Southampton NHS
University Hospitals NHS Trust

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

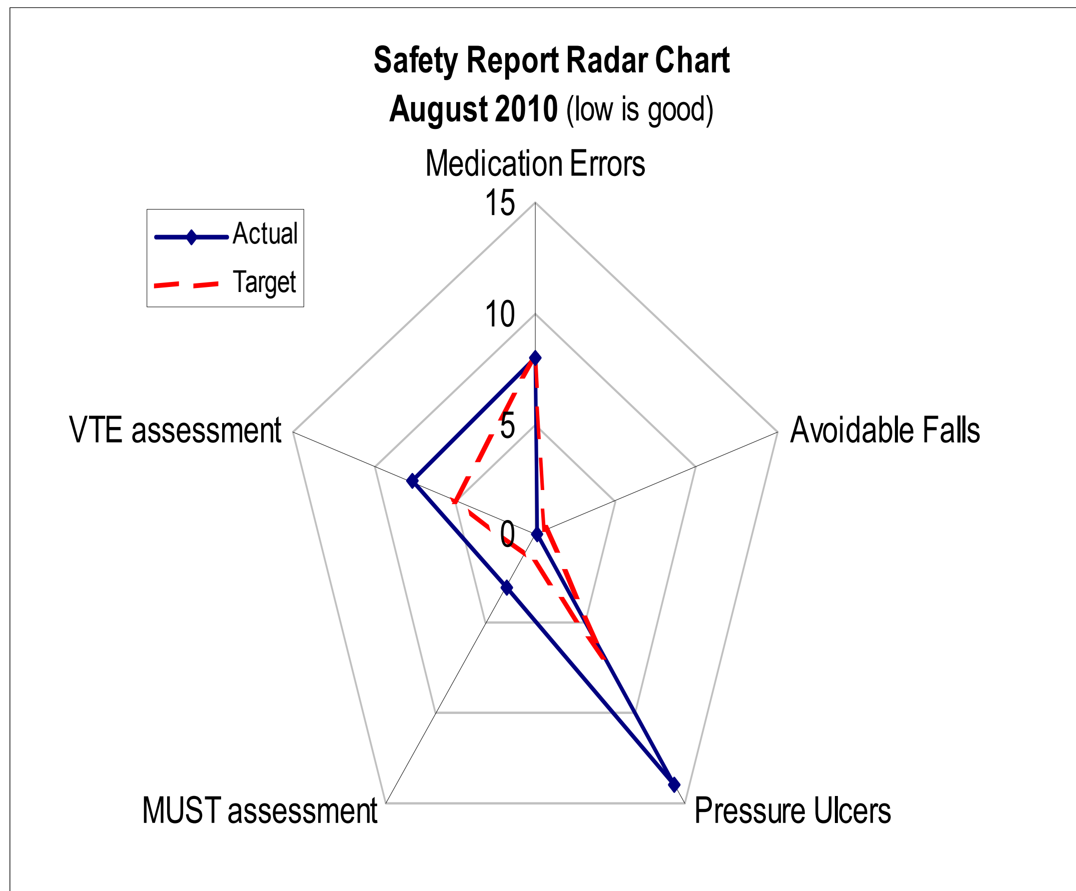
Report to	Trust Board
Report from	Gail Byrne, Deputy Director of Nursing, Head of Patient Safety
Sponsoring Executive	Judy Gillow, Director of Nursing and Patient Services
Aim of Report	▪ To provide members of Trust Board with an update on the delivery of Trust's patient safety targets for 2010/11 (Patient 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
Thromboprophylaxsis	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.

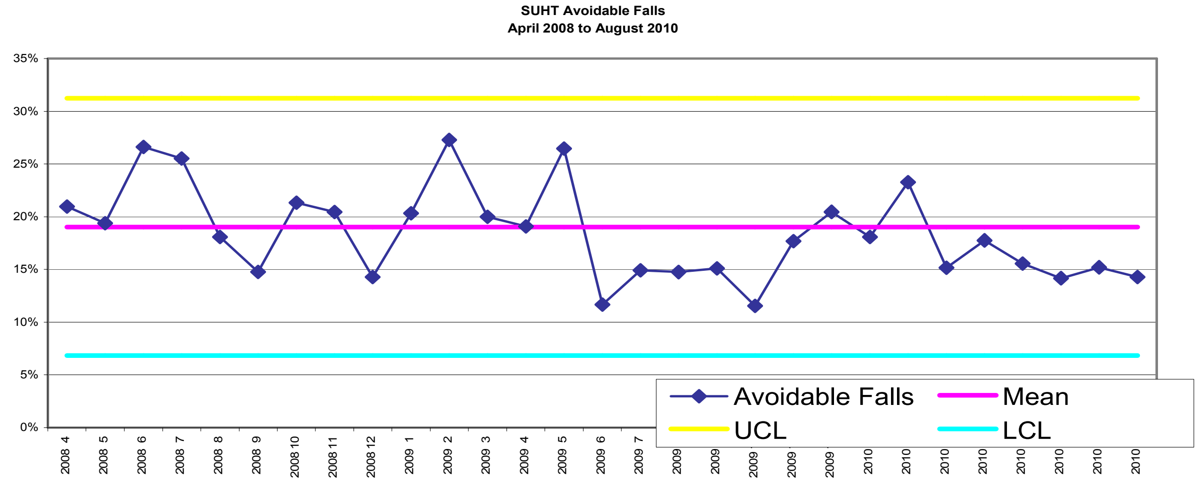
2. Integrated Patient Safety Work streams

