North Tees and Hartlepool NHS
NHS Foundation Trust

Annual Quality Account

2010 - 2011

Draft for Consultation

North Tees and Hartlepool NHS Foundation Trust

Annual Quality Account for 1 April 2010 to 31 March 2011

Annual Quality Account 2010/11
Our approach to quality

Chief Executive Alan Foster

An introduction from the Chief Executive

We welcome the introduction of the annual quality account because we can demonstrate our commitment to quality throughout the organisation. *High Quality Care for All: NHS Next Stage Review (DH 2008)* describes the challenge of delivering high quality care for all. The Next Stage Review describes three dimensions of quality, namely patient safety, effectiveness of care and patient experience.

This report demonstrates some of the actions taken and shows evidence of improvements in quality for our patients. Our patients, carers and our staff gain from all-round efforts to achieve greater things. Our Trust Board and clinical teams demonstrate their commitment to putting patients first through making patient safety and experience its number one priority. This first quality account aims to describe progress in delivering high quality, patient centred services in partnership with the national Patient Safety First (PSF) campaign, Leading Improvements in Patient Safety (LIPS) programme and allied to *Our Vision Our Future* the North East quality indicators framework.

We believe this commitment to quality has already been firmly embedded in the culture of our organisation by continually emphasising our fundamental belief of Putting the Patient First.

The Board has strongly indicated its commitment to quality by making patient safety and experience the number one priority for the Trust. The Director of Nursing and Patient Safety and the Medical Director share responsibility to the Board for leading this. Progress is overseen by the Clinical Governance Committee and reported to the Board on a monthly basis.

We agree with the NHS Chief Executive David Nicholson, and Professor Sir Ara Darzi that quality comprises the dimensions of patient safety, effectiveness of care and patient experience. Our quality strategy and our quality account reflect these priorities and have been developed with patients, carers, staff, governors, patient groups (including the local improvement networks (LINks) and with support from our commissioners.

While direction from the Board is important, quality cannot be delivered without effective leadership at all levels in the organisation. We therefore believe that developing leaders is an integral part of the quality agenda.

Summary of quality of services provided

Our quality pledge

In 2008, our Board and our staff pledged patient safety and experience as their number one priority. During 2009/10 we have listened to patients, staff and governors as well as to key stakeholders to develop a four-year quality strategy.

Putting patients first means creating a patient-centred organisation by engaging and enabling staff to add value to the patient experience, demonstrated through patient safety, service quality and *lean* delivery.

Our staff

We have put much emphasis on workforce development as part of embedding a quality approach to ensure staff are equipped to lead improvement wherever they work and our workforce development programme shows how important this is.

Over 1,700 staff have now had some level of training in *lean* methodology and we have 17 staff who have qualified in our accredited certified leader programme in *lean* management techniques which attracts 60 credits at Masters level from Teesside University. Another 30 staff are in the final stages of assessment.

Productive ward

The Productive Ward Programme has been rolled out to every ward and we are also implementing Productive Community and Productive Theatre programmes. Over the year 38 staff joined the existing 150 successful graduates in an accredited leadership development programme which includes a quality improvement project. A further 2 cohorts are planned for 2010/11.

In addition entry into non-registered nursing posts is now exclusively through an accredited apprenticeship programme to ensure the level of literacy and numeracy skills require to safeguard our patients.

Quality standards

This quality approach is devolved throughout the Trust with good results. In 2009/10 we have successfully delivered high standards of clinical care in relation to all key standards and this has resulted in achievement of a rating of green for patient safety with Monitor (green being the best rating possible).

We achieved all patient safety and experience (CQUIN) targets agreed with our commissioners over the last year and we have worked closely with them to set challenging quality targets for 2010/11 that reflect our four-year strategic quality aims. We received a total of **£875,761** for achieving the CQUIN goals in 2009/10.

We met all of the standards required for successful registration with the Care Quality Commission (CQC) and we have been recognised for our achievements through reaching the final of two national patient safety awards.

The National Patient Safety Agency, Royal College of Nursing and the Patient Safety First Campaign have all promoted the Trust as a best practice site for safety and quality of patient care.

Summary of quality of services provided (continued)

Accountability and audit

The Board of Directors receives a quality report at every meeting and is able to present a balanced and understandable assessment of the Trust's position in relation to quality. We use the clinical governance committee and the audit committee to review the systems of internal control and to provide assurance in relation to patient safety, effectiveness and patient experience and to ensure compliance with legal duties. The clinical governance and audit committees are chaired by non-executive directors with recent and relevant experience.

What patients want

Over the last year we have spoken to over 800 patients to find our how we are doing and what we could do better. We understand that the difference between a good healthcare provider and a great one is the way that we treat patients, carers and staff.

Our patients want and deserve excellent clinical care delivered with dignity, compassion and professionalism, and this was one of our key quality goals for 2009/10 and will continue to be a key aim for 2010/11.

Progress described within this document is based on data and evidence collected locally and nationally, much of which is presented as part of our performance framework each month in our public board meetings.

To the best of my knowledge the information given in this document is accurate.

Alan Foster
Chief Executive

NHS Chief Executive Sir David Nicholson talks to matron for surgery Debbie Blackwood and Hazel Truman who is leading the work on the Productive Ward.

Note – all 2009/10 data within this document accurate to end February 2010; March data to be added once available

Priorities for improvement

2010/11 priorities for improvement

We have set three key priorities for improvement for 2010/11 and these are linked to patient safety, effectiveness of care and patient experience. We will describe the reason for setting these priorities and we will explain how we aim to achieve the improvement and how we will measure and report our progress. Further quality targets are outlined in our quality strategy and they will contribute to achieving the priorities set out within this document.

Priority 1 patient safety; reduce deaths

It is well known that despite the best of intentions, too many patients suffer some form of harm and many others narrowly avoid a similar experience. We are determined not to accept this as inevitable and to take every care to eliminate actual or potential harm from happening.

Our first patient safety priority is to reduce the number of patients that die in our hospitals. We have already reduced our number of deaths to below that expected in an average hospital in England; however we aim to reduce the number of deaths expected in our hospitals by 150 between 1 April 2010 and 31 March 2011.

How will we do it?

We will collect information when things don't go according to plan. Reporting and analysis of such incidents allows us to reveal the root cause of a problem and to learn lessons with a view to preventing the same thing from happening again.

Our clinical teams will use the global trigger tool (GTT) to assess rate and level of potential harm. Use of the GTT is led by a medical consultant and involves members of the multiprofessional team. Over 100 sets of patient records are reviewed every month in our hospitals. The tool enables clinical teams to identify events through triggers which may have caused, or have potential to cause, varying levels of harm. Small changes are introduced by clinical teams in response to findings from the analysis with the aim of reducing rate of harm and ultimately how many patients die.

