North Cumbria University Hospitals NHS
NHS Trust

TRUST BOARD

Date of Meeting: 26/02/2013	**Agenda Item No:** 6.1	**Enclosure:** 4
Intended Outcome:		
For noting ✓	**For information**	**For decision**

Title of Report: Safety, Quality and Patient Experience

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

Executive Summary:
This report summarises the Trust performance relating to patient safety and quality which includes

- Reducing our mortality and harm rate
- Advancing Quality
- Harm from Slips Trips and Falls
- Patient Experience
- LSA Annual Audit Supervision of Midwives
- Winterbourne Report

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.

Prepared by:	**Presented by:**
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APPENDIX 1

TRUST BOARD

SAFETY, QUALITY AND PATIENT EXPERIENCE

26 FEBRUARY 2013

1. TO WHAT EXTENT ARE WE DELIVERING THE SAFEST CARE?

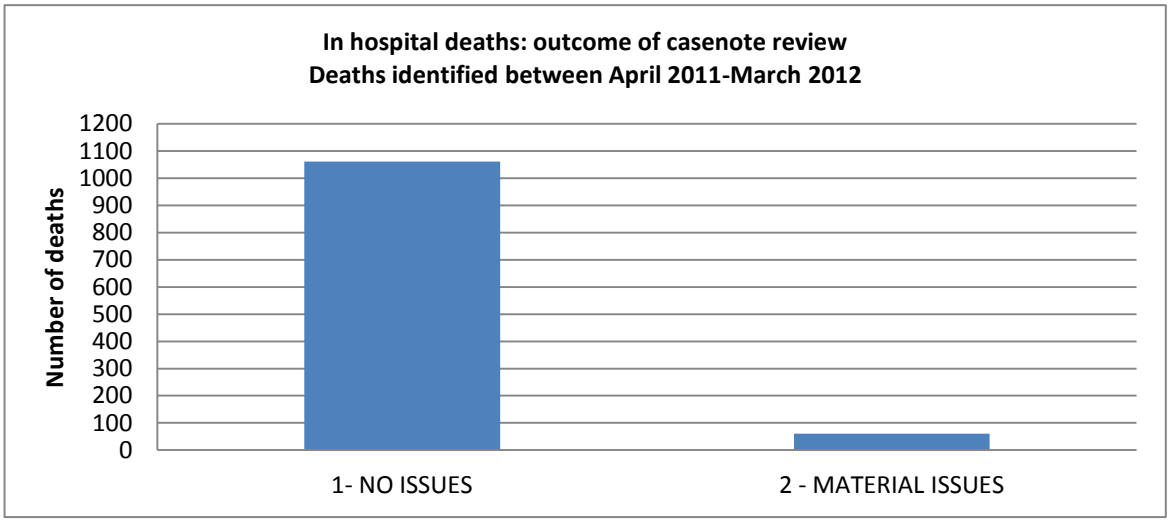
1.1 Introduction

Professor Bruce Keogh, Medical Director for the NHS announced on Monday, 11 February that a further nine hospitals would receive support from a Rapid Responsive Review Team with regards to their HSMR (hospital morality rate) and SHMI (hospital mortality rate which includes deaths up-to 30 days after discharge). This Trust is one of these nine Trusts. Further details of the timing of the review will be known by the time of the Trust Board meeting however, it is expected that the review will take place during March. The support is in the form is everything being done across the whole system of care and is the pace at the right speed.

