Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
26 May 2016

AGENDA ITEM NUMBER	6.2	
TITLE OF PAPER	Quality Report	
Confidential	**NO**	
Suitable for public access	**YES**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
None.		
STRATEGIC OBJECTIVE(S):		
Best outcomes	✓	
Excellent experience	✓	
Skilled & motivated teams	✓	Safety is improved when teams actively engage with care quality improvement.
Top productivity	✓	Performance is improved with effective pathways and safe care.
EXECUTIVE SUMMARY		
	This report summarises clinical quality data for April 2016. 96 in-hospital deaths exceeds limit of 90, with the SHMI and RAMI as expected. MES[1] mortality reviews of 55% are low, a Mortality Surveillance Group will be set up. Emergency 30-day readmissions of 13.3% exceeds the stretch target of 12.5% by Q4. Direct stroke unit admission performance of 65.6% is under the 90% target despite a recovery trajectory and reflects breaches due to disruption in the stroke pathway. Medication errors per 1000 bed days of 3.21 exceeds the limit of 2.01. Improvement actions from an internal audit review of medicines management are being progressed. ED reconfiguration and ambulatory pathway changes aim to raise ED FFT satisfaction. 32 Best Care audits: 7↑, 17 retained level and 8↓ with ED and Swan dropping to 0. Medication safety thermometer medicines reconciliation rates within 24 hours at 50% is below national average of 77.9% and the lack of 7 day Pharmacy may impact this. Complaints response to timescale is 82% with average response times of 32 days for grades 1&2 and 51 days for grades 3&4; volume by due date is under review. Maternity Safety Thermometer data was not submitted, the divisional process is to be reviewed.	

[1] Diagnostics, Therapies, Trauma & Orthopaedics (DTTO); Emergency Department (ED); Medicine and Emergency Services (MES); Theatres, Anaesthetics, Surgery & Critical Care (TASCC); Women's Health and Paediatrics (WH&P).

RECOMMENDATION:	Review the paper and seek additional assurance as necessary.
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	Y
Patient impact	Y
Employee	Y
Other stakeholder	Quality priorities are set following consultation with internal and external stakeholders.
Equality & diversity	All of our services give consideration to equality of access, taking into consideration disability and age and all matters are dealt with in a fair and equitable way regardless of the ethnicity or religion of patients.
Finance	Not applicable
Legal	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Compliance with these regulations is a legal requirement and failure to do so could affect the Trust's Care Quality Commission registration and NHS Improvement licence.
Link to Board Assurance Framework Principle Risk	Vulnerable groups care is part of BAF risk 2.2.
AUTHOR NAME/ROLE	Dr Erica Heppleston, Assistant Director Regulation and Improvement
PRESENTED BY DIRECTOR NAME/ROLE	Dr David Fluck, Medical Director and Mrs Heather Caudle, Chief Nurse
DATE	26 May 2016
BOARD ACTION	Assurance.

1.0 Background and Scope

The Board receives assurance and information on key clinical quality and improvement measures from the performance dashboard in Appendix 1. Results by exception by either the ratings below or significance are summarised in Section 1.1.

Rating table

Delivering or exceeding target		Improvement month on month
Underachieving target		In line with or just below last month
Failing target		Below target

1.1 Performance by exception

Deaths and mortality reviews
In-hospital deaths of 96 exceed the limit of 90. The SHMI and RAMI are in line with expectations. Mortality reviews in MES are low at 55% and deaths will be reviewed in quarterly mortality meetings. The Chief of Patient Safety is to implement a Mortality Surveillance Group to review the mortality review process.

Emergency 30-day readmissions
Emergency 30-day readmissions of 13.3% is above the stretch target of 12.5% by Q4.

Direct stroke unit admission
Direct stroke unit admission performance of 65.6% is under the 90% target despite a recovery trajectory and reflects breaches due to disruptions in the stroke pathway.

Medication errors per 1000 bed days
Medication errors per 1000 bed days of 3.21 exceeded the threshold of 2.01. Pharmacy is actively promoting both reporting and investigation of incidents, along with improvement initiatives. Actions from the recent internal audit review of medicines management are to be progressed through training and localised feedback, supported by audits.

Sepsis screening
Sepsis screening data is pending; audits are undertaken in arrears and reported quarterly.

