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Scrutiny Panel B:
PATIENT SAFETY IN ACUTE CARE INQUIRY

Thursday, 14th October, 2010
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Capozzoli (Chair)
Councillor Daunt (Vice-Chair)
Councillor Drake
Councillor Harris
Councillor Marsh-Jenks
Councillor Payne
Councillor Parnell

Contacts

Democratic Support Officer
Ed Grimshaw
Tel: 023 8083 2390
Email: ed.grimshaw@southampton.gov.uk

Policy and Performance Analyst
Caronwen Rees
Tel: 023 8083 2524
Email: caronwen.rees@southampton.gov.uk

PUBLIC INFORMATION

Southampton City Council's Six Priorities

- Providing good value, high quality services
- Getting the City working
- Investing in education and training
- Keeping people safe
- Keeping the City clean and green
- Looking after people

Fire Procedure – in the event of a fire or other emergency a continuous alarm will sound and you will be advised by Council officers what action to take.

Access – access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Public Representations

At the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Dates of Meetings: Municipal Year 2010/11

2010	2011
Thurs 10 June	**Thurs 13 Jan**
Thurs 15 July	Thurs 10 Feb
Thurs 9 Sept	Thurs 17 Mar
Thurs 14 Oct	**Thurs 21 Apr**
Thurs 11 Nov	

** **bold** dates are Quarterly Meetings

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the contained in Article 6 and Part 3 (Schedule 2) of the Council's Constitution.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

Disclosure of Interests

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "personal" or "prejudicial" interests they may have in relation to matters for consideration on this Agenda.

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Personal Interests

A Member must regard himself or herself as having a personal interest in any matter

(i) if the matter relates to an interest in the Member's register of interests; or

(ii) if a decision upon a matter might reasonably be regarded as affecting to a greater extent than other Council Tax payers, ratepayers and inhabitants of the District, the wellbeing or financial position of himself or herself, a relative or a friend or:-

  (a) any employment or business carried on by such person;

  (b) any person who employs or has appointed such a person, any firm in which such a person is a partner, or any company of which such a person is a director;

  (c) any corporate body in which such a person has a beneficial interest in a class of securities exceeding the nominal value of £5,000; or

  (d) any body listed in Article 14(a) to (e) in which such a person holds a position of general control or management.

A Member must disclose a personal interest.

Continued/……

Prejudicial Interests

Having identified a personal interest, a Member must consider whether a member of the public with knowledge of the relevant facts would reasonably think that the interest was so significant and particular that it could prejudice that Member's judgement of the public interest. If that is the case, the interest must be regarded as "prejudicial" and the Member must disclose the interest and withdraw from the meeting room during discussion on the item.

It should be noted that a prejudicial interest may apply to part or the whole of an item.

Where there are a series of inter-related financial or resource matters, with a limited resource available, under consideration a prejudicial interest in one matter relating to that resource may lead to a member being excluded from considering the other matters relating to that same limited resource.

There are some limited exceptions.

Note: Members are encouraged to seek advice from the Monitoring Officer or his staff in Democratic Services if they have any problems or concerns in relation to the above.

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PREJUDICIAL INTERESTS

In accordance with the Local Government Act, 2000, and the Council's Code of Conduct adopted on 16th May, 2007, Members to disclose any personal or prejudicial interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Panel Administrator prior to the commencement of this meeting.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the Minutes of the Panel Meetings held on the 9th and 23rd September and to deal with any matters arising, attached

7 HAMPSHIRE PARTNERSHIP FOUNDATION TRUST PROGRESS WITH QUALITY ACCOUNTS

Report of the Director of Health and Adult Social Care, detailing a paper by the Hampshire Partnership Trust on the development of their 2010/11 Quality Account, attached.

8 PATIENT SAFETY IN ACUTE CARE INQUIRY – SUHT CURRENT PERFORMANCE

Report of the Director of Nursing, Southampton University Hospitals NHS Trust, detailing information on patient safety, attached.

Wednesday, 6 October 2010 SOLICITOR TO THE COUNCIL

SCRUTINY PANEL B

MINUTES OF THE MEETING HELD ON 23 September 2010

Present: Councillors Capozzoli (Chair), Daunt (Vice-Chair), Drake, Harris, Marsh-Jenks and Parnell

Apologies: Councillor Payne

16. **APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)**

Apologies were received from Councillor Payne.

17. **SOUTHAMPTON LOCAL INVOLVEMENT NETWORK (S-LINK) ANNUAL REPORT AND ACCOUNTS 2009/10**

The Panel noted the report of the Head of Policy and Performance, detailing the S-LINk Annual Report and accounts. (Copy of the report circulated with the agenda and appended to the signed minutes).

Mr Harry Dymond (Southampton Local Involvement Network (S-link)) was present, and with the consent of the Chair, addressed the meeting.

In response to questions the Panel noted that a review of the membership had taken place. In addition the Panel were informed that with the increase of Slink activities new members were being recruited.

The Chair expressed his thanks for the presentation and thanked the Group for the work undertaken.

18. **JOINT STRATEGIC NEEDS ASSESSMENT – CONSULTATION DRAFT**

The Panel noted the report of the Executive Director for Health and Adult Care and the Director of Public Health, detailing the consultative draft of the Joint Strategic Needs Assessment (Copy of the report circulated with the agenda and appended to the signed minutes).

Martin Day (Health and Adult Care Directorate Strategic Business Manager, SCC) and Graham Watkinson(Public health Consultant at NHS Southampton City) were present and, with the consent of the Chair, addressed the Panel.

19. **TRANSFORMING COMMUNITY SERVICES – SOLENT HEALTHCARE**

The Panel considered and noted the report of the Chief Executive of Solent Healthcare, detailing the proposed development for Solent Healthcare to progress autonomy as an NHS provider. (Copy of the report circulated with the agenda and appended to the signed minutes).

Dave Mehan (Business Director for Solent Healthcare) detailed the report circulated with the papers and made the following points:

- the role of Solent Healthcare as the service provider for the primary care trusts of Hampshire, Portsmouth and Southampton and the development history of the organisation;
- the scope of the services offered across the region and the differences within the area. e.g. the provision of community dentistry in Southampton and not Portsmouth; and
- the business plan and the benefits of developing the organisation into a foundation trust.

The Panel sort clarification on the following points:

- whether the stated timetable were achievable and practical;
- the predicted effect of the changes on patients;
- future plans for joint co-ordination of services;
- plans to enhance communication between the Out of hours service and GP practices;
- quality control insurances in the emerging health marketplace; and
- the definition of market agility in relation to the provision of health services.

RESOLVED:

(i) that the Panel thanked the presenter and noted the responses to its questions; and

(ii) that the Panel delegated authority the Chair to co-ordinate electronically a response to the proposals.

SCRUTINY PANEL B

MINUTES OF THE MEETING HELD ON 9 September 2010

Present:	Councillors Capozzoli (Chair), Daunt (Vice-Chair), Drake, Harris, Payne and Parnell
Apologies:	Councillor Marsh-Jenks
In Attendance	Councillors Barnes-Andrews, Kolker, Jones, Vinson and White. Ms Gayle Rossiter and Ms Olga Senior – Strategic Health Authority Ms Pam Sorensen – Hampshire Partnership NHS Foundation Trust Mr Elton Dzikiti – Solent Healthcare Ali Ayres – Southampton University Hospital Trust Mr Bob Deans, Mr Adrian Higgins and Mr David Payton –NHS Southampton City Mr Harry Dymond, Mr Robbie Robinson, Ms Jodie Phillips and Mr Hannigan - Southampton Local Involvement Network (Slink)

11. **APOLOGIES AND CHANGES IN PANEL MEMBERSHIP (IF ANY)**

12. **GOVERNMENT HEALTH WHITE PAPER 2010 - "EQUITY AND EXCELLENCE: LIBERATING THE NHS"**

The Panel considered the report, of the Head of Policy and Performance, detailing for discussion the current Government White Paper. (Copy of the report circulated with the agenda and appended to the signed Minutes).

Penny Furness-Smith (Executive Director Health and Adult Care Southampton City Council) and Bob Deans (Executive Director of NHS Southampton City) detailed the presentation circulated with the papers and answered questions on the following topics:

- the effect of transition to the new arrangements on staff and performance;
- whether it was possible to complete the proposed transfer to the GP consortiums by 2013 and whether the necessary transition steps can be put in place before the Strategic Health Authorities are disbanded in 2012;
- the potential make up and constitutional arrangements of the proposed NHS Commissioning Board;
- the establishment of Health Watch nationally and locally. In particular the Panel questioned the funding for proposed body and noted the expectation that the basis of the new organisation would be the existing Local Involvement Networks. The Panel questioned the proposed make up of the new organisation as to whether they would be staffed by volunteers or by paid members of staff;
- the funding for the Slink it was noted that this was due to expire in June of 2011 and the Panel questioned what ,if any, measures currently existed for the period prior to the establishment of the new Health Watch organisation.
- the development of the Health and Wellbeing Board into a statutory body;
- the definition of Health Outcomes and the transition process involved in moving to these and away from performance targets; and

- the steps taken to avoid the focus of the health service being changed from the provision of health care and not ability to generate profit by the developing GP consortia.

RESOLVED

(i) that the Panel thanked the presenters and noted the responses to its questions; and
(ii) that the Panel delegated authority the Chair to co-ordinate electronically a response to the consultation on the white paper.

13. **UNSCHEDULED CARE ACROSS SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH**

The Panel considered the report, of the Executive Director for Unscheduled Care for Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) outlining the proposals for a model of unscheduled care within the region. (Copy of the report circulated with the agenda and appended to the signed minutes).

Dr David Payton, Executive Director for Unscheduled Care (SHIP), detailed the presentation circulated with the papers and answered questions on the following topics:

- the capacity of the healthcare network to address out of hours service need;
- the transition timescales and process for the introduction of any new proposals;
- how members of the public will be informed of the changes to services and what impression any change will have on them;
- the need from improved communications and integration within the services; and
- how the walk in centres fit into the pattern of health provision across the region.

RESOLVED

(i) that the Panel thanked the presenter and noted the responses to its questions; and
(ii) that the Panel delegated authority to the Chair to co-ordinate electronically a response to the consultation on the white paper.

14. **UNSCHEDULED CARE (EAST SOUTHAMPTON) OPTIONS FOR BITTERNE WALK IN CENTRE**

The Panel considered the report, of the Director of Health and Adult Social Care, detailing the work underway in relation to unscheduled care in East Southampton and the options for the future of Bitterne Walk in Centre. (Copy of the report circulated with the agenda and appended to the signed minutes)

Dr Adrian Higgins, Chair of the Clinical Leadership Board for NHS Southampton City, detailed the presentation circulated with the papers and answered questions on the following topics:

- the rules regarding the transfer of costs from users of the Bitterne walk-in-centre (Bwic) to neighbouring authorities;

- the breakdown of the users of the Bwic including those from outside Southampton;
- who the main users of the Bwic were;
- the types of treatment provided by the Bwic and the numbers of people receiving care;
- whether capacity of the Local GP surgeries would be sufficient to service the needs of the area should the hours of the Bwic be amended or the facility closed;
- the need for a full range of options relating to the Bwic had been discussed and the alarm this had caused in the area;
- what measures were in place to ensure a consistency of out of hours service provision and the hours of GP surgeries;
- the need to view the provision of health care in the East of the City as a whole. Ensuring that no disparity of service is created with the West and that the requirements of the residents are catered for;
- whether the local GP surgeries had been consulted ; and
- the effects of the closure of the Shirley walk-in-centre on accident and emergency demand.

RESOLVED

(i) that the Panel thanked the presenter and noted the responses to its questions; and

(ii) that the Panel delegated authority to the Chair to co-ordinate electronically a response to the consultation on the white paper.

(iii) requested the costs of the Bitterne Walk in Centre prior to 2009-2010.

15. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the minutes for the Scrutiny Panel B Meeting on 29th July 2010 be approved and signed as a correct record. (Copy of the minutes circulated with the agenda and appended to the signed minutes).

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DECISION-MAKER:		PANEL B		
SUBJECT:		HAMPSHIRE PARTNERSHIP FOUNDATION TRUST – QUALITY ACCOUNT 2010/11		
DATE OF DECISION:		14 OCTOBER 2010		
REPORT OF:		DIRECTOR, HEALTH AND ADULT SOCIAL CARE		
AUTHOR:	Name:	Caronwen Rees	Tel:	023 80 832524
	E-mail:	Caronwen.Rees@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY
None

SUMMARY

To receive a paper from Hampshire Partnership Foundation Trust (HPFT) on the development of their 2010/11 Quality Account (QA) and an update on progress on the priorities set out in their 2009/10 QA.

RECOMMENDATIONS:

(i) To note the process Hampshire Partnership Foundation Trust are taking to the development of their 2010/11 Quality Account.