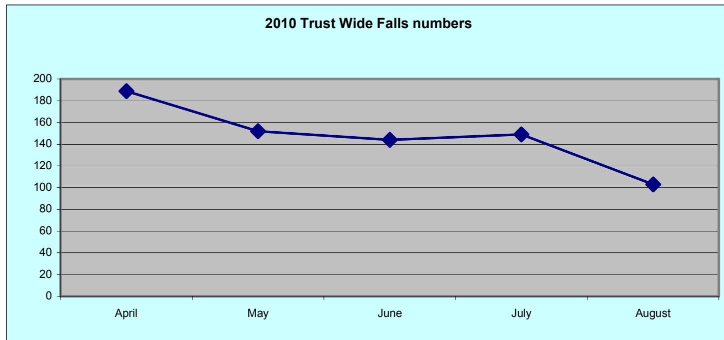
2.1 Falls (High Impact Action, Quality Contract)

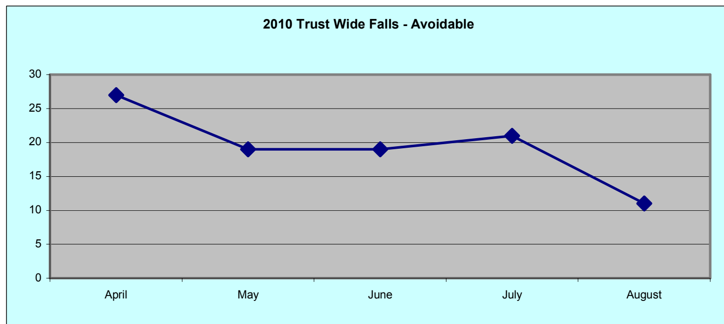
Target

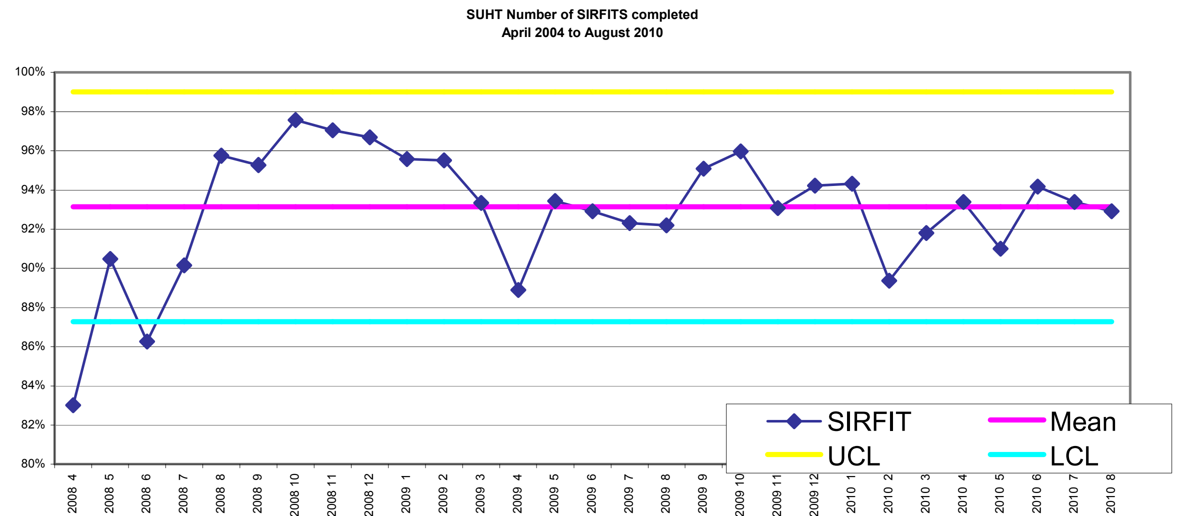
- To reduce avoidable falls to under 5% of total falls (Quality Contract)
- To maintain SIRFIT compliance above 95%