We will ensure that patient observations are carried out in a timely way and that any deterioration in patient condition is escalated and dealt with quickly and by somebody with the right level of knowledge and skill.

How will we measure it?

The Trust subscribes to the Dr Foster mortality database. The Dr Foster database has been adopted widely by Trusts in the UK. Dr Foster is able to predict the number of deaths that should be expected in each hospital in England based upon local demographic information and case mix.

We will monitor Dr Foster data every month to track our progress against our target to reduce the number of patients that die in our hospital.

We will monitor management of the deteriorating patient by reviewing observation charts on at least 50 patients every month and we will undertake a Trust-wide audit of early warning scores (the score provided on completion of a set of patient observations) on all patients in our hospitals on a quarterly basis.

How will we report it?

Dr Foster mortality data will be presented every month in the Director of Nursing and Patient Safety quality report to the Board of Directors. It will be presented in the public section of the Trust board meeting and the mortality data will also be presented to the Council of Governors on a quarterly basis.

A copy of the quality report to the Board of Directors will be sent every month to our commissioners.

Priority 2 effectiveness of care; 70% of patients on the emergency assessment units will have a full assessment within 2 hours of arrival

We recognise that people are often anxious when they are admitted to hospital. We always try very hard to see people as quickly as possible and always according to clinical need. This year, we have set a target that 70% of all patients that are admitted to our emergency assessment unit will have a full assessment within two hours.

How will we do it?

We will use *lean* methodology to review the way we prioritise our clinical staff so that every patient is seen by the right person at the right time. This means that we will be able to make an assessment and let our patients know the plan for their treatment, admission and/or discharge.

We will use our interactive white boards to alert staff if somebody is waiting to be seen. If we do not see a patient as quickly as we should, we will review what happened to understand what we can learn to prevent it happening again. We will aim for zero avoidable waits.

How will we measure it?

We will monitor the time of arrival and the time of assessment to measure the time taken to see and fully assess every patient. We will also monitor the time that a patient spends on the emergency assessment unit to ensure that decisions are being made in a timely fashion and that patients and their carers do not wait longer than necessary. We will collect baseline data from April to June 2010 and aim to achieve our target by the end of the year.

How will we report it?

Learning from occasions when patients are not seen in a timely way will be discussed at our bi-weekly emergency care performance meeting. We will report progress to the Board of Directors on a quarterly basis.

Priority 3 patient experience; care with compassion

We believe that patients have a right to be treated in an environment that makes them feel safe, secure and cared for. We have worked hard to ensure that our staff understand the impact of a smile, a kind word and taking time to listen. We will deliver a healthcare service that people remember for the right reasons. We hope that patients and their carers will leave us with a very positive impression and will recommend us to people they know.

How will we do it?

Every month we will ask at least 50 patients if we have treated them well. We will ask patients if we have treated them with dignity and respect; with kindness and compassion. We will ask what we have done well and what we can improve. Every month we will discuss the results with the senior clinical nursing team and we will use the feedback given by patients to make the improvements that are important to them.

We will share what we are seeing with departmental teams so that they know what they are doing well and what they can do to improve. We will support our teams to achieve the high standards that they aspire to and we will recognise and thank them when patient feedback is great. We will provide the support and resources required when improvement is needed.

How will we measure it?

We have developed a patient experience score-sheet that enables us to record a quality score. This score-sheet will be used every month during our quality review panel visits (a peer-review). Once a department has been reviewed, the quality score will be given to the staff according to the feedback received from patients. Positive comments will be fed back as well as recommended areas for improvement. Where required, we will support individual departments to achieve any required improvements. The scores will be aggregated to give a total quality score for the Trust.

We will compare the findings of our own discussions with patients with the results of visits by patient-user groups such as the local improvement networks to make sure that we really understand how we are doing.

How will we report it?

The aggregated score for patient experience will be reported monthly in the Board of Directors meeting. We will also report the results to the Council of Governors on a quarterly basis. We will report individual department patient experience scores to the department/ward manager, clinical director (most senior medical consultant), senior clinical nurse and general manager.

Review of quality performance

Quality performance 2009/10

2009/10 has been a successful year in relation to safety, quality and patient experience. This section will describe Trust performance against key quality performance targets as well as progress against quality indicators highlighted as priorities for 2009/10.

Selected quality performance targets (to insert 2009/10 dashboard here)

Target	Standard	Performance	Achieved
Inpatient waiting time	26 weeks		
Outpatient waiting time	13 weeks		
18 weeks maximum wait referral to treatment - admitted patients	90%		
18 weeks maximum wait referral to treatment - non admitted patients	95%		
Waiting time for diagnostics	<6 weeks		
Four hour emergency care target	98%		
Access to rapid access chest pain clinics within two weeks of referral from GP	100%		
Booking targets - slot issues	<7%		
Two week out patient appointment cancer referrals	93%		
Two week out patient appointment - breast symptomatic referrals	93%		
31 day maximum wait diagnosis to subsequent treatment all cancers	96%		
31 day maximum wait diagnosis to subsequent treatment (drug therapy)	98%		
31 day maximum wait diagnosis to subsequent treatment (surgery)	94%		
62 day maximum wait referral to subsequent treatment all cancers	85%		
62 day maximum wait referral to subsequent treatment (screening)	90%		
62 day maximum wait referral to subsequent treatment (consultant upgrade)	85%		
MRSA (post 48 hours)	14		
CDIff (post 48 hours)	158		

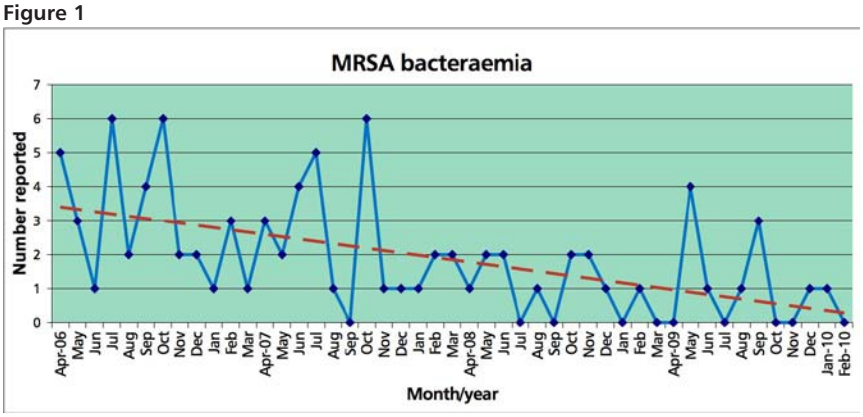
Note – all performance data accurate to end February 2010; March data to be added once available

Hospital acquired infections (HCAI)

During 2009/10, we reinforced our efforts to control and reduce MRSA (Figure 1) and Clostridium difficile (Figure 2) infections. There is no one way in which this problem can be solved but a consistent approach across the three important areas of environmental cleanliness; appropriate antibiotic prescribing and strict hygiene at the point of care have been vigorously pursued. We have invested in new equipment which is easier to clean and which is less likely to harbour bugs.

