Quality and Safety Report
Public Trust Board
August 2012

Introduction
This report aims to inform the Board the high level data relating to trust performance across a number of patient safety and quality metrics. The report provides analysis of data and highlights themes and trends across a range of clinical indicators for the month of July 2012.

Background
The Trust has developed a number of measures which provide ward specific, centre specific and Trust Board information, which enables a true source for assurance from the ward to the Board. This can be used to support improvements within Centres and wards and therefore overall contribute to an improved patient experience. This process is used in conjunction with Strategic Health Authority Quality objectives and processes and provides a range of assurance measures for the Board to consider.

1.0 Quality Monitoring and Assurance
The focus of the headline measures used to front this report are taken from the inpatient experience, but significant work is being undertaken in Outpatients to ensure that improvements are being made in all wards and Depts. The “test your care” process used to produce the high level data below is due for roll out on the Autumn and in future reports will provide high level performance indicators for all areas. Clearly the performance on each ward will contribute to the overall score and the Quality and Safety Committee are reviewing

1.1 Ward to Board Nursing Care Metrics from February to July 2012

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Storage and Administration</td>
<td>89%</td>
<td>91%</td>
<td>97%</td>
<td>98%</td>
<td>99%</td>
<td>96%</td>
</tr>
<tr>
<td>Infection Control and Privacy &amp; Dignity</td>
<td>89%</td>
<td>87%</td>
<td>91%</td>
<td>95%</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>Patient Observations</td>
<td>81%</td>
<td>79%</td>
<td>84%</td>
<td>83%</td>
<td>87%</td>
<td>85%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>72%</td>
<td>81%</td>
<td>84%</td>
<td>87%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Tissue Viability</td>
<td>74%</td>
<td>79%</td>
<td>91%</td>
<td>90%</td>
<td>89%</td>
<td>87%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>82%</td>
<td>83%</td>
<td>91%</td>
<td>92%</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Fluid Management</td>
<td>64%</td>
<td>73%</td>
<td>85%</td>
<td>87%</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>Falls assessment</td>
<td>92%</td>
<td>91%</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>Continence</td>
<td>81%</td>
<td>83%</td>
<td>97%</td>
<td>93%</td>
<td>88%</td>
<td>93%</td>
</tr>
<tr>
<td>Comfort Rounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>83%</td>
</tr>
<tr>
<td>Total</td>
<td>81%</td>
<td>83%</td>
<td>91%</td>
<td>92%</td>
<td>92%</td>
<td>91%</td>
</tr>
</tbody>
</table>
1.1.1 Assurance and performance management of Quality and Safety

The Deputy Chief Nurse reviews each ward specific metrics with senior nurses and is monitoring the action plans for improvement. As described in the introduction, some wards will have varying performance and it is key that they are supported as well as performance managed to ensure ongoing improvements. Some ward areas have acknowledged the gaps in their metrics and introduced their own Quality checks which are helping staff to be aware of the improvements required. Key performance issues relating to Quality and Safety will be discussed at Quality and Safety Committee along with Centre Governance arrangements, whilst key performance Indicators taken to the Centre Performance meetings will hold Centre Chiefs and managers to account for the timely improvements within their centre.

1.1.2 Quality & Patient Safety Walk rounds

During July Executive Quality and Safety Walkabouts (Board Directors) took place on ward 28 and AMU at Princess Royal Hospital. These are announced visits and broadly follow the NPSA patient safety visit format. The reports are reviewed by the Directors to ensure this captures all information reviewed and that any actions required are fed back to the clinical as well as non clinical areas.

1.1.3 Patient Environment Action Team (PEAT) visits

PEAT team inspections involving members of the PEIP took place on the following wards this month:

- Ward 28
- Ward 26S
- Ward 26 U
- OPD at RSH

1.1.4 The Safety Thermometer

The aim established by the Strategic Health Authority through their mandated CQUIN is achieve 95% harm free care across all four harms by 2013.