(ii) To receive a verbal update on progress against the priorities for 2010/11 set out in the Hampshire Partnership Foundation Trust 2009/10 Quality Account.

(iii) To agree that Hampshire Partnership Foundation Trust are asked to present a further update on progress and their draft 2010/11 Quality Account to the Panel early next year.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to engage with HPFT over the development of their 2010/11 QA in order that they might provide an informed comment in due course.

CONSULTATION

3. None.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4. None.

DETAIL

5. The Department of Health introduced from April 2010 a requirement for health service providers to publish annual public reports on the quality of the services they deliver. The aim of QAs is to improve public accountability and to engage boards in understanding and improving quality in their organisations. Providers of acute, mental health, learning disability and ambulance services were required to produce a QA in 2009/10. Therefore the following providers of services to Southampton were required to produce

a QA on part or all of their service this year:

- Southampton University Hospitals Trust
- Hampshire Partnership Foundation Trust
- South Central Ambulance Service

6. In the White Paper 'Equity and Excellence: Liberating the NHS' the Department of Health state that they will:

> "revise and extend quality accounts to reinforce local accountability for performance, encourage peer competition, and provide a clear spur for boards of provider organisations to focus on improving outcomes. Subject to evaluation, we will extend quality accounts to all providers of NHS care from 2011 and continue to strengthen the independent assurance of quality accounts to ensure the content is accurate and fair. We will ensure that nationally comparable information is published, in a way that patients, their families and clinical teams can use."

7. Health Scrutiny and LINks have a role (albeit a voluntary one) in reviewing and providing a statement for the accounts. This means that commissioning PCTs, LINks and OSCs have important roles in the development of QAs and in maximising their success. The statement should be based on year round discussions with providers. This will enable a dialogue on progress towards their objectives and allow the panel and LINk to comment on the accounts next year in an informed way.

8. The attached paper, provided by HPFT, provides details of the process they are using to develop their 2010/11 QA and provides a summary of their 09/10 account. This give the panel an opportunity to understand the process behind the accounts and an opportunity to engage with HPFT on progress on their plans for 2010/11 as set out in their 2009/10 account. This will enable the panel to provide an informed comment for the 2010/11 QA when the draft is published early next year.

FINANCIAL/RESOURCE IMPLICATIONS

Capital

9. None.

Revenue

10. None.

Property

11. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

12. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007

Other Legal Implications:

13. None.

POLICY FRAMEWORK IMPLICATIONS

14. None

SUPPORTING DOCUMENTATION

Appendices

1.	Proposals for the Hampshire Partnership NHS Foundation Trust's 2010/11 Quality Accounts

Documents In Members' Rooms

1.	HPFT Quality Account 2009/10

Background Documents

Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Background documents available for inspection at: N/A

KEY DECISION? **No**

WARDS/COMMUNITIES AFFECTED:	All

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Hampshire Partnership NHS
NHS Foundation Trust

Proposals for the Hampshire Partnership NHS Foundation Trust's 2010/11 Quality Accounts

Briefing for HOSC

1.0 Background

The directors of the Hampshire Partnership NHS Foundation Trust are required under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 ("the Quality Accounts Regulations") to prepare Quality Accounts for each financial year.

In February 2010, the Department of Health (DH) published guidance for the production of 2009/10 Quality Accounts (The framework for Quality Accounts: A consultation on the proposals). Until guidance is published for the 2010/11 Quality Accounts, it has to be assumed that the requirements will be the same as in 2009/10, and is therefore likely to include:-

- A **statement from the Board**, including an overall statement of accountability;
- **Priorities for quality improvement** – confirmation that we have identified key improvement priorities and the monitoring and reporting arrangements we have in place to track progress;
- Review of quality performance – confirmation that we have set at least **three indicators for each of the domains of quality** (e.g. safety, effectiveness and personal); we have reviewed the range of our services with a view to developing a quality improvement plan; and we have demonstrated that we monitor quality by participating in {national} clinical audits;
- **Research and innovation** – confirmation that we participate in clinical research and use the CQUIN payment framework;
- **What others say about us** – a statement on our CQC registration (e.g. whether conditional), and of any concerns arising form periodic and/or special reviews; and a statement from Local Involvement Networks (LINks) and primary care trusts (PCTs);
- **Data quality** – a simple data quality score.

2.0 What next?

In previous years, the Trust has established a bespoke group with membership from staff, service users, carers, Governors and Commissioners to consider, agree and recommend to the FTExe priorities for quality improvement and indicators for each of the domains of quality. The priorities and indicators have then been subject to wider consultation via briefings, articles in Trust publications, the Trust's website and a questionnaire.

This year, to encourage wider staff and service user involvement and to promote smart thinking by ensuring that this work is linked to existing work streams, the Operational Directorates (Adult Mental Health, Older Persons Mental health, Learning Disabilities, Specialised Services and Social Care) are choosing and nominating their:-

1. Priorities for quality improvement
2. At least one indicator for each of the domains of quality (safety, effectiveness and personal)

This work is being undertaken via existing clinical governance structures and service user and carer groups. This approach is being promoted to staff and users/carers via articles in newsletters, the Trust's website, the Governors portal and a briefing to Governors. Once the Operational Directorates have nominated priorities and indicators, these will be considered by an overarching committee (FTExe) with responsibility for approving a final list, which will then be subject to consultation with the following stakeholders:

- Staff;
- Service users, carers;
- Governors;
- Commissioners;
- LINks;
- The public.

This approach was endorsed by the FTExe on 24th August 2010.

The following guidance was issued to the Operational Directorates to help with the selection of quality improvement priorities and quality indicators:-

- The primary audience of our Quality Account is the public
- **Priorities for improvement** – this is our opportunity to show clearly our plans for quality improvement within the Trust and why we have chosen certain priorities.
- The description of the quality priorities must include
    1. At least 3 priorities (for the whole Trust)
    2. How progress to achieve the priorities will be monitored and measured
    3. How progress to achieve the priorities will be reported.

- **Quality Indicators** – a selection of indicators that covers both organisational (e.g. healthcare acquired infection rates) and service specific indicators of quality. Choose indicators that cover the three domains of quality (patient safety, clinical effectiveness and patient experience). Explain why and how you have chosen certain indicators. It is good practice to clearly define the indicator, identify how and by whom it is collected, why it was chosen, what the results mean to the Trust and what the results may mean to service users or readers of our Quality account.
- The quality indicators do not need to be linked to the quality improvement priorities.
- The Quality Account should be reflective of all the services the Trust provides, therefore each directorate is being asked to nominate at least one priority and one indicator.
- Templates for recording your directorates chosen quality priorities and quality indicators have been provided.
- For your information, examples of previous year's quality priorities and quality indicators have been provided.
- This work is to be completed by 12th November 2010.

Finally, the Trust has given consideration to the proposed format and content of our 2010/11 Quality Account, which has been informed via:

- The SHA's review of the 2009/10 Quality Accounts
- The PwC internal review of the Trust's 2009/10 Quality Accounts

- Internal comments relating to our 2009/10 Quality Account.

For example, the inclusion of patient stories in our 2009/10 Quality Account has been well received by service users, carers and the public. In addition, each year the Trust has produced a user-friendly summary of our Quality Accounts, which has also been well received (as example is shown in Appendix 1).

4th October 2010
Ruth Pullen
Interim Deputy Director of Governance

Appendix 1 – User-friendly leaflet summarising the Trust's 2009/10 Quality Account.

Summary of Our 2009/10 Quality Account

Hampshire Partnership NHS
NHS Foundation Trust

A Quality Account is a report which demonstrates that the Board regularly scrutinises the quality of all of its services and that the Board is making year-on-year improvements. Quality Accounts look back at our past performance and tells you our plans for the coming year. The full Quality Account is available via our website at http:www.hampshirepartnership.nhs.uk.

Our performance in 2009/10

Targets	Achieved?
Percentage of beds occupied by service users who have not been discharged when expected (Delayed transfers of Care)	
Percentage of service users who were contacted by our services within 7 days of their discharge	
Percentage of service users who have access to crisis resolution/home treatment services	
Percentage of service users in inpatient learning disability services who have a care plan	
Mental Health Minimum Data Set (MHMDS) data completeness – this is a measure of our ability to submit information to national data collections. We will be able to meet this target when we have an electronic patient record - January 2011	
MHMDS - % of discharged patients on CPA that have a care coordinator in place (Patterns of Care). We will be able to meet this target when we have an electronic patient record - January 2011	
Best practice in mental health services for people with a learning disability (Green Light toolkit)	
Campus closure - number of people receiving care in (or discharged from) Learning Disabilities campus who have a discharge plan	
CAMHS - Child and Adolescent mental health services - assessed against 6 elements and given a rating of 1 to 4, 1 being the poorest and 4 the highest level.	
Drug Users in Effective Treatment (Retaining drug misusers in treatment for 12 weeks)	
Participated in 100% of eligible national clinical audits (4) and national confidential enquiry (1)	

 = Target met

 = Target nearly met

 = Target not achieved

Our plans for 2010/11

Hampshire Partnership NHS
NHS Foundation Trust

These were identified and agreed in consultation with stakeholders (including staff, service user and carer representatives, governors, and commissioners). During 2010/11 we will measure our performance and progress against these priorities.

Priorities	Indicators (how we will measure if we are achieving our priorities)	Initiatives (what we are doing to achieve our priorities)
Maximise safety for service users, staff and visitors	● Escape from medium secure units ● Slips/Trips/Falls – (a) the number occurring and (b) the number resulting in severe injury ● Violence and aggression incidents to (a) patients and (b) to staff	● Revising the risk assessment policy. ● Using a safety climate survey in in-patient wards. ● Improve Critical Incident Reviews (CIRs - the detailed investigations we do after all serious incidents) by ensuring • CIRs are completed within timescales; • CIRs are independently checked • All recommendations in CIRs are SMART (Specific, Measurable, Achievable, Realistic, and Timely).
Improve clinical effectiveness	● Under 18's admitted to adult mental health wards ● Pressure ulcers – numbers of grade 3 and above developing during admission ● Infection outbreaks – (a) the number of outbreaks and (b) how long units are closed due to outbreaks	● Implement a Trust-wide electronic patient record (called RiO) ● Introduce the use of clinical outcome measures (HoNOS and HoNOS65+) in community mental health teams.
Improve the experience of our service users	● Average Length of stay ● 7 day follow-up ● Complaints – (a) the number; (b) how many upheld and (c) themes	● Develop a five year strategy for Patient Experience. ● Identify Patient Experience work that is underway. ● Look at using the Developing Recovery Enhancing Environments Measure (DREEM) to obtain service user feedback. ● Identify and agree patient experience indicators for inclusion in Directorate and Trust dashboards.

Quality is at the heart of everything we do. Our Quality Account provides a small snap-shot of the information and initiatives we use to improve services. Our progress is checked in the Trust by various individuals and groups, including the Board. Our progress is also checked by other organisations, for example NHS Hampshire, NHS Southampton, Hampshire and Southampton Health Overview and Scrutiny Committees.

If you would like to get involved in our future plans for quality or have any comments about our Quality Account please contact us via:

- QI.Team@hantspt-sw.nhs.uk
- 023 8087 4356/4304
- Quality & Governance Team, 6 Sterne Road, Tatchbury Mount, Southampton, SO40 2RZ

Improving mental health and wellbeing together

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DECISION-MAKER:		MEMBERS OF THE OVERVIEW AND SCRUTINY COMMITTEE		
SUBJECT:		PATIENT SAFETY INQUIRY		
DATE OF DECISION:		14 OCTOBER 2010		
REPORT OF:		DIRECTOR OF NURSING, SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST		
AUTHOR:	Name:	Deputy Director of Nursing andad of Patient Safety	Tel:	023 8079 4953
	E-mail:	judy.gillow@suht .swest.nhs.uk		

STATEMENT OF CONFIDENTIALITY
The

SUMMARY

This report provides information on patient safety within Southampton University Hospitals NHS Trust to submit to the patient safety inquiry. It sets out: -

- The context of patient safety within the Trust,
- How safety is reported
- The infrastructure supporting it
- The current performance against the outcomes as set out in the consultation document “Transparency in outcomes”

RECOMMENDATIONS:

(i) To receive performance information from SUHT in relation to patient safety and use the information provided as evidence in the inquiry.

REASONS FOR REPORT RECOMMENDATIONS

1. To enable the Panel to compile a file of evidence in order to formulate findings and recommendations at the end of the inquiry process.

CONSULTATION

2. None

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

3. None

DETAIL

Introduction and Setting the Context

4. Patient Safety is one of the highest priorities for Southampton University Hospitals NHS Trust. The safety key priorities, which reflect national and local agendas, are set out in the Integrated Safety Strategy. The Strategy contains the following work streams: -

- Reducing infection
- Reducing avoidable falls
- Reducing medication errors
- Reducing avoidable pressure ulcers
- Acuity and the deteriorating patient
- VTE
- Implementation of the WHO surgical checklist
- Implementation of the MUST nutritional assessment.