Note – all HCAI data accurate to end February 2010; March data to be added once available.

Figure 1

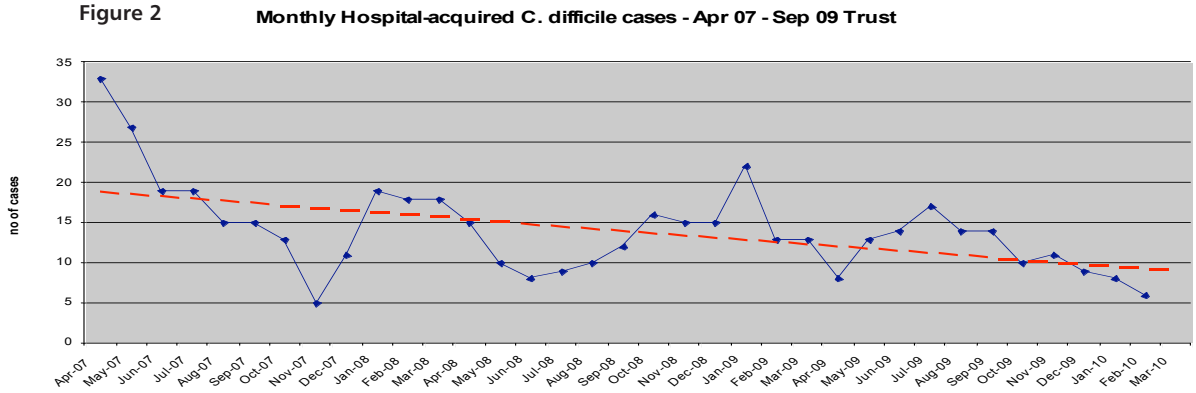


We have employed hygienists who are able to deep clean clinical areas, wards and equipment. We have purchased hydrogen peroxide fogging systems. Fogging with hydrogen peroxide kills the spores responsible for people getting Clostridium difficile.

We have also employed a dedicated antibiotic pharmacist to work with the infection prevention and control team, doctors and nurses to ensure that patients receive the most appropriate treatments to prevent and treat infections.

Our quality review panels monitor cleanliness in clinical areas every month. If any problems are found, they are dealt with immediately and we have found that this approach has contributed to consistent improvements in environmental cleanliness and infection prevention and control practices.

Figure 2



Review of quality performance (continued)

In February 2010, the CQC undertook an unannounced visit and inspected wards and reviewed practices in great detail. The CQC found no evidence that the Trust has breached the regulation to protect patients, relatives and others from the risks of acquiring a healthcare associated infection. The inspection report was published on 24 February.

Of the 16 key standards inspected there were no areas of concern in relation to 15 however they reported that they found some dust, some repairs and decoration and some boxes stored on the floor. Immediate action was taken and the CQC has published an update report on its website stating that actions are completed and no follow-up is required.

The importance of personal hygiene is fully understood by all staff and is visible through the bare below the elbow policy, the presence of alcohol gel dispensers and is evidenced by the results of hygiene audits. Further improvements to our environment and practices are constantly being implemented and evaluated.

Our new four-year quality strategy sets out our ambitious targets for further driving down infection rates.

Formal complaints and compliments

We have worked hard on improving customer satisfaction through its patient experience reviews and by being a pilot site for the early implementation of the new complaints legislation. We have tried to resolve complaints locally and we aim to build on this work and further improve customer satisfaction in 2010/11.

In 2009/10 we started to also record the number of formal compliments received and these continue to increase significantly. By the end of quarter 3 of 2009/10 285 complaints had been received and 1,270 compliments. We continue to work hard to provide high standards of clinical care delivered with dignity and compassion. Feedback from patients is important because it helps us to understand what we do well and what we can improve further.

Note – all complaints/compliments data accurate to time of writing; end of year data to be added once available.

Focus on effectiveness of care

National audits

Trusts up and down the country are audited on the standards of care that they deliver and the Trust actively participates in national audits. The Trust participated in 43 national clinical audits and a summary of some of the findings are outlined below.

Audit title	Findings/actions
National sentinel stroke audit	We are in the top 25% of Trusts for stroke care nationally. An action from this audit was to set up a 24-hour thrombolysis (clot-busting drugs) service.
National bedside transfusion audit	Our performance was significantly better than the national average and the National Patient Safety Agency identified the Trust as a best practice site.
Lung cancer audit (LUCADA)	Recent national report demonstrated positive results for Trust, particularly in surgical resection rates and audit data quality.
Myocardial Infarction National Audit Project (MINAP)	Audit demonstrated local compliance figures greatly above national standards.
Rapid Access Chest Pain Clinic (RACPC)	Both hospital clinics continued to achieve 100% compliance with national standards for seeing patients within 14 days of GP referral.
UK Inflammatory Bowel Disease (IBD) Audit	A full-time nurse specialist was appointed at the University Hospital North Tees as a result of this audit.

The CQC national outpatient survey 2009 showed that the Trust has improved on 21 of the comparable 33 questions since the last audit in 2004. Areas of most improvement included the quality of information given about medicines, tests, discharge and choice of appointment times and waiting list times. The main area for further improvement was linked to waiting for appointments where patients said they would like to be told how long they will have to wait and why.

We were above average on 25 of the questions and below average on 8. We are working to achieve a high score for every standard.

