North Cumbria University Hospitals NHS
NHS Trust

TRUST BOARD

Date of Meeting: 23/10/2012	**Agenda Item No:** 5.1	**Enclosure:** 3
Intended Outcome:		
For noting ✓	**For information**	**For decision**

Title of Report: Improving Patient Safety

Aims: To update the Board on patient safety and quality within NCUH

Executive Summary:

This report summarises the Trust performance relating to patient safety and quality which includes;

- Quality Dashboard (appendix2)
- CQUIN
- NHS Safety Thermometer
- Infection Prevention
- Advancing Quality
- Harm from Slips Trips and Falls
- CQC Inspection reports
- Safeguarding
- Patient experience
- Quality in the New Health System – Maintaining and improving Quality from April 2013 (appendix 3)
- Mortality and Identifying the Potential Causes of Harm

Specific implications and links to the Trust's Strategic Aims:	
Ensure we provide high quality, safe and effective care for all our patients including meeting essential standards of safety and quality as set out by the CQC	✓
Develop a viable integrated clinical strategy for secondary care services which is sustainable and affordable	
Develop a new healthcare facility in West Cumbria that is fit for the 21st century	
Achieve sustainable financial balance through the delivery of the Trust's internal Cost Improvement Programme, securing a viable contract income from our GP commissioners and contributing to the system wide cost reductions	
To develop and implement a successful merger or acquisition plan that enables the Trust to become part of an existing NHS Foundation Trust	

Recommendations:

The Board is recommended to note the content of this report

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APPENDIX 1

TRUST BOARD

IMPROVING PATIENT SAFETY
23 OCTOBER 2012

1. QUALITY DASHBOARD

Work is well underway with North Cumbria and Northumbria Trusts information departments and governance teams to ensure that the Trusts quality dashboards are aligned and that we have a robust dashboard for which future reporting can be monitored.

1.1 CQUIN

The Trusts performance on the Commissioning for Quality Improvement (CQUIN) measures are reviewed and monitored by NHS Cumbria Commissioners. CQUIN measures are based on three separate categories; the Department of Health (DOH) National Measures, the Strategic Health Authority Regional Measures and locally agreed measures set by NHS commissioners. NHS Cumbria has agreed that the Trust has achieved quarter one CQUIN measures subject to them receiving further information requested on dementia and evidence based referrals.

For Quarter 2 there has been one query from Commissioners with regards to the service review in relation to Dementia. This relates a shared action plan with Cumbria Partnership Trust which has still to be formally agreed. There are no further exceptions to report and the Quarter 2 targets have been achieved. The Commissioners will approve Quarter 2 CQUIN targets in November 2012.

1.2 NHS Safety Thermometer

The NHS safety thermometer programme is well underway across the Trust and we now have reviewed four months of data. As previously reported to Board on 9 October it has been identified that a significant number of patients who were eligible to be included in the audit have urinary catheters in situ. This is consistent throughout the audit to date. The nursing and quality team are currently reviewing this data which includes identifying the reasons for patients requiring a urinary catheter.

2. EXCEPTION REPORTING ON AREAS OF UNDERPERFORMANCE

2.1 C Difficile

During September 2012 there were three post 48 hour cases of C difficile at CIC and no cases at WCH. The cases at CIC were on the following wards; Larch AB, one post 48 hour case and Elm C two post 48 hour cases. A full ward deep clean has been completed by the hygiene team on Elm C ward.

2.2 Advancing Quality

As requested from the Board unvalidated data has been included in the quality dashboard (appendix 2) for June 2012. The advancing quality team which is now led by the matron for quality standards have been reviewing current practices and work load with the aim to move towards real time data collection. The Trust has supported this and extra band two hours are currently being advertised.

No new data following the last report in 9 October 2012 to Trust Board is currently available.

2.3 Harm from Slips Trips and Falls

In September, two patient's sustained a fractured neck of femur following a fall on Elm B and Beech A at the Cumberland Infirmary. A root cause analysis has been completed and is under review by the governance team and Deputy Director of Nursing. As all fractured necks of femur following a fall are declared as SUI's, the SUI reports will be reviewed by the Director of Nursing, Medical Director and NHS Cumbria. The two September SUI's for patients who sustained a fractured neck of femur following a fall are included in October 2012 SUI figures.

All cases of harm following a fall are reviewed by the Trust's slips trips and falls group. A number of measures have been introduced across the Trust which include;

- Updated Patient Care Plan (falls trigger assessment)
- Post falls patient care plan
- Patient safety boards
- Slips, trips and Falls training provided to ward sisters/link nurses
- Further training for ward areas where there is an increased incidence of falls
- Undertake a review of the availability and requirements for high low beds of which the Trust currently has 23 beds in stock
- Introduced sensor mats across the Trust of which 17 are available and further 10 have been ordered for CIC which will include training for staff

3. CQC INSPECTION REPORTS

3.1 Cumberland Infirmary Accident & Emergency Inspection

The Executive Director for Operations is the lead director for the CQC Accident & Emergency CQC action plan and there are no exceptions to report. The actions

are monitored through the monthly Division performance reviews and reported to the Governance committee. The board will receive a monthly update via the Governance report.

