Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
Date 25th February 2010

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report brings together the • Quality section of the Balanced Scorecard, with associated commentary and early analysis. • Ward Quality Indicators • Coroners Report • Dr Foster Information
BOARD ASSURANCE (Risk) / IMPLICATIONS	Assurance is given to the Trust Board that the details within this Quality report are discussed and debated in detail within the Clinical Governance Directorates meetings which report to the Integrated Governance Assurance Committee (IGAC). Directorate learning is of paramount importance and feeds into local action plans to make improvements to the patients we care for. IGAC assure there is corporate learning if appropriate.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Good Quality services are essential. The quality metrics used are bench marked by the Strategic Health Authority and Nationally. Poor quality services can affect the level of confidence the patients and commissioners place on our services as well as affecting the reputation of the organisation.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality on access taking consideration into disability, age and that all matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	This paper on our Quality Indicators sets out how the Trust intends to take forward / action any concerns tracked within the metrics and assure this is continuously under review.
The Trust Board is asked to:	Support the action plans noted.
Submitted by:	Dr Mike Baxter, Medical Director & Mrs Caroline Becher, Chief Nurse
Date:	25th February 2010
Decision:	For Noting

Ashford & St Peter's Hospitals NHS Trust
BALANCED SCORECARD

Position as at: 31 Jan 2010

1. To achieve the highest possible quality standards for our patients, exceeding their expectations, in terms of outcome, safety and experience.

	Patient Safety & Quality	Target	Forecast	Actual	Change			YTD
1-01	Summated Adverse Report Index (SARI)	2470	2764	228	▲	▲	▼	2301
1-02	Standardised mortality (Relative Risk)	<100	86.2	64.1	▲	▲	▲	81.9
1-03	Non-elective mortality (Relative Risk)	<100	85.9	63.8	▲	▲	▲	81.6
1-04	Mortality 75+ (Relative Risk)	<100	86.2	63.2	▲	▼	▲	83.5
1-05	Hip fractures treated within 48hrs	100.0%	79.9%	59.5%	▲	▼	▼	81.3%
1-06	Readmissions within 14 days	2.6%	3.0%	3.2%	▲	▲	▼	3.0%
1-07	Pressure Ulcers/10,000 Bed Days	16.5	18.0	5.0	▼	▲	▲	11.5
1-08	DVT during admission	72	94	12	▲	▼	▼	79
1-09	Falls - resulting in significant injury (grade 3)	29	31	3	◄►	◄►	▼	29
1-10	SUIs	12	16	1	▲	▼	▲	15
1-11	Formal complaints	365	385	26	▼	▲	▲	319

Quality Report (Part 1)

Section 1: Commentary on the Balance Scorecard

The Dash Board shows the SMR data for the Trust. All cause SMR is 64.1 for November and 81.9 YTD. Emergency admissions show almost identical SMR figures illustrating that the Trust mortality lie, as expected, with the emergency admissions. (SMR Nov 63.8,YTD 81.6). The SMR for the over 75 year age group also shows almost identical figures (SMR Nov 63.2 and YTD 83.5). This is very reassuring for the Trust indicating that there are no "hidden" age related "hot spots" in the Trust. These figures are very good and continue to identify the Trust as a high performing organisation.

In contrast the figures for hip fracture operated on within 24 hrs are disappointing. We see for the second consecutive month a fall in performance. The Dec in month figure was 71.1%, representing 12 patients failing to have a timely surgery. The explanation offered was that the high numbers of fractures, following the inclement weather, had put great pressure on the system. The Jan in month figures are however, considerably worse (59.5%) giving an extrapolate end of year rate of 79.9%. I have launched an investigation into this position and more detail will be available for the Board.

Review of the absolute numbers of patients show that there where 37 admissions, 22 had timely interventions, 17 patients were not operated on within the 48 hrs period. Reassuringly the SMR for this Jan was 24.8 representing a crude mortality rate of 3.7%. This is a very low figure suggesting no adverse harm was created by this operative delay.

Readmission rates within 14 days of discharge show a worsening performance against last months value of 1.7%. It was reported in last month's commentary that this figure was very low and so it is not surprising that there has been some decline in performance. The month's value of 3.2% does not affect the predicted end of year figure of 3.0%, which although below the Trust's own stretch target of 2.6%, is still well within the PCT imposed target of 6.14 days. Breakdown of the data for readmissions shows a rate of 2.0% for surgical patients and 4.0% for medical patients

Pressure sore rates show the second consecutive month of improvement, with the Jan figure of 5 showing a dramatic improvement from the Dec value of 9.9. If this improvement is consolidated the Trust will reach the SHA target rate of below 16.5 events per 10,000 bed days.