- Pressure Ulcers
- Catheter Acquired Urinary Tract Infections
- Venous Thrombus –emboli
- Falls

The Safety thermometer tool is designed to assist the wards and the trust to build up a picture of patient safety issues, identify hot spots and to help the trust to see the impact of actions that aim to reduce patient harm. It provides snap shot of one day’s activity each month and so the data produced needs to consider carefully.

**Headlines**

- The Trust has contributed to this process since April with the Deputy Chief Nurse leading this process.
- For the first quarter the trust has achieved 91.73 % of patients sampled with harm free care.
- This means that for every 100 patients we treat 8 have suffered harm in our care.
- From this process to date, pressure ulcers are the most common harm to our patients, with Grade 2 pressure ulcers being the most common pressure ulcer harm to occur.
- It is important to note that the majority of patients suffered one harm only, with 0.41% patients who suffered more than one harm, and no patients have suffered more than 3 harms.
- A process through Centre Quality development plans as well as corporate actions for improvements will need to see rapid improvement and progress.

The safety thermometer tool is only one part of a system of triangulation which allows clinicians and non clinicians to have a comprehensive oversight into the patient safety experience. The triangulation system also uses intelligence from sources such as Datix, SI reporting, complaints, ward observations of care and external sources such as LINK and CHC visits. Each month the ward areas complete a patient survey form which is submitted electronically to the SHA, once analysed the published data is available for the wards and clinical centres to utilise. This display of graphical data will be shown on the ward Quality Board which will be in the lobby areas of all wards. Further analysis will be required of the initial outcomes from this first Quarter, to align with other Trust data and action plans for improvement as well as benchmarking with other Trusts.

2.0 Patient Safety Incidents

Quality report to Public Board- August 2012-vm
847 patient related incidents were reported on Datix during July 2012, which is an increase in reporting from June 2012. Over all the Trust has had an increase in patient safety incident reporting of 12% on the same reporting period last year. The ongoing increase in reporting is suggestive of an open reporting culture within the Organisation. Incident reporting is encouraged with all staff at Trust Induction, alongside the advice that the Trust operates a ‘fair blame’ culture.

The percentage of patient related reported incidents which were classified as Serious Incidents in July 2012 was 1.4%. This is a slight increase of 0.3% from the percentage of incidents that were classified as Serious Incidents in June 2012. However, overall, there is a reduction in the percentage of reported incidents being classified as Serious Incidents.

**Incident Monitoring**

The High Risk Scrutiny Group monitors the number of patient safety incidents that breach the time scales applied from: initial identification on Datix to expected review and completion dates. All incidents that are out of date are reviewed and plans identified to ensure review and completion within a given time scale. These are monitored to ensure that they are addressed with the agreed timescales. There are some incidents that require more time to fully investigate the underlying root causes and dates for completion are adjusted accordingly, but action within the incident continues to be reviewed for appropriately and timely updates.

A total of 26 patient safety incidents were identified as being overdue during July 2012 which is a reduction on the number reported in June 2012.

Quality report to Public Board- August 2012-vm
Serious Incidents Performance Aug 2010 - Jul 2012

### 3.3 Never Events
The Trust reported one Never Event in July 2012, this related to a Surgical Error in Ophthalmology. Following detection of the incident, the cataract service was temporarily suspended until the Root Cause Analysis Meeting could be held. The RCA meeting took place on 16th July 2012 and was chaired by the Director of Nursing and Deputy Medical Director. The panel included members from the Clinical Commissioning Group and Care Quality Commission. The assurances gained enabled Cataract services were resumed the following week.