3.2 CQC/Ofsted Safeguarding/Looked After Children Inspection

The Director of Nursing and Head of Nursing for Family Services are contributing and participating with other health providers and partners in the Health Economy action plan. This plan is also aligned to the Ofsted action plan led by Children's Services. Trust specific actions are monitored through the Health Network Group and there are no Trust specific exceptions to report.

Progress made on the Health Economy and Children's services CQC/ Ofsted action plan will be formally reviewed in November by CQC and Ofsted inspectors.

4. SAFEGUARDING

4.1 Consultation on Guidance for the Application of Multi-Agency Thresholds

The Cumbria's Children's Trust Board has launched a consultation on new guidance for people working with children on the application of multi-agency thresholds.
The consultation is aimed at people and organisations who work with children, either in professional or voluntary capacity. The aim of the guidance is to ensure that all people working with children use a common language, have a common approach to meeting children's needs and understand when they should be engaging with other agencies in order to ensure the child's needs are met.

Through the Trust's Safeguarding Board a full review of the guidance will be undertaken to ensure that key Trust staff have engaged in the consultation process.

4.2 Prevent

In September 2012 all Trusts across the North of England were requested from the SHA to complete the Department of Health Self Assessment Tool on '*Prevent*'.

Prevent is part of the Government's counter-terrorism strategy CONTEST, which is led by the Home Office. The health sector has a non-enforcement approach to *Prevent* and focuses on support for vulnerable individuals and healthcare organisations. The Department of Health and the health sector are key partners in working to prevent vulnerable individuals from being drawn into terrorist-related activities.

The '*Prevent*' agenda was outlined in the Department of Health document, *Building Partnerships, Staying Safe – The Healthcare Sector's Contribution to HM Government's Prevent Strategy: for Healthcare Organisations*.

Following the pilot phase, most healthcare organisations at local level concluded that since *Prevent* is about recognising when vulnerable individuals are being exploited for terrorist-related activities, it follows that it is most appropriately managed within existing safeguarding structures, working closely with emergency planning. Situating *Prevent* within safeguarding enables the programme to continue regardless of future changes to the NHS organisational structure. It is also in line with wider attempts to mainstream *Prevent* in other government sectors.

The Building Partnerships, Staying Safe document comprises of three parts;

- Part 1 introduces *Prevent* and explains how it fits with CONTEST. It also explains why the health sector is a key strategic partner in *Prevent* and how, by working with other public sector bodies, the health sector can help to protect vulnerable individuals and those around them from exploitation or harm.

- Part 2 explains the toolkit which is designed to help healthcare organisations to assess whether they have appropriate governance and support mechanisms in place to deal with any concerns that are raised.

- Part 3 is the self-assessment tool.

In line with national guidance, the SHA has recruited a new Regional Prevent Coordinator who will be working with organisations and their safeguarding teams. This role is to support organisations in delivering the *Prevent* agenda and work with the Department of Health to monitor progress made against the key deliverables.

5. PATIENT EXPERIENCE

The Clinical Commissioning Group (CCG) have commissioned a four day collaborative on patient experience for all health care providers. The collaborative will commence in November with the aim for completion in January 2013. As part of the preparatory work for the collaborative, the Trust has participated in sharing their current systems and processes used to gather patient experience with the external commissioned team.

6. NATIONAL QUALITY BOARD

The National Quality Board published a report in August 2012 on *Quality in the New Health System – Maintaining and improving Quality from April 2013*.

Monitor expects all Foundation Trusts to read, understand and hold a Board level discussion about the report with particular regard to the distinct roles and responsibilities for quality for the different parts of the health system and the values and behaviours that all parts of the system will need to display in order to put the interests of patients first.

The report should be read in the context of the quality and safety failures identified in Trusts such as Mid Staffs and Northwick park Hospitals where the wider NHS were unaware of the governance and quality failings within these providers. The report clearly outlines how responsibility for quality and safety within the NHS sits with a number of bodies – particularly at this current time of extensive change.

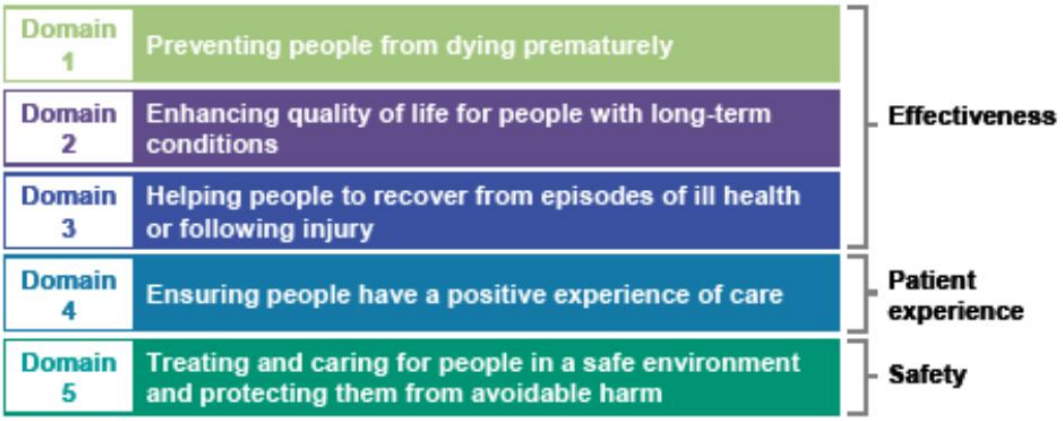
The following is a brief summary of the key points within the report – with the full report attached (Appendix 3).