The DVT figures of 12 show the second month of declining performance. This value is a surrogate for VTE prophylaxis which is an important and now well publicised performance target. I have initiated an urgent review, in advance of the quarterly audit, of VTE prophylaxis performance and will bring an update to the Board ASAP. I have added VTE prophylaxis under-performance to the Trust risk register.

Falls, following a modest increase in numbers in Dec, have again shown an improved performance with a reduction in the numbers this month from 4 to 3. The Trust remains on track to meet this SHA target.

There has been 1 SUI this month, this is reported in detail elsewhere in the Board papers.

The Trust SARI index shows a decline in performance with the number of adverse events increasing from 164 to 228. This increase in adverse incidences appears to be a small but global. This has been reported to the CD to increase awareness and responsiveness.

Specific investigations are in place with respect to hip fracture treatment rates and TVE prophylaxis.

Quality Report (Part 2)

2.1 Dr Foster Review and Update:

2.1.1 Dr Foster Audits

RTM review has ceased indicating colorectal surgery as a double red signal. The audit results are discussed below (2.1.1.3).

The GI haemorrhage report continues as a double red signal. This is discussed in detail below.

2.1.1.2 Audit on GI Bleeds

The full audit report is presented in appendix 1.

The Board will be aware the Dr Foster data base had generated a signal for higher than expected mortality related to GI bleeds at ASPH.

I have checked the current RTM data and the mortality rates have been at a lower and stable rate over the last quarter.

The expected mortality rates for patients are well defined for upper gastrointestinal bleeding (TA Rockall et al, BMJ 1995;311:222-226). This large UK study reported a mortality rate of 14% overall (11% for emergency bleeding admissions, 33% for bleeding occurring in existing in-patients).

I have reviewed the crude mortality data for the Trust from 2003-2008 which shows crude mortality rates of 19.1, 9.32, 14.2, 16.2, 14.2 and 12.96% respectively. This is total mortality and does not distinguish between acute admissions and pre-existing in-patients. As can be seen there is a gradual reduction in mortality over the years and our figures bench mark well with national standards.

The audit asked 3 questions; was the bleed the cause of death, and was there a relationship to the endoscopist or ward of admission:

Was GI Bleeding the Main Cause of Death?

Upper GI Bleeding

Of the 45 patients identified by Dr Foster 32 patients actually had upper GI bleeding, 20 were considered to have this as the main cause of their death or at least as a significant contributing factor.

For 12 of the 32 patients therefore the gastrointestinal bleeding was either far removed in time from their deaths or insignificant compared with other co-morbidities. Of the 12 patients for whom upper GI bleeding was not thought to be a material cause of death, the diagnoses were varied. These included septicaemia from skin infection, alcoholic liver disease, stroke, pneumonia, metastatic lung cancer, small bowel obstruction, renal cancer, etc.

Of the 20 cases in which upper GI bleeding was considered to have been a material cause of death, 14 were given endoscopic treatment and/or were taken to theatre, three exsanguinated so rapidly that endoscopy or theatre could not be arranged in time, and for three a decision was made to treat conservatively in view of co-morbidity. There were three patients with advanced upper GI malignancy in this group of 20 patients.

Endoscopic/Surgical Intervention

These were performed by a variety of consultants and senior specialist registrars and an associate specialist (PJF 4, JRT 2, SME 1, JPT 2, PEB 4, EC 5, AB 4, AN 1). Having reviewed all of the cases these interventions appear to have been conducted in a timely manner. In all cases the appropriate treatments appear to have been given in accordance with established guidelines and medical practice.

The data has also been analysed for individual endoscopists and there is no suggestion of significant differences in outcome based on “operator”.

Wards

The majority of patients with recorded GI bleeding were cared for on wards which are specialist areas for gastroenterology or high dependency/ITU units: these are May, Falcon, MHDU or ITU (23). This is especially true of the 20 patients for whom upper GI bleeding was considered to be a material cause of death, of whom 14 were cared for on these wards at the time of death.

ASP	MAY	FAL	ITU	HOL	CED
3	5	5	8	2	2

MAP	MAU	KIN	MHDU	KES	BIR
3	4	2	5	1	1

Summary

Rather than having 41 deaths caused by gastrointestinal haemorrhage in this year, there were 20 cases of upper GI bleeding and 2 cases of lower GI bleeding in which the bleeding could be said to have been a material cause of death, or significant contributory factor. These cases were dealt with in a timely and professional manner. I have found no evidence of an undue involvement of any particular ward or doctor in these deaths. The coding of our diagnostic data needs to be improved to prevent false conclusions from being drawn. The protocols for dealing with GI bleeding have recently been updated and passed by the CGC.

ACTIONS: This audit will be share with Dr Foster and CQC. All endoscopy providers have been made aware of this audit. All upper GI deaths in the next 3 months will be audited and discussed at the monthly M&M meeting of endoscopy. Progress reports will be made to CGC.