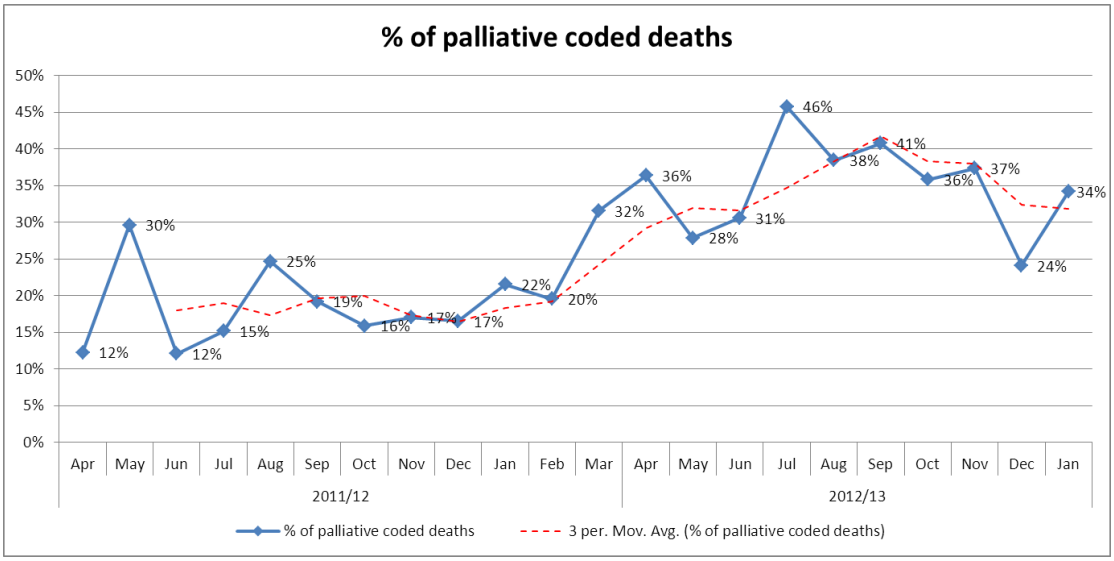
The Trust welcomes this support. The Trust had already undertaken a very open and proactive response to reviewing its mortality and harm rate when in it was notified by Dr Foster that it had a continued high rate for two consecutive years. Over 50 clinicians were involved in a rapid process to review all deaths from the previous year with the objective of learning what more could be done so care was continually improved. From the review, care was found to be safe but for a few patients the outcomes could have been better. The themes in our systems of care that could be better were as follows:

A review of deaths (1121) within 2011/2012 commenced in September 2012 and completed in November 2012.

The purpose of this review was to establish whether there are any causes of concern in our systems of care that we should be taking immediate appropriate action to mitigate the risk.



Death Classification	
1	Death was a likely outcome and all appropriate management was undertaken
2	Material issues that could have been done better



The results of this review were shared at CPG 16 November 2012 where it was agreed to implement the strategic aim of reducing harm by 50% in two years. In order to begin this process of delivering this reduction in harm four themes of work were identified.

Theme One: Clinical Care

- To ensure a robust system of monitoring and escalation to cover all specialties. We would establish a Trust wide group for management of acutely ill patients in accordance with the Northumbria NHS FT model;
- Promote and implement the sepsis bundle across the Trust;
- Pilot and assess the benefits of a Medical Emergency Team to support escalation;

- To improve the outcomes in Pneumonia by extending the AQuA pneumonia bundle;
- Transfer of high risk pathways from West Cumberland Hospital to Cumberland Infirmary

Theme Two: Leadership and Reporting Culture

- To encourage all staff to take responsibility for patient safety and the delivery of harm free care by implementing best practice from teams that have locally embedded reporting and responding systems to all locations in the Trust;
- To promote Patient Safety and local innovative safety improvements by running hospital wide 'Patient Safety Days' from March 2012;
- To improve communication and learning from safety incidents by using new methods of communication and reporting;
- Establish a harm group to review on a bi-monthly basis between 40-60 individual case notes and conduct a review of harm using the Institute of Improvement Global Trigger tool.

Theme Three: Improved Use of Clinical Information

- To promote safe discharge by ensuring all inpatients and day cases have an acceptable discharge summary at the time of discharge;
- To develop and strategic plan for clinical records and improved case note availability, tracking and better structured content.

Theme Four: Improved Identification and Care for Dying Patients

- To develop a shared care document for care of the dying between primary and secondary care, to identify patients and make better use of community facilities for dying patients;
- To ensure that patients identified as receiving specialist palliative care documented appropriately.

