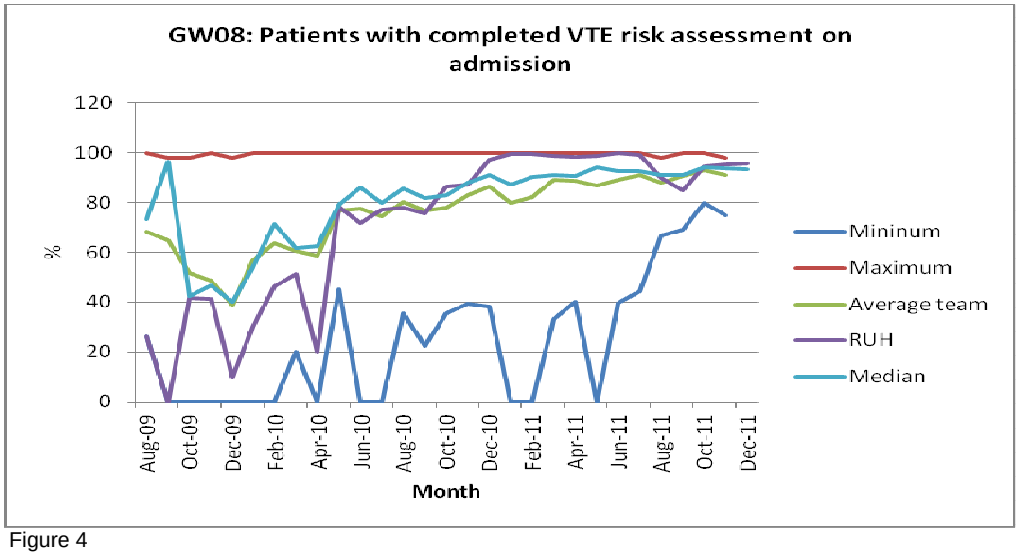

Figure 4

2.7.3 Figure 5 is the number of cardiac arrests calls. This graph illustrates that the RUH has had fewer than the average number of cardiac arrests since September 2010 with a recent rise in November 2011; this reflects the work on recognising the deteriorating patient.

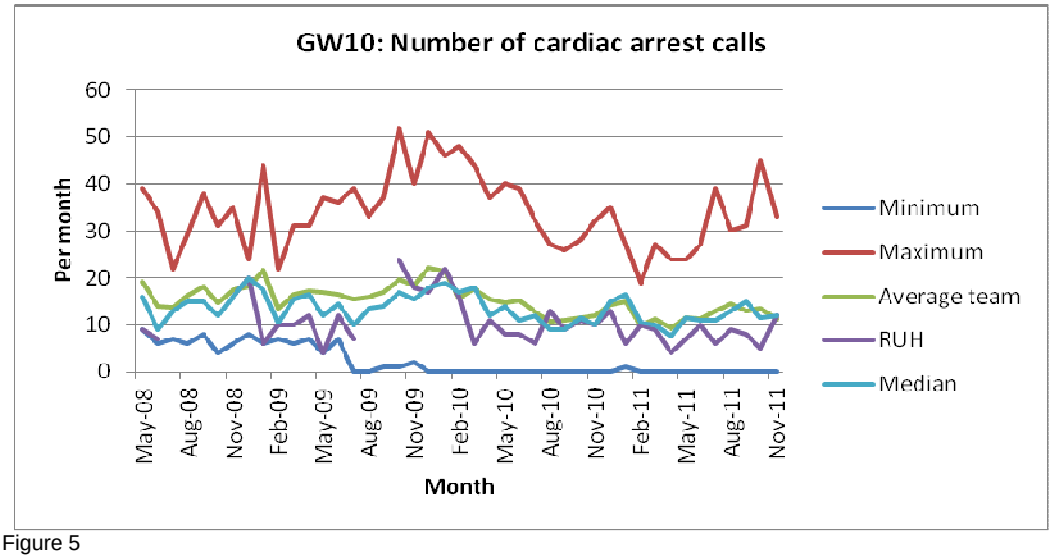

Figure 5

2.7.4 Figure 6 shows the compliance the WHO Safer Surgery checklist; the RUH has remained above average on the compliance compared to other participating organisations in the South West.

