SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 6
23 JANUARY 2013	Public Report

Report of the Executive Director of Care Quality and Chief Nurse, Peterborough City Hospital

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PETERBOROUGH & STAMFORD HOSPITALS NHS FOUNDATION TRUST – QUALITY ACCOUNT PROGRESS

1. PURPOSE

1.1 To meet the requirement for an update on quality performance in year made by the Scrutiny Commission for Health Issues in their comments for inclusion in the Trust's Quality Account for 2011/12.

2. RECOMMENDATIONS

2.1 Consider and comment on the contents of the Quality Report as at Month 9 and note the invitation to the Stakeholders Event at which attendees will be invited to comment on and challenge the Quality Account content and presentation, and contribute to the setting of priorities around quality improvement for 2013/14.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 Priority 1 Creating opportunities – tackling inequalities – improving health and supporting vulnerable people.

4. BACKGROUND

4.1 All Trusts are required to submit a Quality Account annually. There are explicit requirements around content for this report as set out in the Department of Health Quality Account Toolkit. In addition, Monitor sets requirements of Foundation Trusts, the final details for 2012/13 are currently under consultation.

4.2 The document should be written in an open and transparent way that is reader friendly to the public while at the same time meeting the requirements as set out by the Department of Health and Monitor. The content should reflect reporting that has taken place in year and the Board of Directors are required to comment on the quality of the data included.

4.3 Stakeholders are invited each year to provide comments; this includes comments from the Scrutiny Commission for Health Issues.

4.4 The document is subject to external audit each year. This year, a dry run month 9 report is being produced, which will then be added to to incorporate year end data

5. KEY ISSUES

5.1 The report (attached) demonstrates some positive quality improvements achieved in year, including 97.3% harm free care for hospital associated care as measured by the Safety Thermometer, good progress in the wards engaged in the 'Stop the Pressure' collaborative to reduce the risks of pressure ulcer formation, and good progress in the national CQUIN work around early dementia assessment and diagnosis. Areas where there are particular challenges

this year are around the number of hospital acquired *Clostridium difficile* infections, falls, and pressure ulcers.

6. IMPLICATIONS

6.1 The Trust strives to deliver high quality care in order to provide positive patient experiences, clinical effectiveness and safe care. Where this is not optimally achieved the potential implications are poor patient experience that may result in prolonged hospital stays with uncomfortable symptoms and complaints, reduced efficiency, failure to achieve financial incentives (e.g. the CQUIN schemes), or activation of contractual penalties. Where outcomes are very poor, there may be reputational issues that may impact on confidence in the hospital amongst the community.

7. CONSULTATION

7.1 Stakeholders were involved in selecting the priorities for quality improvement for 2012/13. The Quality report is presented at the Board of Director's meeting which is held in public and questions are invited from those present at the end of the meeting. Involvement of stakeholders is invited in relation to the content and presentation of the Quality Account through distribution of the draft document for comment/challenge and attendance at the Stakeholder event held on an annual basis.

8. NEXT STEPS

8.1 Please see Appendix 2 for the schedule of next steps including the date by which the Commission will be circulated with the draft document for comment, and the date for the Stakeholder Event.

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

9.1 Monthly Quality Reports produced by the Trust
Department of Health Quality Account Toolkit 2010/11
Monitor Annual Report Manual
The National Health Service (Quality Accounts) Regulations 2010 Statutory Instrument 2010 No. 279

10. APPENDICES

10.1 Appendix I – Quality Report to the Board of Directors meeting – 18 December 2012
Appendix II - Quality Account preparation 2012/13

Appendix I

Presented for:	Discussion		
Presented by:	Chris Wilkinson, Director of Care Quality and Chief Nurse		
Strategic objective:	Excellent Patient Care - Patient Safety		
Date:	10 December 2012		
Regulatory relevance:	CQC Registration:	Quality and Management	Outcome 16
	CQC Registration:	Personalised Care, Treatment Support	Outcome 4
	NHSLA Risk Mgt:	Clinical Care	Not applicable

Quality Report

Overview

This report summarises performance across the three domains of quality (safety, clinical effectiveness and patient experience) and highlights quality governance issues. It updates board members on issues raised by or with the regulators in relation to quality of care and covers the areas highlighted in the Quality Account and priorities for 2012/13 along with other key indicators monitored in year. Some priority areas are reported in the Management Information Report and others are under development.

Key achievements of note

1. 'Harm free' care: 97.3%
2. Pilot ward in 'Stop the Pressure' collaborative: 111 days without a Grade 2, 3 or 4 pressure ulcer
3. Sustained improvement in dementia risk assessment figures

Key points for discussion

1. Falls (two grade 3 patient falls)
2. Pressure ulcers (one grade 3)
3. *Clostridium difficile* infections (3 hospital acquired infections)

The following papers make up this report:

