6.6

LOTHIAN NHS BOARD

Board Meeting
24 March 2010

Medical / Nurse Director

QUALITY IMPROVEMENT REPORT

1 Purpose of the Report

1.1 The purpose of this report is to inform the Board of current work in quality improvement including measuring patient experience and set out an approach to establishing, developing and reporting system-wide quality of care indicators.

2 Recommendations

The Board is asked to:

2.1 Support the introduction of a system-wide quality of care indicators and reporting structure.

2.2 Note the update on patient experience actions.

3 Summary of the Issues

3.1 Measuring The Quality of Care Provided by NHS Lothian

NHS Lothian aspires to be at the level of Scotland's best performing NHS Boards and a world top 25 healthcare organisation in terms of outcomes and value. To deliver this strategic intent, and to provide data to key stakeholders, a balanced set of system measures are required to:

- show performance over time
- allow the organisation to see performance relative to strategic plans for improvement
- allow comparisons to other similar organisations; and
- assist quality improvement planning.

3.1.1 In April 2010, the Quality Strategy for NHS Scotland will be launched. A central tenet of this strategy is the need to have in place objective indicators and measures of quality to inform decision making and support frontline improvement. In the first instance, the national strategy is focussing on three of the six dimensions of quality: safe, effective and person-centred care. These dimensions are the focus of the indicators proposed here.

It is accepted that other dimensions of quality (timeliness, efficiency, equity) are important and that the dimensions are inter-related; these are partly reported through HEAT, however, further development work is required to robustly report measures in these areas on a routine basis.

3.1.2 This approach also supports the delivery of NHS Scotland Efficiency & Productivity Programme – Delivery Framework 2009.

3.1.3 There is increasing national and local focus on data and measurement, which is reflected in the current number of improvement programmes which require timely data for improvement and for performance. These include the Scottish Patient Safety Programme, Leading Better Care, Lean in Lothian and the Healthcare Associated Infection programme.

3.2 Approach to Measuring Quality of Care

The English Institute of Health Improvement and the King's Fund both recommend a 'less is more' approach with scrutiny of a small number of indicators which are integrated into the organisation's measures in a balanced dashboard approach (*Getting The Measure of Quality 2010*). The approach described in this paper aims to achieve this by aligning currently used indicators and recommending a reporting framework, to ensure a consistent robust approach to the measurement and reporting of safe, effective, person-centred care.

3.2.1 In addition to the system-level measures, it is also necessary to establish measures at a CHCP/CMT level, reported at the appropriate level. These additional measures help to provide context for changes in the system measures.

3.2.2 A Worked example of System and Local Measures :-

NHS Lothian has received its first quarterly Hospital Standardised Mortality Ratio (HSMR) for Hospital sites from Information Services Division (ISD). NHS Lothian improvement goal aligned to the Patient Safety Programme is to reduce HSMR by 15% by 2011. To achieve this goal, cross-department improvements will be required. These include:

- The Surgical Directorate being tasked to eliminate surgical site infections;
- Critical Care reducing ventilator-associated pneumonias and central line infections;
- Accident & Emergency reducing death in patients who arrive in the emergency department with acute myocardial infarction;
- A whole system approach to rescuing deteriorating patients.

Clinical and Management Teams supported by the Quality Improvement Teams and modernisation team will utilise data on local measures to inform improvement activity and demonstrate improvement over time. These local measures will then roll up to affect the system measures for HSMR.

3.3 Quality of Care Indicators

This report builds on system-wide measures which are currently in use in Lothian but are reported to different committees at different levels across the

organisation (see Appendix 1). Through consultation with senior personnel with responsibility for safe, effective, person-centred care and with the chair of the Healthcare Governance & Risk Management Committee, a range of indicators are proposed for routine reporting, along with an aligned reporting framework. Appendix 2 sets out the proposed indicators and reporting mechanisms, and illustrates how the data would be presented.

3.4 Safe Care

3.4.1 Hospital Standardised Mortality Ratio (HSMR)

ISD has published Hospital Standardised Mortality Ratios on a quarterly basis beginning October to December 2006. The most recent data are for January/March 2009. The next publication in April 2010 is expected to only be one quarter behind.

The Scottish Patient Safety Programme aims to achieve a 15% reduction by 2011 against a baseline of October 2006 to September 2007.