Focus on effectiveness of care (continued)

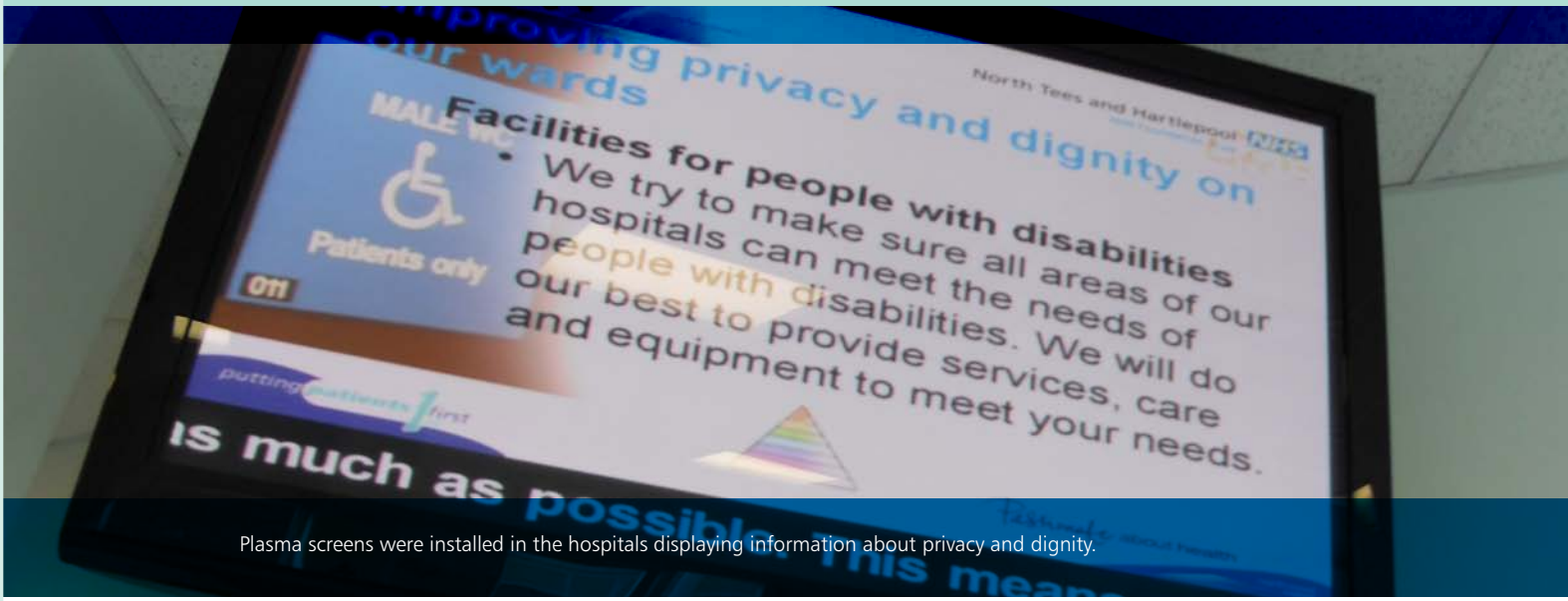
Research and development

In 2009/10 our research and development (R&D) department developed a number of objectives with the aim of increasing the level of research activity undertaken within the Trust. An increase in research attracts income to support innovation and improvement in clinical teams as well as delivering direct benefits to patients though being involved in cutting edge clinical trials.

The R&D team have worked with departments to promote the importance of healthcare professionals being involved in research and they have helped to develop staff knowledge and skills to enable them to lead and/or be involved in research studies.

To date, the number of National Institute for Health Research (NIHR) portfolio studies undertaken in 2009/10 has increased by over 120% when compared with 2008/9. The range of research studies being undertaken is impressive and includes for example, the study of carer reflections on communication during end of life care, improving stroke care and research into the benefits of oxygen saturation targeting in very premature infants. Our clinical teams are also involved in a number of cancer research studies.

Research projects continue to be developed across all specialties and we believe that this approach to developing understanding through research will contribute significantly to our quality strategy and outcomes in relation to safety, effectiveness of care and patient experience.



Plasma screens were installed in the hospitals displaying information about privacy and dignity.

Data quality; clinical information

We recognise know that good quality information underpins effective delivery of patient safety and care. Having confidence in our data enables us to make meaningful decisions to improve care and reduce waste. We submitted records during April-December 2009 to the secondary uses services for inclusion in the hospital episodes statistics (HES) which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS number was:	%	Which included the patient's valid general medical practice was:	%
Percentage for admitted patient care	97.2	Percentage for admitted patient care	100
Percentage for outpatient care	97.4	Percentage for outpatient care	100
Percentage for accident and emergency care	90.1	Percentage for accident and emergency care	100

Our Trust was subject to the Audit Commission payment by results clinical coding audit during the reporting period and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was:

Criteria measured	2009/10 %	2008/09 %
Primary diagnosis incorrect	**7**	12
Secondary diagnosis incorrect	**12**	22
Primary procedures incorrect	**8**	8
Secondary procedures incorrect	**14**	12

We have been looking closely at our documentation and our coding and during 2009/10 we changed the way our coders work so that they are closer to the clinical teams. This has resulted in improvements to clinical documentation, clinical coding and has reduced the number of HRG changes made. HRG means healthcare resource group; it is the currency that describes what we should get paid for the care we deliver.

Coding errors in 2008/9 resulted in 9.7% HRG changes and in 2009/10 this error rate was reduced to 6.3%. The national average HRG change in 2009/10 was 8.1% which shows that we are doing well. We will continue to work hard to improve quality of information because it will ensure that NHS resources are spent effectively.

Data quality; information governance

Information governance means keeping information safe. This relies on good systems, processes and monitoring. Every year we audit the quality of specific aspects of information governance through the national information governance toolkit report. In 2009/10, we achieved an overall score of 77% resulting in a rating of green which is the best rating that is available. We are concentrating on improving our score further and our progress will be monitored, providing assurance to the Board of Directors that we are continuously improving our systems and processes to ensure that information is safe.

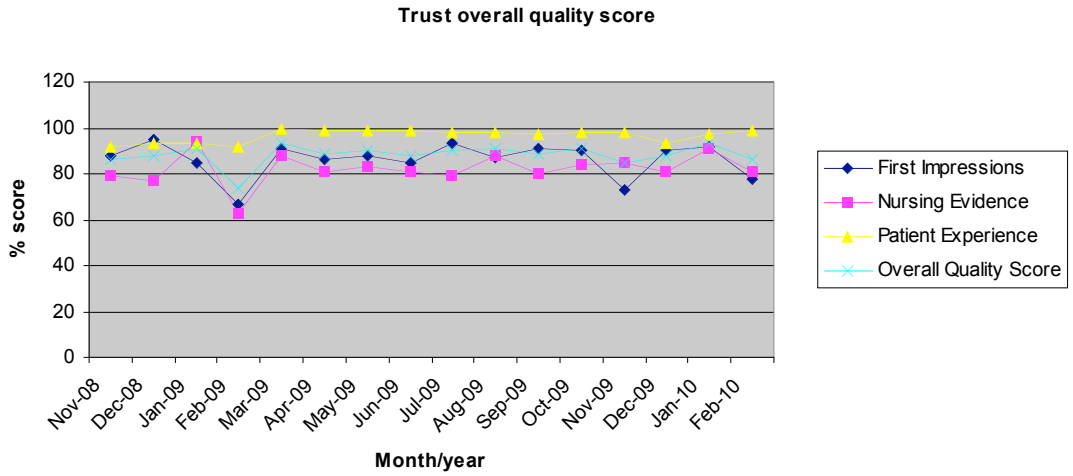
Focus on the patient experience

Quality Review Panel (QRP)

This tool was developed in November 2008 for monthly ward visits by the Director of Nursing and Patient Safety, senior nursing team and ward managers to measure quality across three key domains, namely the patient environment; nursing care and documentation and patient experience.