- Quality Report

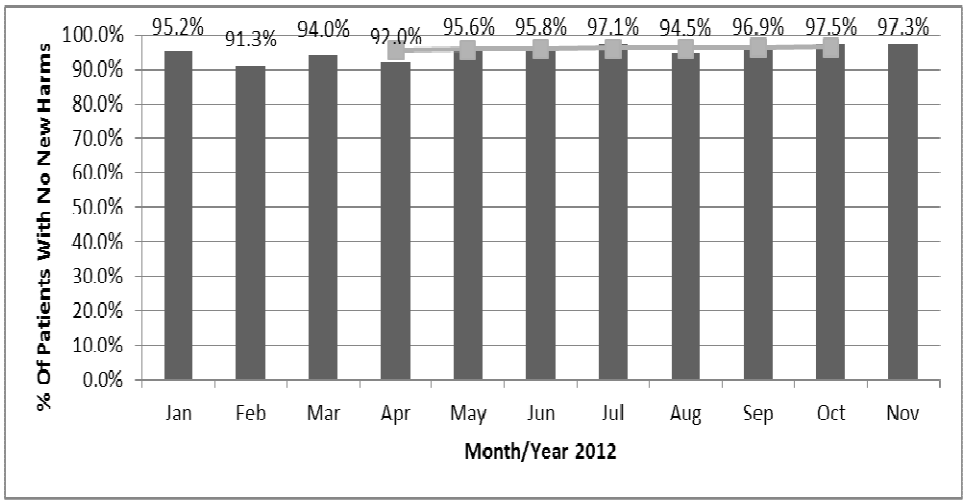
1. Safety

The total number of patients surveyed during the data collection period each month is seen in the table and the graph shows the percentage of patients who have received harm free care within the Trust.

Table to show number of patients surveyed January to September 2012

Month	Patients Assessed In Month
Jan	582
Feb	573
Mar	521
Apr	590
May	589
Jun	598
Jul	594
Aug	567
Sep	588
Oct	606
Nov	586
Total	**6394**

Graph to show percentage of patients receiving harm free care within the Trust and a line to show the national average



The Trust is required to assure the Commissioners that all 'relevant' patients are surveyed (*relevant patients are all admitted in patients except day cases, outpatients, ED attendances, well babies, renal dialysis patients, regular day attenders such as chemotherapy patients) and this month the Information Services Department produced a list of 'relevant' patients at 09.00 on the day to be surveyed. All 586 relevant patients were surveyed and this process will now continue monthly.

Occupied	Surveyed	Excluded:	Day Cases	Well Babies
649	586	63	45	18

Well babies have been defined as children less than 29 days (neonates) not on the Transitional Care Unit or the Neo natal Intensive Care Unit

1.1.1 Reducing the number of patient falls

The table below shows the total number of falls by month with the breakdown by severity against the trajectory set for a 20% reduction in the number over the year. The figure presents a month on month comparison of reported falls.

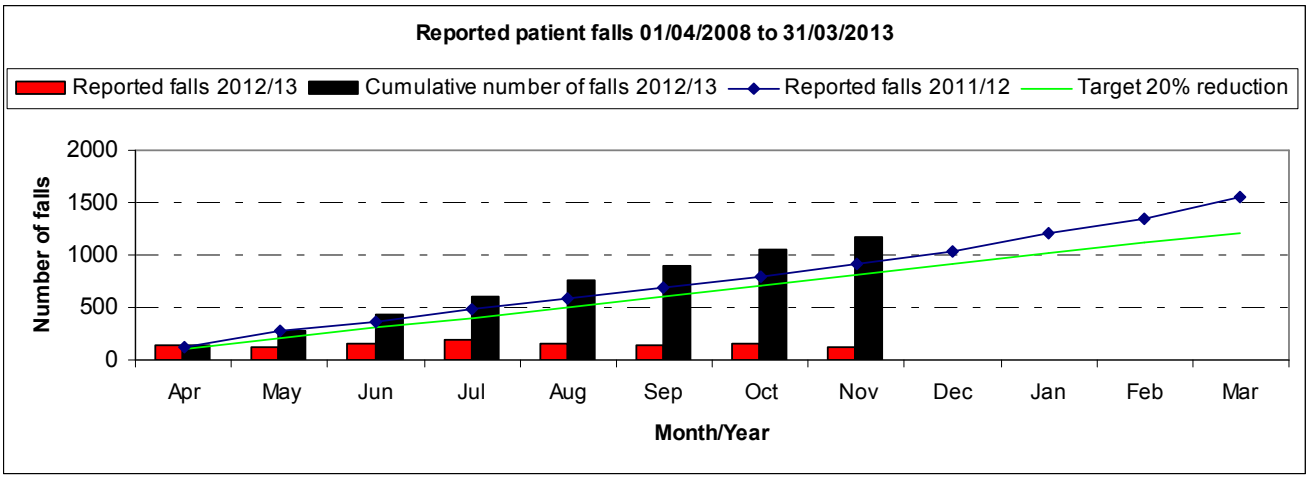
Table to show number of falls by severity and against a ceiling trajectory to achieve a 20% reduction with zero tolerance for grades 3-5

M/Y	Grade 0		Grade 1		Grade 2		Grade 3		Grade 4		Grade 5		Total	
10/11	**867**		**150**		**161**		**23**		**0**		**0**		**1201**	
11/12	**1052**		**250**		**215**		**34**		**0**		**0**		**1551**	
	T	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**
Apr	71	**98**	17	**22**	15	**17**	0	**4**	0	**0**	0	**0**	103	**141**