For the latest quarter available (January to March 2009 the Standardised Mortality Ratios were as follows:

Royal Infirmary	0.79
Western General	0.76
St Johns Hospital	0.92

These figures represent the ratio of actual deaths to expected deaths within 30 days of admission to hospital. Therefore for each of the 3 sites, fewer deaths than expected are occurring (if the HMSR for a hospital is less than 1 then fewer hospital deaths within 30 days of admission are occurring than expected).

These figures suggest good performance by UHD, but the Board should be aware that only the Royal Infirmary appears to be demonstrating any downward trend in SMR. This is illustrated by the baseline figures and the 15% reduction, calculated over a one year period, as shown below:

	Baseline (Oct 06-Sep 07)	Jan 09-Mar 09	15% reduction from baseline
Royal Infirmary	0.88	0.79	0.75
Western General	0.73	0.76	0.62
St Johns Hospital	0.89	0.92	0.76

It is suggested that when the figures are next published that the trajectory for each hospital is assessed and this is used to help identify areas for improvement.

3.4.2 Adverse Event Rate

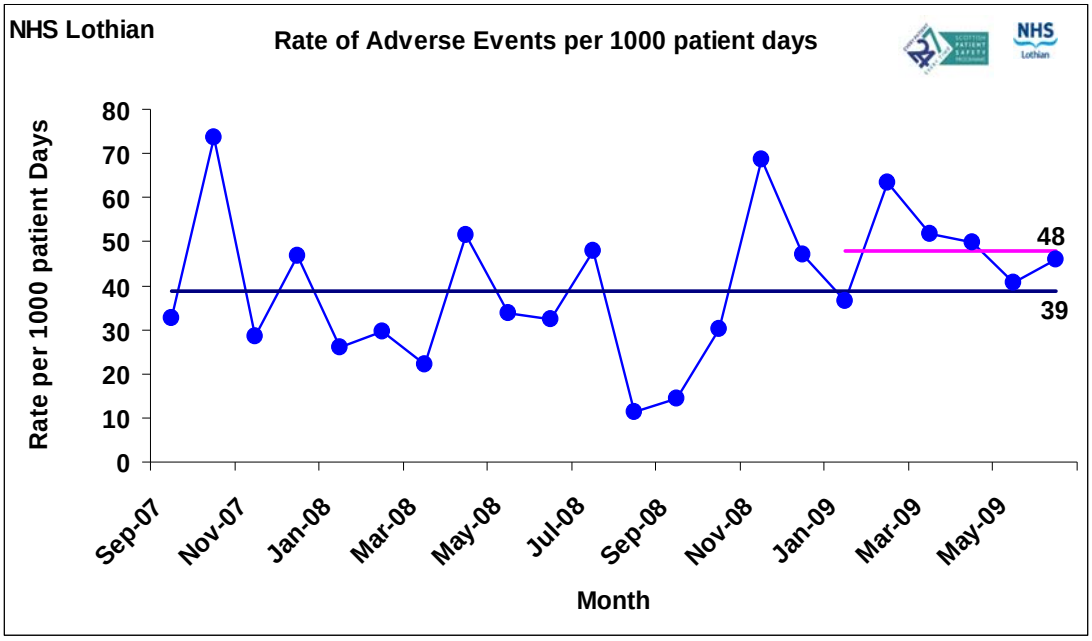
The second SPSP goal is to see by end of 2011 a 30% reduction in the Adverse Event Rate. This is measured by an assessment Tool called the Global Trigger Tool (GTT). Case notes are reviewed for these triggers and the adverse events then recorded and categorised by harm i.e. minimum or no harm to death.

The Institute of Health Improvement, drawing on international evidence, would expect an adverse event rate of between 80-90 per 1000 patient days. NHS Lothian was one of 2 Boards where experts from IHI visited to shadow and test how the assessment tool is used. Doctors, nurses, allied health professionals and pharmacists all contribute to this work and it is important that the definitions and baseline measures are used consistently.

The IHI were impressed with the quality of the process and the health records in Lothian. Their review found an Adverse Event Rate of 64.3 events per 1000 patient days. This is consistent with the best hospitals in the USA and sits well with our progress towards being one of the world's top 25 healthcare systems.

Work continues across Scotland to get a reliable process in place to achieve a baseline in each Board. The rates of individual hospitals or Boards are not intended to be used for benchmarking but illustrate an organisation's trends to track progress.

Chart 1 - Lothian Overall Rate/1000 pt days



3.5 Healthcare Associated Infection (HAI)

This is currently robustly and routinely reported within and outwith NHS Lothian, and remains a strategic priority, data will be captured in the matrix on HAI for completeness.