1.2 External Review

The Advancing Quality Alliance (AQuA) was approached by the Trust in June 2012 to undertake an independent review of mortality rates in North Cumbria. AQuA is a health improvement organisation which supports local improvements in the quality of health services and was able to share their experience of tackling mortality rates within the North West. Their findings identified the same outcomes as the internal review, that is:

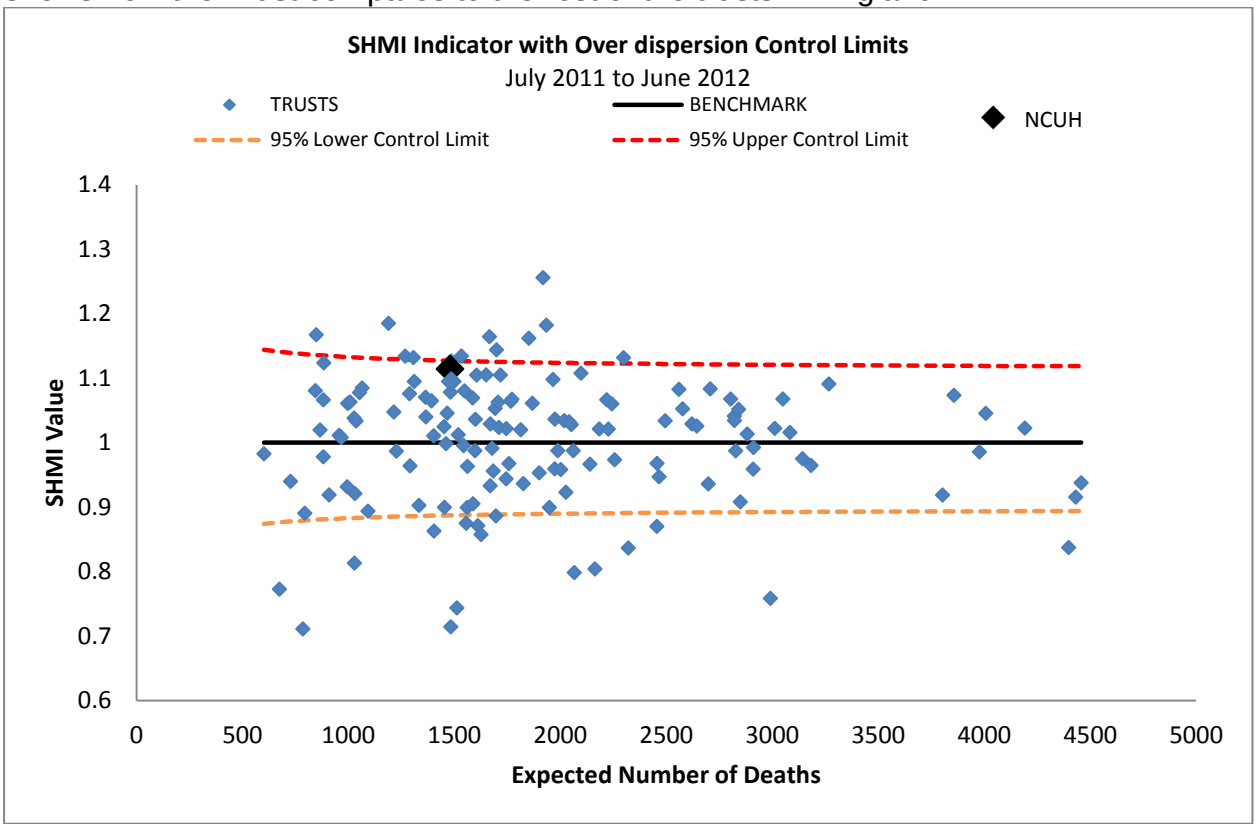
- further develop clinical quality through the adoption of care bundles;
- strengthen leadership and governance of mortality reduction activity linking it more closely to other patient safety and quality initiatives;
- review staffing levels;

- improve data quality and the use of information.

Improvement work has started in each of these four themes and future reports to the Board will provide the evidence of improvement via measurement.

1.3 What is our mortality rate after discharge from hospital (SHMI)?

The latest update of the national mortality indicator, the SHMI (Summary Hospital-Level Mortality Indicator) was published by the NHS Information Centre in January, and covers the period July 2011 to June 2012. This indicator includes all deaths in hospital plus those occurring within 30 days of discharge. The Trust's value of 111 was categorised as "as expected". Although the observed number of deaths is greater than expected, this is not statistically significant using 95% confidence intervals. The funnel plot below shows how the Trust compares to the rest of the trusts in England:



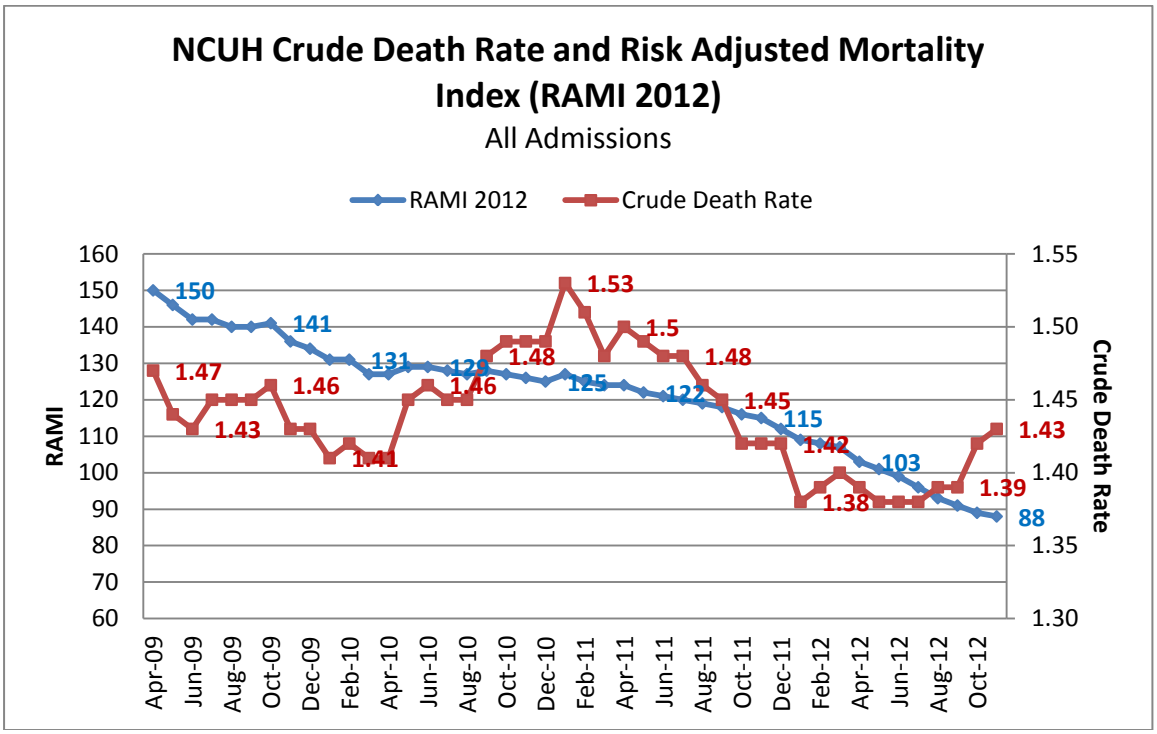
Analysis by diagnostic group, using the CCS (Clinical Classification System) methodology, shows that for 3 diagnostic groups, the number of observed deaths was significantly greater than the expected number produced by the model (using 95% confidence intervals) :-

- Pneumonia;
- Congestive heart failure, non-hypertensive;
- Gastrointestinal haemorrhage (this will be managed by the transfer of high risk pathways from WCH to CI and a 24-hour on-call emergency service, 7 days a week will be provided).