Each of these domains attracts a score and ultimately, produces a quality score for each ward or department. Scoring is undertaken through a review of evidence and by talking to patients to find out their views about dignity and respect, communication, reputation and potential actions to further improve patient experience.

Feedback is given to ward managers at the time of the review to ensure that good work is recognised and support is offered where improvement is required. This verbal feedback is followed up in writing and this approach has been appreciated and welcomed by ward staff and patients alike.



Note – all QRP data accurate to end February 2010; March data to be added once available

Our quality review panels have received national interest and we have had numerous guests join us when we undertake the reviews. The Director of Nursing from the Royal College of Nursing was impressed with the high standards and professionalism achieved by nursing staff in our Trust and believed that the quality review panel helped to support this achievement. David Nicholson, the Chief Executive of the NHS joined the Trust Director of Nursing and Patient Safety on a quality review panel and directors from the North East Strategic Health Authority (SHA) and commissioners have also joined the Trust's senior nursing team on these reviews. This work is being shared nationally as an example of best practice and is being used successfully in a number of our local community clinics.

Releasing time to care

A key component of our *lean* programme is the Productive Ward. Using tested methods the organisation of the ward and the processes that are used are systematically reviewed and improved. Key objectives are to reduce effort wasted on unproductive activity which means less time spent by staff on unnecessary work – resulting in more time for nurses to spend directly caring for patients.

This has resulted in higher nursing visibility, improved clinical care and communication and patients with overall high levels of satisfaction.

In 2009/10 we introduced Productive Community with the official launch taking place on the 26 March.

A launch event for Productive Theatre took place in February with over 70 medical and non medical clinicians and executive directors attending. A project plan has been developed which will deliver significant benefits to both patients and the organisation.

We also secured funding from the Workforce Innovation Development Fund to implement the same productive methodology to our prison services which will be implemented during 2010/11.

We are confident that we will see and measure patient and organisational benefits from these patient focused improvement projects.

Delivering same sex accommodation

We are committed to delivering the highest standards of privacy and dignity for our patients. Our Director of Nursing and Patient Safety oversees a special mixed sex accommodation working group to look at how best to continually improve standards and care for patients in same sex accommodation.

We have built and upgraded bathrooms and toilets in some clinical areas to improve the quality of services we offer our patients. We have also developed information technology to alert staff to whether bays are suitable for men or women. We have communicated the importance of same sex accommodation and staff awareness is high. As a result, we have now almost eliminated mixed sex accommodation and we continue to strive for zero tolerance.

All patient accommodation has been assessed and deemed compliant. Assessment was based on the 17 principles developed by the Department of Health, to ensure each organisation delivers the highest standards of privacy and dignity within all areas of a hospital. The process of assessment has been scrutinised at Board of Directors level.

Every month senior nurses ask at least 50 patients about their view of whether we treat them with dignity. Our non-executive director lead for dignity undertakes a monthly walk-about with the Director of Nursing and Patient Safety to specifically ask patients how we are doing and we report all patient feedback to the Board of Directors each month.

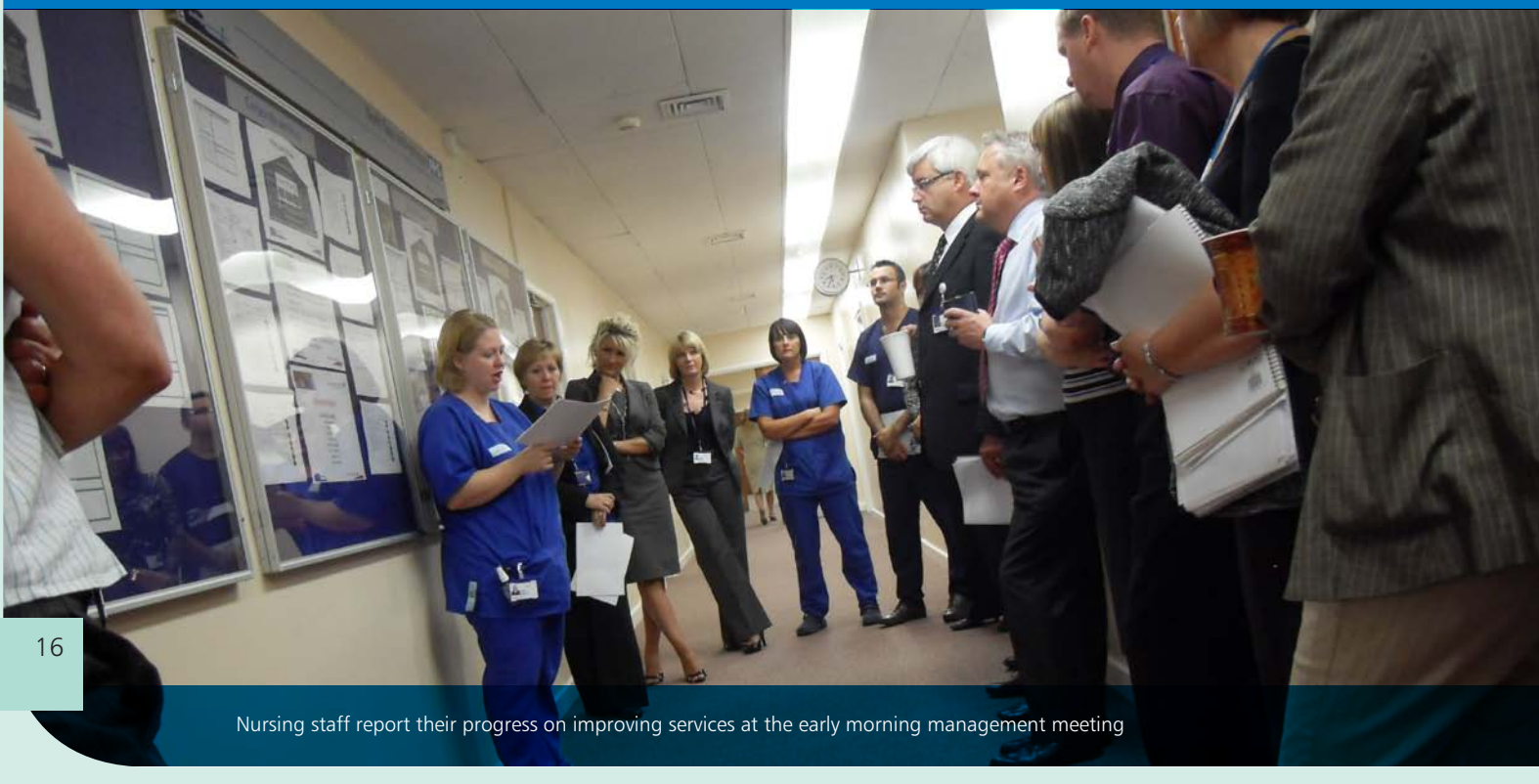
Focus on the patient experience (continued)