3.6 Incidents

Assessment of incident reporting is internationally used as a proxy measure for 'safety culture'. It is increasingly recognised that the higher the incident rate the stronger the reporting and local learning culture (National Patient Safety Agency 2009). The aim therefore should be to see an increase in incidents reported and a reduction in harm.

NHS Lothian has seen an increase in reporting during 2009, and a survey on Patient Safety Culture is underway. During 2010 the focus will be on how to reduce the harm caused by incidents as well as improving reporting.

3.6.1 Incident Trends:

6738 incidents were reported during the period of October to December 2009. Falls continues to be the highest reported incident = 2168 (32%) of which 16 can be attributed to major harm or death. Violence/abuse incidents account for 981 (15%) of which 2 can be attributed to major harm or death and medication 549 (8%) of which 2 can be attributed to major harm or death, of reported incidents for this quarter. This is consistent with reporting throughout the year. For the next report, we will provide benchmark data to provide context for these figures based on preliminary work being undertaken by ISD based on incidents per thousand patient contacts.

Charts 1 and 2 highlight general incident reporting trends, specifically for incidents involving harm.

Chart 1

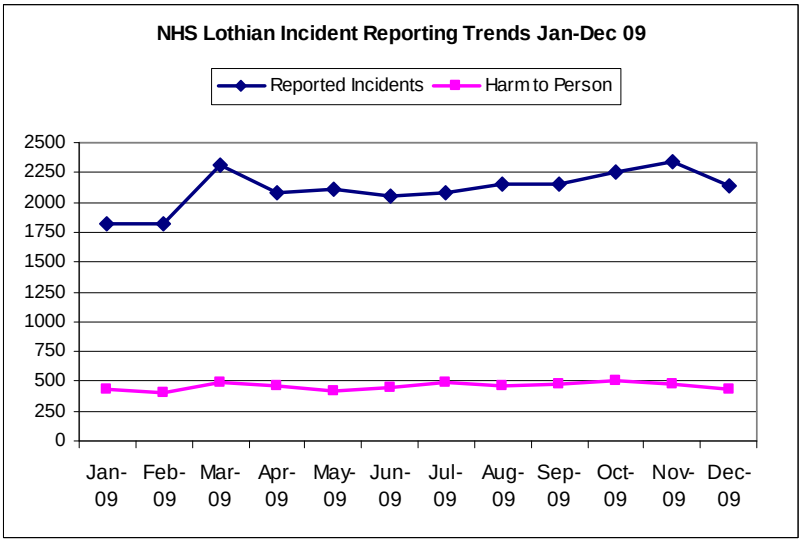
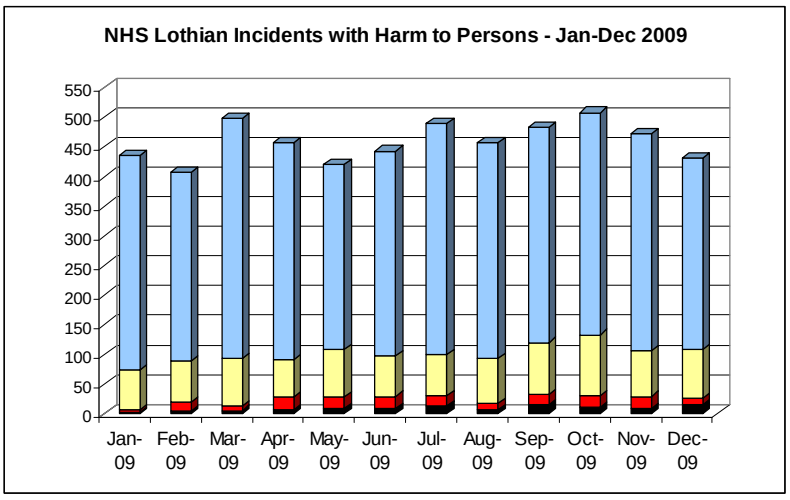


