Ashford and St. Peter's Hospitals NHS
NHS Trust

Trust Board
25th March 2010

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report brings together the • Dash Board, with associated commentary and analysis • Ward Metrics, with associated commentary and analysis • Quality overview In the March report is the Clinical Effectiveness and Audit review which details our current position in relation to Patient surveys, NICE guidance and national and local audit. Hip fractures remain a key risk area for the Trust and we remain below target in this indicator year to date. There has been an improvement in monthly figures this month, the target is well understood by the trauma directorate and they continue to report actions and progress on addressing this underperformance. The SARI indicates a consistent trajectory for improvement (228 to 170) which reinforces the overall indications that the Trust continues to make improvements on the quality and safety agenda. On the ward metrics MAU is indicating below performance in metrics, and A&E has a high number of complaints. It is recognised that this area is under significant pressure and has been over the winter months. Terri Hess is currently in place as Matron providing senior support to this area. The Trust has received an emotional letter form a patient who was involved in a SUI whilst in hospital, expressing thanks at the open and honest communication that has been apparent form one of our Doctors involved. It was felt this was important to share with the Board in relation to recognising the importance of providing an apology and demonstrating compassion in these cases.
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 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, and affect the organisations reputation.

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:	Review the paper and discuss the contents
Submitted by:	Dr Mike Baxter Medical Director & Caroline Becher Chief Nurse
Date:	25th March 2010
Decision:	To Note

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1 Mortality and Morbidity

1.1. Dr Foster RTM.

The current run of the Dr Foster (RTM) indicates a double green flag for mortality, which is the best grading possible. We share this with Frimley Park and the Royal Surrey Hospital; SASH has a slightly lower green/blue rating. In terms of SMR this equates to values for Frimley of 81.7, RSH 88.5 and SASH 95.9 compared to the ASPH in year figure of 81.7 (in month value 73.7).

There are no new red flag alerts on the RTM run. The only double red alert remaining of the report relates to GI bleeding which has been investigated and presented to the board.

We have now moved on to investigate areas of possible early concern or declining performance. This is marked in the Dr Foster report by a red square which shows a declining performance which has yet to trigger an alert (red bell). The review of red square reports is a way of prospectively identifying potential problems and issues. The Trust is only showing 4 red squares; 2 are related to low volume, highly specialised areas and are not of immediate concern. Focus has therefore initially concentrated on two areas for the Trust to review: Non Hodgkin's lymphoma and a "catch all" diagnostic category of "other lower respiratory tract infection".

The Non Hodgkin lymphoma cases will be audited by Dr Andrew Laurie. This is a relatively rare condition and the numbers of patients involved are extremely small and they often receive shared care across organisations. The data suggest a slightly higher than expected overall mortality although the trend appears to have stabilised. This signal is not at a level to trigger an alert but it does warrant a proactive review.

The category of other lower respiratory tract infections is clearly not a single diagnostic category. Initial review of the data suggests that diagnosis as diverse as heart failure and pneumonia are being captured, as well as patients between 2 days and 90 years of age. This clearly needs work to determine what is included and how the conditions are classified.

It is however an area that warrants further investigation. The LIPS mortality audit suggests that there was a high incidence of nosocomial pneumonia than would have been predicted and a recent audit in medicine has also shown an increased signal for broncho/postural related pneumonia. Further review of these cases had not shown any connection to ward or consultant and no indication of care or treatment issues. I have initiated an audit of the identified cases by the respiratory team. I have also made the CN aware of this data asking her to ensure that the matrons and nurses have heightened vigilance to issues around feeding and postural care. The data will be reported back to the board.

1. 2 Crude mortality rates (CMR)

There has been considerable debate over the use of hospital mortality rates, and a suggestion that Trusts should also keep a view on crude mortality rates and further more should ask questions about the trend in these rates against time. This data should be "sub" analysed to gain assurance that there are no adverse trends in particular areas of care.

The Trusts CMR for emergency admissions in medicine and surgery (which account for over 80% of all emergency admissions) has been compared and trends reviewed.

In Medicine the CMR for emergency admissions in Feb 2010 was 6.4%. When compared with the same month last year (9.4%) this shows a 32% improvement. The trend in figures over the last 12 months indicates a progressive reduction in emergency medical admission CMR.

In surgery the CMR for Feb 2010 was 2.5%. This also shows a small reduction on the 2009 February figure of 2.8%. This represents an 11% reduction. The clear trend of a reduction in CMR across the year, seen in medicine, is not so clear in surgery but the figure is consistent, the numbers of patients are smaller and the baseline CMR is much lower.

The CMR/HMR for emergency admissions by speciality will be reviewed on a regular basis and brought to the Board.

1.3 Trust mortality group

We had a very successful pilot of the trust mortality group. This group is being set up to review all deaths in the Trust on a monthly basis. The group will identify cases of unexpected mortality and ensure that they are recorded through the trusts incident process, are placed in the appropriate directorates mortality review process and where there are serious concerns or identified trends these are investigated at the highest level as quickly as possible.

The pilot has allowed us to refine the process, there is full engagement with all directorates and the group will meet monthly on the 3rd Thursday of each month (before CGC). This goes live in April and the results will be part of the quality report.