FFT satisfaction score
ED FFT satisfaction score significantly improved this month from 77.1% last month to 84.5% this month. High attendances continue to impact patient experience. The recovery programme includes reconfiguration of the ED, expanded consultant cover, and further development of ambulatory care and direct GP referral.

Patient safety alerts
1 stage 2 alert was received on *Patient Safety Incident Reporting and Responding* following transfer of statutory functions from NHS England to NHS Improvement. Whilst underlying reporting processes are unchanged nationally the Trust is reviewing to ensure compliance.

Best care audits
32 wards were audited in April 2016 within Best Care: 7 wards/areas improved, 17 retained their level, and 8 locations decreased accreditation level of which the most significant were ED which decreased to level 0 from level 2 and Swan which decreased to level 0 from level 1. Please see Appendix 2 for the results table.

Complaints performance
Whilst 82% of complaints were issued in accordance with agreed response timescale the average response time is 32 days for grades 1 & 2 and 51 days for grades 3 & 4. Complaints volume by due date is being monitored by the Head of Patient Experience and Involvement to address the future trajectory of cases due out.

PHSO[2] cases
3 new cases were opened at the PHSO of which 1 was from TASCC and 2 from MES. 1 closed case was not upheld and 1 closed surgical case was partially upheld reflecting failings in communication and the provision of patient information for which improvements have been made.

Claims
5 new claims were reported: 1 in MES, 1 for DTTO and 3 for WH&P. 2 claims were intimated with 1 for WH&P and 1 for DTTO.

2.0 Strategic issues and options

Quality measures are those deemed strategically important to the Trust.

[2] Parliamentary and Health Service Ombudsman

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Appendix 1 - Quality Performance Dashboard April 2016