May	71	**89**	17	**21**	15	**15**	0	**4**	0	**0**	0	**0**	103	**129**
Jun	70	**107**	17	**27**	15	**19**	0	**2**	0	**0**	0	**0**	102	**155**
Jul	70	**137**	17	**22**	15	**19**	0	**5**	0	**0**	0	**0**	102	**183**
Aug	70	**112**	17	**19**	14	**20**	0	**3**	0	**0**	0	**0**	101	**154**
Sep	70	**102**	17	**19**	14	**15**	0	**2**	0	**0**	0	**0**	101	**138**
Oct	70	**119**	17	**10**	14	**18**	0	**3**	0	**0**	0	**0**	101	**150**
Nov	70	**72**	17	**25**	14	**25**	0	**2**	0	**0**	0	**0**	101	**124**
Dec	70		16		14		0		0		0			
Jan	70		16		14		0		0		0			
Feb	70		16		14		0		0		0			
Mar	70		16		14		0		0		0			
Total	842		200		172		0		0		0		1214	**1174**

Source: Peterborough and Stamford Hospitals NHS Foundation Trust Datix

Figure to show reported falls in 2011/12 and 2012/13 with target 20% reduction



The Quality Improvement Programme supported by the Midlands and East Multiprofessional Deanery has begun with the formation of a steering group and priority actions agreed. These include:

- the provision of supportive slippers recommended for use on hospital surfaces for a trial period on ward B14 as a Trust has reported up to a 30% reduction in patient falls with this intervention
- the completion of a pilot phase of updated hands on practical competency assessed training for nursing staff
- the use of the TABBS sensor pads to alert staff to patient movement which will be in the Trust from 12 December 2012.

A joint project about reducing falls risks associated with medications across the whole health economy is being discussed with our commissioners.

1.1.2 Reducing the number of hospital acquired pressure ulcers

The table below shows the total number of pressure ulcers acquired in hospital with a breakdown by severity against a trajectory set to achieve the ambitious target set through the Quality Schedule in the contract.

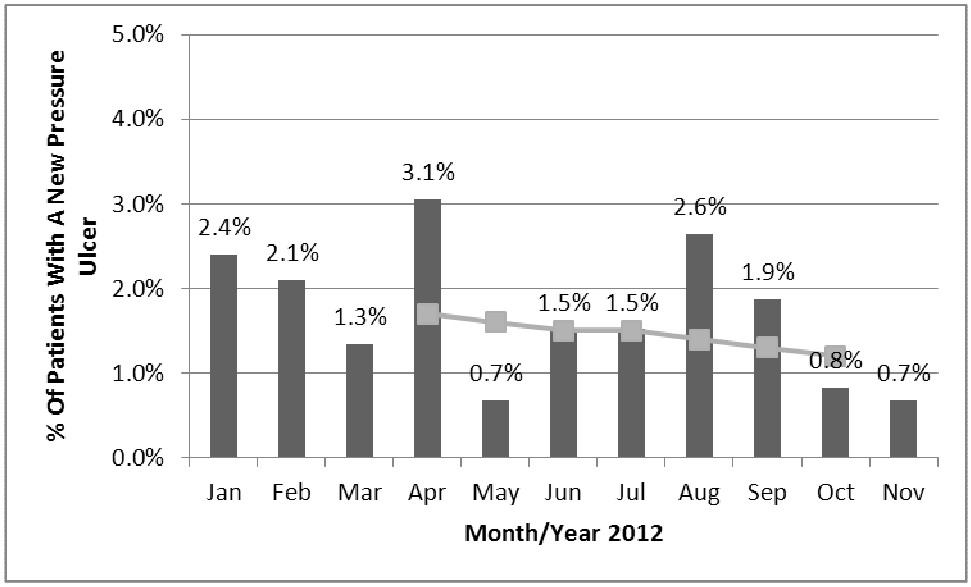
Table to show number of hospital associated pressure ulcers

	Grade1	**Grade2**	**Grade 3**		**Grade 4**		**Total**
10/11	63	103	3		0		169
11/12	99	191	21	9 un + 5	1 un		312

					av				
	T	**A**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**
Apr	14	**14**	30	**30**	3	**3**	0	**0**	50	**47**
May	14	**7**	28	**18**	3	**3**	0	**0**	45	**28**
Jun	14	**13**	23	**23**	3	**0**	0	**0**	40	**36**
Jul	14	**10**	17	**28**	2	**2**	0	**0**	33	**40**
Aug	14	**10**	11	**26**	2	**5**	0	**0**	27	**41**
Sep	14	**10**	7	**16**	2	**6**	0	**0**	23	**32**
Oct	14	**8**	4	**14**	1	**1**	0	**0**	19	**23**
Nov	14	**12**	2	**11**	1	**1**	0	**0**	17	**24**
Dec	14		1		1		0			
Jan	14		0		0		0			
Feb	14		0		0		0			
Mar	14		0		0		0			
Tota l	168		126		18		0		312	**271**

Source: Peterborough and Stamford Hospitals NHS Foundation Trust
**the grade 4 pressure ulcer in 2011/12 was agreed as unavoidable*
Key: T- trajectory; A - actual; Un - unavoidable; av - avoidable

