ITEM: 10/079
Doc: 03

Meeting:	Trust Board
Date:	28th July 2010

Title:	**Update on Patient Safety Strategy**

Executive Summary:

This report provides an update on the Whittington Hospital Patient Safety Strategy. It describes several areas of improvement over the last six months. The next areas for focus are the implementation of the routine use of the Global Trigger Tool (which is also a Commissioning for Quality and Innovation standard [CQUIN]) and the Patient Safety priorities highlighted in our Quality Account: reducing the risk of venous thrombo-embolism, a more systematic use of information from complaints and incidents (Datix reports) and from Patient Safety Walkabouts, to identify areas where improvements should be made, and putting actions into place to reduce the risk of harm from falls in our in-patients."

Key point to note are:

- Data capture will be improved following the implementation of the Datix reporting system which went live in Autumn 2009
- The trust responds to all relevant patient safety risks identified in alerts from the National Patient Safety Agency
- All unexpected deaths or permanent harm to patients are now treated as SUIs requiring Root Cause Analysis and sometimes a panel investigation
- Quality metrics, including CQUINs, are regularly reviewed with commissioners
- Currently the medical director reviews the notes all patients who have died and the Global Trigger Tool (GTT) is also being introduced to review patient deaths
- Patient Safety metrics are included in the dashboard report to the Board
- Patient Safety walkabouts have been extended to include non-executive directors, clinical directors and general managers
- No "never events" have occurred since monitoring began
- Three patient safety priorities for the current year identified in the quality Account are:
  1. Reduce risk of in-patients developing venous thrombo-embolism
  2. Systematic identification of safety themes using the GTT
  3. Reducing harm to patients from falls
- UCL Partners has initiated a Quality Forum to share good practice

Action:	Information and discussion

Report from:	*Mrs Celia Ingham Clark, Medical Director*

Compliance with statute, directions, policy, guidance Lead: All directors	**Reference:** CQC standards Quality Account NHSLondon governance self-assessment

Patient Safety Strategy Update for Whittington Hospital Trust Board July 2010

1.1 Trust Board agreed a Patient Safety Strategy in December 2010. This paper is designed to update Board members on progress towards achieving the aims of the strategy and to highlight current further developments.

1.2 Our overall aim is to achieve
No avoidable patient deaths and no avoidable harm to patients

1.3 This report will provide an update on clinical and organisational elements of patient safety, along with our progress towards achieving the objectives of the national Patient Safety First Campaign. It will also discuss the Patient Safety priorities in our Quality Account and more recent work with UCL Partners that contributes to the patient safety agenda.

2.0 Clinical elements

2.1 Reporting and learning from high level and serious untoward incidents. The Datix reporting system for incidents went live in the Trust in Autumn 2009. It uses electronic reporting with some mandatory fields to improve data capture. It facilitates audit of the process. It also captures information from patient complaints and from litigation. This should enable us to identify clear themes to address to improve patient safety.

2.2 A clearer link is now being made between issues arising from adverse incidents and the development or updating of relevant clinical guidelines and policies. Recent examples of this relate to blood transfusion and the management of severe sepsis.

2.3 We are aiming to improve communication about adverse incidents and systems to prevent them. On 1 July the first letter to consultants regarding specific patient safety issues was circulated and received very positive feedback. We aim to continue this on a monthly basis.

2.4 We respond to all relevant patient safety risks identified to us by the National Patient Safety Agency. For example a recent alert reminded us of the risk of giving the wrong drug into the space around the spinal cord, which could kill a patient. Our Medical Devices lead, Dr Tim Blackburn is working with our head of procurement to buy in special devices to use for spinal space injections that physically do not fit with syringes that are normally used for injections elsewhere. This should make it physically impossible for such things to happen.

3.0 Organisational elements

3.1 Setting, measuring and reporting metrics. This has moved forward since the threshold for declaring and reporting Serious Untoward Incidents has been reduced. Any unexpected patient death or unexpected permanent harm to a patient must now be treated as a SUI and requires root cause analysis and in many cases a formal Panel. We are grateful to non-executive Directors who play a crucial role on such Panels.