All the work streams have improvement plans in place with operational groups to ensure the actions are delivered. The Trust's Patient Safety Steering Group and ultimately Trust Board oversee progress on the delivery of work streams.

Trust Board receive monthly performance reports on patient safety and quarterly in-depth patient safety reports.

Each year the Trust sets out priorities for safety, patient experience, effectiveness and performance in the Patient Improvement Framework.

The Trust provides external assurance on patient safety to its Commissioners against the patient safety aspects contained with in the Quality Contract (schedule 4a) and CQUIN (Commissioning for Quality Innovation and Improvement).

The Trust provides an annual self-assessment on Care Quality Commission (CQC) outcomes, which also contain safety domains. Compliance is regularly reviewed and reported on internally through the regulatory report, which is overseen by the Trust's Audit and Assurance Committee. The Trust can be subjected to randomised or selected visits against the CQC outcomes, such as Hygiene code visits.

The Trust is accredited at level 2 general and maternity through the NHS Litigation Authority (NHSLA) standards, which assess compliance of quality and safety standards ensuring that our policies are embedded in practice.

Year to date out of the 8 work streams there has been no deterioration from position with five showing improvement.

Overview of the draft Operating Plan – Transparency in Outcomes

5. The DH document, Transparency in Outcomes is currently subject to consultation and as a result the priorities and improvement measures have not been agreed. However encouragingly we are already measuring the majority of the improvement areas outlined in the report. Once the outcome improvement areas are agreed then the Trust will need to review the patient

pathways and organisational settings to ensure there is effective delivery.

The following section provides an overview of the Trusts current position against domain 5. “Treating and caring for People in a safe environment and protecting them from avoidable harm.”

Protecting People from Harm

6.

- Through the patient safety work streams the Trust proactively seeks to reduce levels of avoidable harm
- Patient safety incidents; incidents, Never Events and Significant Incidents Requiring Investigation SIRI’s) are reported into the National Reporting and Learning System (NRLS) and are subject to national reports.
- There is a robust consent policy, reflecting national guidance to ensure that patients understand the risks associated with particular procedures and of their condition.

Open and Honest Culture

7.

- The Trust promotes an open and honest culture demonstrated through the high reporting of incidents.
- The Trust’s Being Open Policy has recently been reviewed and amended, in accordance with the NPSA Safety Alert and will be ratified in October 2010.
- Safety culture surveys have been undertaken in all Divisions.
- The Executive and Senior Nursing Team undertake weekly safety walk-abouts and there is a plan in place to provide further training to enhance the outcome of the walk-abouts in terms of openness and learning.

Learning from mistakes

8. The Trust has an incident management policy, which outlines how the Trust learns from incidents.

- Incidents are analysed for trends and reported on.
- The Significant Event Review Group reviews the outcomes of the investigation into all significant events to ensure that the investigation has been robust that the recommendations mitigate the risk and that lessons have been learnt both locally and organisationally.
- Deep dive reviews are undertaken following significant incidents and panels are set up to review the Root Cause Analysis following MRSA, Clostridium Difficile, hospital acquired pressure ulcers, falls and thrombosis to ensure lessons are learnt.
- In terms of the overarching indicator it should be noted that the severity of harm reporting as SIRI’s has increased rather than decreased, this is due the fact that the national categorisation of reporting such events has changed requiring the Trust to report all grade 4 pressure ulcers under the European Advisory Panel guidance and will increase further in the requirement to report pulmonary embolisms and deep vein thrombosis as SIRI’s.

Improvement Areas

9. Within the quarterly patient safety report (enclosed) the Trust reports on all the improvement areas with the exception of: -

- Number of **readmission episodes** is currently reported through performance reports and is contained in Appendix II
- **Patient reported experience of medicines management** is reported through the patient experience report and has been added to the rolling program of local surveys. It is also a local CQUIN. The 2009 survey results are contained in Appendix 3. An action plan to improve compliance is in place
- **Patient survey reported cleanliness** is contained within Appendix 3 demonstrated an improvement in compliance. This is reflected by the Infection Control hygiene code visits and reports that take place on a monthly basis demonstrating good standards of compliance.
- **Number of central line infections:** General and Paediatric ICU are taking part in a South Central wide Matching Michigan audit. Results have not as yet been reported on.
- **Incidence of ventilator associated pneumonia**

  There is currently no agreed local or national definition for ventilator associated pneumonia. Currently the Trust undertakes the Saving Lives audits with compliance currently at 100%
- **Incidence of urinary catheter related infections** There is no agreed national definition of urinary catheter related infections. However the Trust is focusing on a project to reduce the number of indwelling catheters, which are known to introduce infection. A point prevalence survey has recently been undertaken with the results to be reported in the near future.

10 **Next Steps**

- To secure sustainability following the implementation of the Turnaround project in reducing falls and pressure ulcers
- To launch the clinical accreditation dashboard in November providing assurance from Ward to Board on safety, experience and outcome and aligned to the Trust's 20:20 vision
- To further enhance the patient safety walls and culture
- To achieve the CQUIN and quality contract indicators
- To align future reporting to the outcome report once agreed.

11 **Conclusion**

Safety is one of the Trust's top priorities and we are working towards being in the top quartile for all the key safety priorities. Future reporting will also reflect the agreed Outcomes paper.

Members of the Health and scrutiny Committee should note the breadth and depth of the work being undertaken to support the safety agenda.

FINANCIAL/RESOURCE IMPLICATIONS

12 None

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. The duty to undertake overview and scrutiny is set out in Section 21 of the Local Government Act 2000 and the Local Government and Public Involvement in Health Act 2007.

POLICY FRAMEWORK IMPLICATIONS

14 None.

SUPPORTING DOCUMENTATION

Appendices

1.	SUHT Quarterly Patient Safety Report
2.	Re-admission rates
3.	Patient reported experience of medicines management & Patient survey reported cleanliness 2009 survey results

Documents In Members' Rooms

1.	None

Background Documents

		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	None	

Background documents available for inspection a N/A

KEY DECISION? N/A

WARDS/COMMUNITIES AFFECTED:	all

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SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST
3-Monthly Patient Safety Report:

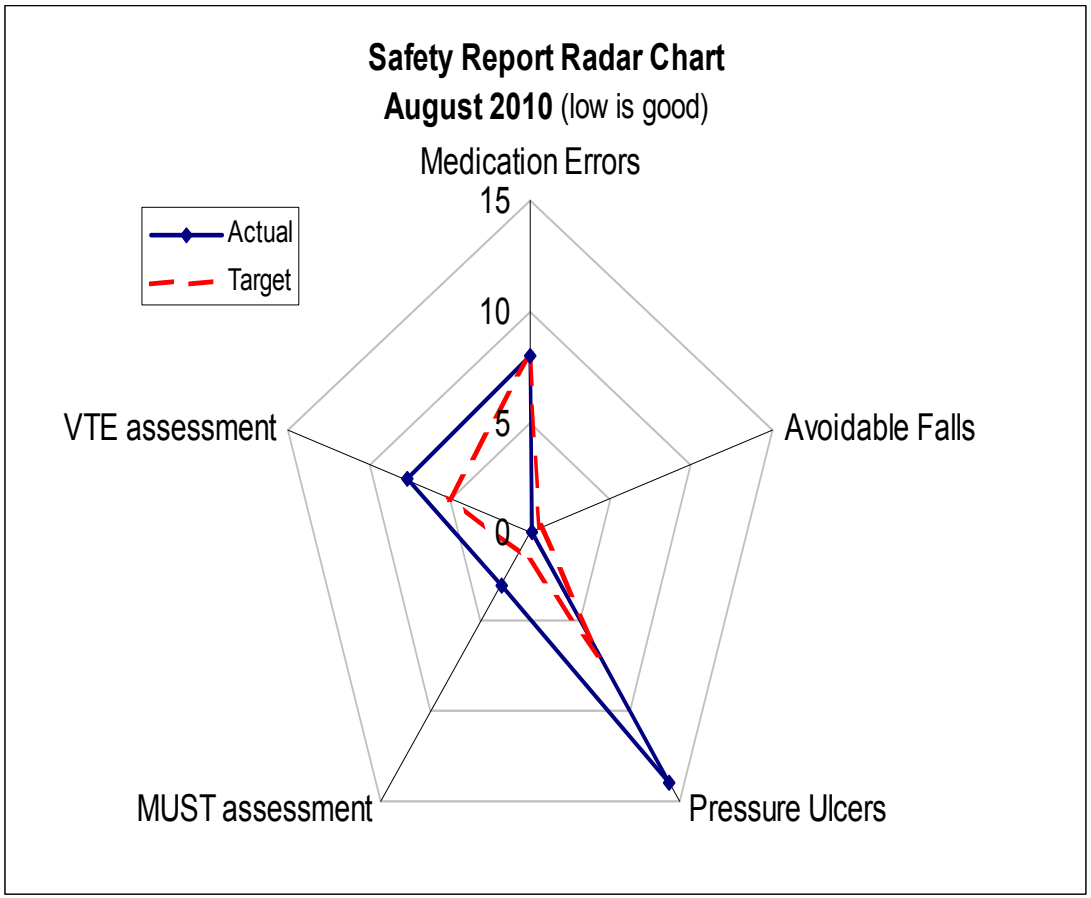
Report to	Trust Board
Report from	Gail Byrne, Deputy Director of Nursing, Head of Patient Safety
Sponsoring Executive	Judy Gillow, Director of Nursing and Patient Services
Aim of Report	▪ To provide members of Trust Board with an update on the delivery of Trust's patient safety targets for 2010/11 (Patient Improvement Framework and the Integrated Patient Safety Strategy) ▪ To highlight any areas for improvement and identify the actions that need to be taken to address
Review History to Date	This is the fifth in-depth three monthly report on patient safety for the period July – Sept 2010.
Assurance Framework	PO1a, PO1b, PO1c, PO2a, P02b, PO2g, Po6b, PO6f
Strategic Objectives:	To be trusted on quality Delivering for tax payers Excellence in healthcare
Recommendations	Members of the Trust Executive Committee should note: - • The continued journey of improvement on the patient safety work streams, with 5 work streams showing improvement and the remaining showing that they are maintaining performance. • That the new simplified report format should enable oversight of this journey over a period of time i.e. 'moving the dot' Members of the Trust Executive Committee are asked to: - • Continue to support the Rapid Spread / Turnaround Project for falls and pressure ulcers • Comment on the different reporting format Divisional Management Teams are asked to: - • Ensure that they support the work on each of the work streams, monitor their Divisional performance against the targets set and ensure action is taken where there is non-compliance

1. Introduction

1.1 Summary of progress

Work- stream	Target 2010/11	RAG	Progress From last report	Action /Comment	end of yr
No of falls	To reduce avoidable falls to under 5% of total falls To maintain SIRFIT compliance above 95%	G	↑	% Avoidable falls at 15% SIRFIT compliance 93% Turnaround Project commenced and continues to be implemented	G
Medications errors	To reduce serious medication errors by 10% i.e. 8 or less	G	–	Compliant. Action plan focusing on missed doses, insulin, medicines reconciliation, Warfarin doses and calculations.	G
Pressure Ulcers	25% reduction in grade 3 & 4 pressure ulcers from baseline set from Dec– March 10. Overall annual trajectory 87	A	↑	Current position against annual trajectory 55. Due to the turnaround project and focus there has been an increase in reporting. Whilst it is perhaps too early for the project to come to fruition in realising a reduction in pressure ulcers there does seem to be a downward trend in reporting Reduction of all pressure ulcers will continue to be monitored as an internal target.	A
Thromboprohylaxsis	90% risk assessment (CQUIN) 90% appropriate treatment	G	↑	Documented risk assessment from e-docs 71%. This picture will continue improve once the denominator is agreed.	G
Deteriorating Patient	85% compliance with patient observations (98% by Q4)	A	↑	88% compliance ROSC at 80% (national average	A
Implementation of the surgical checklist	100% compliance with WHO surgical checklist by February 2010	A	-	No audit since last reported Audit program being developed and clinical lead and manager identified. Service improvement have been supporting WHO checklist compliance through the implementation of the productive theatre	G
Nutrition	To achieve a 20% improvement in the use of MUST	A	↑	71% compliance of MUST audit, although only 31% with a MUST care plan in place .	G
Infection Prevention and Control	MRSA target 7 cases C.Difficile 139 cases = national target 110 cases = local PCT stretch target	G	–	7 MRSA bacteraemia cases 4 of which were post 48hrs C.Diff 35 cases (just below national trajectory) Excellent performance continues	G

\- *Position the same as reported in previous report*
↑ *Improvement since previous report*
↓ *Deterioration since previous report*



A radar chart (as seen above provides a visual representation of quarterly progress against the patient safety work streams and demonstrates the synergy between the work streams.