### Action Plan status by Centre 2011/12

<table>
<thead>
<tr>
<th>Centre</th>
<th>Complete</th>
<th>O/Standing</th>
<th>Total</th>
<th>% Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapies</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Women’s &amp; Children</td>
<td>23</td>
<td>6</td>
<td>29</td>
<td>80%</td>
</tr>
<tr>
<td>Oncology</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>75%</td>
</tr>
<tr>
<td>Surgery</td>
<td>19</td>
<td>9</td>
<td>28</td>
<td>68%</td>
</tr>
<tr>
<td>Medicine</td>
<td>27</td>
<td>18</td>
<td>45</td>
<td>60%</td>
</tr>
<tr>
<td>Musculo Skeletal</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>70%</td>
</tr>
<tr>
<td>Emergency &amp; Critical Care</td>
<td>15</td>
<td>10</td>
<td>25</td>
<td>56%</td>
</tr>
<tr>
<td>Ophthalmology &amp; Pt Access</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>55%</td>
</tr>
<tr>
<td>Other / Corporate</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>66%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111</strong></td>
<td><strong>54</strong></td>
<td><strong>165</strong></td>
<td><strong>67%</strong></td>
</tr>
</tbody>
</table>

There is a small improvement on action plans completed since last month (64%). The percentage completed is now 67%. Some action plans from this financial year are not yet due for completion and some are overdue. These have been escalated to the Centres. Medicine Centre and Emergency and Critical Care Centre are consistently the highest reporting areas. Oncology has sustained their increased reporting compared to May and June 2012, the increased reporting relates consistent concerns with Medical Records availability at Outpatients.

### 3.0 Patient Safety Summary – Key Indicators

#### 3.1 Pressure Ulcers
There were four Grade 3 hospital acquired pressure ulcers reported in June 2012, following investigation one was identified as being present prior to admission. There are learning outcomes for the Ward involved, but this case will be discussed with the Commissioners. This is a 25% increase in acquisitions from the three Grade 3 Trust acquired pressure ulcers reported in June 2012.

**Cumulative total 2011/12 and 2012/13 ytd**

The Chief Nurse and Deputy Chief Nurse are now taking the lead on ensuring that Root Cause Analysis meetings will be held monthly to consider each case in depth. Working to evaluate trends and themes that could lead to cross site learning in order to aim to eliminate all avoidable Trust acquired Grade 3 and 4 pressure ulcers by December 2012. These key performance indicators are fundamental to the Quality Improvement Strategy within the Trust and will be a prioritised focus to achieve the elimination of grade 4 pressure ulcers by end December and Grade 3 pressure ulcers by March 2013.

**Grade 3&4 Pressure Ulcers by Month Jul 10 – Jul 12**

**All reported pressure ulcers**
The identification of pressure ulcers on admission has increased substantially since August 2011, demonstrating raised awareness of the need to complete a complete assessment of patients’ skin integrity within agreed timeframes from arrival.

5.0 Falls
There were 122 patient falls in July 2012 of which 2 were RIDDOR reportable (see appendix 1 for details). The number of falls in July 2012 has decreased slightly from June 2012. Therefore at present the Trust is below last years falls incident rate.

Falls by comparisons July 2012

<table>
<thead>
<tr>
<th>Falls 12/13</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>108</td>
<td>129</td>
<td>132</td>
<td>122</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011/2012</td>
<td>132</td>
<td>143</td>
<td>132</td>
<td>129</td>
<td>130</td>
<td>134</td>
<td>134</td>
<td>136</td>
<td>147</td>
<td>151</td>
<td>121</td>
<td>102</td>
</tr>
</tbody>
</table>

Table 20: Falls per month

Falls by rate from April 2010 to July 2012
September/October 2010 demonstrated a peak of reporting which was consistent with an intensive period of training and education Trust wide on falls reporting and falls prevention. It is not unusual to see a rise in reporting after such an intervention. The subsequent decrease in the number of falls, and reaching our CQUIN target for 2011/12 were consistent with falls prevention measures, such as the falls bundle which were introduced on the back of the training.

**External Visits / Assurance**

1. **Background**

This visit was one of a number of planned announced visits to the Shropshire and Telford Hospital NHS Trust (SaTH). This report is taken from the Primary Care Trust report on the outcome of the visit. In drafting this report, the visiting team were aware of the limitations of the approach taken. A rapid assessment over a brief period can only give a snapshot of the department and although open dialogue with a range of staff and patients is very useful in getting access to a wide range of views, care needs to be taken in assessing these views. For these reasons, the report offers observations and reflections rather than directive recommendations in most areas. Where recommendations are offered, it is usually based on strong evidence from a single source or clear indications from a range of sources. There are no recommendations in areas outside of the scope of the visit.