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

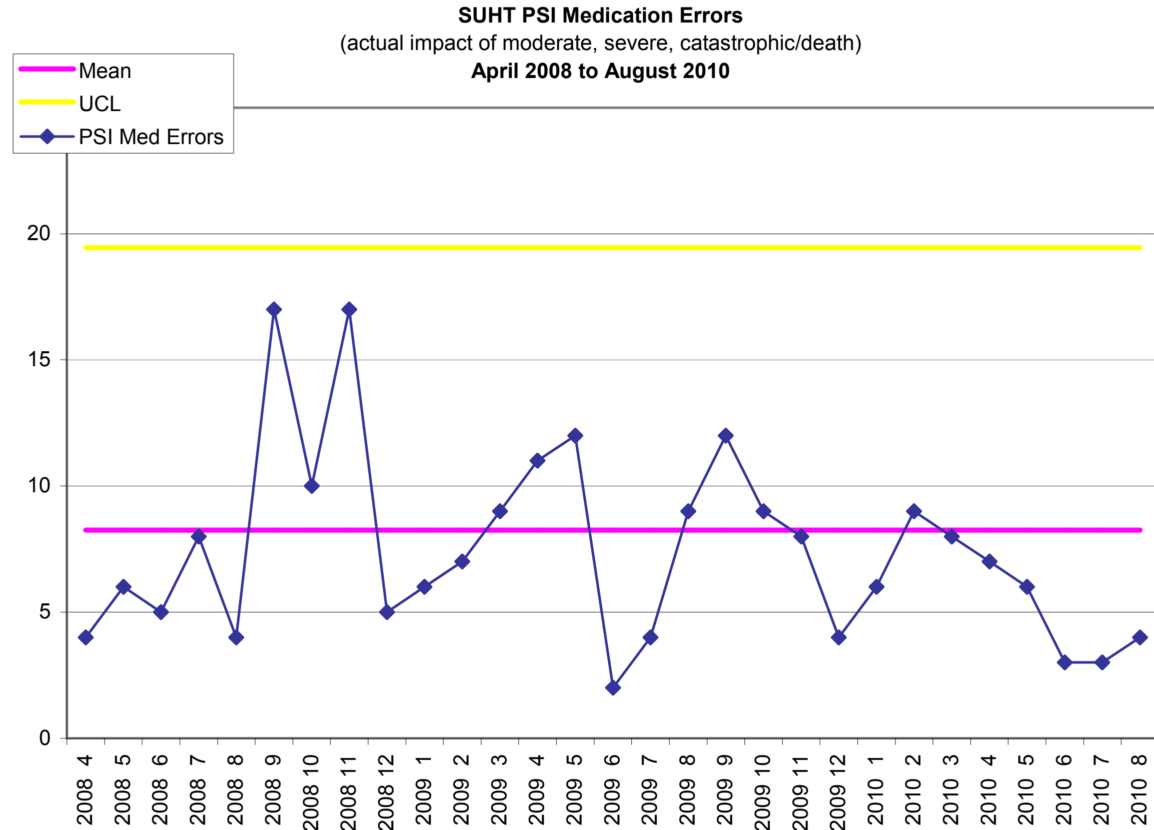
Work continues on the following: -

- 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.



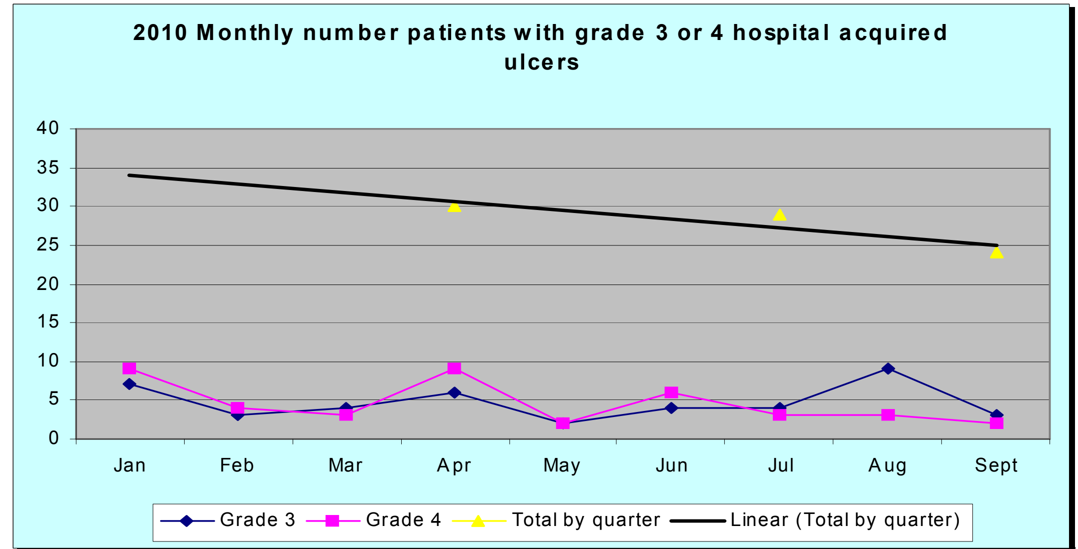
2.3 Pressure Ulcers (CQUIN, High Impact Action)

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

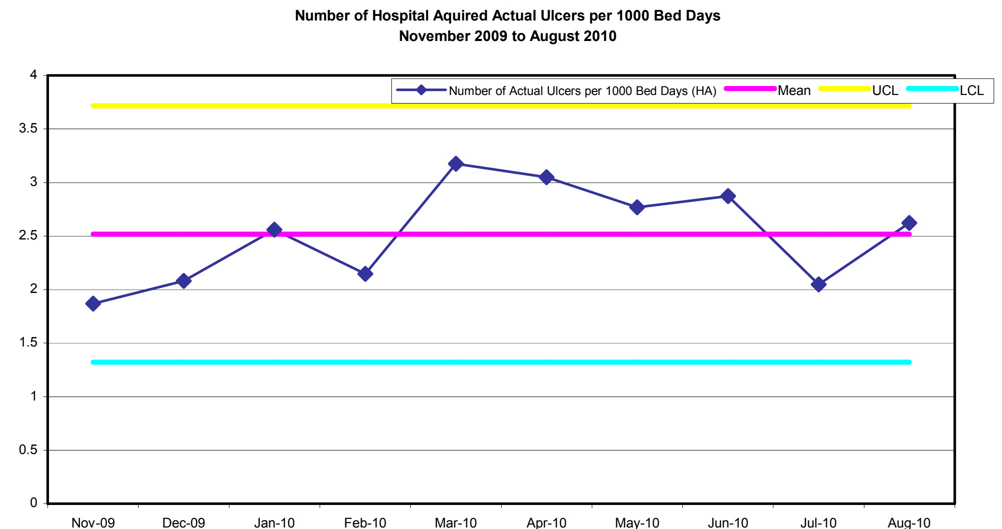
The Turnaround project has been extremely successful in capturing the hearts and minds on frontline staff. However this focus has seen an increase in reporting.