This is the fifth in-depth quarterly patient safety report for 2010-11 for the period July – September 2010. The report provides an update on progress against the work streams from the Integrated Safety Strategy and the patient safety elements of the Patient Improvement Framework. For each work stream there is an action plan in place for 2010/11 for delivering improvement and compliance against the set targets. Quality Contract, CQUIN indicators and High Impact Actions for 2010/11 have been highlighted within the report where they apply.

DH pilot Rapid Spread focusing on pressure ulcers and falls

The Turnaround project has been extremely successful in capturing the hearts and minds of nurses in the Trust who have embraced the two hourly nursing interventions, which reduce avoidable pressure ulcers and falls. The next steps are to ensure these interventions are sustainable. The DH has invited representatives from the Trust to attend a celebration event in Whitehall and an evaluation of the approach will be shared in November. The learning from this project will then be tested in more Trusts and rolled out nationally.

High Impact Actions (HIA)

The eight High Impact Actions (pressure ulcers, falls, keeping nourished, promoting normal birth, end of life care, fit and well to care, ready to go no delays and in dwelling catheters) identify best practice for Trusts to pursue. A self-assessment on how the Trust has approached the HIA been completed and this provides good evidence to demonstrate that the Trust is appropriately moving these forward. The assessment will be submitted to the SHA. The HIA are now being linked with Energising for Excellence and the national nursing quality indicators have been developed and aligned to each HIA. It is likely that HIA will be included in next years operating framework.

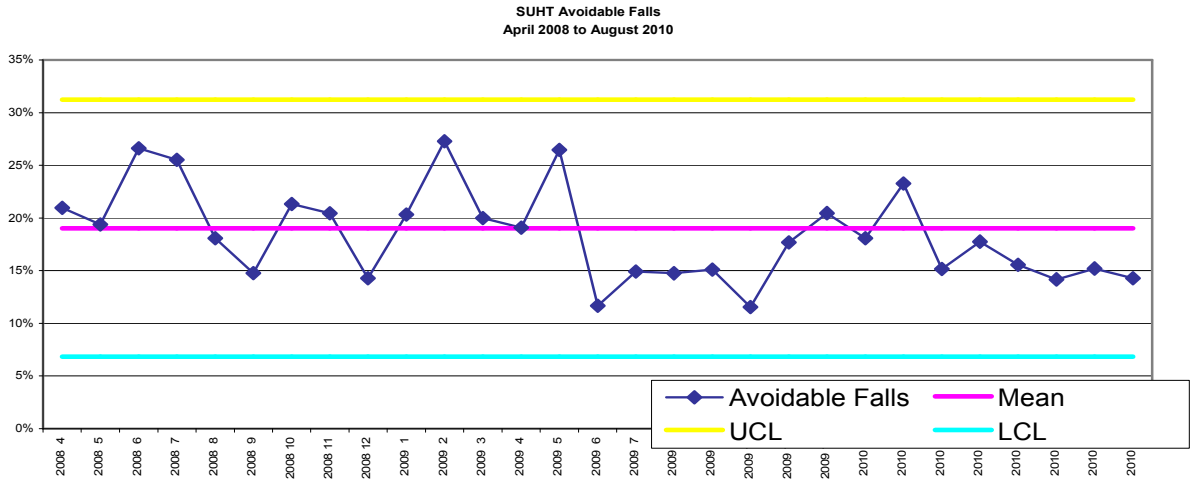
2. Integrated Patient Safety Work streams

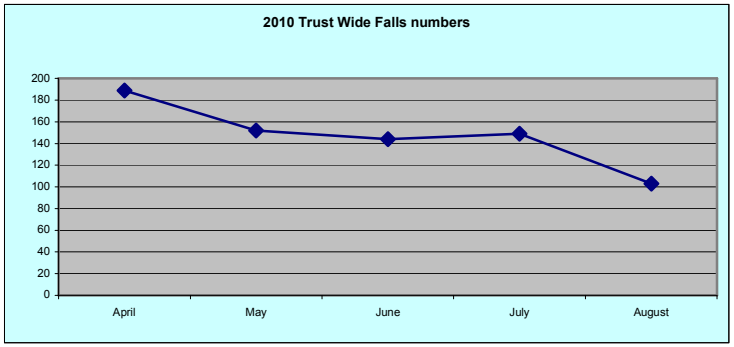
2.1 Falls (High Impact Action, Quality Contract)

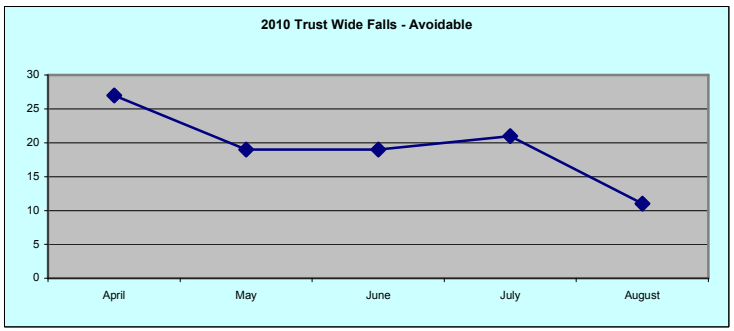
Target

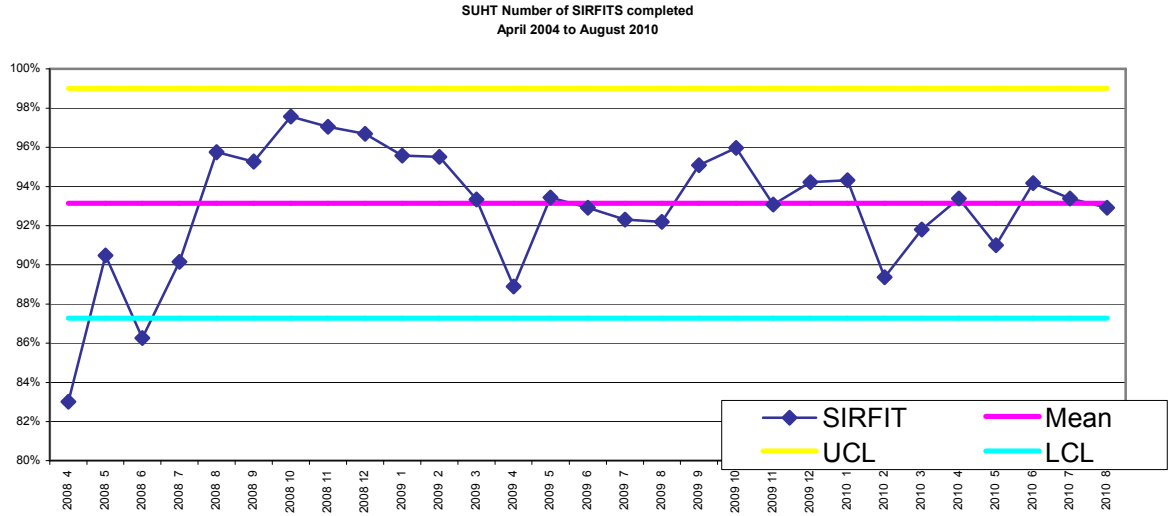
- To reduce avoidable falls to under 5% of total falls (Quality Contract)
- To maintain SIRFIT compliance above 95%

Since June the number of SIRFIT's completed has improved to 93%, although the percentage of avoidable falls remains at 9%. The turnaround project continues to run and this is starting to see a reduction in the number of overall falls and those that are avoidable. It is anticipated that this position will continue to improve. The improvement plan continues to be overseen by the falls prevention group. Future actions include the introduction of memory boxes for patients with dementia and the development of a falls passport to identify patients at risk, the plan of care for the whole pathway of care and facilitate communication between organisations.









2.2 Medication errors (Quality Contract)

Target:
To reduce serious medication errors by 10% i.e. 8 or less

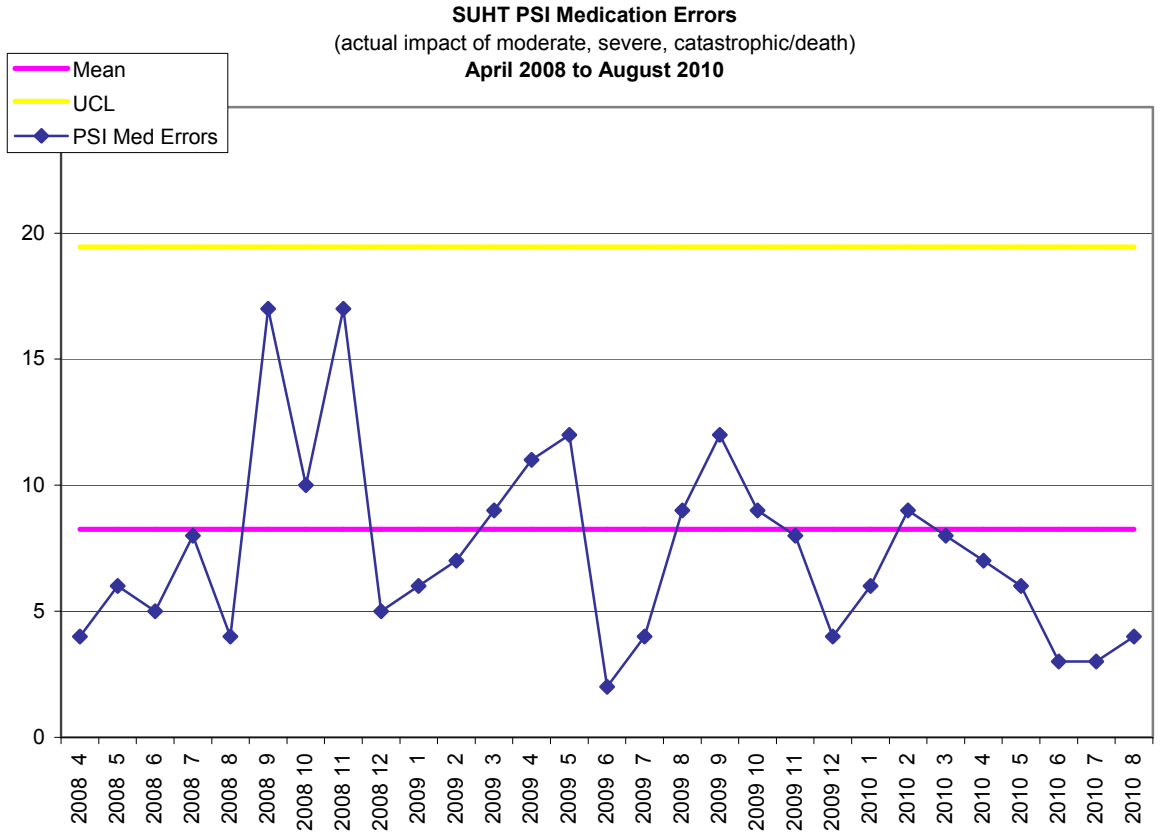
Work continues on the following: -

- Allergy Recording
- Reducing errors from High risk Medicines - Warfarin
- Medicines reconciliation
- Missed doses
- Insulin
- Calculations.

Monthly measurement of allergy recording and medicines reconciliation has been implemented. Results are being discussed at divisional clinical governance groups.

Patients with high INRs are to be retrospectively checked for trends with learning to be shared.

Action plans for reducing missed doses and Insulin errors are being implemented. NPSA medication alerts are being progressed with most action is in place.