2. **The structure of the visit**

A team from NHS Shropshire County visited the Accident and Emergency (A and E) Department of Royal Shrewsbury Hospital (RSH) on 26th June 2012. The visit was organised in three parts:

a. A team of two people assessed the department for its achievement of the standards the department needs to reach to become established as a trauma centre;

b. A team of two people inspected the patient pathway through the department;

c. A team of two people assessed the department using the quality assurance framework developed for all providers.

This report is a report on part c above - i.e. on staffing, clinical standards, patient experience, patient safety and facilities as outlined in the agreed quality assurance framework adopted by the PCT and Shropshire County CCG.

- **Staffing** - "Staffing levels are at a level that enables the clinical team to deliver safe and effective care"
Clinical Standards - "Patients and Carers experience safe and effective clinical care, sensitive to their individual needs and preferences, that promotes high quality care for the patient"

Patient Experience - "the clinical area / ward collects and acts upon feedback from patients and carers / families"

Patient safety - "staff are responsible for ensuring patient safety is maintained"

Facilities - "The care environment meets the needs of the service"

3. Recommendations made by External Review

- Improvement of documentation to include specific issues regarding children or development of specific children's documentation;
- Consideration of the paediatric liaison role to act as a "safety net" for those families who are vulnerable and who require extra support and to help to ensure that potential cases of abuse are not missed;
- Improving the take-up of training (multi-agency wherever possible ) on safeguarding for medics;
- Ensure documentation within the department requests information on cultural issues and that care plans address cultural needs. This should include recording of ethnicity in parental and child notes.
- Produce the agreed template of nursing staffing for the department.
- Continue to improve the CRB checking process for all staff in the department.
- Work to ensure all specialties in the Trust understand their role in the A and E department meeting its waiting time targets.

This report was sent to the Trust for any factual matters to be corrected and the final report reflects comments made by the provider on 26th July 2012. The PCT now requires an action plan to address the recommendations presented to the Clinical Quality Review following agreement of the report at the CQR meeting in September 2012.

2.0 Patient experience section

2.1 Ward to Board Patient Experience Metrics for February to July 2012
This includes: -

- Feedback within our OPD departments, results are being analysed and will be reported in September's report.

- Patient experience and involvement panel (PEIP) members are involved in gathering real time patient feedback within our OPD departments, results are being analysed and will be reported in September's report.

2.2 Actions taken to understand and improve the patient experience across the trust

2.2.1 Outpatient Patient Satisfaction Questionnaire

Patient experience and involvement panel (PEIP) members are involved in gathering real time patient feedback within our OPD departments, results are being analysed and will be reported in September's report. This includes: -

- Graffiti boards have been successfully completed in OPD across both sites to tell the trust how we are doing in meeting the ten point dignity challenge. Initial results from both sites are very encouraging; the results will be reported in September's report.

- Outpatient real time surveys have continued to at both sites, analysis of the data so far will be reported in the September's report. Both this initiative and the graffiti boards have utilised our PEIP members in facilitating the surveys.

- 500 Inpatient Questionnaires have been sent out to patients who were inpatients in the trust during April 2012, the questions relate directly to the areas in the national survey were we needed to demonstrate an improvement. The survey will help the trust measure our progress in achieving the action plan formulated to, the audit results will be reported in September's report.