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 Thromboprophylaxis (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[6]

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%)

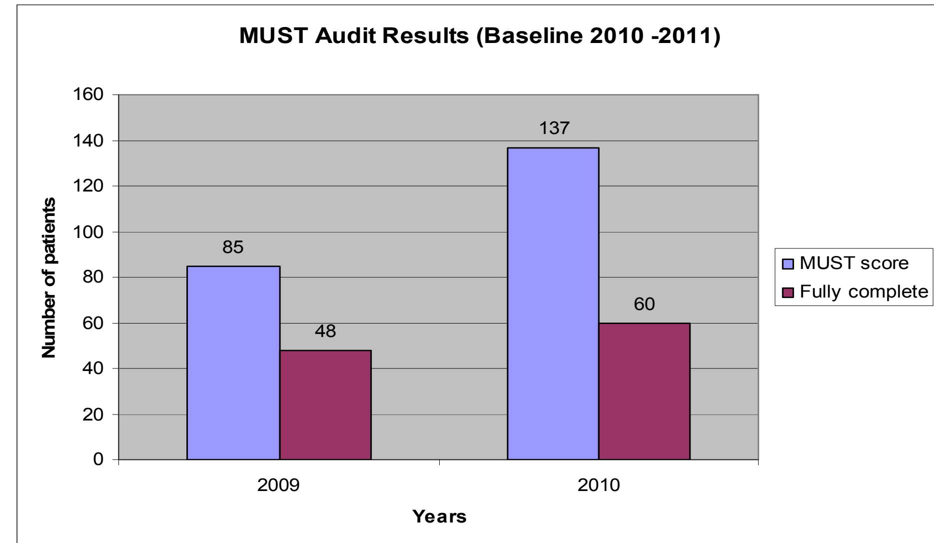
Progress

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.



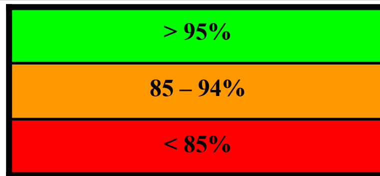
2009	n = 222 MUST score 85 (38%) Fully complete 48 (22%)	2010	n = 191 MUST score 137 (71%) Fully complete 60 (31%)

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).