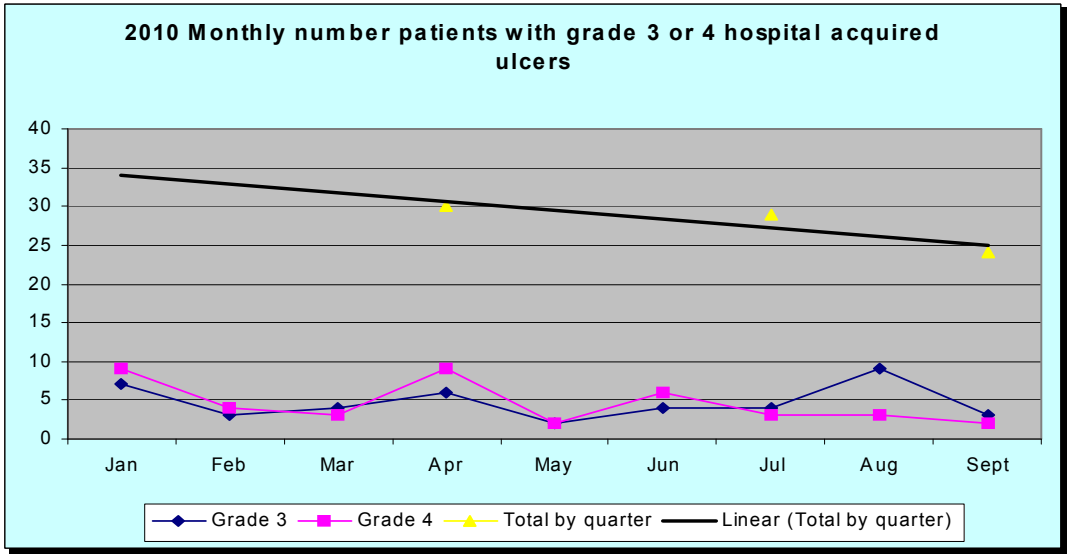
2.3 Pressure Ulcers (CQUIN, High Impact Action)

Target: 25% reduction in patients with grade 3 &4 pressure ulcers from Q4 and Q1 baseline in, overall annual target of 87

Performance: - year to date 55

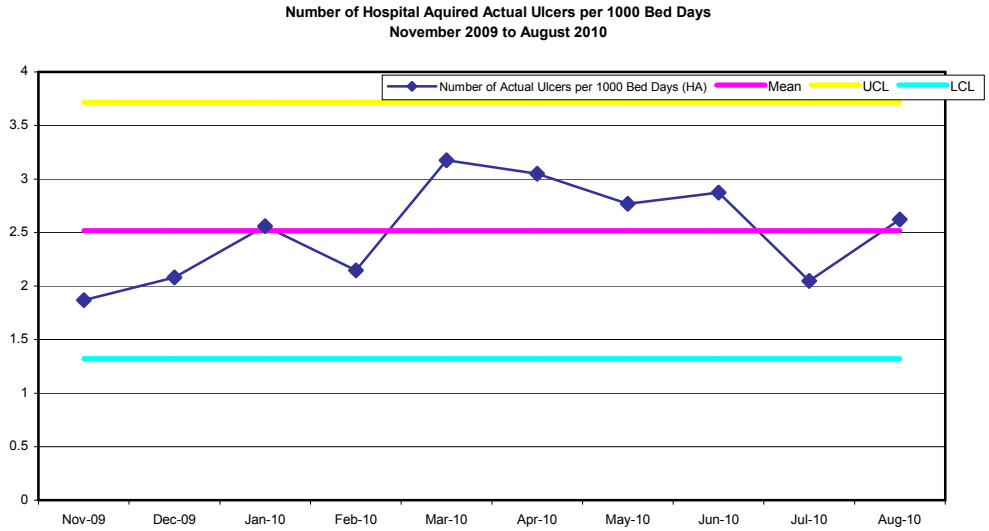
The Turnaround project has been extremely successful in capturing the hearts and minds on frontline staff. However this focus has seen an increase in reporting.

The Turnaround project – DH Rapid spread (how it works)
Patients are assessed as to whether they are risk of falling or pressure ulcers and those who are medium high risk are put on a two hourly interventional pathway where nurses provide pressure relief for the patient, ensure the bed space is clutter free, offer a drink, ensure the patient has appropriate slippers and offer the patient commode / toilet. The approach taken is being evaluated by the DH and will be reported back to the Trust.



Other Actions being undertaken:-

- The Braden risk assessment has been rolled to all wards in the Trust
- The improvement plan is being revised to contain actions to ensure sustainability around the turnaround project
- A review of grade 4 hospital acquired pressure ulcers that have been reviewed at panel shows that 1-2 a month (out of an overall average of of 5 a month) are unavoidable, for example vascular patient who proceeded to have an amputation, patient with ascites who could not turn on their side. This information is being recorded and will be submitted to the Commissioners to exclude such pressure ulcers from reporting. Divisions are being asked to undertake a similar exercise for grade 3 pressure ulcers.



2.4 Thromboprohylaxis (ISS)

Target: Targets for 2010-11

	Q1	Q2	Q3	Q4
Risk Assessment	40%	60%	80%	90%
Appropriate Treatment	60%	60%	80%	90%

Trust wide	**Q3**			**Q4**			**Q1**			**Q2**	
	Oct 09	**Nov 09**	**Dec 09**	**Jan 10**	**Feb 10**	**Mar 10**	**Apr 10**	**May 10**	**Jun 10**	**Jul 10**	**Aug10** [1]
Number of patients captured via eDocs	not captured									1304	2679
Documented Risk assessment[2] (eDocs data)	not captured									66%	71%
Number of patients audited manually	104	44	93	98	99	90	85	79	104	127	97
Documented Risk assessment[3] (Audit data)	23%	11%	12%	11%	25%	24%	40%	29%	39%	60%	54%
Documented Re-assessment within 24 hours[4]	not captured										33%
Appropriate pharmacological prophylaxis[5,6]	69%	64%	66%	69%	64%	73%	62%	72%	77%	86%	88%
Appropriate mechanical prophylaxis prescribed[5,6]	not captured										62%
Appropriate mechanical prophylaxis fitted[5,6]	not captured										76%

Key Actions:

- Clinical leaders have a vital role to play in achieving and sustaining improvement
- Trust guidelines now updated in line with new NICE guideline.
- Updated national risk assessment tool being tailored for local practice
- Areas are being challenged if data submissions not made
- Patient information leaflet being piloted
- Run chart versions of audit results to be prepared for clinical areas and future reporting
- Risk assessment record added to each drug chart
- Process for Incident reporting and root cause analysis of venous thrombotic events being developed

NICE guidance was published in January 2010, the Operating Framework included VTE risk assessment as a key requirement for 2010-11, and the CQUIN framework has a requirement to achieve 90% recorded risk assessments.

NB these documents and requirements apply to adult patients, the thrombosis group does consider the needs for children

Progress

- Documentation of risk assessment has improved but considerable further improvement is required
- The average mean of compliance for appropriate chemoprophylaxis is around 70% though some areas achieve 100% compliance
- The thrombosis group will continue to lead on implementation of this programme, developing and implementing detailed actions for 2010/11.
- The Chief Executive is meeting with care groups where there is greatest need for improvement

[1] New audit tool reflecting updated Thromboprophylaxis guideline according to NICE guidance
[2] based upon ward patient was originally admitted to
[3] Oct 2009 - July 2010 data based upon ward patient was on at time of audit; from August 2010 based upon ward patient was originally admitted to
[4] Based only on patients who have been admitted for more than 24 hours
[5] "appropriate treatment" includes "no treatment" where "no treatment" is the appropriate option
[6] based upon current ward

2.4 Thromboprohylaxis – Continued

August 2010 – Detailed results

Documented risk assessment and reassessment[3,4]

Division	Care Group	Speciality	Pts	Risk-assessed	RE-assessed
Division A	Cancer Care	Clinical Haematology	1	100%	100%
		Clinical Oncology	4	75%	50%
		Medical Oncology	2	100%	100%
		Palliative Medicine	2	100%	0%
	Cancer Care Total		9	89%	56%
	Critical Care	CICU	1	0%	0%
		General ICU	2	50%	100%
		NICU	5	80%	100%
	Critical Care Total		8	63%	88%
Division A Total			17	76%	71%
Division B	Emergency Medicine	CDU	5	20%	N/A
		General Medicine	21	81%	18%
		Geriatric Medicine	1	100%	N/A
	Emergency Medicine Total		27	70%	18%
	Specialist Medicine	General Medicine	9	56%	56%
		Ophthalmology	5	100%	0%
	Specialist Medicine Total		14	71%	50%
Division B Total			41	71%	30%
Division C	Women and Newborn	Gynaecology	5	20%	25%
	Women and Newborn Total		5	20%	25%
Division C Total			5	20%	25%
Division D	Cardiovascular and Thoracic	Cardiac Surgery	2	50%	50%
		Cardiology	10	10%	0%
		Thoracic Surgery	5	0%	0%
		Vascular Surgery	3	0%	0%
	Cardiovascular and Thoracic Total		20	10%	5%
	Neurosciences	Neurosurgery	5	40%	20%
	Neurosciences Total		5	40%	20%
	T&O	T&O	9	56%	43%
	T&O Total		9	56%	43%
Division D Total			34	26%	16%
Grand Total			97	54%	33%

Appropriate prophylaxis[5]

Division	Care Group	Speciality	Pts	Pharmacol.	Mechanical prescribed	Mechanical fitted
Division A	Cancer Care	Clinical Haematology	2	100%	50%	50%
		Clinical Oncology	2	100%	50%	50%
		Medical Oncology	2	100%	0%	0%
		Palliative Medicine	2	100%	100%	100%
	Cancer Care Total		8	100%	50%	50%
	Critical Care	SHDU	2	100%	0%	50%
		NICU	5	100%	0%	80%
	Critical Care Total		7	100%	0%	71%
Division A Total			15	100%	27%	60%
Division B	Emergency Medicine	CDU	5	100%	100%	100%
		General Medicine	11	82%	82%	82%
		Geriatric Medicine	4	75%	75%	75%
		MHDU	1	100%	0%	0%
	Emergency Medicine Total		21	86%	81%	81%
	Specialist Medicine	General Medicine	13	92%	92%	100%
		Ophthalmology	6	100%	17%	17%
	Specialist Medicine Total		19	95%	68%	74%
Division B Total			40	90%	75%	78%
Division C	Women and Newborn	Gynaecology	5	80%	80%	100%
	Women and Newborn Total		5	80%	80%	100%
Division C Total			5	80%	80%	100%
Division D	Cardiovascular and Thoracic	Cardiac Surgery	2	100%	50%	50%
		Cardiology	10	90%	60%	70%
		Thoracic Surgery	5	80%	40%	100%
		Vascular Surgery	5	60%	100%	100%
	Cardiovascular and Thoracic Total		22	82%	64%	82%
	Neurosciences	Neurology	1	100%	100%	100%
		Neurosurgery	5	80%	40%	60%
	Neurosciences Total		6	83%	50%	67%
	T&O	T&O	9	78%	56%	78%
	T&O Total		9	78%	56%	78%
Division D Total			37	81%	59%	78%
Grand Total			97	88%	62%	76%

2.5 MUST Assessment

Quality contract Target for 2010/11

- To establish baseline measures for 2010/11 working towards 100% compliance
- Working towards 100% of staff having nutritional induction training and appropriate training thereafter

(Baseline for Q1 70% Q2: 75%, Q3: 85% Q4 95%)

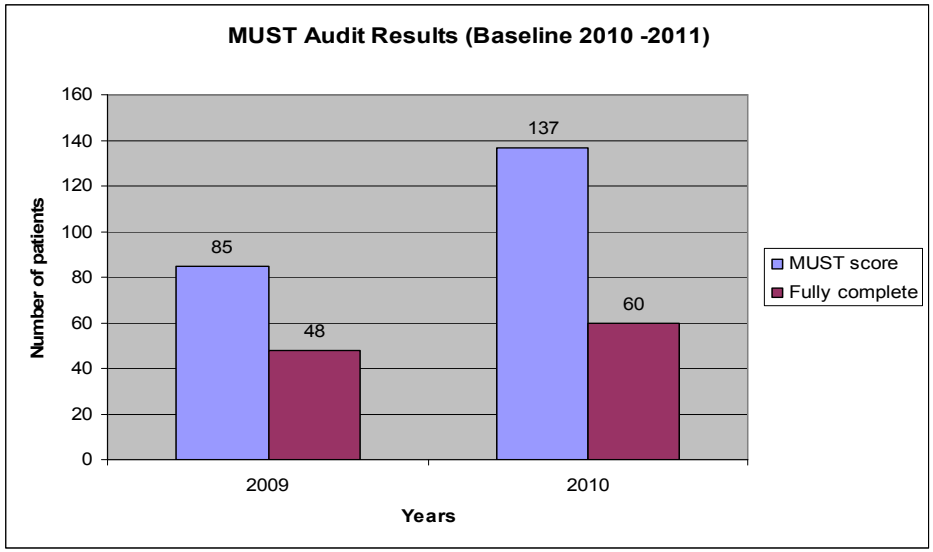
Progress

Audit to determine baseline measures for 2010/11 conducted. (191 patients across the Trust). Results:

- 80% had height and weight recorded within 24hours of admission
- 71% had a MUST score within 24hours
  (although only 31% had a fully completed MUST, including care plan).

This indicates significant improvement in the numbers being MUST screened (38% in Sept 2009). Further improvement (in frequency and validity of screening and translation of scores into personal care plans) was seen to need a "relaunch" of the MUST agenda, adapted in line with learning from experience to date.

The focus over Q2 has been to improve understanding of the importance of nutrition screening and its relevance to wider healthcare.