External reviews

We welcome and value the opportunity for external agencies to meet staff and review the quality of our environment, clinical care and patient experience. Over the last year, we have been subject to a number of formal and informal visits. We have enjoyed visits from the Royal College of Nursing, the National Patient Safety Agency, the Strategic Health Authority and we have also welcomed our commissioners on validation visits where they reviewed our progress in relation to delivering same sex accommodation and to review the effectiveness of our emergency services. We received excellent feedback in relation to each of these visits.

Our LINks have also undertaken a number of *enter and view* visits to wards and departments where they have reviewed standards of cleanliness and asked patient views in relation to key aspects of patient care. LINks are independent volunteers who reach out and involve hundreds of local people in public and patient involvement in health and social care. The independence of LINks reviews and feedback is important to us as a Trust because it helps us to understand other people's views of how we are doing. Feedback has been constructive, positive and motivating for staff and it has helped us to understand that the approach we are taking to provide excellent healthcare is working well. LINks reports can be viewed on their website along with our responses.

In February 2010, we were honoured to receive a visit from Sir David Nicholson, the Chief Executive of the NHS. In March 2010, the Secretary of State for Health, Andy Burnham visited the Trust and gave the go-ahead for a new £464million hospital which will play a key part in transforming health services for our local population.



Nursing staff report their progress on improving services at the early morning management meeting

Focus on leadership

In addition to developmental activities designed for senior managers and directors in the Trust, more wide ranging training is also offered. We believe that we need leaders at every level. That's why we continue to invest in training and development of our staff. We recognise that it is essential that individual staff not only have the ability but also the opportunity and motivation to do well and that this investment results in staff who deliver effective healthcare services. We believe that our staff are an asset to be maximised rather than a cost to be minimised.

Following a one-day visit by the National Patient Safety Agency (NPSA), their Medical Director wrote 'we saw that with effort and focus on quality driven by strong leadership, that staff understood the most important issues in relation to delivering safe and effective patient care'. The NPSA intend to use the Trust as an exemplar site in relation to patient safety.

In November 2009, we hosted a one-day Celebrating Excellence event where our staff had an opportunity to share the excellent progress that they have made in improving patient safety, effectiveness of care and patient experience. Staff were joined by governors and directors who were able to see the range of innovative solutions developed by clinical teams to enhance quality of care.

Sue Smith
Director of Nursing and Patient Safety
Director of Infection Prevention and Control

David Emerton
Medical Director

2009/10 quality improvement policies

Key projects

In our 2009/10 quality report, which was designed as a predecessor to this quality account, we identified a number of quality improvement priorities that it would focus on over the year. These priorities linked to the quality domains: patient safety, effectiveness of care and patient experience. Progress against the project plans and improvement outcomes have been regularly monitored via the clinical governance committee and by the Board of Directors and progress will be described for each priority in this section.

Patient safety

Minimising injury from inpatient falls

With increasing numbers of elderly and frequently confused patients being treated on our wards the incidence of falls rose in the early half of 2008. Frail patients can seriously injure themselves as a result of a slip or trip and that is why this was chosen as a key priority for 2009/10.

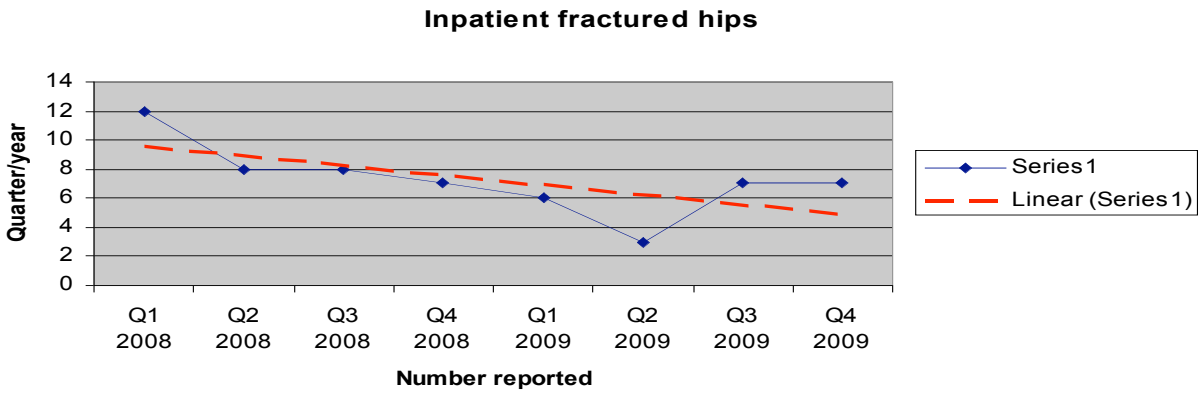
What did we say we would do?

- Record the number of falls occurring per 1,000 admissions and the number of falls that cause significant harm to patients
- Individually and thoroughly investigate those falls causing harm and take action to reduce avoidable falls

What did we achieve?

By investigating falls to reveal the causes we systematically addressed the problem through support and training for staff. We have achieved a reduction in both the numbers of falls and the resulting injuries (Figure 4); a key aspect of our quality improvement objectives. Inpatient falls can often result in injury or fracture and can often be avoided.

Figure 4



The result of a fall from a patient perspective can be significant, resulting in loss of confidence, increased hospitalisation and/or treatment and can in some cases, contribute to death. There is also a cost to the NHS when a patient falls and injures themselves.

The Health Foundation (2009) estimate the cost associated with one patient fall resulting in a broken hip to be £11,452*. In just one year, we have reduced our number of patients that fall and fracture their hips by 32% which results in a cost-avoidance of approximately £114,520* when compared against the previous year.

Safeguarding the deteriorating patient

There is a lot of evidence to show that prompt attention to early signs of a patient's deteriorating condition can prevent them coming to serious harm and can even save lives.

Through training and awareness, auditing of good practice and putting rapid response teams in place we believe that avoidable harm can be minimised in this group of very ill patients.

What did we say we would do?

- Audit the recording of the signs warning of deterioration and the response to those warnings
- Record and investigate any episode where harm has occurred due to our system failing and take action to reduce avoidable harm

What did we achieve?