3.2 Commissioners have set up monthly meetings with each Trust to discuss quality metrics including those specified in the Service Level Agreements and the CQUINs (payments for quality). A list of the CQUINs agreed for the year 2010/11 is at Appendix 1.

3.3 The nationally agreed CQUIN for this year is about preventing venous thrombo-embolism. There are an estimated 30,000 deaths a year in the UK from this condition as well as long-term problems for many more patients (a much higher individual risk than that of death from MRSA). We must do a risk assessment on every adult patient admitted to the hospital, and if they are at risk give clearly identified prophylaxis. This risk assessment must be repeated within 24 hours of admission. Along with all other acute trusts our performance on this will be monitored prospectively.

3.4 The Commissioners expect us to review every patient death and to report back to them any death that is perceived to have been avoidable. At present the Medical Director continues to review the medical records of all patients who have died, but this work is gradually being taken over by the specialties concerned.

3.5 High risk incidents are those which have not resulted in patient death or permanent harm but which could potentially have a serious effect and which seem likely to recur. These are each investigated, often with a root cause analysis, and the resulting action plans have been monitored by our Patient Safety Committee. We are now considering bringing these reports directly to the relevant Divisional Board to facilitate "closing the loop" – improving our systems to reduce the risk of similar things happening again.

3.6 Patient Safety metrics continue to be reported monthly in the quality dashboard. Our Hospital Standardised Mortality Rate has now fallen further to 71 against an average of 100 across the country. (The only three hospitals in London that perform better than the Whittington on this metric at present are UCLH, the Royal Free and Imperial Healthcare).

4.0 Patient Safety First Campaign.

4.1 The Leadership intervention involved the aim to reduce the HSMR, which we have done, to use the Global Trigger Tool and to carry out patient safety walkabouts and complete the actions arising from them.

4.2 The introduction of the Global Trigger Tool is also one of our CQUINs for this year. We have completed the initial review of 50 patients who died and now need to embark on a programme of monthly audit of a random sample of the records of 20 discharged patients. Dr Ihuoma Wamuo, Director of Audit and Effectiveness is leading on this.

4.3 Our Patient Safety Walkabouts are flourishing, especially with the addition of our non-executive Directors, Clinical Directors and General Managers to the cadre of people doing the Walkabouts. Each Walkabout results (if necessary) in an action plan. A summary of the action plans, with progress against completion, is going to be brought monthly to the Executive Committee.

4.4 Reducing harm from deterioration is an important aspect of improving patient safety. We have introduced new patient observation booklets

with what is known as “MEWS” scoring to make it easier to see if a patient’s observations have deteriorated. We still need to spread the training for staff on how to make timely and focussed calls for appropriate help when a patient deteriorates.

4.5 Our Critical Care Outreach Team provides robust support to the wards when a patient is deteriorating. This may involve additional treatment and monitoring on the ward or may require admission to HDU or ITU.

4.6 The Critical Care Outreach Team records how often it is called and to which wards. We now need to add to this formal recording of which wards generate cardiac arrest calls, and seek any correlation. A low rate of CCOT calls accompanied by a high rate of cardiac arrest calls could mean that the ward staff need more training in recognising a deteriorating patient early.

4.7 In the critical care unit we now use the ventilator care bundle and the central line care bundle and we monitor the frequency of ventilator acquired pneumonia and central line infections prospectively. Both rates are very low.

4.8 ITU length of stay is monitored, and a reducing average length of stay reflects improved care. ITU can also be assessed using a specific ITU Standardised Mortality Rate and at the Whittington this has fallen to well below the national average over the last four years.

4.9 Reducing harm in peri-operative care involves a range of initiatives. We record our Surgical Site Infection Rates. These are low in maternity and reducing in orthopaedics.

4.10 The Surgical Safety Checklist is well embedded in normal theatre practice at the Whittington. A recent audit showed 100% compliance with the checklist.

4.11 No “Never Events” (for example operating on the wrong side) have occurred at the Whittington since monitoring began, and in surgery this is likely to be associated with the robust use of the Surgical Safety Checklist.

4.12 Other operative measures to improve patient safety which are in place include maintaining a normal temperature for the patient, maintaining a normal blood sugar, using antibiotics appropriately and on time. Snapshot audits have been done but there is not continuous prospective audit.