The Stop the Pressure Collaborative based around the Midlands and East SHA ambition to eliminate grade two, three or four pressure ulcers continues. The pilot ward, B12, has now reached an impressive 111 days with no grade two, three or four pressure ulcers. The second tranche of wards, B14, Haematology/Oncology and A4 have all reached 36 days respectively and ward A3, A9 and B5 are the latest wards to join the campaign. The collaborative, led by our two Tissue Viability Nurse Specialists, consists of training, a focus on essential assessment and nurse documentation and primarily the development of a culture where staff believe the ambition can be realised. Ward B12 will be presenting their work on 13 December 2012 at a region wide meeting and this will then be used to demonstrate good practice to the other wards in the Trust. The graph below shows the reduction in prevalence of new pre3ssure ulcers as recorded on the Safety Thermometer data collection day each month this year.



1.1.3 Venous thrombo-embolic (VTE) prevention

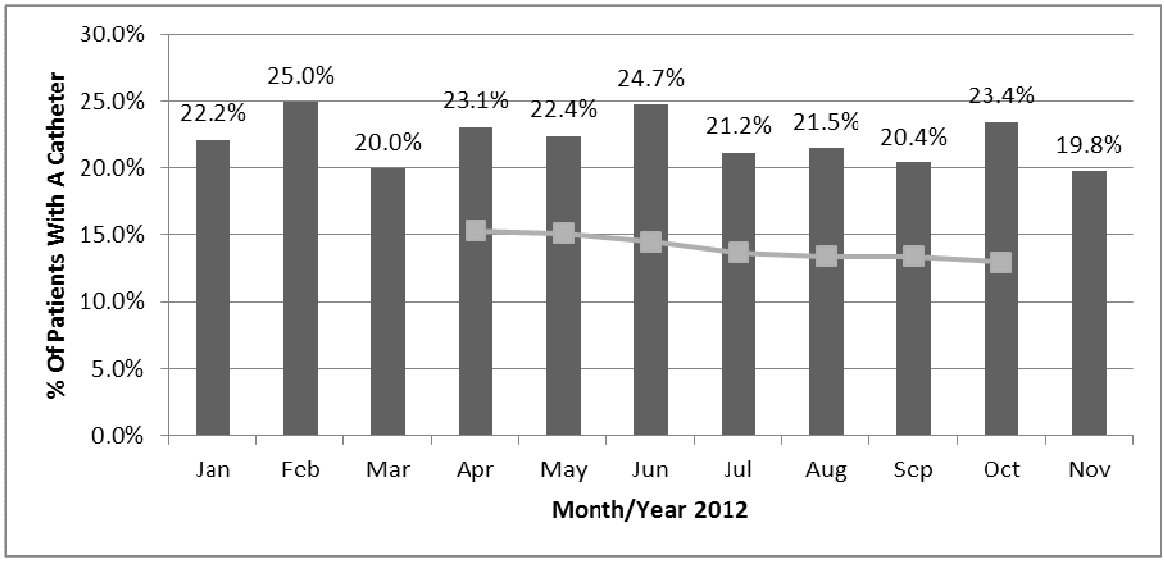
VTE risk assessment compliance in November was 96.9% (aggregated monthly data) whilst the VTE thromboprophylaxis compliance on 14 November 2012 was 100% (from NHS Safety Thermometer survey November 2012)

The VTE scrutiny panel met on 8 November 2012 and reviewed four patients who had developed a hospital associated VTE. The panel found that one patient developed the VTE despite treatment in line with NICE Guidance and whilst two other patients had blood clots deemed to be not preventable the reviews found errors in the timeliness and/or the accuracy of the risk assessment which will be reported back to the Thrombosis Committee. A fourth patient had a blood clot that the panel assessed as potentially preventable and this has been discussed with the relevant Clinicians and at the Thrombosis and Patient Safety Committees.

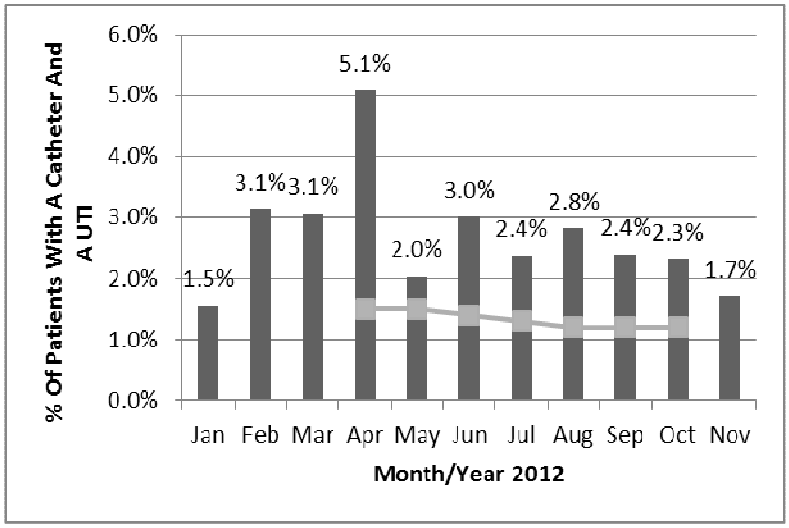
1.1.4 Reduction in catheter associated urinary tract infection (CAUTI)

The Urinary Continence Expert Group has continued to work to reduce the number of catheters inserted and the associated urinary tract infections. The graph below shows data from the Safety Thermometer collection with some progress made in both indicators.