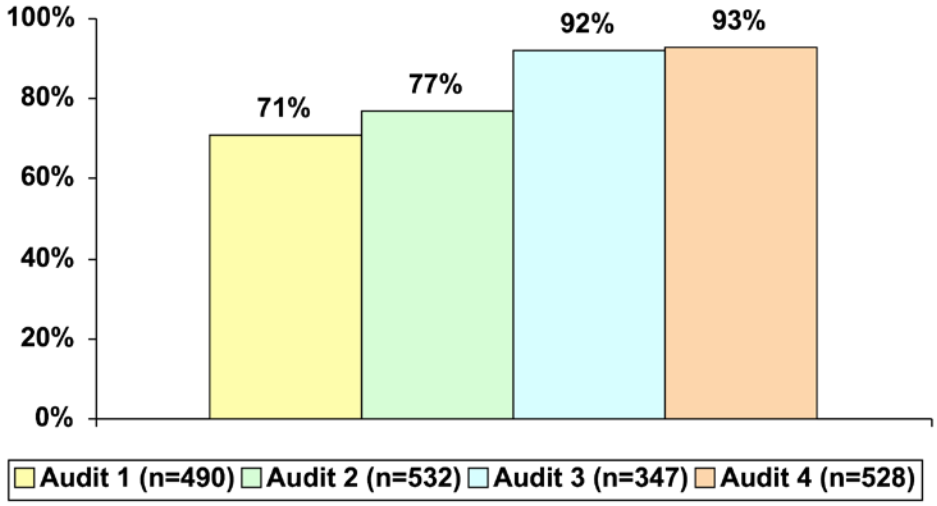
We have made significant improvements over the last year. The SHA funded some dedicated clinical educators to help us to achieve heightened levels of understanding of how we can reduce risk of deterioration. We monitored observations and evidence of action through our quality review panels and clinical teams used the global trigger tool to look for evidence of deterioration.

We have undertaken root cause analysis of incidents which has helped us to understand what we can improve. As a result we introduced a communication tool that gives a clear description of the *situation, background, assessment and recommendation* (SBAR) for action. Introducing this tool has already resulted in clearer spoken and written communication leading to appropriate and timely actions.

*Health Foundation estimated cost

2009/2010 quality improvement priorities (continued)

A Trust-wide audit is undertaken every three-months and this shows a significant improvement in relation to all standards measured. An early warning score is created when all patient observations have been undertaken (these can be tracked over time) if something is outside of normal parameters the EWS will trigger (resulting in something being done about it). Our improvements in monitoring early warning score triggers and actions in 2009/10 are shown below.



Reducing medication errors

Every day hundreds of prescriptions are written and thousands of medicines are dispensed and given to our patients. From time to time human errors occur which can lead to the wrong dose or the wrong drug being received. In some cases this can cause serious harm.

With teams of doctors, nurses and pharmacists working together systematically review our systems to ensure that the chance of mistakes occurring is kept to the lowest possible level.

What did we say we would do?

- Record progress against our project plan
- Appoint a pharmacy nurse to lead on the reduction of medication errors
- Record the number of medication errors occurring per 1,000 admissions and the number of errors that cause significant harm to our patients

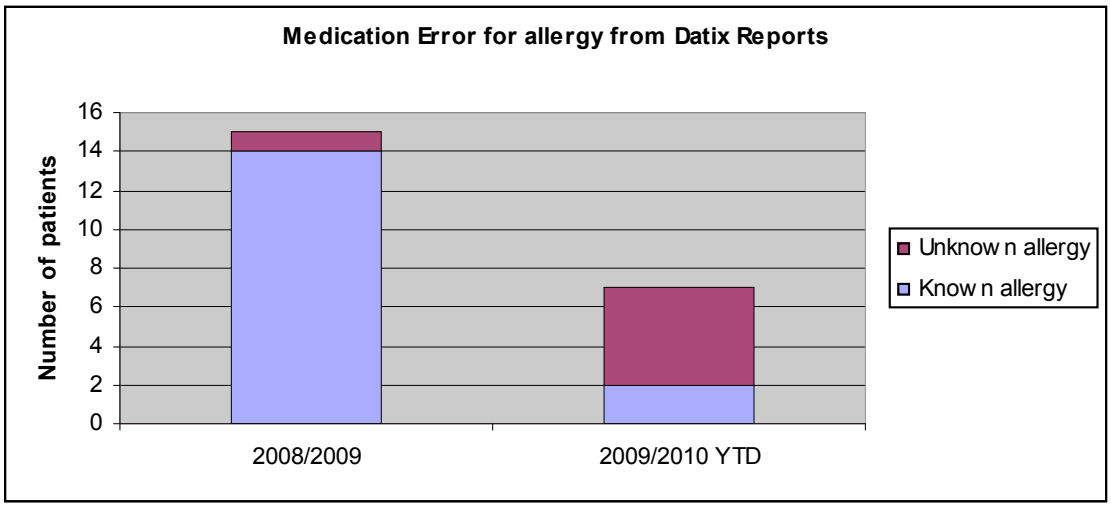
What did we achieve?

We have undertaken a quantitative analysis of medication incidents; developed a medicines incidents action plan and an associated work programme.

Training is key to reducing medication errors through increased awareness and promotion of safer practice so in August 2009 we appointed a medicines management nurse. Since coming into post she has, with the pharmacy team contributed to a number of audits including missed doses, medicines storage, the use of purple oral medicine syringes, controlled drugs and fridge storage. These audits have resulted in development and delivery of training packages on medicines management and the management of controlled drugs. Pharmacy is also working closely with the training department on the development of a training package in the use of injectable medicines.

In September 2009 we appointed an antibiotic pharmacist to identify best practice in the prescribing and use of antibiotics. Working closely with microbiology and medical staff she is helping to develop protocols to make our use of antibiotics even more effective.

During 2009/10 we aimed to reduce the number of medication allergies experienced by patients. An action plan was developed to raise awareness through audit, departmental visits, education and posters. In 2008/9 the number of medication allergies reported has reduced by over 50% when compared to 2008/9 (below).



In December 2009 we appointed a pharmacy educator and a safe prescribing educator will be soon be in post.

We are closely monitoring the number of medication errors to identify emerging patterns. This will allow us to identify and address any weaknesses with our systems or processes and do something about it. The data will enable us to develop or amend policies and identify further training needs. We will also use the information in monthly bulletins to raise awareness of clinical staff.

Effectiveness of care

Communication

When under pressure, when there are many jobs to be done the importance of sharing information with colleagues is sometimes forgotten. If the result is that vital information about a patient is not shared then our healthcare staff can no longer work as effective teams.