1.4 What is the real-time trend in our risk-adjusted within-hospital mortality level?

Risk Adjusted Mortality Index 2012

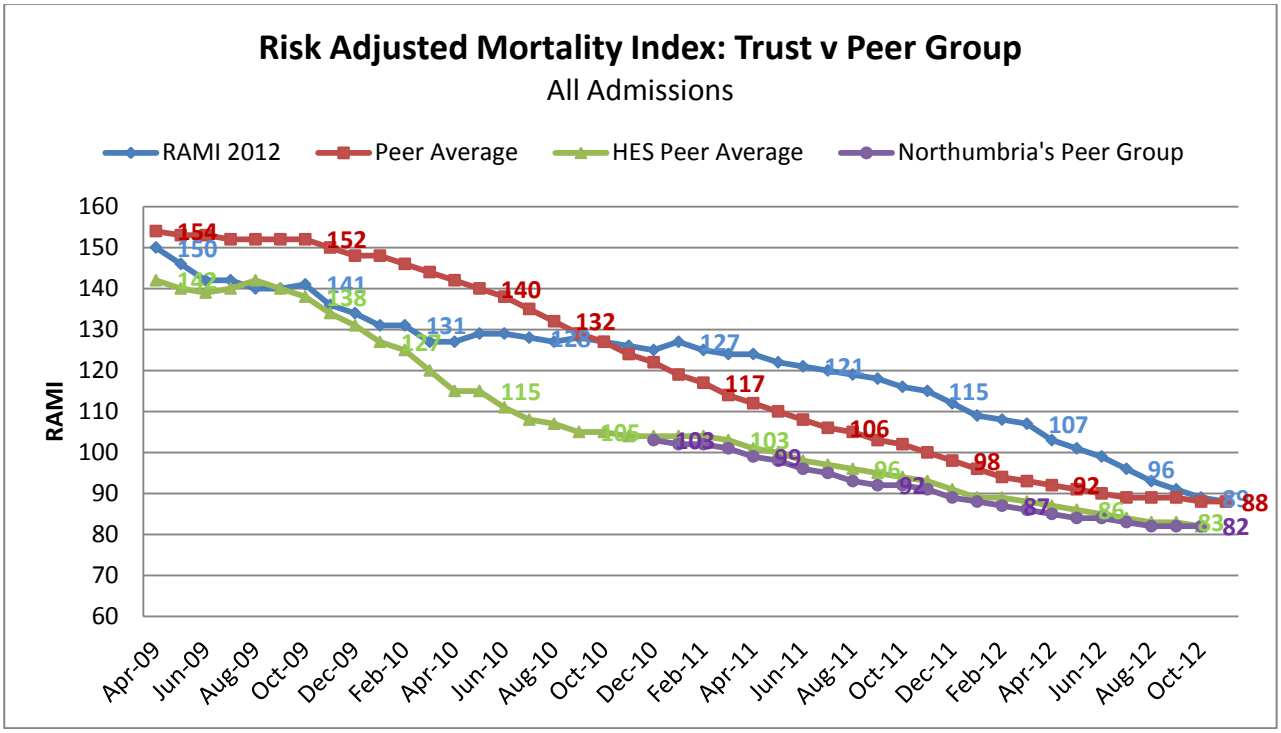
The chart below shows that our risk-adjusted index is now 88 (Oct11-Nov12).



Crude Death Rate

Over the last 3 years, the Trust's Crude Death Rate peaked in December 2010 at 1.53%. During the following year, the rate declined steadily and reached a low of 1.38% in January 2012. Year to Date figures for 2012/13 suggests that the rate may be starting to rise again, 1.43% during October 2011-November 2012, although this is still below the high rates seen in 2008/09 and 2011/12.

1.5 How does our hospital mortality level compare with that of our peer group of Trusts?



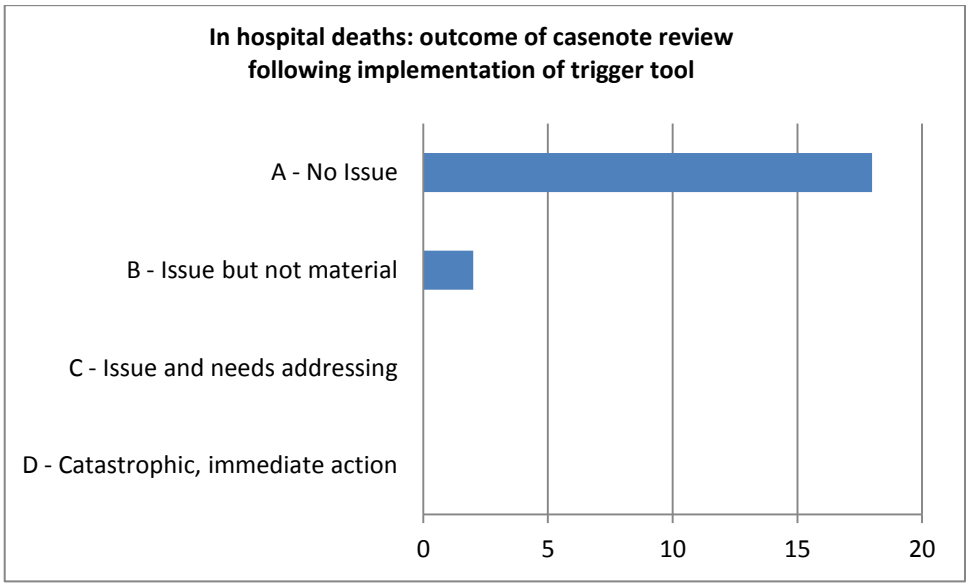
The chart above shows how the Trust's mortality index (standardised to the CHKS RAMI 2012 model) has changed during the period Apr 2008 to Oct 2012, compared to the mortality index of the peer group of Trusts, and also HES peers. Prior to Oct 2010, the Trust's Index was lower than that of its peer group. From Nov 2010 however, the Trust's index rose above its peers, although still showing a steady decline. Since then, the rate has continued to decline and the latest position (Oct11-Nov12) shows that the trust's index is now in line with that of the peer group at 88. The index has been consistently above HES peers since 2008/09, although the gap has been seen to be narrowing throughout the last 12 months.