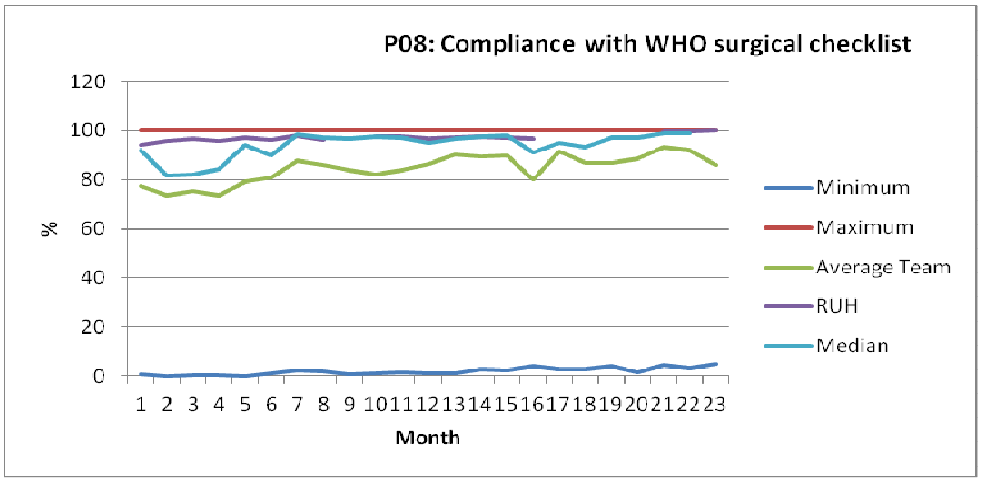

Figure 6

3.0 Aggregation of data to support Quality Improvement

Staff from the Business Intelligence Unit (BIU) are working with staff in the Qulturum to ensure that data relating to quality is aggregated to allow for better monitoring of patient safety and that quality information is robust allowing for scrutiny at all levels in the organisation.

This supports the Trust focus on using quality data to improve patient care and in its application to be a Foundation Trust. Draft quality indicators are now included in the Trust performance scorecard and plans are in place to develop specialty based balanced scorecards to include quality indicators.

3.1 A business analyst for quality has been appointed whose focus is to lead on the Trust wide reporting and management of information to support the quality agenda. Bernadette Burt is working alongside staff in the Qulturum. Her focus will be to take the lead responsibility for the aggregation of all quality related indicators including:

- VTE
- Best Practice Tariffs
- Infection Control
- Falls and other safety measures
- All quality related scorecard information
- Re-admissions

In addition this post will support the work of the Clinical Outcomes Group (COG) and in the management and use of Dr Foster, providing benchmarking information to support performance management.

A key responsibility will be to develop and manage data from quality systems already established in the Trust into the data warehouse in line with the Trust's Information Reporting Strategy. This will ensure information is readily

available and accessible to staff. By making processes easier and simpler for: staff, this in turn will allow for:

- Identification and elimination of duplication
- Opportunities for integration both logically and technically
- Utilisation of Millennium processes and data
- Increased use of the RUH Data Warehouse (Business Objects)

The business analyst will be a co-author of this report providing performance reports that allow for improved analysis of quality information. From February 2012, quality and safety reports will include patient experience. Reporting on patient feedback will be supported by 'Meridian' the new I-Pad device that will provide immediate comments from patients.

5.0 Summary

We continue to engage and support our ward staff to ensure that we deliver the highest quality care as set out in our Quality Improvement Strategy 2010-2014 and the NHS South Quality and Patient Safety Improvement Programme.