1.4 SUI learning and update

The core SUI group met this month, with relevant clinical directors, clinical governance leads, and clinical governance managers to discuss recommendations put forward following SUI investigation. The process worked well and allowed for discussion of recommendations, sharing of learning and plans for dissemination. It was decided that for 'closing the loop' on the SUI process, the core group would plan to meet with the lead investigator, and relevant others, 6 weeks after SUI initiated, in line with planned timescales for completion, to receive the report, discuss recommendations and organise action plan. Progress against plans will be requested by Clinical Governance Committee and will be reviewed at IGAC via the SUI report.

2 Quality update

2.1 Safety alerts

Following on from the Surrey Herald article relating to our safety alerts the outstanding alerts have been reviewed to ensure that progress is continuing, and that the reason for outstanding items is related to ensuring robustness in implementation rather than poor process.

In addition the current process, already under review, has been amended and approved at TEC on 12th March. The new process provides executive input into the decision of allocating leads, and separates out safety alerts from the more easily implemented estates alerts.
The discussion at TEC emphasised the need for clinical input and a focus on closing alerts within the timeframes indicated, whilst still maintaining our emphasis on ensuring robust actions are in place and changes required of a high standard.

The alerts group within the Committee structure has been under review. It has been recognised that this group is ineffective in its current format, and that there is a need to raise the profile of alerts and their completeness to a higher level in the Committee structure. The Non Clinical Risk Management Group (NCRMC), under which the alerts group has reported through the Health and Safety Committee, has agreed to disband this lower level group, and all alerts will be reported directly to NCRMC.

(The NCRMC is currently under review and is proposed to be replaced by a Patient Safety and Risk Committee, proposals are currently going through the relevant channels for approval)

The amended process and structure will be reviewed by IGAC in April to provide assurance that governance requirements are met.

There are 5 alerts that are currently outside their time deadline, all of which have action plans in place. Action plan detail will be provided to IGAC in April.

A list of the current status of safety alerts is attached as Appendix 1

2.2 Being Open

Being Open is a fundamental part of the NHS way of working. There is national policy related to 'Being Open' and it is a principle prioritised by the National Patient Safety Agency. The aim is to promote a culture of openness and honesty between staff, patients and relatives in order to continually improve our services through shared learning and experience.

One of the junior doctors (under our supervision and guidance) sent a letter to the mother involved in a perinatal death , which had been reported to the board as an SUI and an action plan agreed. This demonstrated the level of commitment that the Trust has to address communication, live our ideal of an open and honest organisation and to improve patient perception. The letter received back serves to show how powerful and potential helpful open, honest and empathic interaction can be for both the patient and the medical staff.

"Dear A,
We received the letter today. The letter meant more to me than words can express – I must let B go in peace now. I think it was brave of C to write such a letter and I would be grateful if you could let him know the impact his letter has had on us. Maybe now C can feel a sense of peace with this too; I rather hope he won't forget B, but as he suggested I hope he will use this experience in a positive way by making others aware so that together you can all give the highest level of care. Thank you."

2.3 Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust

The independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust, chaired by Robert Francis QC was released in March. There are a number of recommendations and three related reviews which are all under consideration. A gap analysis is being undertaken.

2.4 Enhancing Quality (EQ) Programme

The Enhancing Quality programme is a CQUIN linked programme set up to deliver improvements in five clinical pathways. It is co-ordinated by the SHA supported by a private US partner who has successfully delivered the programme in the North West.
The clinical pathways and clinical leads are detailed below:

Heart Failure and acute Myocardial infarction	Dr Peter Wilkinson
Pneumonia	Dr Paul Murray
Hips and Knees	Mr Constant Busch

The work involves continually auditing clinical pathways and benchmarking key interventions against best practice as defined by NICE, national guidance and local process. Audit data is analysed by the external partners and results fed back into the organisation, providing a score which relates to how well the clinical pathway is delivered. Results will be benchmarked regionally and will be published as part of the programme. The programme has clear links for utilising audit in a proactive way and links to the Patient Reported Outcome Measures (PROMs) for hips and knees. Clinical teams will be able to consider how effectively their interventions are delivered alongside information from patients about the impact of the operation on their lives.
This is an exciting programme of improvement which should engage clinical staff, deliver improved care for patients, improve our reputation with the public when we demonstrate high performance, and delivers a level of financial benefit through the CQUIN process.
The launch has been attended by Head of Quality and we are currently setting up the programme and receiving training.

2.5 Integrated non clinical and clinical risk

A review of the effectiveness of having two risk groups/committees separating clinical and non clinical risk has been undertaken. In line with best practice a recommendation is being put forward to IGAC to amalgamate these two committees into one Patient safety and Risk committee.
The recommendation has been agreed by TEC and is widely supported by clinical governance managers, and members of the two committees. The new Committee will be a Tier 2 Committee, reporting into IGAC.

The Committee will provide the following improvements to our risk management

- Executive leadership for all risk
- Integrated membership to provide a whole systems approach to risk
- More effective way of working; removing one group and releasing time, providing forum to discuss risk across all areas facilitating better understanding of issues and co-operative working
- Focus for areas of work that currently need higher profile and improved assurance: clinical claims, external reviews and benchmarking, NPSA alerts, partnership risks, and risks identified by corporate functions.