Chart 2



Incident reported with harm 2009:
Severity of harm

- Minor harm 78%
- Moderate harm 17%
- Major harm 3%
- Death 2%

3.7 Clinical Effectiveness

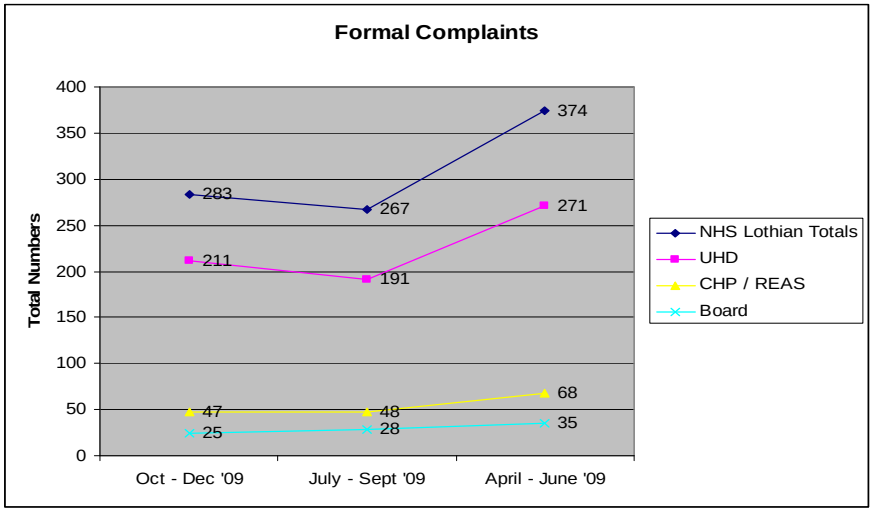
NHS Lothian currently monitors clinical effectiveness in a number of ways, from compliance with NHS Quality Improvement Scotland standards to annual reports on surgical and maternal deaths. There is however no agreed routine reporting of effectiveness outcomes. This is an area for development, and will be informed by the national Quality Strategy. It is proposed that during 2010 we develop these indicators, by working with colleagues at CMT/CHCP level.

3.8 Person-Centred Care

A central component of the Quality Strategy is to measure patient experience and demonstrate continuous improvement. Current indicators such as complaints will be added to with a systematic, fast frequent feedback process. This was the recommendation of one of the 5x5x5 projects and implementation is being progressed.

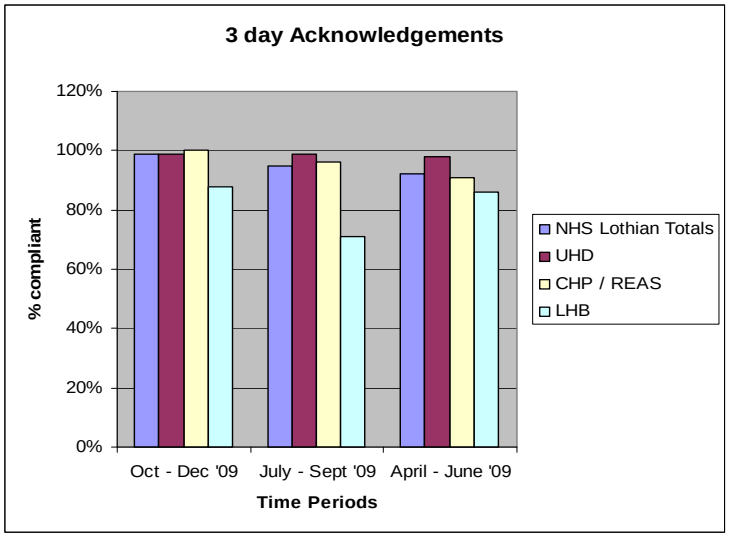
3.8.1 Quarterly Complaints Trends – NHS Lothian received a total of 283 formal complaints during the period October to December 2009. This represents a small increase on the previous quarter. The main reason for this increase is a large number of complaints to facilities due to car parking and traffic management at St John's and Western General Hospital.