Graph to show percentage of patients with an indwelling urinary catheter (not suprapubic)

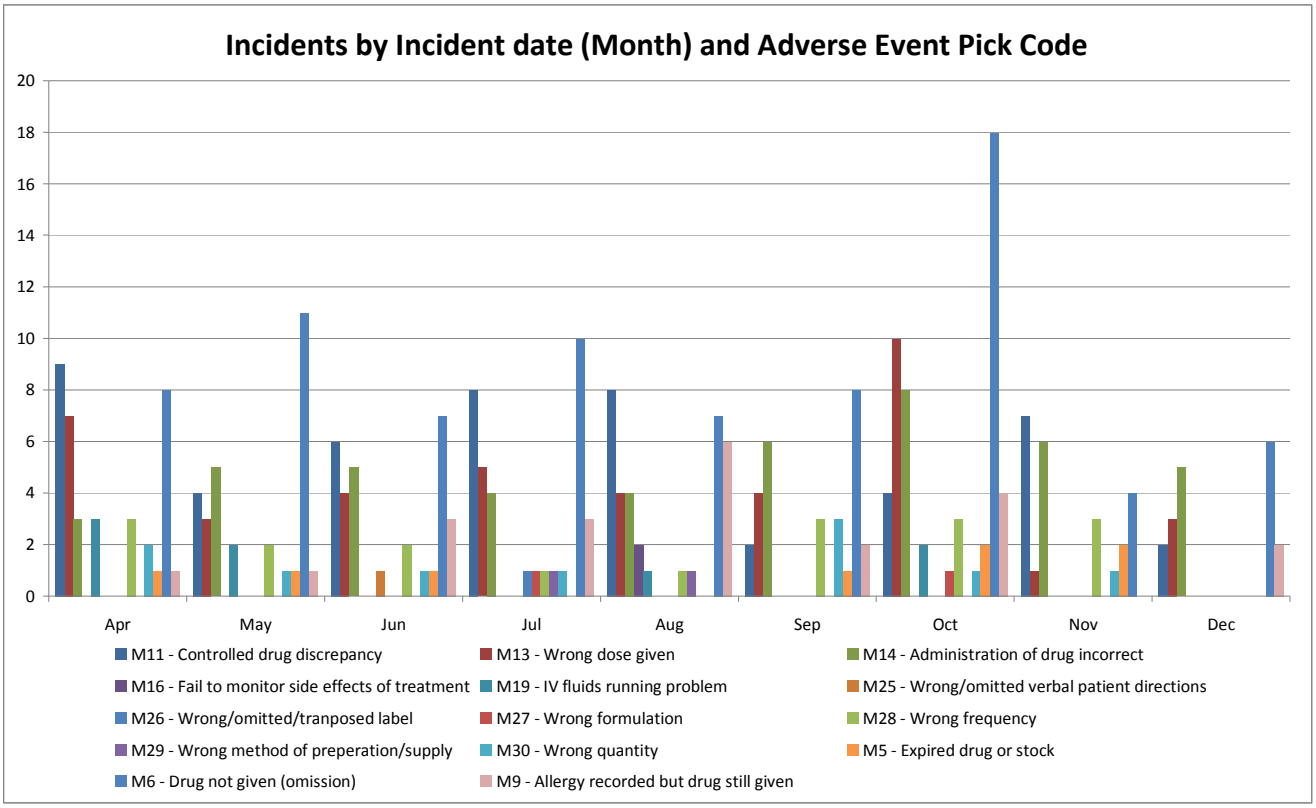


Graph to show percentage of patients with an indwelling urinary catheter (not suprapubic) and a urinary tract infection



1.2 Reduction in prescribing errors

The Trust continues to be in the highest 25% reporting medium acute organisations as per the Commissioning Board's Organisation Patient Safety Incident Report (October 2011-March 2012) at 9.4 reported incidents per 100 admissions. This is seen to be indicative of a better and more effective safety culture providing the opportunity to learn from reported incidents. The report shows a breakdown of the type of incidents reported comparing the top 10 for our organisation with all the medium acute trusts. This breakdown shows that medication incidents account for 13.7% of incidents reported in our trust compared to 11.2% for all trusts. The graph below shows a breakdown by type of drug error by month for this year. The group leading on improving this safety issue is specifically targeting omission errors which is the most common error in this reporting period.