IGAC will be asked to approve the recommendation in April

3 Quality reports

3.1 Clinical Effectiveness and Audit Report

3.1.1 Patient Experience

The hand held device for patient frequent feedback pilot ran for one month and 118 patients provided feedback. The wards included in the pilot were Elm 40 (5 patients declined), Kingfisher 51 (2 patients declined), and MAU 27 (2 patients declined)

Two reports were provided by Picker: one showing a breakdown of responses by ward and an overarching report.
The main areas for improvement were:

- Noise at night from other patients (47%) / hospital staff (17%);
- Help eating meals (of 24 patients needing help only 6 always got the help needed);
- Someone to talk to about worries and fears (33% responded "No")
- Responding to call bell (35% waited more than 5 minutes)
- Doctors washing hands (42% patients responded that they didn't know)
- Matron speaking to patients (70% had not spoken to matron)

Overall results:

- Treated with respect and dignity (91% patients responded, "Yes, always")
- Rate care overall (34% "Excellent"; 47% "very good")
- Doctors and nurses working well together (15% "Excellent"; 41% "very good")
- Recommend to family and friends (75% "Yes, definitely"; 19% "to some extent")

The results for many of the questions exceed those from the Picker 2009 inpatient survey and also when compared to the national averages for e.g. pain, privacy and dignity, confidence and trust in doctors, opportunity to talk to a doctor.
Caution is required in interpretation of this shift as it is known that patients' responses whilst still an inpatient are more positive than when surveyed post discharge at home.

The Patient and Public Engagement group will be discussing the outcomes of the pilot and the benefits and constraints of this method of patient feedback in order to make a recommendation to TEC as to whether the hand held devices should be taken up.

Patient Comment Cards number completed for February is similar to January = 198; top wards: Kingfisher (58), Oak (45), Cedar (20), and Coronary Care Unit (20).

Would you recommend us to family and friends?

Period	Yes, definitely	Yes, probably	No	Total Responses
Feb 2010	82.7%	16.8%	0.5%	185
Jan 2010	91.2%	8.2%	0.6%	171

A&E Postal Patient Survey

500 patients who had attended A&E from October to December were sent a survey in January; 125 patients responded (25%). The aim of the survey was to identify whether changes made to the service as a result of the last A&E national Picker survey in 2008 improved the patient experience.

Areas that worsened were:

- Explaining purpose of medication to take away
- Explaining possible side effects

Improvements were seen relating to:

- Courtesy of the receptionist
- Waiting to be seen by the assessment nurse

- Waiting for pain relief

Areas that remained the same were:

- Waiting to see a doctor
- Doctor or nurse listening carefully to the patient
- Doctor or nurse discussing anxieties with patient
- Explaining treatment or investigation clearly
- Involving patient in decisions about care
- Written information about condition
- Being told about danger signals

Communication and waiting were the main causes for concern. Results are being considered within the Directorate targeted actions being developed.

PROMs (Patient Reported Outcome Measures) – (CQUIN linked)

All patients over the age of 12 undergoing: unilateral hip and knee replacement, groin hernia and varicose vein surgery are invited to complete a pre-op PROMs questionnaire. The PCT is monitoring progress with around 80% compliance anticipated; an actual target has not yet been set. The first, provisional data was released to Trusts in February 2010 and includes the number of pre-operative questionnaires submitted with participation rates calculated using HES data to provide number of procedures. At the moment this data is only available to the NHS; the first formal release of PROMs data is scheduled for 8 April 2010.

The Tables below depict the participation rates for ASPH (cf RSCH, FPH) for the period April to October 2009. Data is provisional and may be incomplete or contain errors for which no adjustments have yet been made.

TOTAL FCEs (number of procedures undertaken)	**Total Pre-op Q1s**	**Participation rate (%)**
ASPH 754	404	53.6%
RSCH 726	385	53.0%
FPH 850	248	29.2%

The Trust response rates for hips and knees continues to do well and for groin hernias there has been significant improvements in submissions for Jan and Feb; however, low levels of varicose vein procedures are undertaken at the Trust and submissions for veins remains very low. The surgical directorate is looking at ways to improve participation rates and also providing patients with information on what to expect post-operatively.

3.1.2 NICE Guidance

Period	Total	Awaiting feedback	Total 2	Not relevant	Relevant	Fully compliant	Partial compliance	Planning / reviewing	Not compliant
Apr-Feb 2009-10	70	5	65	41	24	21	0	1	2
Pre 2009	584	12	572	353	219	190	23	6	0
Total	654	17	637	394	243	211	23	7	2
						86.83%	**9.47%**	**2.88%**	**0.82%**

Partial compliance: 18 clinical guidelines, 1 public health guideline and 4 technology appraisals. Partial compliance generally relates to some of the clinical guidelines (not mandatory) which are

large pieces of work and require adapting to local practice. Non compliance refers to 2 guidelines relating to pain management with responses that: "the British Pain Society has recommended that these guidelines be withdrawn", and "insufficient evidence to offer to patients just yet".
Actions include:

- Review of all queries and updates by members of the Clinical Effectiveness and Audit Group (bimonthly);
- All directorates are requested to provide updates on NICE Guidance compliance when reporting 6 monthly to the Trust Clinical Governance Committee.

No new interventional procedures registered.