Table 1: Quality Performance Dashboard 30 April 2016

REF	Quality Scorecard Measures	Outturn 15/16	Monthly Target	Annual Target	Mar	Apr	6 month trend	YTD 16/17	Current month commentary
1.01	In-hospital SHMI	64	<72	<72	63	64		64	Mortality indices in line with expectation.
1.02	RAMI	62	<70	<70	54	61		61	Mortality indices in line with expectation.
1.03	In-hospital deaths	1139	90	<1082	112	96		96	In-hospital deaths for the month exceed the limit. As below the Chief of Patient Safety is to implement a Mortality Surveillance Group to review the mortality review process.
1.04	Proportion of mortality reviews (data 1 month in arrears)	56%	>90%	>90%	63%	58%		56%	Completion rates were WH&P 100%, TASCC 79%, MES 55% and DTTO 33%. The 2 outstanding DTTO mortality reviews will be discussed at the May QUASH half day. MES has implemented quarterly mortality meetings to review deaths in more depth and a Trustwide Mortality Surveillance Panel will be implemented as an improvement per our gap analysis against the findings of the Mazars Report. (The Mazars Report from December 2015 is an independent review of deaths of people with a Learning Disability or Mental Health problem at Southern Health NHS FT).
1.05	Number of cardiac arrests not in critical care areas	56	-	-	3	5		5	There were 5 cardiac arrests in non-critical care areas in April. A national TEP (Treatment Escalation Plan) is due from the Resuscitation Council in mid 2016 so our implementation of TEP is deferred until this guidance is released.
1.1	Methicillin Resistant Staphlococcus Aureus (MRSA) -	0	0	0	0	0		0	On track with zero cases.
1.1	C. Difficile (hospital only)	15	1.4	17	2	0		0	On track with zero cases.
1.1	Falls (per 1000 beddays)	2.59	2.46	2.46	2.49	2.05		2.05	Falls rate remains below target and the risk assessment is now within the Adult Nursing Assessment. The falls reduction plan is continuing.
1.1	Pressure ulcers (per 1000 beddays)	2.08	1.98	1.98	2.17	1.91		1.91	The Trust is aiming for < 18.2 hospital acquired stage 2 pressure ulcers (PUs) monthly (a 15% reduction) with no avoidable stage 3 PUs or stage 4 PUs. There were 21 hospital acquired stage 2 PUs in April including Swan (6), Swift (4) and ITU (3). No stage 3 or 4 ulcers arose. Ward managers are to prepare action plans.
1.10	Readmissions within 30 days - emergency only	13.1%	12.5%	12.5% by Q4	14.0%	13.3%		13.3%	Readmissions within 30 days continues to be above the stretch target limit.
1.11	Stroke patients (% admitted to stroke unit within 4 hours)	65.0%	90%	90%	73.8%	65.6%		65.6%	Direct admission to the stroke unit continues to be a challenge and breaches were due to disruptions in the stroke pathway. We have yet to reach the 90% target despite a trajectory to recover this.
1.1	Medication errors (rate per 1000 beddays)	2.92	2.01	2.01	2.74	3.21		3.21	The Trust continues to promote reporting and investigation of medication errors. Internal audit has recently undertaken a review of medicines management and improvement actions are to be progressed including training and localised feedback.
1.1	Sepsis screening audits - % of eligible patients that were screened	70.5%	90%	90%					Data pending. Audits undertaken in arrears and reported quarterly.
1.1	Sepsis antibiotic administration audits - % of eligible patients that had antibiotic administration within 1 hour	71.6%	90%	90%					Data pending. Audits undertaken in arrears and reported quarterly.
3	Serious Incidents Requiring Investigation (SIRI) reports overdue to CCG	8	-	-	8	7		7	The Safety Team continue to actively progress completion of overdue SIRI reports.
3	Serious Incidents Requiring Investigation (SIRI) reports submitted to CCG	116	-	-	11	7		7	As above.
3.07	Friends and Family Satisfaction Score - Inpatients including Daycase	96.2%	95%	95%	96.0%	96.0%		96.0%	Ward level feedback and improvement initiatives are continuing.
3.08	Friends and Family Satisfaction Score - Accident and Emergency including Paediatrics	84.3%	87%	87%	77.1%	84.5%		84.5%	Whilst attendance levels continue to impact patient experience ED satisfaction rate improved considerably this month. Our refreshed recovery programme includes ED reconfiguration, expanded consultant cover, developing ambulatory care and direct GP referral. UCC patient experience will be captured to guide improvements.
3.1	Friends and Family Satisfaction Score - Maternity Touch Point 2	96.3%	97%	97%	100.0%	94.4%		94.4%	Service users continue to provide favourable feedback. The return rate is lower than anticipated due to the inability to analyse a few damaged forms which were not machine readable.
3.09	Friends and Family Satisfaction Score - Outpatients	0.9	92%	92%	95.5%	95.8%		95.8%	The Trust is continuing its ongoing Outpatients service improvement plan and feedback remains high.
3.10	Follow-up complaints - complaint rate per rolling 12 month average	8.3%	<10%	<10%	8%	5%		5%	In April 5% of complaints were follow-ups from 2 cases. One case was MES and the other was a complex Corporate complaint. Performance is well within limits.
3.11	Dementia case finding	96%	>90%	>90%	94%	94%		94%	94% of patients eligible for screening were screened which exceeds the target.
3.11	Dementia diagnostic assessment	99%	>90%	>90%	100%	100%		100%	All eligible patients received a diagnostic assessment.
3.11 c	Dementia referral	87%	>90%	>90%	94%	100%		100%	All patients eligible for referral to specialist services, e.g., Psychiatric Liaison, the Trust Dementia Team, or a General Practitioner, were referred.