2.1.1.3 Colorectal Surgical Audit

An audit of the 8 cases of death following “elective” colorectal surgery identified by Dr Foster was undertaken. The data collected by Mr Phil Bearn is presented in Appendix 2.

The data shows that all 8 cases were inpatients with malignant disease. 2 cases were deaths related to the underlying malignant disease with the patients dying over 3 months from surgery and both established on the Liverpool care pathway.

2 cases were emergency procedures, which required major surgery for malignant obstruction. High mortality rates are to be expected in this situation and review of the clinical notes did not indicate concern with the management of these cases.

Only 4 of the 8 reported cases were in fact inpatients undergoing elective procedures. In these patients the underlying pathology was malignant disease. Age range of the patients was 70-86. Three surgeons were involved in the 4 cases. One surgeon was involved in 3 of the 4.

This surgeon showed a very highly developed level of professional responsibility and self reflective practice. He personally identified that he had had a run of bad results. He undertook a self imposed period of peer review including overseen assisted operations. No causes of concern were identified in either the peer review of the case notes or the period of supervised operating. There have been no further issues for this surgeon.

All cases were discussed at the colorectal M&M meetings and subject to peer review.

Action: Continued review of outcomes. Correction of coding errors. Inform Dr Foster and CQC

2.2 General Enquiry of Dr Foster and Trust’s Database

2.2.1 Stroke Mortality

Stroke care and the treatment pathway has been included in the best tariff payment mentioned in the operating framework and the SHA enhancing quality initiative. Mortality from stokes will almost certainly be a metric used by the PCT in CQUIN payments in 2010/2011. I interrogated Dr Foster; the Trust’s stroke mortality in Nov SMR was 81, with a year to date SMR of 92. This is higher than the Trust’s baseline mortality rates. The crude mortality for stroke in the Trust has seen a general improvement from a value of 23.8% in 07/08, 19.3% 08/09 and 21.4% in 09/10. The Trust needs to set a target of reducing mortality by 20% (actual rate reduction of 4%). It is hoped that 24/7 thrombolysis, the hyper-acute stroke unit and improved rehabilitation will impact on mortality and morbidity associated with this condition. I have asked for data specifically for the stroke.

2.2.2 Ward Mortality Data

The Trust collects data which can be broken down to show mortality rates by ward.

The data is crude mortality for emergency admissions and needs to be interpreted with care. Some baseline observations can however be made.

The mortality on medical HDU is 53.8% and has shown a rise from 50% 07/09 to 54% 09/10. This reflects the unit is dealing with very sick patients.

Cedar, Holly, Maple, May and Aspen deal with a very similar (but not identical) patient mix . The mortality rates over the last 3 years for the wards are 20.6%, 24%, 19% , 14.3 % and 17.1% respectively. There are no year on year trends for Cedar, Holly, Maple and Aspen.

May has the lowest crude mortality and has shown a year on year improvement (17% to 13%). This data will be reviewed quarterly to monitor performance.

SMR data will be compared to take account of case mix. The trend for improved performance on May will be investigated further.

Comparing the surgical wards; Falcon, Kestrel and Kingfisher. The mortality for emergency admission is 5.6%, 5.2% and 2.4% respectively. This shows that, as expected surgical mortality is much lower than that of medical admissions. I will compare the SMR for surgical and medical emergency admissions.

The elective mortality on the same wards is 0.7%, 0.7% and 0.16%. This again illustrates that elective mortality in the Trust is very low.

Of interest is the high performance of Kingfisher ward. This ward had been identified as having a high rate of complaints and issues with staffing suggesting under performance. However the outcome data for emergency and elective admissions shows a 50% reduction for these adverse outcome markers for Kingfisher compared to the other surgical wards. This difference in performance will be investigated further.

2.3 Coroners reports

NAME / REF	Date of Death	Summary	Cause of Death	Current Status
JS SPH/1046	20.11.08	Suffered an asthma attack at home, arrested whilst in the care of the ambulance, admitted to A &E where patient died.	1a) Acute Asthma	Statement with Coroner.
WC SPH/1075	16.12.09	Baby WC was born on the 25 04.09 assisted by Ventouse. Following birth, WC became hypoglycaemic and hypothermic and was admitted to the neonatal unit. He was discharged on 02.05.09 to his home with a plan to follow up as an outpatient. WC subsequently had 6 attendances as an outpatient. On 09.12.09, WC was admitted via A & E with a history of D & V. He was discharged on the 10 12.09. WC re-attended A &E on 13.12.09 with complaints of wheeziness. WC was prescribed an inhaler and discharged. On 15.12.09, WC was brought to A &E in cardiac arrest. He was later transferred to the PICU at the Evelina Children's Hospital. His condition was thought to be grave and following discussion treatment was withdrawn. WC died on16.12.09.	Under investigation	08.01.10 requested Statements from Drs.
SPH/1080 JH	26.12.09	Pt died on 26.12.09 having been admitted from a Nursing Home the previous day. Death was due to a procedure carried out in the Nursing Home where he was resident.	1a) Peritonitis, 1b) Instrumental perforation of urinary bladder.	02.02.10 report requested from Mr Chisholm
SPH/1087 EC	26.01.10	Pt admitted to Holly Ward on the 21.01.10 having tripped on a down step, CT of the head showed evidence of acute extra-axial haemorrhage adjacent to the right cerebral hemisphere. Pt subsequently died on the 26.01.10. .	1a) Bronchopneumonia 1b) Subdural Haemorrhage	08.02.10 report requested from Dr Nari

There are no specific or current issues raised by this corners report.