Chart 3



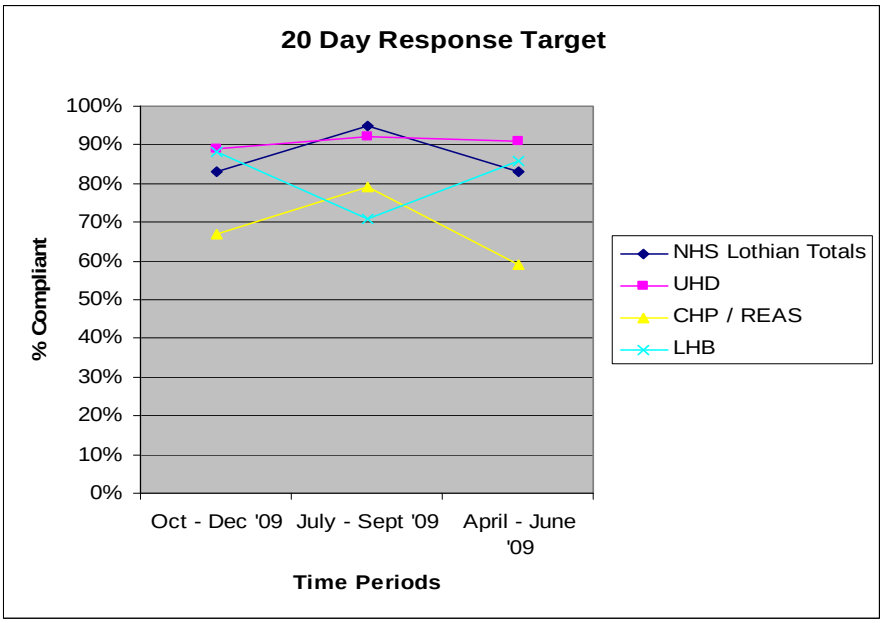
There is a national target of acknowledging all formal complaints within 3 working days. For this quarter, NHS Lothian has acknowledged 99% of formal complaints within 3 working days. The breakdown is detailed in the bar chart 4 below.

Chart 4



3.8.2 Working towards the national target to respond to formal complaints within 20 working days has been a challenge for most NHS Boards across Scotland. The current quantitative data on the ISD website (2007/8) demonstrates that NHS Scotland is 67.1% compliant with this target. NHS Lothian's performance for the same period was above the Scottish average at 73.4%. Work continues to improve performance of this target and the line chart 5 below demonstrates NHS Lothian's current performance.

Chart 5



3.8.3 In his recent commentaries, the Ombudsman has published 2 case reports which relate directly to NHS Lothian. The issues that have arisen from these cases include: consent process prior to surgery, lack of information, clinical treatment and incorrect reporting of X-Rays. As a result of these cases a number of actions have been put in place across the organisation to reduce the risk of recurrence.

3.9 An Infrastructure to collect quality measures

To deliver improvements and provide timely and efficient assurance reporting, a mechanism for data capture from ward level through to the Board has been identified. A business case for a generic solution to capturing quality indicators has been approved by eHealth and will be progressed during the 2nd quarter of 2010. This would provide rapid feedback of data to ward level to support continuous improvement and produce reports at all levels of management within NHS Lothian for performance management and assurance reporting.

3.9.1 It is acknowledged that these indicators are only one tool for assessing quality of care, and this needs to be recognised by those who are applying and interpreting them. The ability to make informed inferences from these indicators requires an understanding of their origins and limitations. It is recommended that key stakeholders should be trained in the interpretation and application of quality indicators to support a systematic approach to identifying areas of concern and the intervention required.

3.10 Reporting Quality of Care Indicators

It is proposed, and has been supported by Healthcare Governance and Risk Management Committee and the Executive Management Team, that this Quality Indicators report brings together reporting on Safe Person Centred Effective Care. This will replace the separate reports on complaints, SPSP and previous quality papers. It would be submitted quarterly to the Board.

Future reporting will also be influenced by the National Quality Strategy for NHS Scotland due to be launched later in April 2010. NHS Lothian is an active partner in informing what the quality indicator matrix will look like nationally. That however does not limit NHS Lothian in having more ambitious reporting and monitoring.

3.11 Better Together Scotland's Patient Experience Programme

3.11.1 There are currently two major surveys underway. The GP practices survey of nearly 500,000 people in Scotland, closes end March. The adult inpatient survey of around 3,600 people in Scotland will close mid April 2010. Results of these surveys will be available in the summer and be reported through a number of groups and to the Board.

3.11.2 Scottish Renal Patient Experience Survey Transplant and Dialysis Reports:

These surveys were published by NHS Quality Improvement Scotland in January 2010. They included NHS Lothian specific evidence from patients receiving dialysis and transplantation services. The Renal Services Quality Improvement Team will progress the detailed consideration and resulting improvement plans. Significant plans are also in place to expand capacity and infrastructure.

Some key findings include:

- Good response rates to postal survey – 62% dialysis, 70% transplant

- For people receiving dialysis, comfort, cleanliness and privacy and choice of time for dialysis could be improved.
- For transplant patients, RIE was mid-range for compared to other units and general recommendations include: - better information and liaison with GP's and multi-disciplinary team.