The definition of quality for the NHS has 3 dimensions – all 3 of which must be present in order to provide a high quality service:

- Clinical Effectiveness – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- Safety – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety and
- Patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

This definition of quality is now part of legislation through the Health and Social Care act 2012.

The NHS outcomes framework sets out the national outcomes that all providers of NHS funded care should be contributing towards. The framework builds the definition of quality through setting out five overarching outcomes or domains. These are illustrated in the diagram below



The Health and Social Care Act 2012 defines what quality means in the NHS and also highlights the need for different parts of the health system to carry out their roles and responsibilities to ensure continuous improvement in the quality of care provided for people. The phrase 'different parts of the system' include:

- Secretary of State for Health
- NHS Commissioning Board
- Clinical Commissioning Groups
- Regulators – Monitor, CQC
- Providers – including governors, Boards, clinical leaders and healthcare professionals
- Professional regulatory bodies such as GMC, NMC.

It is essential that no part of the system works in isolation when addressing matters of quality. The system should work together to ensure that information and intelligence is shared and acted upon where concerns about quality are identified.

Quality Surveillance Groups

The new Quality Surveillance groups (QSGs) will be a forum whereby different parts of the health economy can come together to share information and intelligence about quality within services.

The QSGs will operate at two levels:

- Locally, on the same basis as the NHS Commissioning Board's 27 local area teams and
- Regionally, on the basis of the NHS Commissioning Board's four regional teams

The QSG will act as a virtual team across a healthcare economy bringing together organisations and their respective information and intelligence gathered through performance management, commissioning and regulatory activities to maintain quality in the system by routinely and methodically sharing information and intelligence. The model is envisaged to create a network which encourages and creates expectation of open and honest cooperation in every local area, in a regular and tangible way.

Members of the local QSGs should, as a minimum include: all local commissioners, representatives from the NHS Trust Development Authority where there are NHS Trusts in the area, LETB, Local Health Watch, Monitor and CQC.

The membership will be mirrored in the regional QSGs with the addition of the professional regulators, HEE and Health Watch England. This tier will consider some of the more strategic issues that arise.

The QSGs will provide routine and ongoing surveillance and assurance of quality within a local health economy. Any statutory organisation – local, regional or national – who has concerns about the quality of care of a provider should alert other QSG members to their concerns by triggering a risk summit. The CQC will then make an independent regulatory judgement as to whether there has been, or there is, the potential to be a significant breach of the essential standards of quality and safety. Where they determine there has been a breach – regulatory action will be taken by the CQC.

Organisations are required to consider the report in full as part of a leadership team, as a Board and as a group of clinical leaders and senior managers. They should commit to the principles and behaviours that underpin it and should examine ways to ensure that:

- We are clear within our own organisation about our own roles and responsibilities particularly statutory responsibilities with regards to identifying, responding and learning form failure.
- We are clear what we expect from other partners within the health economy.
- That we have a reliable process in place to engage our staff, governors and members.
- The values and principles of the NHS constitution are a reality within and between our different organisations.
- Do we have good relationships with our local/regional/national partners built on open and honest cooperation
- Is there a reliable process in place to engage our staff governors and members

In its simplest form the following operating principles should be used by all professionals working in healthcare:

- The patient comes first – not needs of the organisation.
- Quality is everybody's business – from Ward to Board; from the supervisory bodies to the regulators, from the commissioners to primary care clinicians and managers.
- If we have concerns we speak out and raise questions without hesitation.
- We listen in a systematic way to what our patients and our staff tell us about the quality of care.
- If concerns are raised, we listen and 'go and look'.

7. MORTALITY AND IDENTIFYING THE POTENTIAL CAUSES OF HARM

The Medical Directors office has now completed the review of hospital records for in hospital patient deaths in 2011/2012 supported by several multidisciplinary groups of clinicians. An analysis of the findings is underway with support from the patient information team.

The IHI trigger tool is now being adopted across the Medical and Surgical Divisions in order to continuously improve the safety and quality of patient care.

The Clinical Policy Group on 16 November will consider the findings and agree the Trust action plan which will be reported to Trust Board in November. The Board development day in October received the preliminary findings and actions, where appropriate, have started.

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