- In supporting patients with a Learning disability or Dementia a number of actions continue to support their care, and dignity.
  o Training has commenced in July for the 72 link nurses who will act as champions for LD patients across the clinical areas.
  o The trust has engaged with SSSFT in the provision of Rapid Assessment and Intervention Dementia (RAID), the RAID will enhance the care of the care of patients experiencing dementia, delirium and depression by providing on site mental health access teams 24/7. SATH staff are undertaking two days training accredited by Staffs University in to support best practice and effective use of clinical pathways

- The implementation of the “This is Me” patient passport to support the care of patients with dementia is about to be launched across both sites.
• The trust will recruit a senior nurse to support the West Midlands NHS composite model of dementia care, the trust has secured funding for 12 months for this post.
• Dignity Champion training continues during August, there had been very poor uptake on this training but with clear promotion and discussion, there has been a significant increase in uptake in booking of places on training from previous months.

2.2.2 Friends and Family Test – Net Promoter Question

Friends and Family test – Net Promoter score July
The overall trust score shows a slight increase on the previous months score, we are on target to achieve the required score of 72.48 by March 2013. We have seen a marked increase in response this month due to raising of awareness within clinical centres and by the feedback provided to each ward and centre of their previous month’s scores. We now provide wards with their individual response rates and also a rank their score against other wards. Each wards score will be published on the Quality Boards which are due to placed within each ward lobby area.

The quarterly scores are illustrated in the following table

<table>
<thead>
<tr>
<th>Net-promoter Results Summary 1st Quarter</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No of responses</td>
<td>901</td>
<td>646</td>
<td>690</td>
<td>871</td>
</tr>
<tr>
<td>Overall monthly score</td>
<td>54.43</td>
<td>65.74</td>
<td>65.58</td>
<td>68.88</td>
</tr>
</tbody>
</table>

3.0 Organisational NPS Response July 2012 SATH

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>START DATE</td>
<td>01/07/2012</td>
<td>08/07/2012</td>
<td>15/07/2012</td>
<td>22/07/2012</td>
</tr>
<tr>
<td>END DATE</td>
<td>07/07/2012</td>
<td>14/07/2012</td>
<td>21/07/2012</td>
<td>28/07/2012</td>
</tr>
</tbody>
</table>

| 3.1 Total number of inpatients in period (number of defined DISCHARGES within the period) | 1217 | 1293 | 1144 | 1186 |
| 3.2 Total number of responses in period (number of NPS responses from cohort in 3.1) | 159 | 152 | 290 | 270 |
| 3.3 Number of promoters | 126 | 87 | 212 | 205 |
| 3.4 Number of passives | 31 | 54 | 70 | 56 |
| 3.5 Number of detractors | 2 | 11 | 8 | 9 |

4.0 Net Promoter Score

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Organisation NPS - weekly (automatically populates from data entered above)</td>
<td>77.987421</td>
<td>50</td>
<td>70.344828</td>
<td>72.59259259</td>
</tr>
<tr>
<td>4.2 Organisation Monthly (automatically populates from data entered above)</td>
<td>68.88633754</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.2.3 Patient Services – Complaints activity and analysis

2.1 Complaints, Incidents and Serious Incidents (SI’s)

Monthly activity – new complaints and closures

Quality report to Public Board- August 2012-vm
2.2 Ombudsman activity
During July 2012, the Ombudsman’s office has made further contact in respect of a number of cases undergoing local resolution where complainants are seeking closure. There are presently a number of cases that have been referred back for local resolution to conclude and one case has been closed following receipt of the final information on compliance was sent. There have been no new cases accepted by the Ombudsman for investigation.

2.1 Themes

2.3 Coroner’s Inquests – Rule 43 Letters and Trust Actions
There were no rule 43 letters received in July

6.0 Purple Cards / GP Liaison

6.1 Purple Cards
No new purple cards were received.
2 purple cards were lodged with the PCT:
- Inappropriate admission

Quality report to Public Board- August 2012-vm
6.2 GP Liaison
24 GP liaison queries were raised in July 2012. This month, the majority of concerns were related to appointments (11). There was a further reduction in the number of concerns relating to the standard of discharge summaries (2). The ‘administration’ category related to the chasing up of letters or referrals that had not yet been received either by the Trust or the GP.

Conclusion

The Board are asked to note the Quality report which is based on safety, patient outcomes and patient experience

Vicky Morris
Director of Quality and Safety/Chief Nurse