2.4 SHA Benchmark Observational Report

At this time there is no further data from the SHA observatory.

This data had suggested an apparently high drug error rate at ASPH. This data was not confirmed by internal metrics which had been reassuring.

It has become apparent that the data the SHA draws directly from the Trust actually relates to adverse outcomes from prescribed medication. This is NOT a drug error but reflects adverse drug response such as bleeding secondary to warfarin and hypoglycaemia following insulin treatment. This is very reassuring. I am currently investigating why the Trust reports higher adverse responses. This may be paradoxically related to good data capture.

Drug errors in the Trust do need further investigation. There is a requirement to re-audit the data breaking it down by the nature of the error e.g. narrative versus clinical errors.

It has been agreed with the SHA that the Trust will conduct these 2 audits which will be initiated in March 2010 and reported in May 2010.

2.5 CQUIN Exception Report

The CQUIN data was not available at the time this report was generated. A verbal update will be given at the Trust Board meeting. The data is available in the Trust performance report.

2.6 Patient Experience & Improving our Patient Experience Work programme

The Improving our Patient Experience Delivery programme has met three times under the chair of the Chief Nurse. It is the intention that all strands of qualitative work will report into this delivery programme.

An action plan underpins the work programme and there are very many components which are ongoing but those that are worthy of reporting on are:

- Children friendly meals on Ash ward introduced
- Tuck boxes Ash ward introduced
- Communication & Engagement Strategy approved by TEC 12th of Feb
- Scoping exercise commenced on reviewing visiting times
- Hospital gowns being reviewed for higher quality competitive samples
- Standards for Practice and Care being reviewed to reflect commentary in the patient surveys.
- Hospital patient information (appointment letters etc) reviewed for more appropriate wording.
- Learning disability development with PCT support

The out-patient survey was presented within the Trust (Jan 2010) and has been shared with the Board. The Deputy Chief Nurse is heading a task force to generate an action plan to address the weaknesses identified in the survey which will report into the Improving our Patient Experience Work Programme as well as being shared with the Patient & Public Engagement Group.

The Care Quality Commission has now bench marked ASPH the adult outpatient survey results nationally with 17 categories showing us in the Intermediate zone & 20 areas in the lower 20 % and 1 question in the top 20%.

The Adult in patient results of July 2009 will be reported by Picker to the staff at ASPH at a date to be agreed. The exercise of the CQC bench marking these results still has to be conducted.

We are awaiting the results and de-brief following the Picker Hand Held pilot which was conducted on MAU, Kingfisher & Elm wards.

We are working to prepare a programme of using the hand held audit devices Trust wide to capture timelier and greater detail of our patients experienced in outpatient and on the wards.

2.7 EQUIP

A series of bronze training events have been organised to increase the organisational exposure to the EQUIP methodology.

3 further major EQUIP projects have been selected these are:

Hip surgery (elective and emergency)

Emergency admissions

Corporate functions (recruitment and procurement)

Additionally 2 smaller projects involving paediatric outpatients and clinical coding would be supported

2.8 LIPS

Trust mortality meeting pilot will be run in late Feb 2010.

The Trust roll out is scheduled for April 2010. This will enable us to review all deaths in the Trust's on a monthly basis. The results of this review will be reported in the Trust Quality Report monthly, commencing May 2010.

2.9 Ward Quality Indicators

This is the second month that the ward quality indicators have been reported to the Trust Board. To identify improvement or deterioration of scores, the matrix now has an extra column which reflects the arrows used in the balanced score card.

It should be mentioned that an additional indicator, Blood traceability has been incorporated into the report this month,.