3.11.3 Participation Standard

The Scottish Health Council is finalising a Participation Standard for NHS Boards for 2010-2011. This will replace current assessment methods and is set to introduce a systematic collection of comparable data on involving people in the work of NHS Lothian. The work will cover three areas of participation:

- **Patient Focus –** responsive, person centred care which involves people; treating individuals with respect and dignity
- **Public Involvement –** effective involvement of people in service planning and improvement
- **Corporate Governance –** robust governance arrangements are in place for involving people, founded on mutuality, equality, diversity and human rights principles.

The current Patient Focus and Public Involvement assessment process will be reported to a future Board meeting.

3.11.4 Patients' Rights Bill

The development of the Bill is underway for introduction into the Scottish Parliament in Spring 2010. Key proposals include:

- A 12-week waiting time guarantee from agreement to treatment to the start of that treatment for day cases and inpatients.
- Patients Rights Officers for NHS Health Board areas.
- Reinforcement of existing rights to make a complaint and strengthening of the support to patients through the complaints process.
- Better clarity about responsibilities for patients – for example attending agreed appointments and offering feedback on health services.

3.12 <u>New Development - Health Economics Research Unit (HERU)</u>

The HERU at the University of Aberdeen has evaluated projects assessing the cost effectiveness of automated diabetic retinopathy grading in Scotland. Systematic screening for diabetic retinopathy is already in place with national screening programmes based on high quality digital photography. The three-level manual grading system is currently used in Scotland. HERU have now investigated automated algorithms to improve the sensitivity of image grading with no loss of specificity. New automated algorithms cost approximately the same as the original and detect slightly increased numbers of referable cases. The result of this work is that automated grading should now be implemented across NHS Scotland. This will be taken up by the Ophthalmology services and the Diabetes Managed Clinical Network

3.13 Summary

There is evidence that focussing on quality and patient safety can impact on the care we provide and reduce costs (Health Foundation 2009). It is of critical importance there is senior management engagement and support in the development and application of quality of care indicators. The indicators set out in this paper are the start of this process, and will develop over time, including the presentation of data and commentary, but are required if we are to deliver the Board's strategic objectives.

4 Impact on Health Inequalities

4.1 The work proposed by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality. A Rapid Impact Assessment (RIA) was carried out on the Scottish Patient Safety Programme on 5 May 2009, which has significant overlap with elements of this paper. This identified communication with patients and staff, and improved monitoring, as key issues. The plan proposed by this paper will be developed during 2010 and will incorporate a further RIA to determine the impact of increased monitoring and collation and use of quality and safety data. Actions arising from this RIA will be incorporated into the diversity monitoring action plan, a key part of NHS Lothian Quality & Human Rights Scheme to be published in June 2010.

5 Resource Implications

5.1 There are no resource implications associated with this report.

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17 March 2010

List of Appendices

Appendix 1: Quality of Care Indicators
Appendix 2: Quality of Care Reporting Matrix
Appendix 3: RMIS Lessons Learned October to December 2009

Quality of Care Indicators

APPENDIX 1

SAFE CARE							
Patient Safety Programme				Level of current routine reporting at NHS Board			
Reported by:	Performance Indicator	Measures	Current frequency of collection	CGRM	Board	Note	Proposed Frequency of Reporting
Medical Director	Hospital Standard Mortality Rate (HSMR)	All acute inpatient/day care admissions including 30 day mortality	Quarterly from ISD per hospital site	x	x	Went to Board once March 2009 as a baseline. Published quarterly ISD from Dec 2009. National target 15% reduction by 2011.	For inclusion on a quarterly basis to HCGRM & Board.
Medical Director	Adverse Events	Adverse events identified in casenote review using Global Trigger Tool rate per 1,000 inpatient bed days	Baseline October 2007 & July 2008. Casenotes conducted monthly basis on 3 sites	x	x	30% reduction from baseline based on adverse event rate per 1,000 inpatient bed days by 2011.	For inclusion on a quarterly basis to HCGRM & Board.
HAI							
Reported by:	Performance Indicator	Measures	Current frequency of collection	CGRM	Board	Note	Proposed Frequency of Reporting
Infection Control Team (Alison McCallum)	S. Aureus Bacteraemias	No of positive blood cultures within 14 days	Weekly	Quarterly	Two-monthly	40% reduction - national target 2010.	Reported quarterly to HCGRM & Board, cross-referenced to HAI papers.
Infection Control Team (Alison McCallum)	Clostridium Difficile	No positive stool sample within 28 days for C.Difficile to Jan	Weekly	Quarterly	Two-monthly	30% reduction (65yrs) by 2011 on target. Figures collected monthly.	Reported quarterly to HCGRM & Board, cross-referenced to HAI papers.
Infection Control Team (Alison McCallum)	Hand Hygiene	% Compliance of all staff groups hand hygiene policy	Monthly	Quarterly	Two-monthly	90% compliance rate - national target to have been achieved and sustained.	Reported quarterly to HCGRM & Board, cross-referenced to HAI papers.
Incidents							
Reported by:	Performance Indicator	Measures	Current frequency of collection	CGRM	Board	Note	Proposed Frequency of Reporting
Medical Director	No of incidents	Total no and type of incidents reported on Datix.	Monthly	Quarterly	x	To illustrate a safety culture we would see an increase in incident reporting and decrease in harm	Quarterly basis to HCGRM Committee and Board.
Medical Director	Number of incidents with moderate harm, major harm or death	As recorded on Datix.	Monthly	Quarterly	x	We would expect to see incidents within context of harm and adverse event rates plus other patient safety measures.	Quarterly basis to HCGRM Committee and Board.