2009	n = 222 MUST score 85 (38%) Fully complete 48 (22%)	2010	n = 191 MUST score 137 (71%) Fully complete 60 (31%)

Actions include:

- Following Trust-wide audit of activity re "Nutrition Education", proposals submitted for inclusion of "Nutrition" in the Statutory and Mandatory training programme and at Trust Induction. Development of resources to support this are in progress, including, ongoing investigation of e-learning options.
- Pilot of "new" ward level MUST education process and documentation in T&O. Findings will inform wider roll-out.
- Revised job role for ANTs (nutrition link nurses). Documentation to link nutrition responsibilities / objectives with the appraisal process being discussed.
- Proposals for Ward level MUST audit circulated. Plan:
  - monthly audit of 10 patients per ward, reported by Divisions for discussion at Trust performance meetings
  - paper format of audit tool shared for consultation and online version to be developed to support the process and monitoring/ evaluation of compliance
- Programme of development to provide access to nutritional resources and "first-line advice" on Staffnet and extranet.
- Links with BRU: further progress with plans to integrate research on "MUST" with clinical practice. A research nurse to support this is now in post.
- Collaboration with Solent Healthcare and Southampton City Council re Staff Healthy Workplace Policy (which will support the aim of improving nutritional knowledge amongst staff by encouraging reflection on their own nutritional health).

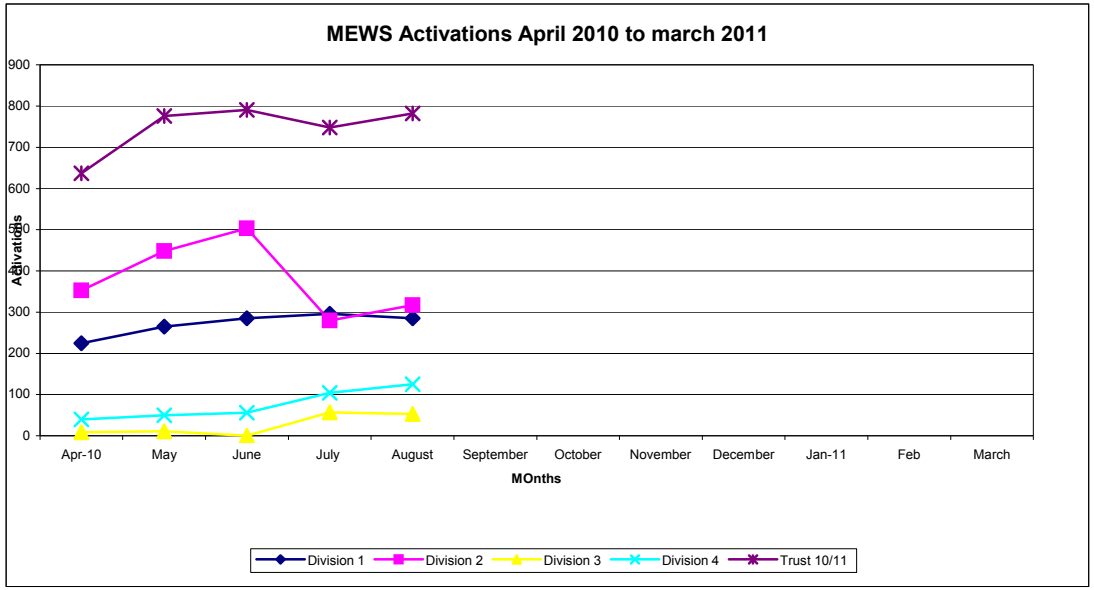
2.6 Deteriorating Patient

Target

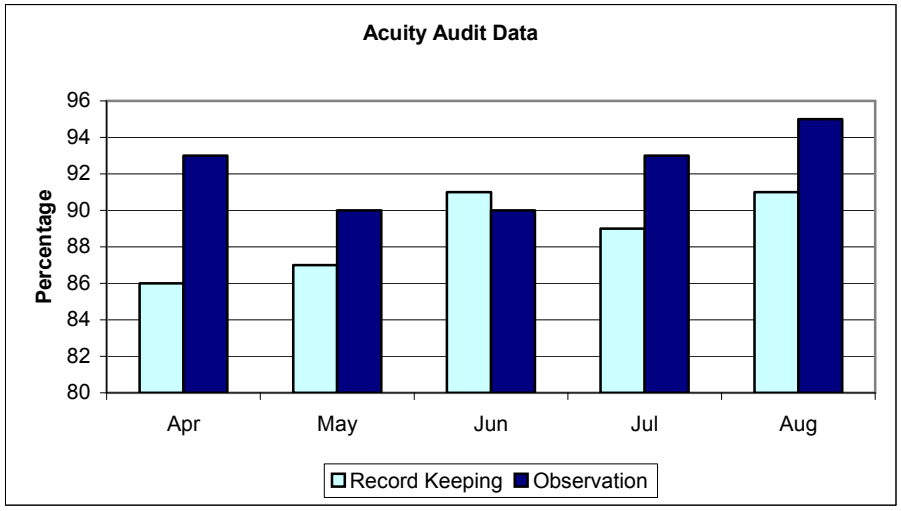
> 95%
85 – 94%
< 85%

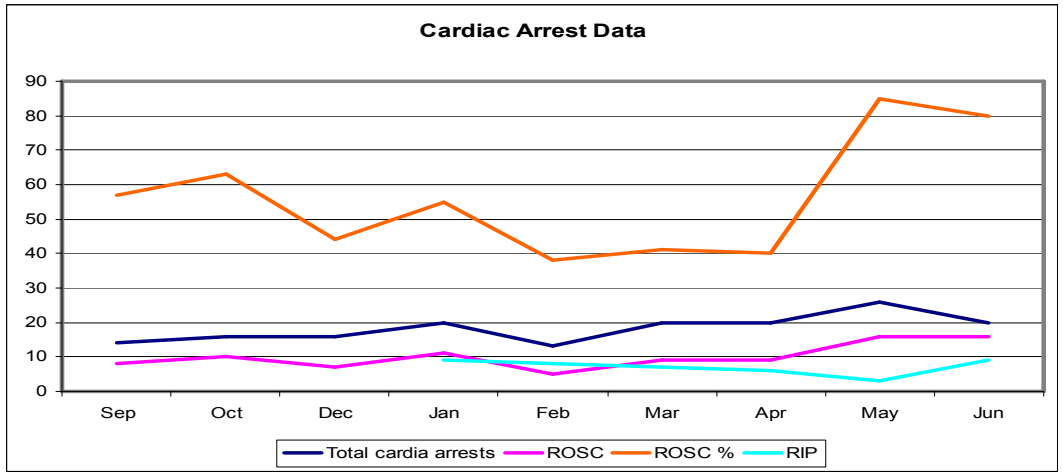
>95% compliance in Q4 for Record keeping
Observation
>85% compliance in Q4 for Fluid Management
>95% compliance in Q4 for Initial Activation Review
>85% compliance in Q4 for Senior Review.

Care Indicator	YTD	Q1	Q2	Q3	Q4
Record keeping	89%	88%			
Observation	92%	91%			
Fluid Balance	N/A	N/A			
Initial Activation Review	N/A	N/A			
Senior Review	N/A	N/A			



MEWS activation recorded via voicemail demonstrates an increasing incidence of activation despite closure of beds for CIP across the summer. Previous audits have demonstrated that approximately 80% of activations are recorded. Comparison of Q2 unexpected admissions into GICU will demonstrate if this increase in acuity is reflected in an increase use in L3 beds.





National data for return of spontaneous circulation (ROSC) indicates 35 – 40% success rate. Trust data indicates a level of ROSC far greater than the national average with a significant increase from beginning of Q1.

2.6 Deteriorating Patient (Continued)

Key Action Points

- Quarter 2 data unavailable for reporting currently in relation to acuity audit and review of unexpected admissions into GICU.

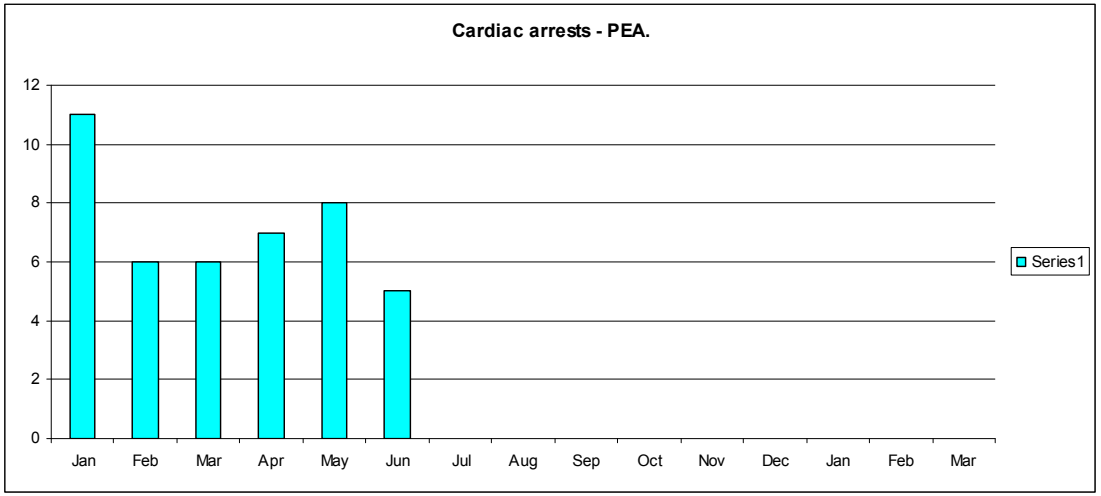
- IT department working to overcome data entry anomalies within Fluid Balance, Initial Activation Review and Senior Review and Divisional restructuring. In support of this, from Q3, each ward will be audited once a month to capture a larger sample size and increase audit of MEWS activations and Fluid Charts.

- In Q3 self-assessment discontinues and peer review commences.

- All Care Groups requested for plans to improve data collection and outcomes. These plans will be monitored through Care Group and Divisional Governance groups in addition to the Acuity Strategy Group.

- Hydration Policy and Observation policy in development to standardise practice across the Trust. Scoping of Fluid charts identified 13 different charts in use across the Trust.

- Awaiting pilot of Doctors Workbook with a view to developing electronic monitoring of MEWS, escalation, senior review and effectiveness of the management plan.



Target: 15% Reduction in Cardiac arrests from P.E.A.

The average instance of PEA is 7 per month, 15% reduction would reduce this to 6 arrests from PEA per month. Currently this information is retrospective due to availability of resources.

2.7 Infection Control

Target:

MRSA bacteraemia target for 2010/11 is 7 post 48 hr.

C.Difficile target for 2010/11 is 139 national target 110 Cases + local stretch PCT target .

Progress

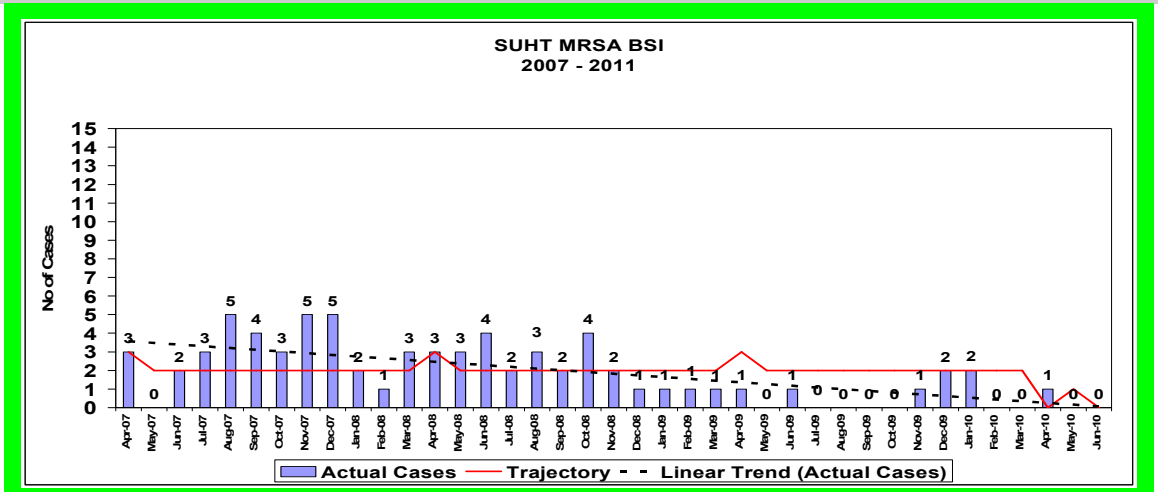
MRSA Bacteraemia: 2009/10 – 7 MRSA bacteramias, 4 of which were post 48 hr. Currently on 1 case for 2010/11.