1.6 Weekly Monitoring of Patient Deaths that Trigger a need for a Review

Following CPG (Clinical Policy Group) in November 2012, and as part of the Trusts commitment to improving safety and quality, the Northumbria model for reviewing mortality has been implemented at the Cumberland Infirmary and West Cumberland Hospital. This is recognised as best practice and demonstrates a proactive approach to learning and continually improving care.

The process was introduced at WCH August 2012 and implemented at CIC in November 2012 and involves identifying in hospital deaths that have occurred which require investigation using the Institute for Healthcare Improvement Global Trigger Tool. This process has 'triggered' within 3 different areas since it was introduced at CIC and once at WCH.

The Medical Director confirms that in hospital deaths highlighted by the trigger mechanism were predictable and no issues were identified in the 18 cases. Two issues were identified and these related to documentation and access to diagnostics. The other clinical areas that have triggered are currently reviewing the relevant case notes and the findings will be reported in March 2013.



1.7 Next action and priorities of work

Priorities for March will focus on:

- Reporting of low risk mortality and assessment of deaths following an elective admission is to commence as of March 2013;
- Updating the Trust wide framework for Mortality and Harm;
- First reducing harm group meeting takes place on 28 March 2013;
- First Management of Deteriorating Patient Group takes place on 8 March 2013.

1.8 Conclusion

The purpose of monitoring and review is to understand the causes of our mortality, and how we compare with our peers. We are developing robust and proactive systems to continually improve the quality of care we provide. The evidence demonstrates that we are using a range of methods to achieve this goal.

2. ADVANCING QUALITY

2.1 Acute Myocardial Infarction

The data for October shows an underperformance with fibrinolytic therapy for the Acute Myocardial Infarction measure at 75%. This measure is where fibrinolytic therapy is administered within thirty minutes of arrival. This data is currently being reviewed by the AQ team.

2.2 Stroke

Underperformance is shown with the measure for admission to a stroke unit within 4 hours of arrival at 83%. This relates to forty two patients of which seven patients were not admitted to a stroke unit within the four hour time frame.

2.3 Pneumonia

Underperformance is shown with the measure for smoking cessation advice and counselling at 80%. This relates to five patients of which one patient is not documented nor recorded to have received smoking cessation advice.

Underperformance is also shown relating to initial antibiotic selection within six hours of arrival to hospital at 75 %. This data is currently being reviewed by the AQ team.

The AQ team with the support of the Associate Director for Operations are working with clinicians in developing a revised care bundle which will be initially piloted across the Trust.

3. HARM FROM SLIPS TRIPS AND FALLS

In January 2013, 115 patients were reported to have slipped, tripped or fallen with the cumulative figure of 956 falls. The increased in reporting is in line with the work we have undertaken with staff to encourage reporting and raising awareness through the Slips Trips and Falls Group.

There were two fractured neck of femurs reported in January and to date there have been twelve fracture necks of femurs for 2012/2013 and all actions and recommendations are in place.

4. NEVER EVENTS

Two Never Events were reported during January. The first event relates to a retained guide wire and the second event relates to an incorrect eye lens implant. Both of these incidents have been declared as Serious Untoward Incidents with a full root cause analysis. The Medical Director and Director of Nursing have reviewed the immediate actions required.

5. PRESSURE AREAS

One grade three reported pressure area is currently under full review and a root cause analysis (RCA) being completed. The RCA is currently under review by the Deputy Director of Nursing and Specialist Nurse for Tissue Viability.