Initial findings

- Hand Hygiene submission compliance has improved for the month of January. Apart from Chaucer, A/E and Theatres at SPH who achieved a red rating. The rest of the Trust has achieved healthy scores within this indicator. This is an improvement from last month due to raised awareness with the Matrons.
- MRSA Bacteraemia; there have been no MRSA Bacteraemia for the month of January
- C Difficile There were 2 cases on Maple and 2 cases on Elm ward for the month of January. This is a reduction on last month's figures

- Cleanliness scores are better this month although there needs to be consistency with the audit of these areas. Labour ward has dropped their score to 82% for January and will be highlighted to the Associate Director of Midwifery.
- Blood traceability has been added to the matrix. This indicator reflects the Tag return of the blood bag to pathology. Clearly this shows we are not fully compliant in most areas. This will be highlighted to the ward staff.
- Falls; there have been less falls this month and less resulting in injury.
- Complaints have risen across the wards and departments this month which may be due to the capacity and adverse weather issues that we have experienced during the month of January.
- Although hospital acquired pressure ulcers have reduced this month, there is an issue of complying to monitoring in some areas which will be raised through the Matrons.

Access to the Ward Quality Indicators is available to the Matrons and senior nurses across the Trust and has been discussed at the NMC. Results of these indicators will be acted upon by the Matrons and fed back to the NMC for discussion.

N/S: No submission

				Saving Lives		
		Hand Hygiene	Number of	Number of C Diff	Central Lines	Urinary Catheter	Cleanliness
		>=90%	=0	=0	>=95%	>=95%	>=85%
		80% - 90%			85% - 94%	85% - 94%	75% - 84%
		<80%	>=1	>=1	<85%	<85%	<75%
Medicine 1, 2, 3	ASPEN	100 %	0	0	N/A	100 %	91 %
	CCU	100 %	0	0	N/A	100 %	94 %
	BIRCH	100 %	0	0	N/A	100 %	90 %
	MHDU	100 %	0	0	100 %	100 %	94 %
	HOLLY	100 %	0	0	N/A	100 %	96 %
	CEDAR	100 %	0	0	N/A	100 %	95 %
	MAY	100 %	0	0	N/A	N/A	97 %
	MAPLE	98 %	0	2	N/A	100 %	98 %
	COLPOSCOPY	100 %	0	0	N/A	N/A	N/S
Ashford	CHAUCER	46 %	0	0	N/A	100 %	97 %
	WORDSWORTH	100 %	0	0	N/A	100 %	96 %
	FIELDING	96 %	0	0	N/A	100 %	94 %
	DICKENS	100 %	0	0	N/A	N/A	100 %
Orthopaedics	ELM	100 %	0	2	N/A	100 %	98 %
	JUNIPER	96 %	0	0	N/A	N/A	93 %
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/S
Surgery	KINGFISHER	95 %	0	0	N/A	100 %	95 %
	FALCON	95 %	0	0	N/A	100 %	96 %
	KESTREL	100 %	0	0	N/A	100 %	95 %
	SDU	98 %	0	0	N/A	100 %	98 %
	ADMISSIONS LOUNGE	100 %	0	0	N/A	N/A	N/S
	HERON	100 %	0	0	N/A	100 %	N/S
	MAXFACS CLINICS ASH	N/S	0	0	N/A	N/A	N/S
Emergency Services	MAU	N/S	0	0	N/A	N/A	89 %
	SAU	100 %	0	0	N/A	100 %	99 %
	A&E	54 %	0	0	N/A	N/A	N/S
Paediatrics	OAK	100 %	0	0	N/A	N/A	99 %
	ASH	100 %	0	0	N/A	N/A	98 %
	PAED A/E	100 %	0	0	N/A	N/A	91 %
	NICU	90 %	0	0	N/A	N/A	95 %
Theatres	THEATRES SPH	30 %	0	0	100 %	100 %	94 %
	THEATRES ASH	100 %	0	0	N/A	N/A	N/S
	DSU SPH	80 %	0	0	N/A	N/A	97 %
	DSU ASH	100 %	0	0	N/A	N/A	97 %
Imaging / Endoscopy	ENDO	100 %	0	0	N/A	N/A	N/S
	IMAGING ASH	95 %	0	0	N/A	N/A	N/S
	IMAGING SPH	99 %	0	0	N/A	N/A	N/S
Critical Care	ITU	100 %	0	0	100 %	100 %	92 %
Maternity	JOAN BOOKER	100 %	0	0	N/A	100 %	N/S
	LABOUR	N/S	0	0	N/A	N/A	82 %
	LABOUR THEATRES	N/S	0	0	N/A	N/A	N/S
Outpatients	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/S
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/S
	DISCHARGE LOUNGE	N/A	0	0	N/A	N/A	N/A
Ophthalmology	EYE CLINIC ASH	96 %	0	0	N/A	N/A	96 %
	EYE CLINIC SPH	100 %	0	0	N/A	N/A	N/S
	EYE WARD ASH	96 %	0	0	N/A	N/A	98 %