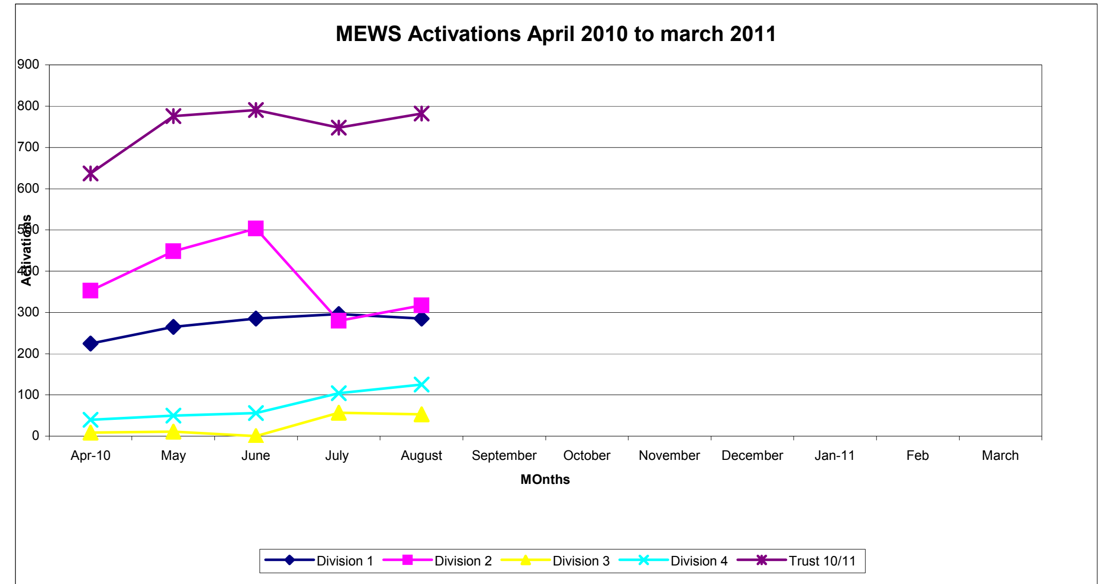
2.6 Deteriorating Patient

Target

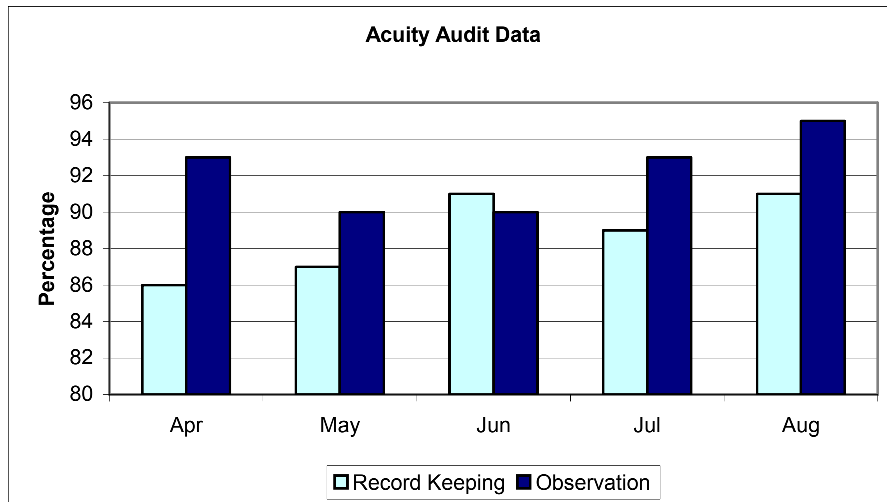


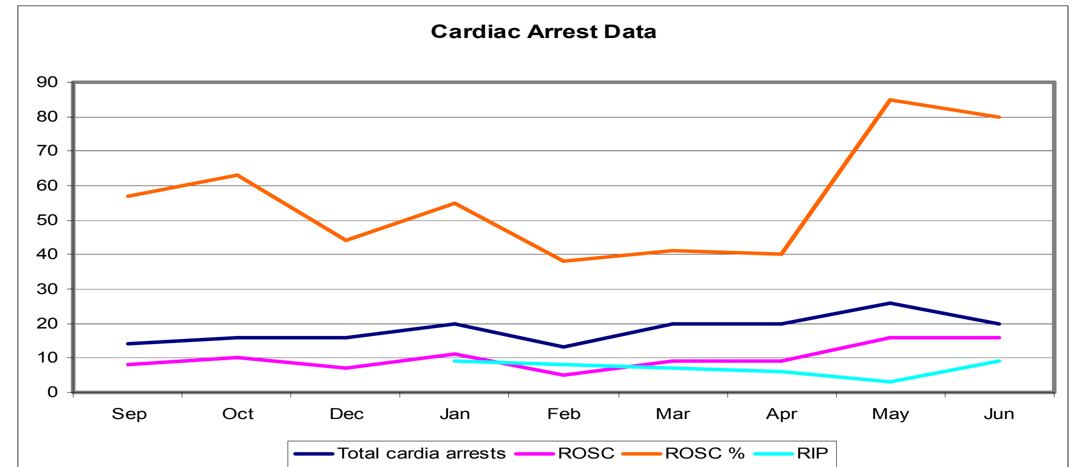
>95% compliance in Q4 for	Record keeping **Observation**
>85% compliance in Q4 for	Fluid Management
>95% compliance in Q4 for	Initial Activation Review
>85% compliance in Q4 for	Senior Review.

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.

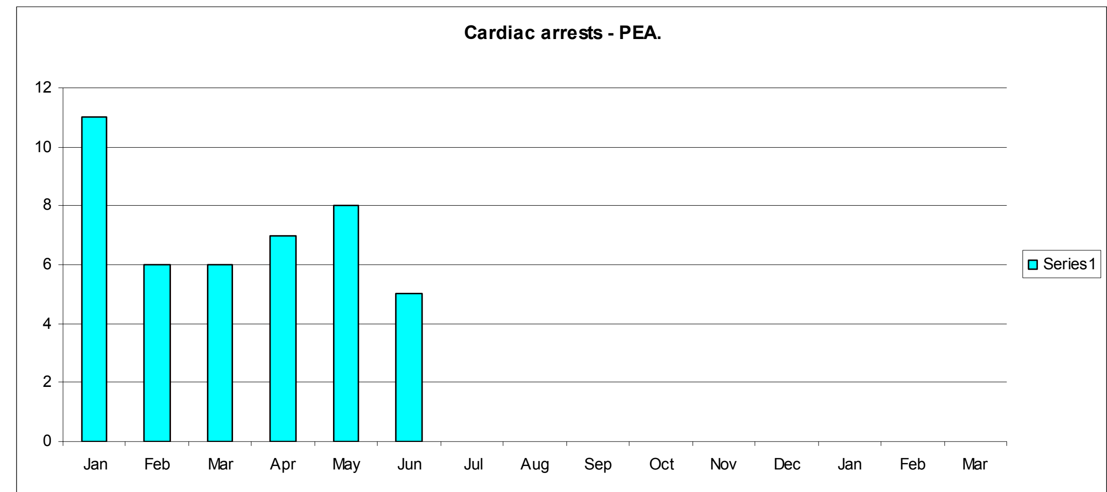
- IT department working to overcome data entry anomalies within Fluid Balance, Initial Activation Review and Senior Review and Divisional restructuring. In support of this, from Q3, each ward will be audited once a month to capture a larger sample size and increase audit of MEWS activations and Fluid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