Service Development
Ms Shrotria, Consultant Breast Surgeon, has completed a pilot project using a system called OSNA (One Step Nucleic Acid). The device provides a rapid method for analysing lymph nodes to establish whether or not there is malignancy. Compared with results sent to Pathology, there are good, reproducible, results in the 45 lymph nodes that were evaluated. Ms Shrotria is preparing a business case to incorporate this system into routine practice; the benefit is that results are obtained whilst the patient is in theatre and, if positive, auxiliary clearance could be undertaken immediately rather than for the patient to be sent home and be re-admitted to undergo another procedure at a later date. (This technology is recommended by the NHS Technology Adoption Centre).

3.1.3 Clinical Audit

Progress with National Audits

National audit provides valuable comparative information at national and local level for organisations and clinicians. Information is also available to the public about the quality of clinical care provided by NHS services. Participation in national and local clinical audits and outcomes monitoring is the mark of a service that is constantly striving to improve. This aspect of good clinical governance feeds into the Care Quality Commission's Annual Health Check and the Trust is measured through essential standards and the performance framework.

A full list of clinical audit inputs is provided at appendix 2

During 2009-10 the Trust participated in 31 national audits and 5 regional audits.

The National audit of Dementia Care is a new audit beginning in mid March with Dr Nari, Consultant in Elderly Care, leading.

Dr Jonathan Robin, Clinical Director Emergency Services and Dr James Marsh, Renal Consultant, have reviewed the recommendations of the NCEPOD report, “Adding insult to injury”, which audited the care of patients at risk of acute kidney injury. Changes being implemented include: MEWS scoring in A&E, education of all admitting junior doctors, plans for urinalysis to be performed on all emergency admissions, development of a clinical guideline covering the interaction between critical care, non-specialist ward and the renal unit.

Trust Audits

- VTE Audit results February 2010: Of 376 patient records audited 59% patients had a risk assessment undertaken. (Target to be achieved for all patients is 90%, CQUIN).
- Key Priority Audits for each directorate to be completed by end of March; good progress in all areas.

Clinical Audit Registration: for Q4 2009-10, 25 clinical audits were registered.

4 Quality Performance Monitoring

4.1 Dashboard Definitions

The Information team was tasked with compiling a document to explain the content and meaning of the quality section of the balanced scorecard.

The table is made up of 6 columns namely:

1. Description of Measure - self explanatory.

2. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2008/09 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

3. Forecast - the calculation is as follows:

    - For month 7 (Oct) we divide 2008/09 Total by 2008/09 YTD at month 7 to give us the proportion of activity that historically took place as a guide to how much more activity will take place during the rest of 2009/10. This is then multiplied out by the YTD figure for 2009/10. To further account for recent up or downward trends we have divided the average monthly figure for 2008/09 by the most recent 12 months average and multiplied this by the first figure. If we are improving this will better forecast that improvement, conversely if we are getting worse the forecast will reflect this also.

    - The formula is this 1/(SUM(2008_09 up to m7)/SUM(2008_09 Total)) x 2009_10 YTD x (2008_09 Ave/Last 12 Months Ave)

4. Actual - this is the actual achievement for the month.

5. Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, worse than the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an up arrow as higher numbers may be worse and thus will be represented by a down arrow.

6. Year to Date - The sum of the activity from the beginning of the financial year (April).

Line-by-line explanation of each Measure:

1-01 Summated Adverse Report Index (SARI)
This measure is a sum of all the patients who were subject to an adverse event during the month. An adverse event in this case excludes mortality as that is reported 2 months in arrears.

1-02 Standardised mortality (Relative Risk)
This measure is taken from Dr Foster for a limited set of diagnoses standardised across all NHS trusts so that mortality can be compared fairly with other trusts. The data is presented as a relative risk of mortality, a number below 100 means that the trust is better than the average for England, the lower the number the better performing the trust.

1-03 Non-elective mortality (Relative Risk)

The same as 1-02 but filtered for emergency admissions only.

1-04 Mortality 75+ (Relative Risk)
The same as 1-02 but filtered for patients 75 and over.

1-05 Hip fractures treated within 48hrs
The number of patients admitted for hip fractures that have been treated within 48 hours of admission. We specifically look for the time difference in hours between the admission date and the first procedure date.

1-06 Readmissions within 14 days
The percentage of acute patients who have been re-admitted to hospital to the same specialty within 14 days, where the admission method is an emergency admission. We exclude patients who died in hospital, under 16's, maternity, planned and cancer patients.

1-07 Pressure Ulcers/10,000 Bed Days
All patients with a diagnosis of 'L89X' in the first 3 diagnosis fields, criteria supplied by the SHA.

1-08 DVT during admission
All patients with a primary diagnosis of 'I80.1 or I80.2', criteria supplied by the SHA.

1-09 Falls – resulting in significant injury (grade 3+)
Data supplied from Datix by Quality department

1-10 SUIs
Serious Untoward Incidents - Data supplied from Datix by Quality department

1-11 Formal Complaints
Total complaints for the month - Data supplied from Datix by Complaints department.