N/S: No submission

			Pressure Ulcer Prevention				
		Blood Traceability	Compliance with monitoring of Pressure Ulcer	Hospital Acquired Grade 1	Hospital Acquired Grade 2	Hospital Acquired Grade 3	Hospital Acquired Grade 4
		=100%	=100%	<=3	<1	<1	<1
			76% - 99%	1- 2	1- 2	1- 2	1- 2
		<100%	<=75%	>3	>=3	>=3	>=3
Emergency Services	A&E	61 %	N/A	0	0	0	0
	MAU	95 %	N/S	0	0	0	0
	SAU	90 %	50 %	0	0	0	0
Paediatrics	ASH	89 %	N/A	0	0	0	0
	NICU	98 %	N/A	0	0	0	0
	OAK	100 %	N/A	0	0	0	0
	PAED A/E	N/A	N/A	0	0	0	0
Medicine 1, 2, 3	ASPEN	100 %	N/S	0	0	0	0
	BIRCH	100 %	100 %	1	0	0	0
	CCU	100 %	25 %	0	0	0	0
	MAPLE	87 %	100 %	1	1	0	0
	MAY	98 %	75 %	0	1	0	0
	MHDU	94 %	100 %	1	0	1	0
	CEDAR	57 %	75 %	0	0	0	0
	HOLLY	100 %	75 %	1	1	0	0
Ashford	DICKENS	100 %	75 %	0	0	0	0
	FIELDING	N/A	100 %	0	0	0	0
	WORDSWORTH	80 %	100 %	0	1	1	0
	CHAUCER	N/A	75 %	0	0	0	0
Orthopaedics	ELM	100 %	100 %	0	3	2	0
	JUNIPER	100 %	100 %	0	0	1	0
Surgery	FALCON	94 %	100 %	0	0	0	0
	KESTREL	96 %	75 %	0	0	0	0
	KINGFISHER	97 %	75 %	0	0	0	0
	SDU	97 %	100 %	1	0	0	0
	ADMISSIONS LOUNGE	25 %	N/A	N/A	N/A	N/A	N/A
	HERON	86 %	50 %	N/A	N/A	N/A	N/A
Critical Care	ITU	89 %	25 %	0	0	0	0
Theatres	THEATRES SPH	62 %	N/A	0	0	0	0
	DSU ASH	100 %	N/A	0	0	0	0
	DSU SPH	100 %	N/A	0	0	0	0
	THEATRES ASH	N/A	N/A	0	0	0	0
Maternity	JOAN BOOKER	85 %	N/A	N/A	N/A	N/A	N/A
	LABOUR	94 %	N/A	N/A	N/A	N/A	N/A
Outpatients	OUTPATIENT ASH	93 %	N/A	N/A	N/A	N/A	N/A
	OUTPATIENT SPH	93 %	N/A	N/A	N/A	N/A	N/A
Imaging / Endoscopy	ENDO	N/A	N/A	0	0	0	0
	IMAGING SPH	N/A	N/A	0	0	0	0
	IMAGING ASH	N/A	N/A	0	0	0	0
Ophthalmology	EYE CLINIC SPH	N/A	N/A	0	0	0	0
	EYE CLINIC ASH	N/A	N/A	0	0	0	0
	EYE WARD ASH	N/A	N/A	0	0	0	0

N/S: No submission

		Patient Falls						Medication Errors	
		Number of falls		Resulting in Injury		Complaints		Administration	
		=0		=0		=0		=0	
		>=1		>=1		>=1		>=1	
Medicine 1, 2, 3	ASPEN	0		0		0	↑	0	↑
	CCU	0		0		0		0	
	BIRCH	0		0		0		0	
	MHDU	0		0		0		0	
	HOLLY	0		0		0		0	
	CEDAR	0	↑	0		0		0	
	MAY	1	↑	1	↓	0		0	↑
	MAPLE	0	↑	0		0	↑	0	↑
	COLPOSCOPY	N/A		N/A		0		N/A	
Ashford	CHAUCER	0		0		1	↓	0	
	WORDSWORTH	1	↑	1	↓	1	↓	0	
	FIELDING	0	↑	0		0		0	
	DICKENS	0	↑	0		0		0	
Orthopaedics	ELM	1	↑	0	↑	0	↑	0	
	JUNIPER	3	↓	1	↓	1	↓	0	
	ROWLEY BRISTOW	0		0		4	↓	0	
Surgery	KINGFISHER	0		0		0	↑	1	↓
	FALCON	1		0		1		0	
	KESTREL	0		0		0		0	↑
	SDU	0		0		0		1	↑
	MAXFACS CLINICS ASH	0		0		0		0	
	HERON	0		0		0		0	
	ADMISSIONS LOUNGE	0		0		0		0	
Emergency Services	MAU	1	↑	0	↑	5	↓	1	
	SAU	0	↑	0		1	↓	0	
	A&E	1	↑	0		4	↓	0	
Paediatrics	NICU	0		0		0		0	
	OAK	0		0		0		0	
	ASH	0		0		1		0	
	PAED A/E	0		0		0		0	
Theatres	THEATRES SPH	0		0		1	↓	0	
	THEATRES ASH	0		0		0		0	
	DSU SPH	0		0		0		0	
	DSU ASH	0		0		0		0	
Imaging / Endoscopy	ENDO	0		0		0		0	
	IMAGING SPH	0		0		1	↓	0	
	IMAGING ASH	0		0		0		0	
Ophthalmology	EYE CLINIC SPH	0		0		0		0	
	EYE CLINIC ASH	0		0		1	↓	0	
	EYE WARD ASH	0		0		0		0	
Critical Care	ITU	0		0		0		0	
Maternity	JOAN BOOKER	0		0		0		0	
	LABOUR	1	↓	0		1	↓	0	
	LABOUR THEATRES	N/A		N/A		0		N/A	
Outpatients	OUTPATIENT ASH	0		0		1	↓	0	
	OUTPATIENT SPH	0		0		N/A		0	
	DISCHARGE LOUNGE	N/A		N/A		0		N/A	