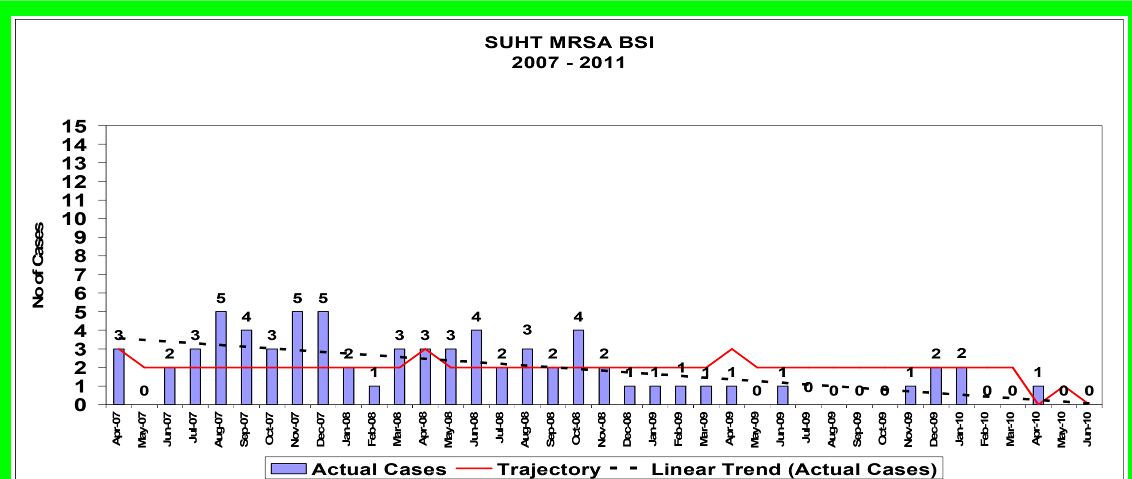
Target:
MRSA bacteraemia target for 2010/11 is 7 post 48 hr.
C.Difficile target for 2010/11 is 139 national target 110 Cases + local stretch PCT target .

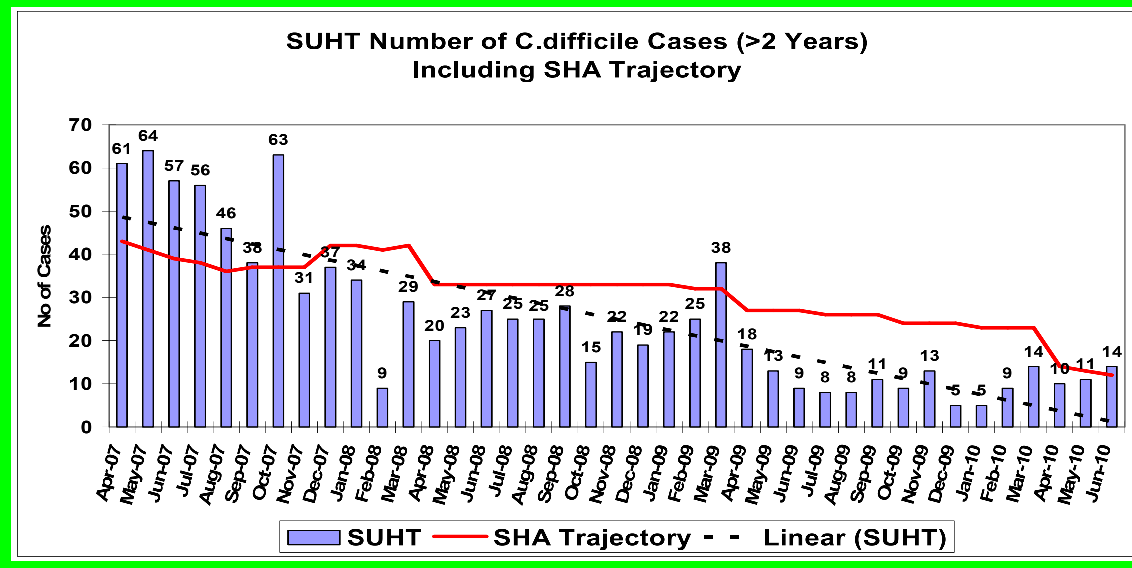
Progress
MRSA Bacteraemia: 2009/10 – 7 MRSA bacteramias, 4 of which were post 48 hr. Currently on 1 case for 2010/11.

***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

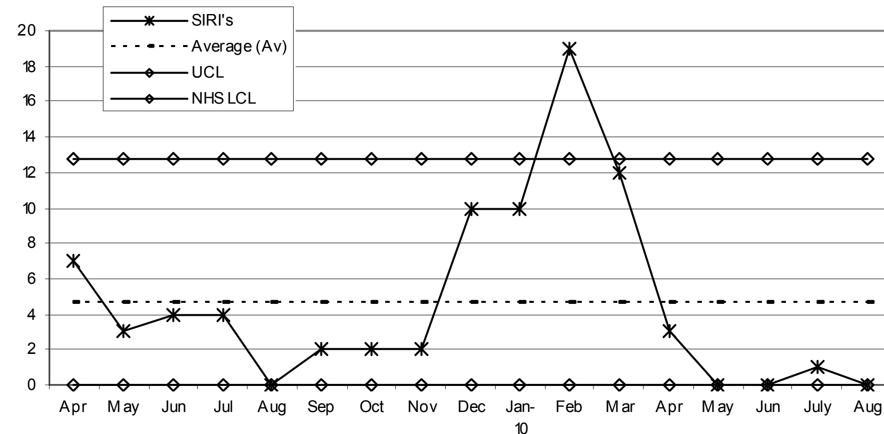
Serious Incidents Requiring Investigation (SIRI's)
previously referred to as Serious Untoward Incident (SUI's)