4.13 Reducing harm from high risk medicines has been taken forward by Helen Taylor the head Pharmacist. Drug charts have been changed to ensure that anticoagulant drugs are given and monitored better.

4.14 Helen Taylor has also instituted a programme of regular feedback from ward pharmacists to junior doctors to help them improve their prescribing.

4.15 We plan to introduce electronic prescribing within the next year. If implemented well this can reduce harm from medicines considerably.

5.0 Quality Account.

5.1 We were asked to agree three priorities for patient safety, for clinical effectiveness and for improving patient experience in our Quality Account.

5.2 Our first priority for improving patient safety this year is to reduce the risk of patients developing venous thrombo-embolism in hospital (described in detail above)

5.3 Our second priority for improving patient safety this year is to be more systematic in the way we look for themes to address to reduce risk. This involves the introduction of the Global Trigger Tool for monthly random records audit and pulling together the patient safety issues that arise from this and from incidents and complaints into a single programme for improvement.

5.4 Our third priority for improving patient safety this year is to reduce the harm to patients arising from falls. The National Patient Safety Agency reported 152,000 falls in England and Wales acute hospitals last year, including 500 at the Whittington.

5.5 It is estimated that on average each patient fall in hospital costs the NHS an additional £92,000 in costs of care. (Following a fall that involves a hip fracture, many patients who were previously independent require residential care). Of the falls at the Whittington last year, seven resulted in a fracture.

5.6 We plan to extend our falls risk assessment to all adult patients admitted to the hospital. After risk assessment, specific mitigations can be used to protect patients perceived to be at high risk of falls. The Falls group within the hospital is working hard to deliver improvements.

6.0 Work with UCL Partners

6.1 UCL Partners has initiated a Quality Forum for all the acute trusts in the sector to work together to share good practice on driving up quality. The first meeting was held at the end of June 2010 and was well-attended by quality leaders from the trusts. It was facilitated by Professor Lord Ajay Kakker, UCLP's Director of Quality.

6.2 The trusts agreed to go forward with a work programme which is being finalised this month. Likely topics for inclusion under the heading of patient safety are delivering the venous thrombo-embolism CQUIN, facilitating timely transfer of patients between hospitals (both to Centre and back again), increasing the range of documents that are common across all the trusts (we already use a common drug chart, thanks to John Farrell's hard work), and working together to provide out of hours rotas for key worker telephone support and advice to cancer patients in our communities.

7.0 Conclusion

7.1 Considerable progress has been made with our Patient Safety Strategy implementation. Further work is still necessary. The traditional approach to patient safety is that we find out about some things that go wrong from patients who are able to complain, and try to correct them just by telling staff to try harder (and maybe adding the topic to an already over-loaded induction programme). We now need to move forward to actively seeking systematic information about patient safety in ways that are embedded in our systems and are not dependent on one named individual. And we need to be courageous enough to

discuss what went wrong not just with those concerned but with the whole specialty or department and to work with them to develop safer systems.

7.2 However hard we try as individuals and as an organisation we will never be able to stop individuals making mistakes. However we have the ability to stop bad things happening to our patients. We must continue to prioritise this work.

Celia Ingham Clark
Medical Director

Appendix 1

CQUIN	Description
N1	VTE assessment
N2	Patient Survey
R1 (a)	Global Trigger Tool
R1 (b)	Enhanced Recovery Programme
R2 (a)	Discharge Information
R2 (b)	(1)% discharged at weekend
	(2) % discharged by 12 noon
	(3) % discharged by EDD
R2 (c)	Outpatient letters
R3	HfL Dementia Pathway
R4	Readmission rates (14 day)
	1) Diabetes
	2) COPD
	3) Heart failure
	Readmission rates (28 day)
	4) Diabetes
	5) COPD
	6) Heart failure
L1 (a)	Hospital SMR
L1 (b)	Deaths in low mortality conditions
L1 (c)	Extend use of SSISS
L2	Nutritional Assessment
L3	Choose & Book
	1) 99% services on DOS
	2) 98% slot availability
	3) DOS quality = 0 or 1
TOTALS	