Appendix 1:

GI Bleed audit Dr Steve Evans (Feb 2010)

Introduction

I have been asked to consider the data collected by the Trust which suggest that 41 patients died of gastrointestinal (GI) bleeding in the year between 1 November 2008 and 31 October 2009. Dr Foster has highlighted to the Trust's management that this might be considered an excessive number. This audit will consider for each case: a) if the diagnostic coding is accurate; b) if gastrointestinal bleeding was the main cause of death and, if not, what was the primary diagnosis; c) whether there is a pattern in the doctors looking after these patients, or in the wards on which they were cared for.

ICD10

The codes used for the data collection were:

I850	Oesophageal varices with bleeding
K250	Gastric ulcer, acute with haemorrhage
K260	Duodenal ulcer, acute with haemorrhage
K625	Haemorrhage of anus and rectum
K920	Haematemesis
K921	Melaena
K922	Gastrointestinal haemorrhage, unspecified

I850, K250, K260, K920, K921 refer to upper gastrointestinal bleeding, whereas K625 refers to lower gastrointestinal bleeding, and K922 is by definition unspecified. It is important to consider upper and lower gastrointestinal bleeding separately for a number of reasons. The expected mortality rates for patients are well defined for upper gastrointestinal bleeding (TA Rockall et al, BMJ 1995;311:222-226). This large UK study reported a mortality rate of 14% overall (11% for emergency bleeding admissions, 33% for bleeding occurring in existing in-patients). Lower gastrointestinal bleeding normally accounts for about 20% of all GI bleeds with mortality rates of between 10 – 20% (http://emedicine.medscape.com/article/195246-overview).

In three cases I was unable to obtain the original hospital notes and I have made inferences from the electronic data available to me. After detailed review of the 41 patients selected, 32 had some evidence of upper GI bleeding, 7 had lower GI bleeding, and two had no good evidence of GI bleeding at all. Of the 7 patients with lower GI bleeding, 5 had the correct ICD10 code (K625), one had an upper GI code (K921) and one was unspecified (K922). Of the 32 patients with upper GI bleeding, 29 had an upper GI code, one had a lower GI code (K625) and two were unspecified (K922). A small number (3) could have had more specific codes applied to indicate the known source of upper GI bleeding (e.g. K260 for duodenal ulcer instead of the more general K920). In the case of the two patients in whom I found no evidence of GI bleeding, confusion for the coders may have arisen, for example, because blackish vomiting or dark stool had been mentioned in the initial medical history-taking, perhaps reported by a relative, whereas it was subsequently found not to be the case.

Was GI bleeding the main cause of death?

Upper GI bleeding. Of the 32 patients with reported upper GI bleeding, 20 were considered to have this as the main cause of their death or at least as a significant contributing factor. For 12 of the 32 patients therefore the gastrointestinal bleeding was either far removed in time from their deaths or insignificant compared with other co-morbidities. On the other hand I have included in the group of 20 patients those who had a significant episode of upper GI bleeding but who, having survived initially, died perhaps several days later of multi-organ failure, which ought properly to be attributed to the initial GI bleed.

Of the 20 cases in which upper GI bleeding was considered to have been a material cause of death, 14 were given endoscopic treatment and/or were taken to theatre, three exsanguinated so

rapidly that endoscopy or theatre could not be arranged in time, and for three a decision was made to treat conservatively in view of co-morbidity. There were three patients with advanced upper GI malignancy in this group of 20 patients.

Of the 12 patients for whom upper GI bleeding was not thought to be a material cause of death, the diagnoses were varied. These included septicaemia from skin infection, alcoholic liver disease, stroke, pneumonia, metastatic lung cancer, small bowel obstruction, renal cancer, etc.

Lower GI bleeding. Of the 7 patients with evidence of lower GI bleeding, only two were thought to have this as a material cause of death. One of these died suddenly over 3 weeks after admission to hospital with rectal bleeding evident as a terminal event; the exact cause is unknown. Another was a 35 year old man with Crohn's disease and liver failure due to sclerosing cholangitis, who died of acute rectal bleeding (probable varices) whilst on the waiting list for urgent liver transplant.