4.2 Balanced Scorecard

Balanced Scorecard

Quality Section

Table 1

Ashford & St Peter's Hospitals NHS Trust

BALANCED SCORECARD — **Position as at:** **28 Feb 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)	2421	2690	170	▲	▼	▲	2466
1-02	Standardised mortality (Relative Risk)	<100	81.7	73.7	▲	▲	▼	81.7
1-03	Non-elective mortality (Relative Risk)	<100	81.2	71.8	▲	▲	▼	81.2
1-04	Mortality 75+ (Relative Risk)	<100	82.4	72.2	▼	▲	▼	82.4
1-05	Hip fractures treated within 48hrs	100.0%	82.0%	87.80%	▼	▲	▲	83.4%
1-06	Readmissions within 14 days	2.6%	3.0%	2.5%	▲	▼	▲	3.0%
1-07	Pressure Ulcers/10,000 Bed Days	16.5	16.2	11.3	▲	▲	▼	11.2
1-08	DVT during admission	72	91	4	▼	▼	▲	83
1-09	Falls - resulting in significant injury (grade 3)	29	31	1	◄►	▼	▲	30
1-10	SUIs	12	17	1	▼	▲	◄►	16
1-11	Formal complaints	361	392	46	▲	▲	▲	362

1-01 The SARI has shown a continued improvement over this month (228 to 170) and is showing a consistent trajectory for improvement; 3 months of improvement over the last 4 months. This reinforces the overall indications that the Trust continues to make improvement on the quality and safety agenda.1-02 The Dr Foster run has shown a small increase in the months SMR rate from 65 to 73. This still represents a very low mortality rate and comparison between the SMR for emergency admissions and the SMR for patients over the age of 75 does not indicate any hot spot areas. This represents the first increase in SMR rates for the Trust over the last 3 months. The YTD figure of 81, when compared to the current month's figure of 73 suggests that performance over the latter part of the year has improved. Mortality figures are being broken down by medicine, surgery, trauma and gynaecology which represent the major specialities that have emergency patients.

1-05 Hip fracture operative rates within 48 hrs have improved to 87%. This represents the 2nd month of improvement following on from the December nadir figure.
The actual numbers show that;

- 41 patients were admitted with fractures
- 33 were operated on within the 48 hr target
- 3 were medically unfit
- 5 missed the operative target for non medical reasons.

The importance of this target is well understood by the trauma directorate and they continue to report actions and progress on addressing this underperformance. The CGC will receive a further report this month. It is clear that the major issues are theatre

capacity (coping with case "clustering") and the balancing of other emergency activity (which is not the subject of a reported target. The solutions appear to lie with creating flexible capacity and more active case management of the target.

1-06 Readmission rates within 14 days are a highly commendable 2.5%. As reported to the last board this readmission rate is 2% for surgery and 4% for medicine. Further analysis has suggested that there is no pattern in the readmission to days of the week, discharging wards or consultant.
Work is being undertaken to ascertain if there is a pattern for readmission linked to diagnosis, GP/GP practice or destination (home vs. nursing home). This may link with the case management work in progress with the LEC. (Local executive committee). MB will report this to the board next month.

1-08 DVT numbers have reduced considerably (12 to 4); the VTE audits have shown that compliance with VTE treatment is over 60% in the Trust. There have been major improvements in orthopaedics with rates of compliance going from 20% to 65%; the focus is now on surgery. This has been recognised by the directorate and they are actively managing the situation. VTE prophylaxis is now on the corporate risk register. It is also a prominent objective in the WHO stop check list work. Recently the EQUIP day surgery improvement RIE also identified mechanisms to support moving this agenda forward. New drug forms are coming into use this month and it is anticipated that this will have a positive effect on compliance. As expected VTE prophylaxis will be a CQUIN target for 2010/2011 and the Trust is developing direct measures for compliance with VTE which will be captured in future dash boards.

1-11 The target and forecast for complaints has been removed of the dashboard whilst work is in place to clarify the measure and appropriate source of information. This month the Trust had 46 complaints, of which 38 were attributed to a ward environment.

4.3 WQI (Ward Quality Indicators) commentary

It should be noted that the Matrons environment audit has been added as a ward quality indicator.

Initial findings

- Hand Hygiene on the whole is reassuring although 2 areas showed a red score, these were Cedar and Rowley Bristow
- MRSA Bacteraemia; there have been no MRSA Bacteraemia for the month of February
- C Difficile There has been 1 case on Chaucer for the month of February. This is a reduction on last months figures
- Cleanliness scores have improved and the numbers of areas audited have significantly increased.
- There has been an increase in the numbers of complaints in MAU and A/E. This could be a reflection of capacity issues during the bad weather period and the significant pressure the emergency services department have been under during this time. Terri Hess is now acting matron for this area and is spending time understanding processes and practice in this area.

- Pressure ulcer monitoring continues to illustrate a lack of compliance in the return of the compliance monitoring forms. There is a red rating in Surgery, Aspen and ITU for this indicator

- The Matron's environment audit has been to the WQI.

The Trust has now collated three months data; this will be analysed and a report submitted to the Board in April.