Work in this project had several different strands which included achieving robust systems for sharing information when patients are transferred to the care of the next team, when shifts change and at the time of discharge from hospital. Our system of recording notes was reviewed so that everyone's contribution is clear and shared.

The theme of communication and teams working more closely together was repeated as we rolled out the WHO Surgical Safety initiative in which all members of theatre teams review potential problems before each list and before each operation.

What did we say we would do?

- Record progress against our project plan indicating which areas of the hospital each part project has reached
- Produce a new system for sharing patient information
- Record the speed and quality of our discharge process
- Record our "never events" such as surgery to the wrong site

What did we achieve?

We have investigated and shared learning from incidents that were the result of inadequate communication. We implemented the SBAR communication tool and improved handover when patients are transferred between departments or teams.

Clinical teams have reviewed documentation and we have developed integrated care planning which is being piloted by the orthopaedic team in 2010.

We have audited quality of documentation and we have seen significant improvements in the quality of clinical note-keeping.

Interactive whiteboards have been developed to communicate a number of important information including early warning scores (an indicator that a patient is deteriorating), mixed sex accommodation, MRSA status and risk of falling.

Discharge planning is started at admission in a number of areas and we monitor the timeliness and quality of discharge information.

We have introduced the World Health Organisation (WHO) surgical checklist in every operating theatre environment; this involves a pre-operative brief and a post-operative debrief to ensure that every patient is received by a fully informed and prepared theatre team.

We record every never event and are pleased that in 2009/10 there were no never events recorded at all. Never events are things that should never happen, and include for example wrong site surgery and wrong route chemotherapy. A full list of never events can be found in our quality strategy document.

We have introduced quarterly directorate quality reports and these enable each directorate to communicate to the Board of Directors and to each other the progress that they are making in relation to safety, effectiveness of care and patient experience.

Patient Experience

Quality Review Panel

This system, described earlier, helps us to see ourselves from the patient's perspective. We ask patients about their experience in relation to the following key areas:

- Has the patient been treated with dignity and respect?
- Has nursing communication been good?
- Has medical communication been good?
- Would the patient recommend the hospital to others?
- What single thing could we do to improve the patient stay in our hospitals?

In 2009/10 we aimed to continue to use this tool to assess and improve quality of patent care and experience. We are working with colleagues in the community to adapt the tool for use by community teams. We will also use it to educate junior clinical staff so that they understand the importance of delivering not only safe and effective healthcare, but a patient experience that is second to none.

What did we say we would do?

- Continue to record the results of these visits
- Respond to concerns raised at the time of the visit
- Invite student nurses to accompany senior staff on the panel visits

What did we achieve?

Over the last year we have undertaken a quality review on 211 wards and departments and we have evaluated the clinical care of and asked about the experience of over 600 patients and carers.

We have asked the patients to tell us about their experience relating to dignity and care; the way we communicate and we have asked them if they would recommend us. These key patient experience questions result in an overall patient experience quality score. The score for patient experience based on these discussions has consistently been between 93-99%.

We also ask patients if there is one thing we could do to improve. Where a patient has had a problem, our clinical teams have resolved it immediately. An example of what we have done includes asking the chef to visit patients who have complaints about the quality or choice of food. Listening to patients views about food has resulted in changes to our catering services. As a result, we now seldom have complaints about quality or choice of food.

Quality review panels are attended by all of our senior nurses, by matrons and ward managers, by community nurses and by student nurses. We believe that including nurses at all levels, helps nurses to understand the importance of attention to detail in relation to patient safety and professional nursing accountability.

Importantly feedback is given to the nursing team at the time of the visit. Feedback is always constructive and includes the many good practices seen as well as an offer of support where an area for improvement is identified. Examples of support given include rapid replacement of equipment, immediate cleaning, training of key skills and clarification of roles and responsibilities. Our staff have embraced this constructive support and challenge and their high standards, professionalism and compassion was noted by the Director of Nursing and Patient Safety from the Royal College of Nursing who is advocating this approach to achieving excellence.

Our community teams have introduced a modified version of the tool into the community where it is being used with excellent results. Our prison healthcare team is now considering how the tool can be adapted for use in prisons.

Catering

Following patient feedback, the catering team decided to pilot a new ward hostess service with the specific aim of improving the patient enjoyment of food. It was anticipated that this initiative would also greatly assist in reducing the amount of food wasted enabling re-investment in improved offerings on the menu, modified consistency meals and other important patient focused issues.

Patient Experience (continued)

What did we say we would do?

- Record progress against our project plan indicating which areas of the hospital each part project has reached
- Survey and audit patient feeding
- Monitor the food wastage levels
- Patients' views will be monitored in our satisfaction surveys

What did we achieve?

The hostess system was introduced on a small number of wards. Meals are served on the wards and patients have appreciated the resulting portion management and overall quality of the food. The number of complaints about food has reduced since this pilot started.

Food wastage has been monitored over the year and the result of this initiative, apart from the improved patient satisfaction has been a food cost saving of around £30,000.

In 2010/11 we will evaluate the ward hostess pilot so that we can understand the benefits with the cost and we will make a decision on whether this pilot will be extended to other areas.

In Falls Awareness Week Justin Ditchburn from the community falls team gives information to a resident of the Hartfields Retirement Village

Summary

The Trust has made excellent progress during 2009/10 in enhancing quality of patient experience. None of this would have been achievable without the hard work and commitment of staff and the honest and constructive feedback given to us by patients and carers. We look forward to delivering further improvements in 2010/11 in partnership with staff and service users. We would like to thank our staff and our stakeholders for their constructive feedback and support and we look forward to working together to further enhance the quality of healthcare that our patients and their carers receive.

Third party declarations

We have invited comments from our key stakeholders. Third party declarations from key groups are outlined below.

Council of Governors
Invite comments to be included here

Primary Care Trust commissioners
Invite comments to be included here

Local Improvement Networks
Invite comments to be included here

Overview and Scrutiny Committees
Invite comments to be included here

National Patient Safety Agency
Invite comments to be included here

Royal College of Nursing
Invite comments to be included here

Patient Safety First Campaign
Invite comments to be included here

Anyone we might have missed!!
Invite comments to be included here

Glossary

Care Quality Commission (CQC); the body which regulates, inspects and reviews all health and social care in England.

Monitor; the regulator of NHS Foundation Trusts.

Commissioner; the organisations which buys healthcare on behalf of the local population.

CQUIN; commissioning for quality and innovation – payment for innovation and improvement.

***Lean* methodology;** using tools and techniques which eliminate waste.

Portfolio study

Strategic Health Authority; the body responsible for managing the local NHS on behalf of the Secretary of State.

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