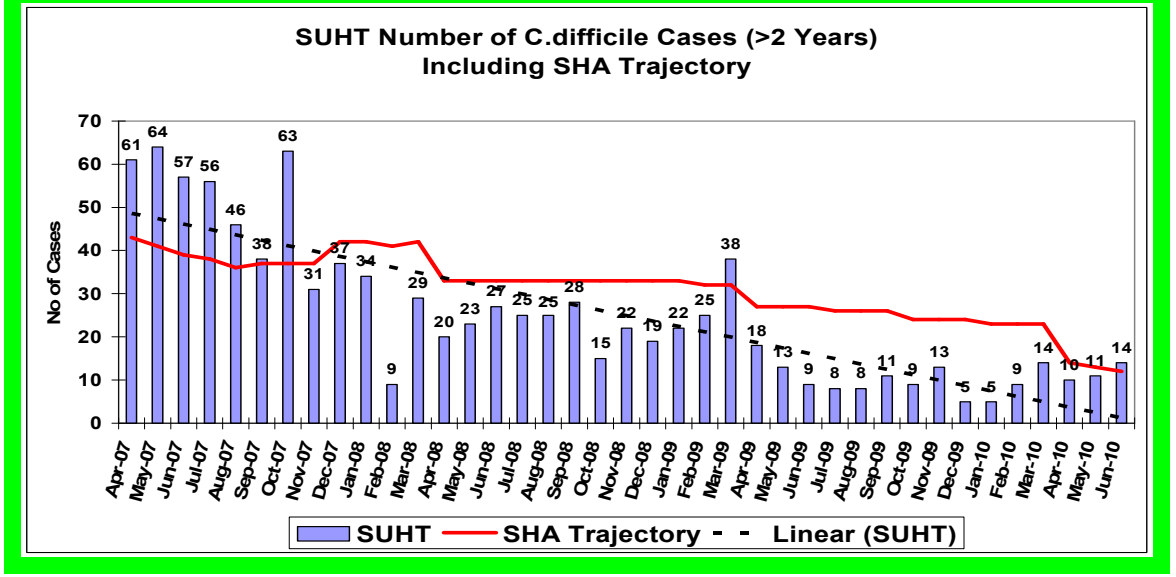
***C. Difficile* infection: 2009/10 –** 122 cases as per HPA definition. Currently at 35 cases for 2010/11 against the annual stretch target of 110 cases.

Focused work around C.difficile due to target set. This includes:-

- Introduction of ribotyping C.difficile cases in order to identify issues around transmission.
- CEO review panel meeting for C.Diff outbreaks.
- Focus work on cleaning, clinical cleaning and decontamination

	Year to Date		
	Target	Actual	Rating
DIVISION A	**14**	**5**	**G**
Surgery	6	3	G
Cancer Care	6	1	G
Critical Care	2	1	G
DIVISION B	**16**	**15**	**G**
Ophthalmology	0	0	G
Emergency Medicine	2	1	G
Medicine for Older People	7	6	G
Medicine	6	8	R
Specialist Medicine	1	0	G
Pathology	0	0	G
Radiology	0	0	G
DIVISION C	**1**	**2**	**R**
Child Health	0	1	R
Obstetrics & Gynaecology	1	1	A
Therapies	0	0	G
DIVISION D	**8**	**13**	**R**
Cardiothoracic	3	7	R
Trauma & Orthopaedics	2	1	G
Neurosciences	3	5	R
Community/other provider		**24**	
SUHT TOTAL	**39**	**35**	**G**





MRSA Screening compliance (patient level): -

Elective	**99.5%**
Emergency	**99.5%**

2.8 Incident Reporting

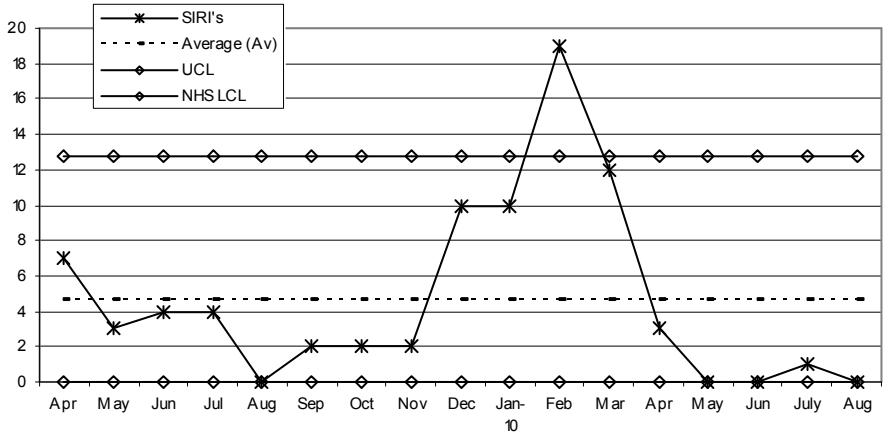
Serious Incidents Requiring Investigation (SIRI's)
previously referred to as Serious Untoward Incident (SUI's)

Management
All SIRI's are investigated by Divisional Governance Teams and monitored by the Trust Significant Event Review Group (SERG).

2009/10
Target: **<5 SIRI's/mth**
Performance: Non Compliant in April (7) December (10) January (10) February (19) and March (12)

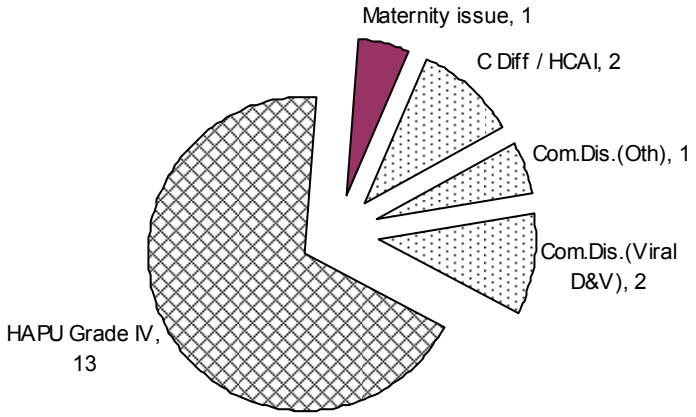
2010/11
Target: **<3 SIRI's/mth** (*excluding* Pressure ulcers, Communicable diseases D&V and C.Difficile)
Performance: Non Compliant in April (3)

Non excluded SIRI's reported by SUHT between Apr 09 and Aug 10



SIRI's by Case Type

SIRI's by Case Type (Jun to Aug 2010)



Never Events
There were No 'Never Events' within this 3 month period.

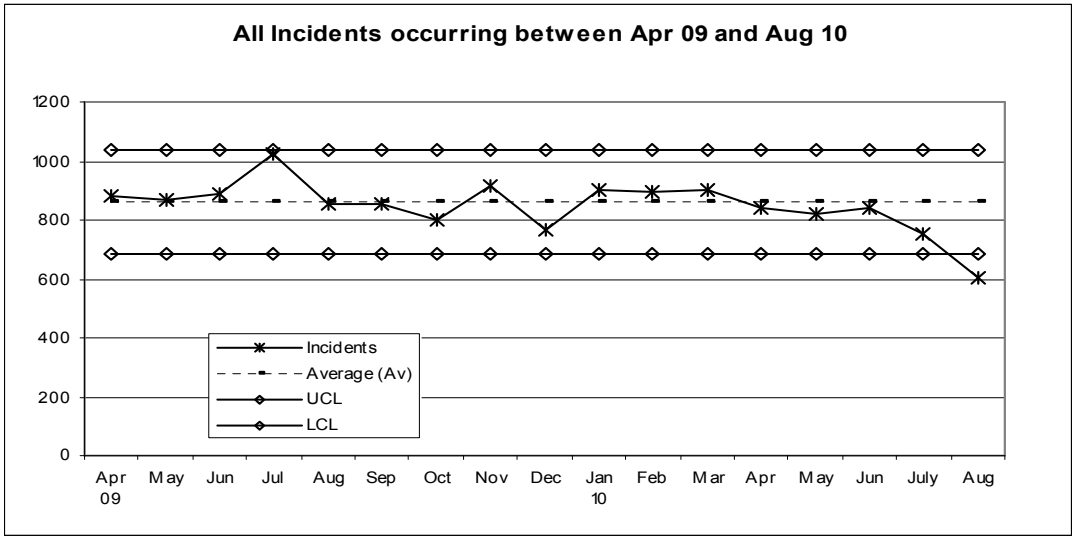
Patient Safety (non excluded) SIRI's
There was 1 Patient Safety SIRI within this period. This was a Maternity event relating to a fractured skull noted following failed forceps attempt at delivery. No significant care failings have been identified to date.

Hospital Acquired Pressure Ulcer (HAPU) SIRI's
HAPU's were the largest percentage of SUI's reported (68% / 13 SIRI's). Robust systems are in place to detect and validate as reportable Grade 4 HAPU's.

Healthcare Acquired Infection (HCAI) SIRI's
HCAI SIRI's comprised 26% (5) of the total for the period. These are managed by the Infection Prevention Team and monitored by the Trust Infection Prevention Committee.

The total number of incidents reported has remained reasonably constant over the period in question although it has not increased in line with a target of 25% increase p.a.

NB Due to some incident reporting lag the inclusion of the last 2 months worth of incident data depreciates the period average and SPC control limits. The resulting Special Cause Variation (Aug data below LCL) is considered to be a data anomaly.

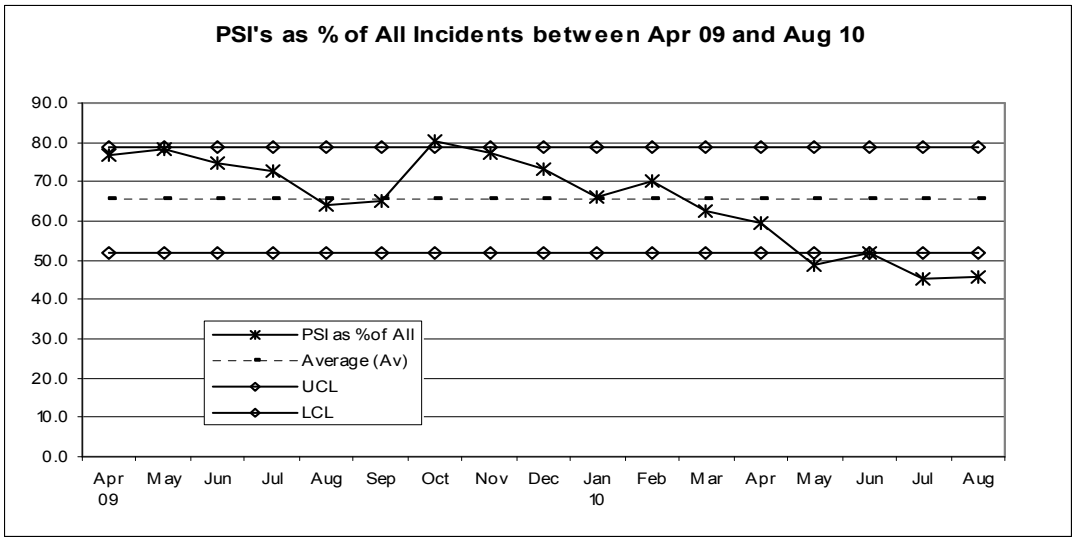


Patient Safety Incidents as % of All Incidents

Whilst total incident numbers has remained constant over the period in question the number, and therefore the proportion of the total, of Patient Safety Incidents has decreased from around 80% to less than 50% of the total (or from 600-700 to 400-500 a month).

The SPC graph demonstrates an almost consistent downward trend in the proportion of PSI's over the last 11 months with the last 4 data points beyond (below) 2 sigma.

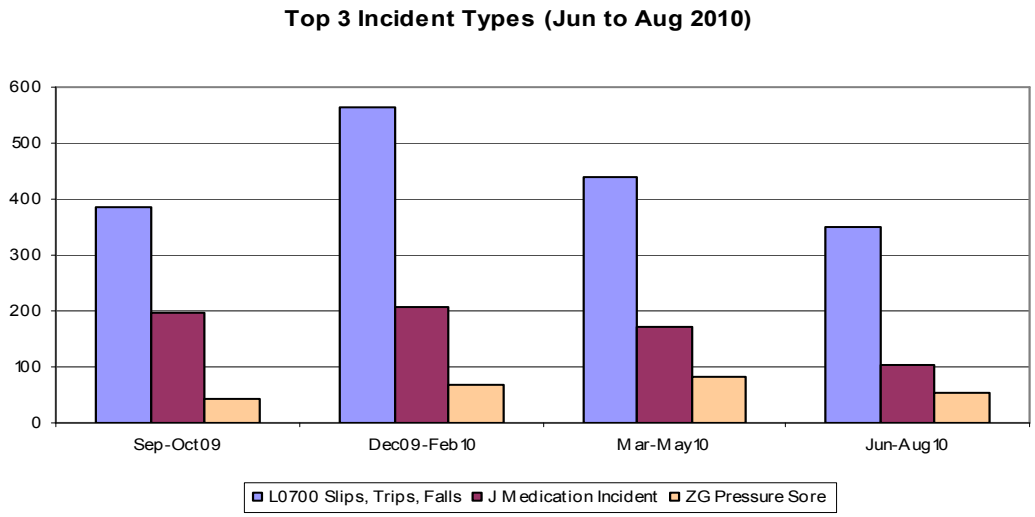
NB the incident reporting anomaly noted above can be largely ignored as this chart is based on percentages and both incident types (PSI and All) are likely to be equally affected by any lag.