The WQI definitions can be found at Appendix 3

The WQI scorecard can be found at Appendix 4

- End -

Submitted by: Caroline Becher Chief Nurse and Dr Mike Baxter Medical Director

Edited by Sarah Johnston, Head of Quality and Integrated Governance

Date: 17th March 2010

5 Appendices

Appendix 1

CENTRAL ALERTING SYSTEM SAFETY ALERTS STATUS REPORT MARCH 2010

Alerts not closed by deadline			
Ref	Title	Date Issued	Deadline
NPSA/2007/16	Early Identification of Failure to Act on Radiological Imaging Reports	05-Feb-07	28-Feb-08
NPSA/2007/18	Actions that can make Anticoagulant Therapy Safer	28-Mar-07	31-Mar-08
NPSA/2008/RRR011	Reducing Risk of Overdose with Midazolam Injection in Adults	09-Dec-08	09-Jun-09
NPSA/2009/RRR012	Reducing Risk of Harm from Oral Bowel Cleansing Solutions	19-Feb-09	07-Sep-09
NPSA/2009/SPN002	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	24-Jun-09	18-Sep-09
Ongoing Alerts			
NPSA/2009/PSA003	Being Open: Communicating with Patients, their Families and Carers Following a Patient Safety Incident	19-Nov-09	23-Nov-10
NPSA/2009/PSA004A	Safer Spinal (Intrathecal), Epidural and Regional Devices - Part A	24-Nov-09	01-Apr-11
NPSA/2009/PSA004B	Safer Spinal (Intrathecal), Epidural and Regional Devices - Part B	24-Nov-09	01-Apr-13
NPSA/2009/PSA005	Safer Lithium Therapy	01-Dec-09	31-Dec-10
NPSA/2010/RRR008	Vaccine Cold Storage	21-Jan-10	21-Jul-10
Alerts Received in February (Open)			
NPSA/2010/PSA001	Safer Use of Intravenous Gentamicin for Neonates	09-Feb-10	09-Feb-11
NPSA/2010/RRR009	Reducing Harm from Omitted and Delayed Medicines in Hospital	24-Feb-10	24-Feb-11
Alerts Closed in February			
MDA/2010/008	Intraocular Lens (IOL) Hydrophilic Acrylic	21-Jan-10	18-Feb-10
MDA/2010/009	T-Piece Connector Incorporated into Various Breathing Systems.	28-Jan-10	11-Feb-10
MDA/2010/010	C-Max U/2 Stair Climbers	01-Feb-10	04-May-10
MDA/2010/011	Servo 300 and 900 Ventilators	08-Feb-10	22-Feb-10
MDA/2010/012	Teligen Implantable Cardioverter Defibrillators	10-Feb-10	10-May-10
MDA/2010/013	Arjo Passive Clip Sling and Arjo Passive Clip Flite Slings	18-Feb-10	18-May-10
MDA/2010/014	Powerheart AED G3 and CardioVive Automatic External Defibrillators	18-Feb-10	18-Mar-10
MDA/2010/015	Powerheart AED G3 Automatic External Defibrillators	26-Feb-10	19-Mar-10

Audit Status Report **Appendix 2**

Mandatory Studies NCEPOD (National Confidential Enquiry into Patient Outcome and Death); CMACE (Centre for Maternal and Child Enquiries)

- NCEPOD – Elective & Emergency Surgery in the Elderly – completed, awaiting report
- NCEPOD – Paediatric Surgery – ongoing submission of data until June 2010 – to date no cases identified for inclusion in this study
- NCEPOD – Peri-operative Care Pilot - Anaesthetic consultants completed the pilot study in December; main study from 1 to 7 March 2010.
- CMACE – National Confidential Enquiry into Head Injury in Children – leads Dr Erin Dawson and Dr Alison Groves, Consultant Paediatricians – ongoing data submission until April 2010.

Continuous Data Collection

Cancer

- HQIP – LUCADA (National Lung Cancer Audit) submitted on monthly basis and extending dataset
- HQIP – NOGCA (National Oesophago-gastric Cancer Audit) being collected manually on spreadsheet (deadline 20 Feb). Online system being developed
- Cancer Waiting Times (CWT) database work to extend dataset; submit monthly

Cardiology 2009 data

- HQIP – British Cardiovascular Intervention Society National Audit (deadline 3 May 2010)
- HQIP – Cardiac Rhythm Management Audit (deadline 3 May 2010)
- HQIP – Heart Failure Audit (deadline 3 May 2010)
- HQIP – MINAP (deadline 31 May 2010).