EFFECTIVE CARE - to be developed							
Reported by:	Performance Indicator	Measures	Current frequency of collection	CGRM	Board	Note	Proposed Frequency of Reporting
Medical Director/Director of Strategic Planning	Range of Clinical Outcomes	tbc. Potential stroke, CHD,				To be agreed and informed by new Quality Strategy. Correlate with 5x5x5.	Need to be developed over forthcoming year. Could include: PROMS, Compliance, Beta Blockers per MI, Tissue viability, Food Fluid & Nutrition, Readmission rates, staff absence rates, A&E 4-hour wait.

PERSON-CENTRED CARE							
Reported by:	Performance Indicator	Measures	Current frequency of collection	CGRM	Board	Note	Proposed Frequency of Reporting
Nurse Director	Complaint Response Times	% of new complaints responded to within timescale agreed - 20 days	Quarterly	x	x	85% national target and local target. Only gone by EMT, but not routinely. Has been once to Board (25th Nov 2009) as part of Patient Experience paper. Targets to be agreed: (100% complaints acknowledged 2 working days and 95% within 20 days)	Quarterly basis to HCGRM Committee and Board.
Nurse Director	Complaints	No of complaints per quarter	Quarterly	x	x	As above.	Quarterly basis to HCGRM Committee and Board.
Nurse Director	PEAT - Measures environment, food and meeting patient needs	% of sites graded as good/excellent per quarter	Bi-annually collated	x	x	Reported various audience up to EMT but not routinely at Board level / HCGRM. Reported once at Board as part of Patient Experience paper (25th Nov 2009).	Bi-annual basis to HCGRM Committee and Board.
Nurse Director	Patient Experience NHS Lothian	% of sites graded as good/excellent per quarter	Bi-annually collated	x	x	Recommended approach through 5x5x5 workstream.	Bi-annual reporting to HCGRM Committee and Board.

Quality Indicators Reporting Matrix **APPENDIX 2**

SAFE CARE

Patient Safety Programme

Reported by:	Performance Indicator	Measures	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Note
Medical Director	Hospital Standard Mortality Rate (HSMR) - RIE	All acute inpatient/day care admissions including 30 day mortality	0.79*				*January to March 2009 HSMR National target 15% reduction by 2011. RIE (Baseline 0.88 Target 0.75)
Medical Director	Hospital Standard Mortality Rate (HSMR) - WGH	All acute inpatient/day care admissions including 30 day mortality	0.76*				*January to March 2009 HSMR National target 15% reduction by 2011. WGH (Baseline 0.73 Target 0.62)
Medical Director	Hospital Standard Mortality Rate (HSMR) - SJH	All acute inpatient/day care admissions including 30 day mortality	0.92*				*January to March 2009 HSMR National target 15% reduction by 2011. SJH (Baseline 0.89 Target 0.76)
Medical Director	Adverse Events	Adverse events identified in casenote review using Global Trigger Tool rate per 1,000 inpatient bed days	48.5	51.7	45.5		30% reduction from baseline based on adverse event rate per thousand inpatient bed days. The baseline rate was 24.1, which is the lowest quarterly rate. This is mirrored across Scotland and discussions are ongoing re the appropriate baseline rate.