6. PATIENT EXPERIENCE

6.1 Friends & Family Test: National Minimum Standard

The Friends & Family Test will provide timely feedback from our patients about their experience. NHS Providers are required to provide the scores from the 1 April 2013. The Trust is working with our colleagues in Northumbria and our Commissioners and we are adopting the Northumbria post card system to deliver this. The Information Department is also working with colleagues in Northumbria to ensure that the system and processes are aligned.

6.2 Patient Perspective

It was agreed by the board in November 2012 that the Trust will be implementing patient perspective which is one of a number of patient experience tools used in Northumbria. Crea Simpson Matron for Patient Experience is working closely with Northumbria's Director for Patient Experience to ensure this is up and running from April 2013. To be effective, 50 patient responses, per Consultant are required for both inpatient and outpatient care. This has the potential for 17,000 patient responses. These responses will strongly influence our priorities to improve patient care and our behaviors. The contract is signed and the first patients to be asked about their experience will be those receiving care during February. The first report to the clinical teams and the Trust Board will be June.

6.3 Patient Experience Time Out Workshops

An intensive quality improvement programme has been established and will be rolled out across the Trust. The programme will be delivered to clinical teams on an individual ward and department basis. The Emergency assessment team at the Cumberland Infirmary are the first team to participate in this quality improvement programme. The whole team is included in the programme which is undertaken over a period of sessions which includes doctors, nurses, ward clerks, physiotherapists and the ward pharmacist.

The overarching aim of the programme is to:

- To ensure we provide high quality, safe and effective care for all our patients including meeting the essential standards of safety and quality as set out by the Care Quality Commission,
- To facilitate a culture shift towards consistent and compassionate patient centred care within the emergency care pathway.

The specific outcomes are:-

For individual team members:

- For all staff to be aware of issues and concerns raised;
- To reaffirm areas of strength and identify areas for personal development (style, behaviours and attitudes);
- To further develop skills in reflective practice;
- To reframe and practice tips for strengthening communication which supports positive patient experience and in doing so safety and clinical effectiveness;
- To clarify arrangements for personal support and supervision for the future.

For the Team:

- To establish standards of behaviour and attitudes;
- To agree methods of sustaining standards within the team;
- To agree team support mechanisms;
- To agree how progress will be communicated.

For the Trust:

- Evidence to provide further assurance on CQC outcomes;
- Support the implementation of actions identified in the Chief Nursing Officer Vision, and Strategy “Compassion in Practice” DOH December 2012.

6.4 National Annual Patient Survey

The four most important areas for improvement and evidence of improvement are explained in the table below:

Area for Improvement	Measure of Success
Ensure discharges are planned on the right day and at the right time	The weekly report to SMT confirms that more patients are discharged on the day they are planned to be discharged but these still needs to improve. Home for lunch has been promoted and the role of the discharge lounge actively promoted. Spot checks by the Director of Nursing

	and Medical Director are starting from February.
All patients should receive better explanation of their medicines and how to manage them when they leave the hospital	This needs further work and we are looking to adopt the approach by Northumbria which focused on visual reminders to both patients and staff.
More patients and their GPs should be provided with an electronic discharge communication	This is now changed from e-discharge to discharge summary. We now have evidence that 70% of patients and GPs receive their discharge summary on the day of discharge. This is expected to improve week by week and be sustained.
There needs to be better engagement and feedback from children, young people and their parents about the care they have received	An engagement forum has been established by the Children's Business Unit and has active involvement. The view of patients will be assessed by patient experience systems.

7. LSA ANNUAL AUDIT OF SUPERVISION OF MIDWIVES IN NORTH CUMBRIA

Supervision of Midwives is a statutory responsibility which provides a mechanism for support and guidance to every midwife practising in the United Kingdom. The purpose of Supervision of Midwives is to protect women and babies by actively promoting a safe standard of midwifery practice.

The Supervisor of Midwives is accountable to the Local Supervising Authority (LSA) and is supported in their role by the Local Supervising Authority Midwifery Officer (LSAMO). The local supervising authority midwifery officer ensures the standards of Supervision of Midwives and Midwifery Practice, meet those required by the Nursing and Midwifery Council (NMC). The LSAMO promotes and measures the effectiveness of the Supervision of Midwives in the interests of women, their babies, families and the wider public.