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

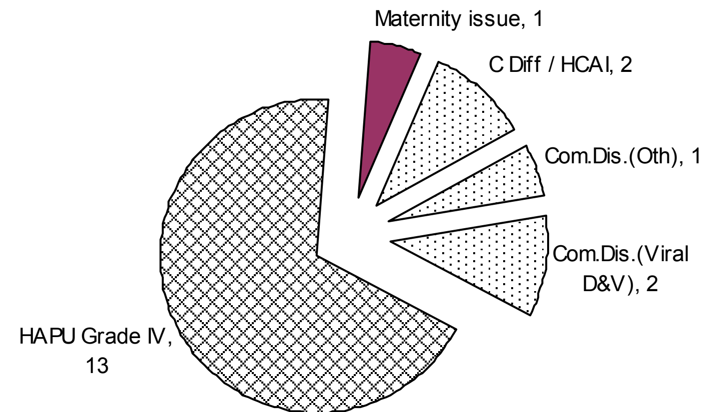
Never Events
There were No 'Never Events' within this 3 month period.

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.

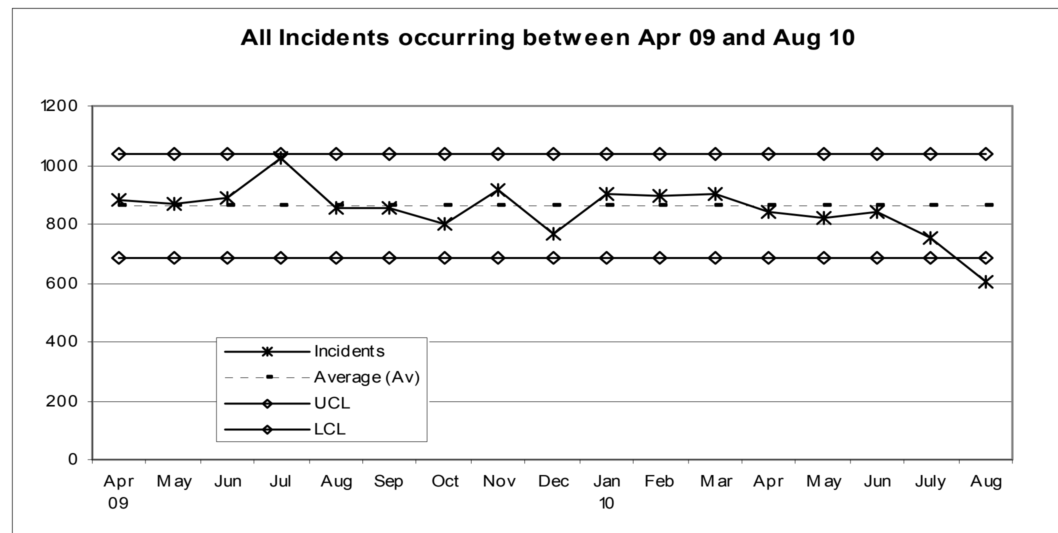
Healthcare Acquired Infection (HCAI) SIRI's
HCAI SIRI's comprised 26% (5) of the total for the period. These are managed by the Infection Prevention Team and monitored by the Trust Infection Prevention Committee.

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



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.

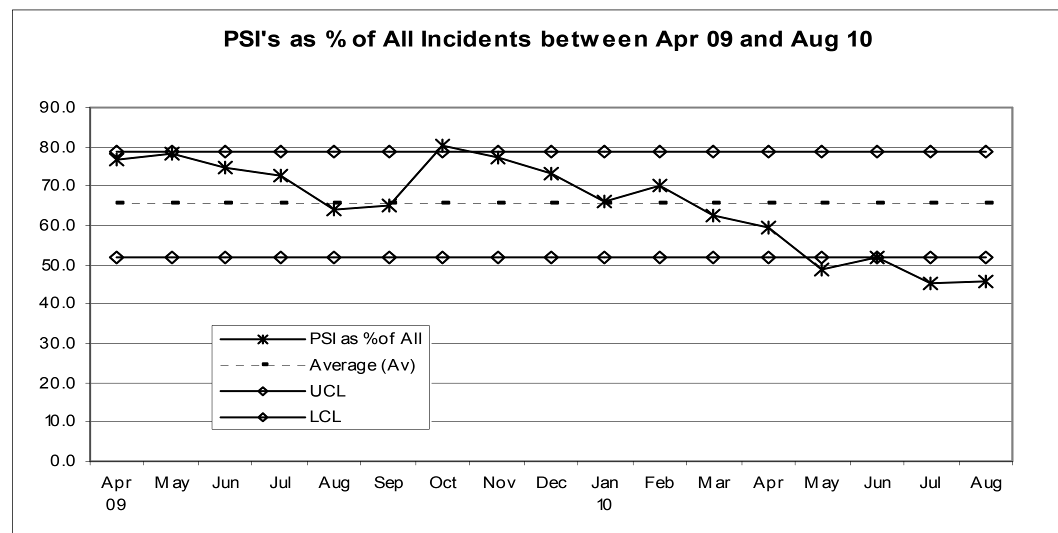


Patient Safety Incidents as % of All Incidents

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.