Of the 5 other patients for whom lower GI bleeding was not thought to be a material factor in their deaths, the diagnoses were hospital-acquired pneumonia (2), diverticulitis, small cell lung cancer, and acute myeloid leukaemia.

Endoscopic / surgical intervention

At weekends there is a rota of 8 gastroenterologists and GI surgeons who operate an on-call endoscopy bleeding service. During weekdays emergency endoscopy is either done during office hours by endoscopy staff or by on-call surgeons out-of-hours.

Altogether 22 of the 41 patients identified had endoscopic or surgical intervention on one or more occasions in the 30 days before they died. These were performed by a variety of consultants and senior specialist registrars and an associate specialist (PJF 4, JRT 2, SME 1, JPT 2, PEB 4, EC 5, AB 4, AN 1). Having reviewed all of the cases these interventions appear to have been conducted in a timely manner. In one instance (405750P) a duodenal ulcer was noted at endoscopy but it is not recorded that it was injected with adrenaline or treated in another way to stop it bleeding; but it is not clear from the endoscopy report that the ulcer did or did not manifest stigmata of recent haemorrhage. In all other cases the appropriate treatments appear to have been given in accordance with established guidelines and medical practice.

Wards

The majority of patients with recorded GI bleeding were cared for on wards which are specialist areas for gastroenterology or high dependency / ITU care: these are May, Falcon, MHDU or ITU (23). This is especially true of the 20 patients for whom upper GI bleeding was considered to be a material cause of death, of whom 14 were cared for on these wards at the time of death.

ASP	MAY	FAL	ITU	HOL	CED
3	5	5	8	2	2

MAP	MAU	KIN	MHDU	KES	BIR
3	4	2	5	1	1

Summary

Rather than having 41 deaths caused by gastrointestinal haemorrhage in this year, there were 20 cases of upper GI bleeding and 2 cases of lower GI bleeding in which the bleeding could be said to have been a material cause of death, or significant contributory factor. These cases were dealt with in a timely and professional manner. I have found no evidence of an undue involvement of any particular ward or doctor in these deaths. The coding of our diagnostic data needs to be improved to prevent false conclusions from being drawn. It would be useful to know what are the denominators for all cases of GI bleeding (according to the same ICD10 criteria) so that we may compare the Trust's percentage mortality from GI bleeding with known national averages.

Appendix 2 : CRC audit (PEB Feb 2010)

KAG	25/12/21 86yr Ca rectum	19/7/09 (emergency) Ant resection Loop ileostomy Repair of ureteric injury	Cx: pneumonia	+3/8/09 pneumonia (mort 11.0% morbidity 83%)
HJS/SPR	1/10/32 76yr Ca rectum ASA3 IHD	3/6/09 (elective) Open anterior resection+loop ileostomy	Redo anastomosis at time of surgery No leak on Xray 5/6/09	+6/6/09 sepsis ?coroners case (mort 7.3% morbidity 7.3%)
JPT	16/7/20 88yr Ca sigmoid	29/10/08 (urgent) Lap converted to open hartmann's procedure for disseminated CRC	One cycle of chemotherapy 13/1/09 emergency admission for abdo distension, vomiting and renal failure	+18/1/09 Liverpool care pathway
Medical admission (DRD?SE)	3/2/44 64yr Ca rectum	28/8/07 Synchronous ca anorectum and rectum with multiple liver 2o RX palliative chemotherapy: No surgery at all	11/12/008 Emergency admission with metastatic disease	+1/01/09 Liverpool care pathway
HJS	19/8/22 Aet 86yr Ca rectum (upper 1/3)	8/4/09 Elective lap anterior resection	13/04/09 Anastomotic leak => Laparotomy Hartmanns procedure	+14/4/09 Multi organ failure on ITU (mort 1.49% morbidity 33.4%)

PEB/HJS	19/12/35 Aet 72yr Ca rectum preop DXT	17/12/08 Elective lap assisted anterior resection (with low midline incision) + loop ileostomy	HAP ITU	+ 24/12/08 (mort 2% morbidity 43%)
SPR (HJS in attendance)	13/7/33 Aet 75yr Inoperable ca rectum Emergency admission) cardiomyopathy	21/9/08 Urgent laparoscopic loop colostomy	HAP Urinary sepsis	+28/10/08 Palliative care
JPT	26/8/25 Aet 83yr Ca rectum (upper 1/3) Pulmonary fibrosis	15/10/08 Elective lap anterior resection + loop ileostomy	HAP Resp failure tx on critical care Pelvic collection Drained radiologically 24/10/08	+7/11/08 Palliative care (mort 3.86% morbidity 58.9%)