1.3 Healthcare associated infection

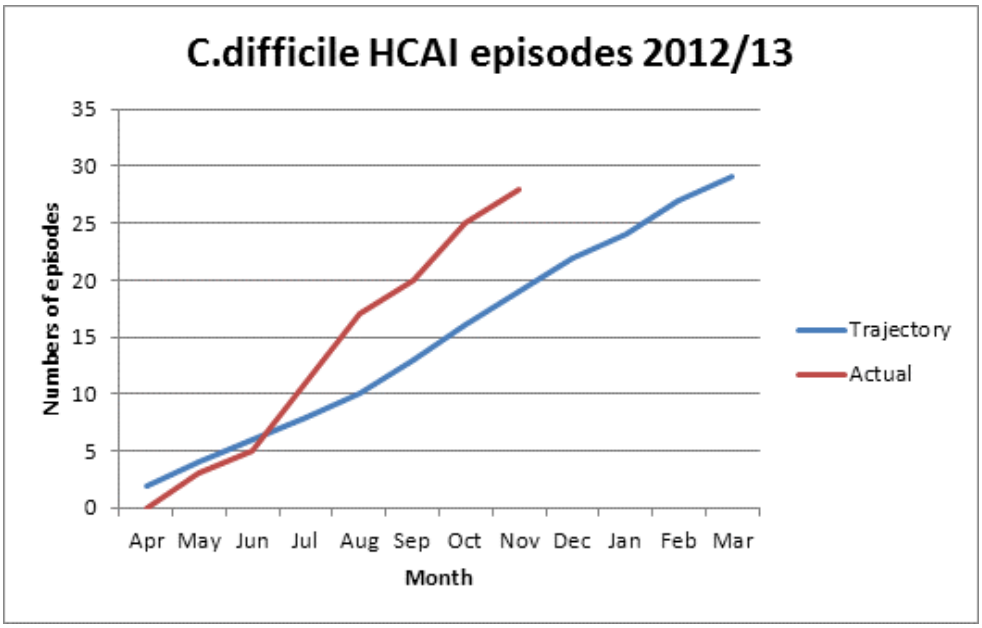
1.3.4 MRSA

There were no cases of MRSA bacteraemia diagnosed after 48 hours of hospital admission during November 2012. The two cases diagnosed in October 2012 have been investigated and found to be contaminated samples. Actions have been taken around reinforcing vigilance around asepsis. In terms of benchmarking with other Trusts in the Midlands and East SHA the Trust is ranked 27 of 46 (up to September) for the MRSA rate per ten thousand bed days.

Compliance with MRSA screening for elective patients in November 2012 was 100% and 87.9% for patients admitted as an emergency.

1.3.2 *Clostridium difficile*

There were three cases of hospital acquired *Clostridium difficile* infections reported in November 2012. The graph below shows performance against the trajectory for meeting the ceiling target for the year: the Quarter 2 has been breached and the risk of breaching the year end target has been raised to 20 (year to date performance is 28 infections against a year end ceiling target of 29). In terms of benchmarking with other Trusts in the Midlands and East SHA the Trust is ranked 39 of 46 for the C diff rate per thousand bed days.



1.3.3 MSSA and E. coli

There was one cases of *E. coli* bacteraemia and no cases of hospital acquired MSSA bacteraemia reported in November 2012.

1.4 Adverse event reporting and Never Events

There were 990 safety incidents reported during the month of November 2012, a reduction of 81 compared to the October figure. Falls and pressure ulcers present on admission remain the two most reported incidents. The number of interpreter related incidents fell from 36 reported in October to 19 reported in November and continues to be monitored. There was one grade 3 pressure ulcer reported in November.

The CLAEP report for Quarter 2 has been circulated to Board members: this report collates various governance reports and compares them seeking any patterns or trends and early warning signs of quality issues.

1.5 Safeguarding

Following a letter from Sir David Nicholson we were asked by our commissioners to provide assurance that we had robust processes in place in relation to:

- Safeguarding
- Access to patients (including that afforded to volunteers or celebrities); and
- Listening to and acting on patient concerns.

Following the submission of our evidence we received confirmation from our commissioners that they were reassured about our safeguarding practices and processes.

In November 2012 there was an increase in activity related to the safeguarding of vulnerable adults. There were six alerts related to care received by adult patients prior to hospital admission in either the patients own home or the care home they were residing in and 2 alerts related to the care given to patients whilst in hospital. Neither of these alerts have resulted in any findings against the Trust.

2. Effectiveness

Several indicators in this quality domain are reported within the Management Information Report, including:

- 4 hour Emergency Department (ED) wait and progression of new quality indicators for ED patients
- Reduction of emergency readmissions within 30 days of discharge following a day case, ordinary elective, regular day or night admission
- % time spent in a stroke unit
- Reduction in the number of cancelled elective operations for non-clinical reasons on the day

2.1 Completion of nutritional risk assessment and food intake monitoring

The Trust wide score for compliance with nutritional risk assessment as recorded by audit of ten patient records in each ward area during the month of November was 99.7%.

2.2 Completion of risk assessment for patients over 75 for dementia

November has seen sustained improvement. Compliance with all three indicators has now been achieved for 2 consecutive months (see table below). The target for all three indicators is 90% and must be met for three consecutive months in order to achieve the CQUIN payment. Dementia training for staff continues throughout the remainder of the year and has been well received. We have also secured £28K from Midlands and East SHA to improve the Dementia care experience.