Incident Types
The top three incident types, by number of incidents occurring in the last 3 months are:

- Slips Trips Falls
- Medication errors
- Pressure Ulcers

The 3 incident types are the same top 3 as the last period and have been in the top 4 for the 2 previous quarters. All 3 of these topics are being addressed by Patient Safety work streams.



2.9 Central Alert System

Internal Divisional CAS Target

For each financial calendar year more than 75% of alerts and other communications concerning patient safety issued which require action should be acted upon within the required time-scales'.

Divisional Progress (measured against internal deadlines)

80.3% compliance on alerts completed within deadline

Trust Progress (measured against external deadlines)

*91% compliance on alerts completed within deadline, with 22 (27) outstanding alerts and 4 (4) breached

(*Source: DH CAS website, 6th Sep 2010)

Detailed CAS reports are provided and overseen by QGSG

SUHT performance compared to other acute trusts nationally and within local SHA (% of alerts completed by deadline)

Nationally	41 (45th) in a table of 168
South Central Health Authority	7th (6th) in a table of 11

	Cumulative Rating	CAS - % Actions Completed	Cumulative Rating	All - % Actions Completed	Breaching CAS Alerts	Outstanding CAS Alerts
DIVISION A	G	77.78%	G	83.72%	0	8
Surgery	G	77.14%	A	72.92%	0	2
Cancer Care	G	77.78%	G	83.72%	0	1
Critical Care & Theatres	G	75.28%	G	78.52%	0	5
DIVISION B	G	83.33%	G	85.82%	0	8
Emergency and Specialist Me	G	83.33%	G	85.82%	0	5
Radiology & Pathology	G	95.35%	G	93.85%	0	3
DIVISION C	G	75.56%	A	72.06%	2	14
Child Health	G	75.56%	A	72.06%	0	3
Women and Newborn	A	71.79%	A	69.49%	1	4
Support Services	G	82.05%	G	82.61%	1	7
DIVISION D	G	80.00%	G	77.59%	0	4
Cardiovascular and Thoracic	G	80.00%	G	77.59%	0	2
Neurosciences	G	80.56%	G	78.57%	0	1
Trauma and Orthopaedics	G	78.13%	G	82.98%	0	1
Trust HQ	G	76.92%	G	76.92%	0	7
Wellcome - Trust HQ	G	90.00%	G	89.66%	0	1
Estates - Trust HQ	G	76.92%	G	76.92%	0	5
Procure - Supplies Dept - Trus	G	100.00%	G	100.00%	0	1
Nominated Trust Leads - Trus	R	50.00%	R	50.00%	0	0
TRUST OVERALL	G	80.30%	G	80.71%		

TARGETS	
Excellent - Green (G)	75%
Acceptable - Amber (A)	74-70%
Poor - Red (R)	69%

Summary of actions

1. Blood tracking pilot started in Cancer Care. To be rolled out across trust during 2010. Trust wide compliance with blood competency training is 52%. A revised blood competency-training package is now in place, which will help all Divisions move forward with the KPI target. Must be 100% compliant by Nov 2010. **[ALERT ISSUED 03 APR 08]**

2. NHS patient number ID policy approved by QGSG 18th Aug 2010 (June 2010). IM&T aiming for Dec 2010 completion **[ALERT ISSUED 03 JUL 07]**

3. Draft policy completed – on 14th Oct QGSG agenda**. [ALERT ISSUED 07 AUG 09]**

Areas of slow/no progress (NPSA breached alerts against national deadline)

Alert Deadline	Deadline	Lead	Target
1. NPSA Right blood, right patient	01 May 09	M Clunie	31 Dec 10
2. NPSA NHS patient number IDs	18 Sept 09	Risk/IM&T	31 Dec 10
3. NPSA Infusions/sampling arterial lines	30 Jan 09	Critical C	14 Oct 10

NPSA alerts due to breach within the next 120 days

Alert Deadline	Deadline	Lead	Target
Being open	23 Nov 10	Trust HQ	By deadline
Reducing the risk of retained swabs after vaginal birth and perineal suturing	26 Nov 10	Obs&Gyn	By deadline
Safer administration of insulin	16 Dec 10	Support S	By deadline
Safer lithium therapy	31 Dec 10	Support S	By deadline

NPSA alerts issued since last meeting

Alert Deadline	Deadline	Lead	Target
Prevention of over infusion of intravenous fluid+ and medicines in neonates	28 Feb 11	Awaiting lead to be nominated	By deadline
Reducing treatment dose errors with low molecular weigh heparins	28 Jan 11	Support S	By deadline

2.10 Trigger Tool

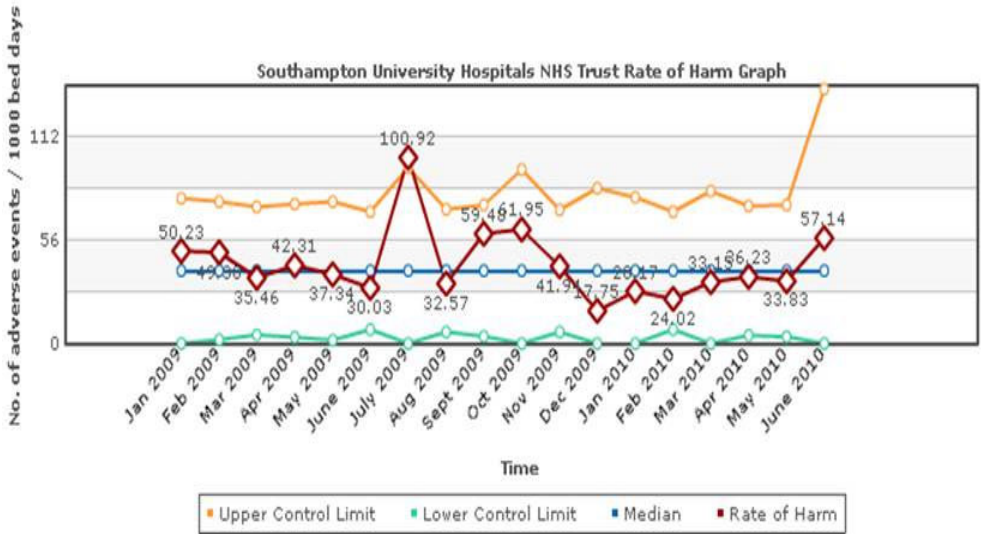
Over the quarter, there has been an improvement in the Divisional engagement with the trigger tool, with 141 reviews conducted in April – June, compared with 88 in the preceding quarter. There remain areas of significant underperformance, and the Divisional Management teams for these areas are being approached. Rather than inferring the number of monthly Divisional reviews from the Divisional entries into the TT web portal, each Division now returns the numbers of reviews per month to the Patient Safety Team.

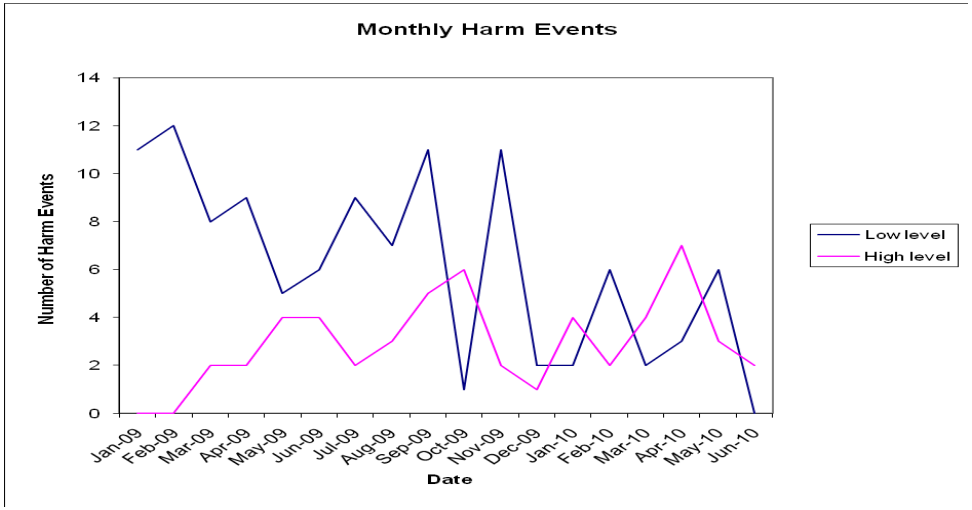
The process for feeding back areas of specific clinical concerns to the Divisional Teams is becoming embedded, and to date, the results of case reviews undertaken in response to high harm being identified have been that there were no avoidable factors found.

During this quarter, it was also identified that addition support could be given the Trust Thromboprophylaxis work stream by the addition of a SUHT specific trigger. This is one of 5 available additional triggers, which can be added by an organisation. 'Lack of thromboprophylaxis assessment' was added as a trigger at the end of June. Results for this will be available from the next quarter.
The next steps for the trigger tool are to widen the membership of the harm adjudication panel to involve senior clinicians from across the Divisions and to embed the process of investigation of identified high harm triggers.

The Divisional management teams are asked to ensure that: -

- 20 sets of case notes are review consistently, every month
- Identified triggers are passed to harm adjudication
- That they support their Divisional representative on the Harm Adjudication panel, which is in the process of being expanded.





3. Conclusion

3.1 Members of the Trust Executive Committee should note: -

- The continued journey of improvement on the patient safety work streams, with 5 work streams showing improvement and the remaining showing that they are maintaining performance.
- That the new simplified report format should enable oversight of this journey over a period of time i.e. ‘moving the dot’

3.2 Members of the Trust Executive Committee are asked to: -

- Continue to support the Rapid Spread / Turnaround Project for falls and pressure ulcers
- Comment on the different reporting format

3.3 Divisional Management teams are asked to: -

- Ensure that they support the work on each of the work streams, monitor their Divisional performance against the targets set and ensure action is taken where there is non-compliance

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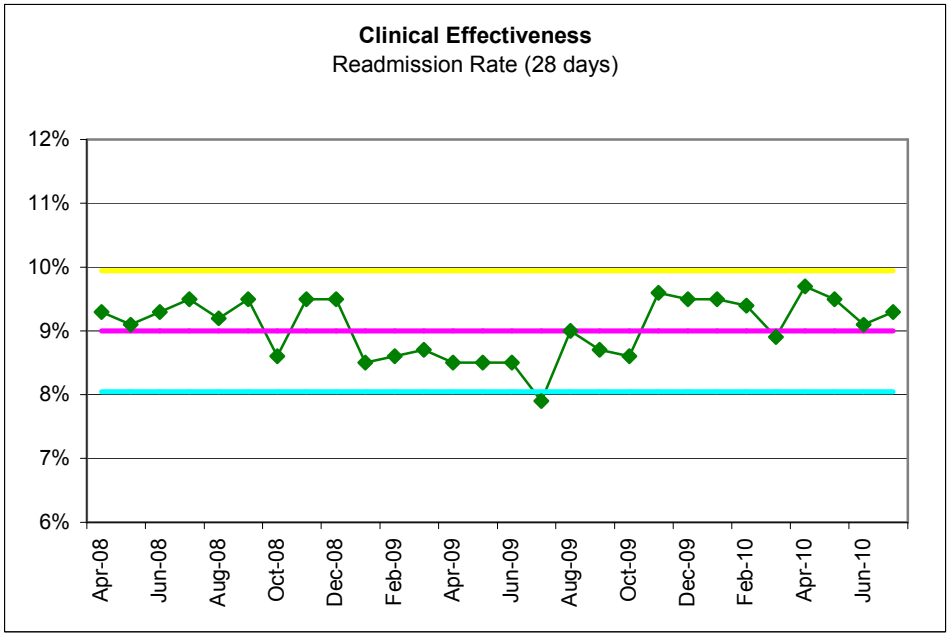
Appendix 2 Re-admission rates



Appendix 3

Patient reported experience of medicines management & Patient survey reported cleanliness 2009 survey results

Question	Trust	Average
Staff did not do everything to help control pain	26%	28%
Not fully told purpose of medications	18%	20%
not fully told side-effects	52%	47%
not told how to take medication clearly	17%	19%
not given completely clear written information about medicines	30%	30%
Room or ward not very clean	6%	4%
Toilet not very or not at all clean	9%	7%

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