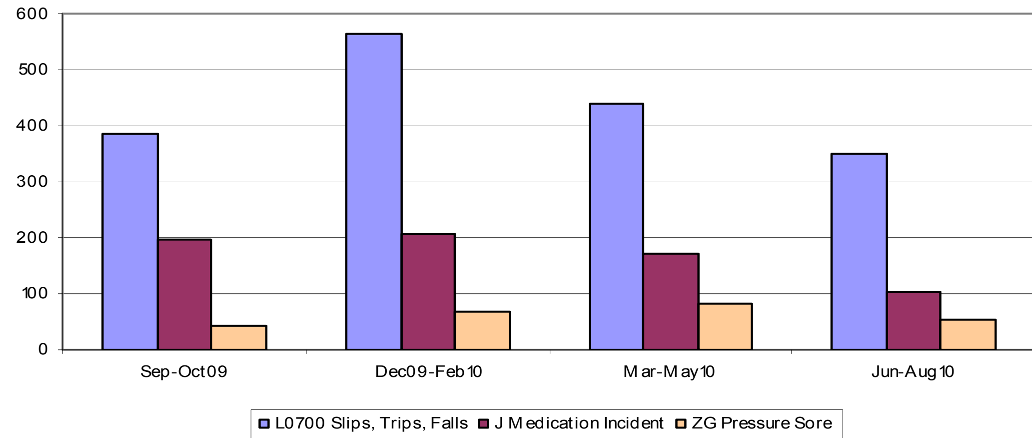
NB the incident reporting anomaly noted above can be largely ignored as this chart is based on percentages and both incident types (PSI and All) are likely to be equally affected by any lag.



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 Med	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

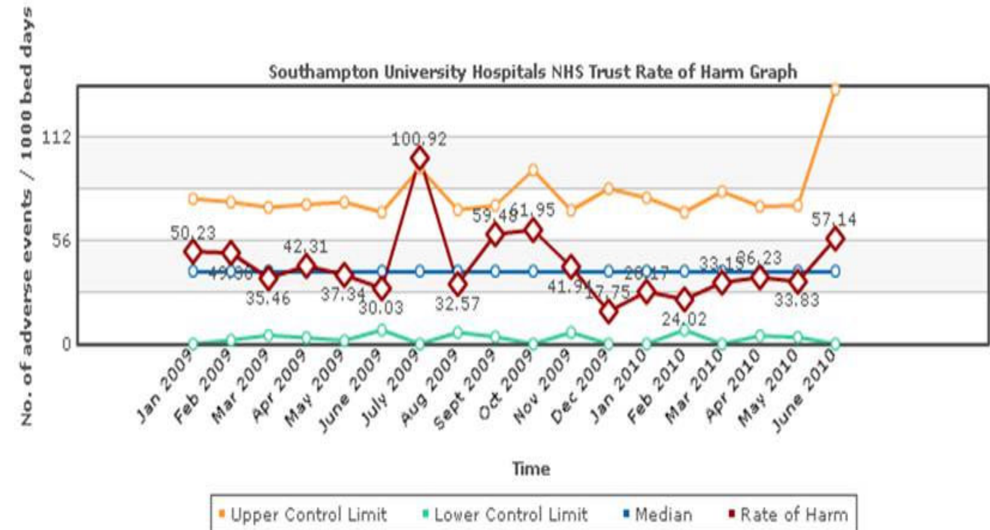
Over the quarter, there has been an improvement in the Divisional engagement with the trigger tool, with 141 reviews conducted in April – June, compared with 88 in the preceding quarter. There remain areas of significant underperformance, and the Divisional Management teams for these areas are being 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.

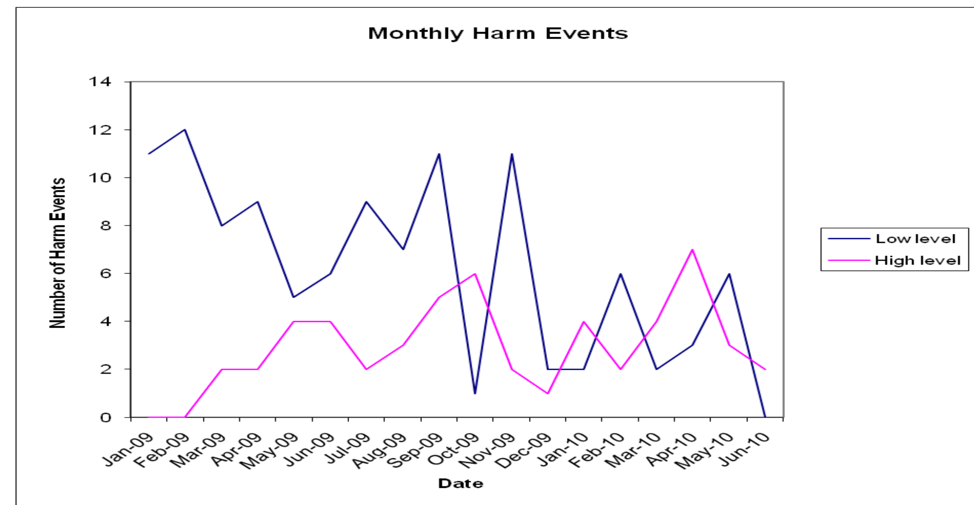
The process for feeding back areas of specific clinical concerns to the Divisional Teams is becoming embedded, and to date, the results of case reviews undertaken in response to high harm being identified have been that there were no avoidable factors found.

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