Supervision of midwives is closely linked to clinical governance and is integral to governance processes within the local supervising authority.

The North West LSAMO undertakes an annual audit of each maternity unit in the North West region to assess whether the standards of supervision are being met. The information obtained during the audits is used to inform the annual report required by the NMC, in accordance with Rule 13 of the Midwives Rules and Standards (NMC 2012). The report outlines supervisory activities over the past year, key issues, audit outcomes and emerging trends affecting maternity services. The report provides assurance that the local supervising authority is meeting the standards set by the NMC for the delivery of the statutory Supervision of Midwives.

The recent audit report on Supervision of Midwives in North Cumbria concluded:

'*the Supervisors of Midwives are a confident team who have the ability to promote statutory supervision not only as supporting midwives in their practice but also as a robust quality assurance mechanism'*.

The audit identified that In relation to standard 4, criteria 4.2; *where each midwife has a named Supervisor of midwives, of his or her choice with the option to change to another,* this criteria was not met. As reported previously to Board this related to two midwives, who at the time that the audit was undertaken could not identify who their named supervisor was. This has been fully addressed and it was noted that a letter had been sent to all midwives prior to the audit following a recent reallocation of Supervisors.

The LSAMO made recommendations within the report and an action plan (has been developed by Supervisor of Midwives team to address these recommendations. The Director of Nursing and Head of Midwifery have received the action plan; the progress and any exceptions will be reported quarterly to the Governance Committee.

8. WINTERBOURNE VIEW HOSPITAL REVIEW REPORT

Winterbourne View Hospital was a private hospital, owned by Castlebeck Care Limited. The hospital was registered to provide assessment, treatment and rehabilitation for people with learning disabilities. Most of the patients in Winterbourne View Hospital had been placed under the Mental Health Act.

After the transmission of the BBC Panorama *Undercover Care: the Abuse Exposed* in May 2011, which showed unmanaged Winterbourne View Hospital staff mistreating and assaulting adults with learning disabilities and autism, South Gloucestershire's Adult Safeguarding Board commissioned a Serious Case Review.

The Review was based on information provided by Castlebeck Care (Teesside) Ltd, the NHS South of England, NHS South Gloucestershire PCT (Commissioning), South Gloucestershire Council Adult Safeguarding, Avon and Somerset Constabulary and the Care Quality Commission; correspondence with agency managers; contact with some former patients and their relatives; and discussions with a Serious Case Review Panel.

The Serious Case Review identified evidence of poor quality care in Winterbourne View Hospital:-

- Families were not allowed to visit patients on the ward or in their bedrooms; which made the abuse even harder to spot;
- Patients had very little access to advocacy;
- Policies and procedures were not put into practice;

- Recruitment of staff did not appear to focus on quality and job description's did not ask staff to have experience in supporting people with learning disabilities/autism and challenging behaviours;
- The hospital staff training was focussed too much on restraint;
- The Safeguarding Authority knew about safeguarding issues but failed to identify a trend in the number of times they were contacted;
- The Commissioners should have made sure the hospital provided quality care;
- The Care Quality Commission failed to respond to the concerns raised by the Whistleblower;
- The Mental Health Act Commission knew about incidents but did not follow up to make sure improvements had happened;
- The Police were reported to on 29 incidents, 8 of these were physical restraint on the patients and they failed to follow these up.

In December 2012 the Department of Health (DOH) published its final report into the events at Winterbourne View Hospital. The DOH report sets out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice.

The programme of action includes:

- the Police were reported to on 29 incidents, 8 of these were physical restraint on the patients and they failed to follow these up
- by spring 2013, the DOH will set out proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provide,
- by June 2013, all current patient placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014,
- by April 2014, each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behavior described as challenging, in line with best practice,
- as a consequence, there will be a dramatic reduction in hospital placements for this group of people,
- the Care Quality Commission will strengthen inspections and regulation of hospitals and care homes for this group of people, including unannounced inspections involving people who use services and their families,
- a new NHS and local government-led joint improvement team will be created to lead and support this transformation.

The DOH will publish a progress report on these actions by December 2013.

Mr Mike Walker **Medical Director**	**Mrs Chris Platton** **Acting Director of Nursing & Quality**	**Mrs Ramona Duguid** **Acting Director of Governance**

APPENDIX 2

QUALITY DASHBOARD