National Audits 2009-10

Area	Audit Title
Anesthetics	National Obstetric Anesthetic Database (NOAD) through Obstetric Anesthetist's Association
Anesthetics, Critical Care	NCEPOD - Peri-operative Care
Cancer	National Lung Cancer Audit - LUCADA
Cancer	National Head and Neck Cancer Audit - DAHNO
Cancer	National Oesophago-gastric Cancer Audit - NOGCA
Cancer	Cancer Registry
Cardiology	Myocardial Ischaemia National Audit Project (MINAP)
Cardiology	Cardiac Rhythm Management Audit (Pacing/ICD)
Cardiology	BCIS (British Cardiovascular Intervention Society) Angioplasty Audit (PCI, Percutaneous Coronary Intervention)
Cardiology	Heart Failure Audit
Cardiology	National Audit of Cardiac Rehabilitation (NACR)
Care of the Elderly	Audit of National Standards relating to Parkinson's Disease Care
Care of the Elderly, Nursing	Falls Patient Involvement Project
Diabetology	National Diabetes Inpatient Audit
Emergency Services	NAO Hospital Survey - Major Trauma
Emergency Services	AIAU - Head Injury Audit Phase II
Haematology	National Comparative Audit of Blood Collection
Medicine	AIAU - The Pan Thames Renal Audit Group. Audit of management practice of bone mineral parameters in haemodialysis patients.
Medicine, Surgery, Paediatrics	NCEPOD - Parenteral Nutrition Study
Neonatal	AIAU – Perinatal transmission of HIV in England 2002-05 Report - Evaluation Exercise
Nutrition & Dietetics	BAPEN Nutrition Screening Week: Malnutrition in Winter, 12-14 Jan 2010
Occ Health	National audit of depression screening and management of NHS staff on long-term sickness absence by occupational health services: round two
Orthopaedics	National Joint Registry
Orthopaedics	National Hip Fracture Database
Paediatric A&E	CMACE/CEMACH - National Confidential Enquiry into Head Injury in Children
Paediatrics	RCPCH National Neonatal Audit
Paediatrics	National Children's Mapping Exercise 2009 (Gateway reference number: 12836, ROCR/OR/0246)
Paediatrics	AIAU – Perinatal, Paediatric and Young People with HIV baseline audit
Paediatrics, Sp Surgery, Surgery	NCEPOD – Paediatric Surgery Study
Pathology	AIAU - Monitoring exercise: Evaluation of the report and adherence to recommendations. A survey of the financial, developmental and quality mechanisms of perinatal pathology services.
Respiratory	BTS pleural procedures pilot audit
Rheumatology	NAO - Services for people with rheumatoid arthritis
Surgery, Endoscopy, Anaesthetics	NCEPOD - Emergency and Elective Surgery in the Elderly
Vascular Surgery	National Organisational Audit of Vascular Services 2009
Woman's Services	CEMACH: National obesity in pregnancy audit
Woman's Services	UKOSS: Amniotic fluid embolus

Trust Audits

Clinical Audit Registration: for Q4 2009-10, 25 clinical audits were registered.

Directorate	Audit Title
A & E	Audit on Sepsis Management in A&E
A & E	VTE Prophylaxis Audit
A & E	Antibiotic re-audit for A&E
Anaesthetics	Audit on Reasons for Cancellations on the day of surgery in DSU
Anaesthetics	Audit of Blood Tests Performed on patients for Day Surgery
Anaesthetics	Audit of Outcomes following Induced Hypothermia following Cardiac Arrest
Children's Services	Audit on Developmental Care on NICU
Imaging	Audit of Inpatient Ultrasound Requests (abdominal)
Medicine	Audit of GP Awareness of TIA/Stroke
Nursing	Inpatient Audit Cancer Services
Nursing	Audit on Mouth Care in Palliative Care Patients
Orthopaedics	Allogenic transfusion in THR - a closing loop audit
Orthopaedics	Peri- & post-op pressure care and mobilisation in fractured neck of femur patients
Orthopaedics	Audit on Effectiveness of Haematology Guidelines for Low Molecular Weight Heparin Treatment
Pharmacy	Pharmacy interventions in Orthopaedic wards
Pharmacy	Audit on intravenous antibiotic prescribing
Sp Surgery	Outcome of corneal endothelial cell transplant surgery
Sp Surgery	Review of Pterygium excision results
Sp Surgery	Outcome of Botulinum Toxin injections in strabismus
Sp Surgery	Nurse led l & c chalazian clinic
Surgery	Surgical Consent Audit
Surgery	Inappropriate TWR colorectal referrals
Therapies	BAPEN Nutrition Screening Week
Women's Health	Obesity audit
Women's Health	Audit on Laparoscopic Surgery for Endometriosis as Daycase

WQI definitions **Appendix 3**

1 Hand Hygiene Compliance
Audits of members of staff cleaning/decontaminating their hands between procedures

2 Number of MRSA bacteraemia
MRSA isolated in a blood culture therefore present in the patient's blood stream

3 Number of C Diff cases (Hospital post 72 hours)
Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.

4 Saving Lives
The compliance measurements that indicate the use of High Impact Interventions in key clinical procedures which aims to decrease the risk of infection

5 Central Lines
Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections

6 Urinary Catheter
Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections

7 Cleanliness
Audit undertaken by facilities on a monthly basis related to cleaning standards

8 Matrons Environmental Audit
Matrons environmental audit undertaken weekly of the ward and department and the mean taken for the month

9 Pressure Ulcer Prevention
2 are audited: Compliance with the monitoring return, and Actual Grade of Pressure Ulcer

10 Falls
Total number of falls and number of falls resulting in significant injury i.e. graded 3, 4 or 5
Data supplied from Datix system via Quality department

11 Complaints
Actual number of complaints registered to the clinical area in reporting month. Data supplied from Datix system via Complaints department

12 Mediation Errors
Number of errors reported via incident reporting. Data supplied from Datix system via Quality department