HAI

Reported by:	Performance Indicator	Measures					
Infection Control Team (Alison McCallum)	S. Aureus Bacteraemias	No of positive blood cultures within 14 days	88	94	83		40% reduction - national target 2010. Not on target.
Infection Control Team (Alison McCallum)	Clostridium Difficile	No positive stool sample within 28 days for C.Difficile to Jan	262	234	170		30% reduction (>65yrs) by 2011. On target.
Infection Control Team (Alison McCallum)	Hand Hygiene	% Compliance of all staff groups hand hygiene policy	93%	93%	94%		90% compliance rate - national target is achieved and sustained.

Incidents

Reported by:	Performance Indicator	Measures					
Medical Director	No of incidents	Total no and type of incidents reported on Datix	6247	6385	6738		To illustrate a safety culture we would see an increase in incident reporting and decrease in harm.
Medical Director	Number of incidents with moderate harm, major harm or death	As recorded on Datix	297	313	346		

EFFECTIVE CARE - to be developed

Reported by:	Performance Indicator	Measures	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Note
Medical Director/Director of Strategic Planning	Range of Clinical Outcomes	tbc. Potential stroke, CHD,	-	-	-	-	Will be developed over forthcoming year. May include PROMS, Compliance, Beta Blockers, Tissue Viability, Food Fluid & Nutrition, Readmission Rates, Staff Absence, A&E 4-hour wait.

PERSON-CENTRED CARE

Reported by:	Performance Indicator	Measures	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	Note
Nurse Director	Complaint Response Times	% of new complaints responded to within timescale agreed - 20 days	83%	95%	n/a		Local stretch targets to be implemented in 2010. 100% complaints acknowledged in 2 working days and 95% within 20 days. (National target 85% achieved and sustained) Not available for October to December - staff in process of examining the data.
Nurse Director	Complaints	No of complaints per quarter	360	263	277		
Nurse Director	PEAT - Measures environment, food and meeting patient needs	% of sites graded as good (75% to 95%) or excellent (96% to 100%) per quarter	-	75% to 95%	-		75% to 95% standards almost always met and often exceed expectations.
Nurse Director	Patient Experience NHS Lothian	To be confirmed	-	-	-	-	Part of 5x5x5 workstream being considered Partnership Forum Feb 2010.

APPENDIX 3

1. Examples of Lessons Learned and Changes in Clinical Practice Initiated to Improve Patient Safety from Reported Incidents

Some examples of incidents where there has been learning and changes made:

1. An out of date medication was kept in-house and dispensed by a member of staff. The patient was advised not to take further tablets. The GP was contacted and they issued another prescription and visited the patient to check all was well. The patient was advised to take medication to the pharmacy for safe disposal. Procurement procedures have now been reviewed and are ongoing. Staff training has been commenced and implemented. The incident has been shared in the weekly staff bulletin to share lessons learnt and a regular procedure for checking stock control has been implemented.

2. Blue bags were inappropriately used for confidential waste, as white bags were not available. The blue bag was uplifted but not treated as confidential waste. An action plan has been initiated. All blue bags have been removed for use as confidential waste and a supply of white bags has been replenished. All staff have been reminded to follow Waste Management Policy and escalate any deviations through the Datix reporting system.

3. The handle of a piece of equipment used in surgery disintegrated while being used by the surgeon. This resulted in a slightly more invasive procedure and a greater risk of infection for the patient. The incident initiated a system wide review of this type of instrument. Hospital Sterilisation and Decontamination Unit (HSDU) have been replacing devices of this type where their suitability for purpose is been questioned. Under the replacement programme, new devices have been purchased and a build up of stock is underway. The Incident Reporting and Investigation Centre (IRIC) were promptly informed and they, in turn, reported it to the Medicines and Healthcare Products Regulatory Agency (MHRA), in case a national alert was required, so far this has not been required. The incident review demonstrates collaboration between Theatres directorate, HSDU, Medical Physics and Risk Management.

4. As the Paediatric Intensive Care Unit (PICU) in Edinburgh was full, but patients required beds, PICU contacted the unit in Newcastle to see if they had beds, but were told there were none. It was later discovered there were four beds in Newcastle. Staff in Edinburgh were unaware that Newcastle had more than one PICU. An important lesson has been learned; that Newcastle has 3 PICU's but one central switchboard. Staff have been advised that if there is an inappropriate response, they are to check who the call has been put through to. A laminated notice with a single point of contact direct dial line for Newcastle General has been placed for staff information.