Table to show % monthly compliance with CQUIN indicators

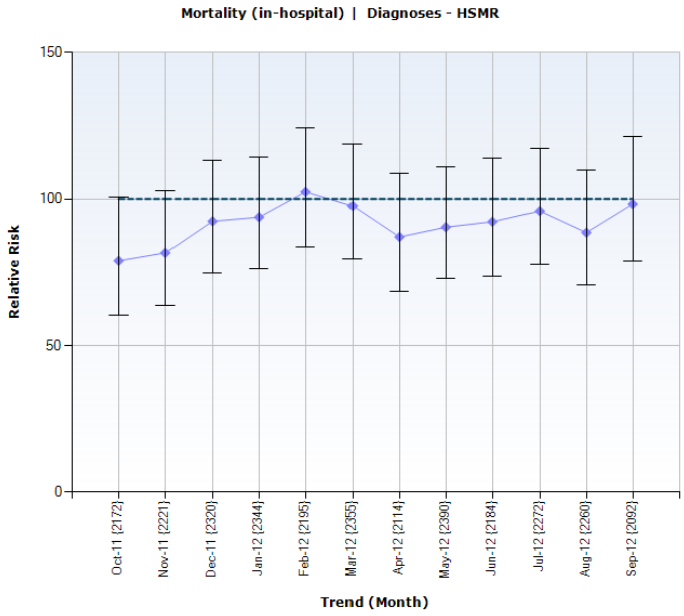
CQUIN Indicator	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
1. Dementia case finding	9.3%	93.2%	84.2%	88.6%	91%	92.2%				
2. Diagnostic risk assessment for dementia	85.4%	88.6%	89.8%	89.3%	97.3%	98.3%				
3. Referral for specialist diagnosis	81.3%	93.6%	92.8%	94.2%	97.4%	98.4%				

2.3 Reducing mortality rates

The graph below shows the Hospital Standardised Mortality Ratio (HSMR) data for October 2011 - September 2012 and shows the rolling annual HSMR relative risk currently as 91.9. This benchmarks well with Trusts across the SHA where the HSMR for all Trusts is 95.3.

The Standardised Hospital Mortality Indicator (SHMI) for April 2011 to March 2012 was 101.28 compared to 104.03 for April 2010 to March 2011.

Rolling annual HSMR (October 2011 to September 2012)
Relative Risk (RR) = 91.9



Data source: Dr foster RTM Clinical Benchmarking data

3. Patient experience

3.1 Patient satisfaction monitoring including the 'Net Promoter' or Friends and Family test

In November the Friends and Family Test submitted score was 75 (volunteer acquired and face to face) compared to 74 for October. This is the second highest score since starting the data collection in April 2012 (the highest being in August when we scored 78). The score based on the Friends and Family Test question being asked by the receptionists post discharge was 41 (compared to 50 last month). There is a separate report showing a breakdown of scores by ward together with any comments made that has been circulated to Board members by e-mail. There are multiple positive comments included in this report but areas where concerns are being raised are around communication with patients not being made aware of their treatment pathway and also patients commenting that they did not feel that there were enough nurses on duty.

The action plan that each ward is required to produce in respect of their NPS score is available should they be required as evidence of this work. The action plans are monitored by the Directorates and progress checked at the Conformance Committee.

We continue to collect data for the Access and Radiotherapy Survey, Inpatient Survey, Radiotherapy Survey and the new Chemotherapy Patient Survey. The action plan from the Cancer Survey has been submitted to our Commissioners for review and work is currently underway within that Directorate in respect of the survey results.

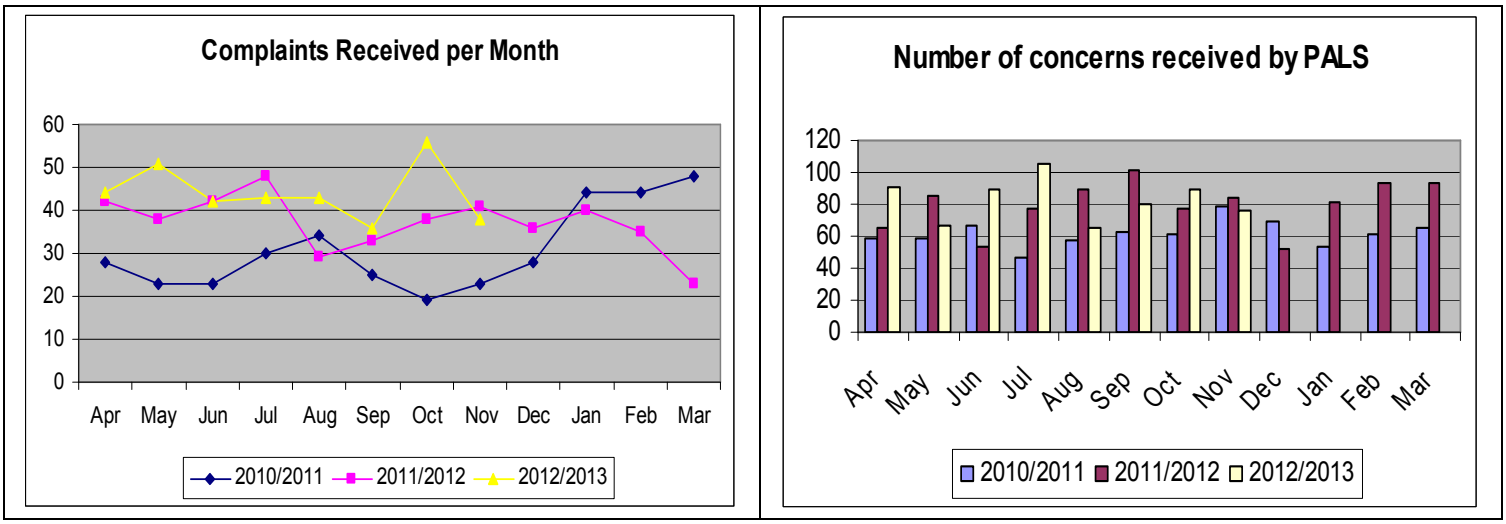
The Emergency Department National Patient Survey report published by the Care Quality Commission became public on 6 December 2012. Each trust is assigned to a category, to identify whether their score is 'better', 'about the same' or 'worse' than other Trusts. For our Trust in all but one of the categories we came out as 'about the same' however in one area 'patients leaving hospital without test results' we came out as worse compared to other Trusts. An action plan is already being devised to address the details of the report and this coupled with