Ashford and St Peter's Ward Quality Scorecard - February 2010

N/S: No submission

		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Saving Lives						Cleanliness	Matron Environment Audit	Pressure Ulcer Prevention					Patient Falls		Complaints	Medication Errors
					Central Lines Insertion	Central Lines After Care	Urinary Catheter Insertion	Urinary Catheter After Care	Peripheral Cannula	Peripheral Cannula After Care			Compliance with monitoring of Pressure Ulcer	Hospital Acquired Grade 1	Hospital Acquired Grade 2	Hospital Acquired Grade 3	Hospital Acquired Grade 4	Number of falls	Resulting in Injury		Administration
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	=100%	<=3	<1	<1	<1	=0	=0	=0	=0
		89% - 80%			94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	84% - 75%	89% - 80%	99% - 76%	1- 2	1- 2	1- 2	1- 2				
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<=75%	>3	>=3	>=3	>=3	>=1	>=1	>=1	>=1
Medicine 1, 2, 3	ASPEN	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	88 %	100 %	25 %	1	0	0	0	1	0	3	0
	CCU	97 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	87 %	100 %	100 %	0	1	0	0	0	0	0	0
	BIRCH	100 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	85 %	100 %	100 %	1	0	0	0	3	0	0	0
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	85 %	100 %	100 %	1	1	0	0	2	0	0	0
	HOLLY	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	91 %	97 %	100 %	0	1	0	0	1	0	1	1
	CEDAR	74 %	0	0	N/A	N/A	100 %	100 %	70 %	80 %	94 %	94 %	100 %	0	1	0	0	1	0	1	0
	MAY	97 %	0	0	N/A	N/A	N/A	100 %	100 %	100 %	96 %	86 %	50 %	0	0	0	0	0	0	1	0
	MAPLE	95 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	94 %	100 %	0	0	0	0	11	1	0	0
	COLPOSCOPY	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0
Ashford	CHAUCER	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	93 %	94 %	100 %	0	0	0	0	4	0	0	0
	WORDSWORTH	80 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	94 %	100 %	0	0	0	0	2	0	0	0
	FIELDING	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	94 %	75 %	0	0	0	0	3	0	0	0
	DICKENS	100 %	0	0	N/A	N/A	100 %	N/A	100 %	N/A	99 %	93 %	50 %	0	0	0	0	1	0	0	0
Orthopaedics	ELM	96 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	98 %	88 %	100 %	1	0	0	0	3	0	2	0
	JUNIPER	96 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	100 %	91 %	100 %	0	2	0	0	5	0	0	1
	ROWLEY BRISTOW	58 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	83 %	N/A	N/A	N/A	N/A	N/A	0	0	2	0
Surgery	KINGFISHER	98 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	93 %	93 %	50 %	0	0	0	0	1	0	1	0
	FALCON	94 %	0	0	N/A	N/A	100 %	100 %	75 %	67 %	95 %	91 %	50 %	0	1	0	0	0	0	0	0
	KESTREL	100 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	90 %	N/A	50 %	0	0	0	0	0	0	0	0
	SDU	94 %	0	0	100 %	90 %	N/A	100 %	80 %	90 %	93 %	91 %	50 %	0	0	0	0	0	0	0	0
	ADMISSIONS LOUNGE	98 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	2	0
	HERON	92 %	0	0	N/A	N/A	100 %	100 %	100 %	80 %	95 %	86 %	100 %	1	2	N/A	N/A	0	0	0	0
	MAXFACS CLINICS ASH	N/S	0	0	N/A	N/A	N/A	N/A	N/A	N/A	98 %	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0
Emergency Services	MAU	100 %	0	0	N/A	N/A	100 %	N/A	30 %	80 %	97 %	82 %	0 %	0	0	0	0	0	0	5	0
	SAU	80 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	93 %	90 %	100 %	0	1	0	0	0	0	1	0
	A&E	95 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	78 %	N/A	N/A	0	0	0	0	0	0	7	0
Paediatrics	OAK	94 %	0	0	N/A	100 %	N/A	N/A	100 %	N/A	93 %	96 %	N/A	0	0	0	0	0	0	0	0
	ASH	86 %	0	0	N/A	100 %	N/A	N/A	100 %	N/A	91 %	86 %	N/A	0	0	0	0	0	0	0	1
	PAED A/E	96 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	91 %	93 %	N/A	0	0	0	0	0	0	0	0
	NICU	91 %	0	0	N/A	N/A	N/A	N/A	N/A	100 %	89 %	89 %	N/A	0	0	0	0	0	0	0	0
Theatres	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	94 %	N/A	N/A	0	0	0	0	0	0	1	0
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	100 %	99 %	86 %	N/A	0	0	0	0	0	0	0	0
	DSU SPH	100 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	97 %	N/A	N/A	0	0	0	0	0	0	0	0
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	91 %	95 %	N/A	0	0	0	0	1	0	0	0
Imaging / Endoscopy	ENDO	99 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	100 %	99 %	N/A	0	0	0	0	1	0	2	0
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	100 %	N/A	0	0	0	0	0	0	0	0
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	93 %	100 %	N/A	0	0	0	0	0	0	3	0
Critical Care	ITU	80 %	0	0	100 %	100 %	100 %	100 %	100 %	75 %	90 %	92 %	75 %	0	0	0	0	0	0	0	0
Maternity	JOAN BOOKER	99 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	96 %	87 %	N/A	N/A	N/A	N/A	N/A	0	0	0	1
	LABOUR	88 %	0	0	N/A	N/A	100 %	80 %	N/A	90 %	N/A	90 %	N/A	N/A	N/A	N/A	N/A	0	0	1	0
	LABOUR THEATRES	N/S	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0
Outpatients	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	95 %	N/A	N/A	N/A	N/A	N/A	0	0	1	0
	OUTPATIENT SPH	99 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	78 %	N/A	N/A	N/A	N/A	N/A	2	0	2	0
Ophthalmology	EYE CLINIC ASH	95 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	2	0
	EYE CLINIC SPH	95 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	98 %	N/A	N/A	0	0	0	0	0	0	0	0
	EYE WARD ASH	95 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0