ED now being included in the Friends and Family Test we are confident we will be able to improve our scores for next year.

3.2 Complaints and PALS

The number of formal complaints for this month was 38 (56 last month). The complaints and PALS data is again varied in nature but we have seen an increase in concerns being raised about appointments being delayed in clinics especially in Ophthalmology and some other out patients areas. We have also seen a rise in complaints about discharge in that there is a feeling that the patient may have been discharged too early or with insufficient information and follow up given following discharge.

The right hand graph shows the number of concerns raised and investigated by PALS in November 2012 compared to the other months this year and previous years. The November data demonstrates there has been a decrease in the number of concerns raised. Trends will be discussed and triangulated through the CLAEP meeting and report.



Our second report from Patient Opinion has been sent out to all wards and departments. This has shown all of the postings we have responded to since July and details the actions we have taken as a result of these postings. We have been pleased to see that one patient who had previously posted some negative comments about the Trust has now posted a very complimentary comment following a meeting with the Assistant Director of Nursing and Care Quality (patient experience) and the PALS Manager, which occurred as a result of the concerns she raised on Patient Opinion. We have also been held up as an example of good practice in the eastern region following our utilisation of Patient Opinion.

3.3 Delivering same sex accommodation

In November 2012 there were no reported breaches in relation to the same sex sleeping accommodation policy.

4. Regulators

4.1 Care Quality Commission (CQC) – visit to John van Geest Ward

The CQC report following their unannounced visit to John van Geest Ward on Saturday 4 August has been received for accuracy checking.

4.2 Nursing and Midwifery Council (NMC)

The triennial review by the NMC of entry to register nursing and midwifery programmes run by Anglia Ruskin University included visits to the clinical placement areas of Peterborough City Hospital. Verbal feedback was positive about the mentorship and support offered to the students, the quality of care observed in the ward settings and the environment in which the patients were being cared for. A formal report will be supplied in due course but a summary of the ratings is provided in the table below:

KEY RISK	LEVEL OF ACHIEVEMENT
1. Resources	Good
2. Admissions and Progression	Good
3. Practice Learning	Good
4. Fitness for Practice	Outstanding
5. Quality Assurance	Good

5. Feedback from Quality Governance Operational Committee

Quality Governance Operational Committee
The December meeting included the following issues and discussed actions required:

- Serious incident reports and adverse events
- Infection control - increase in *Clostridium difficile* numbers
- Medicines management report
- Mortality data
- Information governance incident action plan update
- Policy endorsement
- Quarter 2 CLAEP report

Recommendations

Board members to note the report and to raise questions or concerns as appropriate.

Appendix II: Quality Account preparation 2012/13

It is important that all the individual contributions are combined in to one document with a consistent style of delivery and language. It is also essential that all key stakeholders have the opportunity to shape the development of the document and its final presentation. The following timeframes will allow this:

Timeframe	
12/12/12	Set up meeting – Stakeholder and KPMG representatives invited
13/12/12	Council of Governor engagement in selecting mandated local indicator for 2012/13 and selection of priorities for 2013/14
09/01/13	Final chance for Governor involvement in selection of indicator
Dec & Jan	Compile M9 Quality Account
Feb	KPMG testing of indicators x 3
Feb – Apr	Contributors to add M9 -12 data to draft report
25/02/13	Circulation of draft M9 report
11/03/13	Governors Development and Assurance Committee review of M9 draft
14/03/13	Audit Committee review of M9 draft
27/03/13	Community Engagement Committee review of M9 draft
15/03/13	Audit Committee
11/04/13	Board of Governors NB CW on leave
16/04/13	Submission by all contributors to CW
23/04/13	Final draft submitted to key stakeholders
26/04/12	Trust Management Board
02/05/12	Stakeholder event
08/05/13	All comments and Stakeholders comments for inclusion in QA to CW by 12 midday Audit Committee workshop – review of final draft
13/05/13	Final content completed incorporating comments and styling
14/05/13	Quality Assurance Committee
16/05/13	Audit Committee sign off
28/05/13	Board sign off
30/05/13	9 am - submission to Monitor by courier and via portal
TBC	Publication deadline for NHS Choices website Publication on Trust web site