REF	Reference items	Target description & limit		Mar	Apr	6 month trend	YTD 16/17	Current month commentary
1	Overdue safety alerts	<1 overdue	<1	0	0		n/a	n April a stage 2 alert was received on Patient Safety Incident Reporting and Responding following transfer of statutory functions from NHS England to NHS Improvement. Whilst the underlying reporting processes and policies are unchanged the Trust is ensuring it meets the alert requirements and a review is underway.
2.1	NHS Safety Thermometer - % of patients on spot day with new harms	< National av.	2.23%	1.10%	0.23%		0.23%	New harms of 0.23% were below the national average of 2.23%.
2.2	NHS Safety Thermometer - % of patients on spot day with new CAUTIs	< National av.	0.31%	0%	0.00%		0.00%	There were no new CAUTIs on the April spot day.
2.3	NHS Safety Thermometer - % of patients on spot day with new pressure ulcers	< National av.	1.01%	0.88%	0.00%		0.00%	There were no new pressure ulcers on the April spot day.
2.4	NHS Safety Thermometer - % of patients on spot day with falls with harm	< National av.	0.57%	0.00%	0.00%		0.00%	There were no falls with harm on the April spot day.
2.5	NHS Maternity Safety Thermometer - % of patients with combined harm free care (physical harm and women's perception of safety)	> National av.	70.30%	75.0%	0.0%		0.0%	The Maternity Safety Thermometer was not submitted in April 2016 and the submission process is to be reviewed by the Division.
2.6	NHS Medications Safety Thermometer - % of patients with reconciliation started within 24 hours of admission	> National av.	77.90%	48.05%	50.00%		58.0% *	*YTD actual is rolling median in line with national charts. Patients with reconciliation started within 24 hours of admissions at 50.0% was lower than the national average of 77.9% and may reflect absence of a 7 day pharmacy service.
2.7	NHS Medications Safety Thermometer - % of patients with an omission of a critical medicine in the last 24 hours	< National av.	6.45%	7.79%	2.94%		2.9% *	*YTD actual is rolling median in line with national charts. Patients with an omission of a critical medicine at 2.94% were lower than the national average of 6.45% and this is an improvement this month.
3	Best care audits undertaken this month	Level 3 ward count	-	-	17	-	n/a	32 wards were audited in April 2016. 7 wards/areas increased their accreditation levels; of note were Cedar, DSU and SDU all of which increased to level 3 from level 1. 17 wards retained their previous accreditation levels, including ITU, HDU, Joan Booker, Labour Ward and Maple. 8 wards/areas decreased in accreditation levels; of these, most significant were ED which decreased to level 0 from level 2 and Swan which decreased to level 0 from level 1.
4	WOW awards	-	n/a	61	75		n/a	TASCC received 29 WOW nominations and MES received 25. WH&P had 11 nominations and DTTO had 6. Workforce Planning & Intelligence had 3 proposals and Patoral Care received 1.
5.1	Complaints % Responded to timescale as agreed with complainant	Timeliness	>95%	95.0%	82.0%		82.0%	In April 14 out of 17 complaints were issued within agreed timescale. Of the exceptions 2 were complex Paediatrics cases and 1 was a MES case. The low volume of 17 responses issued is an indication that cases are being extended beyond 1 month and this is being monitored.
5.2	Complaints % Responded to timescale (Grade 1 & 2 in 25 days)	Timeliness	No target	30.0%	27.0%		27.0%	3 from 11 complaints were issued within 25 days. Complaints volume by due date is being monitored by the Head of Patient Experience and Involvement to address the future trajectory of cases due out.
5.3	Complaints % Responded to timescale (Grade 3 & 4 in 35 days)	Timeliness	No target	50.0%	17.0%		17.0%	1 from 6 complaints were issued within 35 days. As above a complaints trajectory is being reviewed currently.
5.4	Complaints mean response time in days: variance from 25 day target (Grade 1 & 2)	Responsiveness	No target	5	7	-	7	On average this complaint grade takes 32 days to issue, up from 30 days last month. The earliest response was on the 25th day and the longest took 66 days. As above this is under review.
5.5	Complaints mean response time in days: variance from 35 day target (Grade 3 & 4)	Responsiveness	No target	18	16	-	16	On average this complaint grade takes 51 days to issue, improved from 53 days last month. The earliest response was on the 35th day and the longest took 76 days. As above this is under review.
5.6	PHSO (Ombudsman) cases open - total number	Response quality	No target	6	7			There are currently 7 open cases with the PHSO. Case openings and closures are outlined below.
5.7a	PHSO (Ombudsman) cases closed but not upheld	Response quality	No target	0	1		1	1 case was closed and not upheld by the PHSO.
5.7b	PHSO (Ombudsman) cases closed and partially upheld	Response quality	No target	0	1		1	1 surgical case was closed this month and was partially upheld reflecting failings in communication and the provision of patient information. Improvement actions have been made.
5.7c	PHSO (Ombudsman) cases closed and upheld	Response quality	No target	0	0		0	No cases occurred this month.
5.8	PHSO (Ombudsman) new cases received	Response quality	No target	0	3		3	The TASCC case was from 1 year ago and 1 MES case was from 15 months previously. The 2nd MES case arose 2 years ago with a follow-up complaint in progression until late 2015.

Appendix 2 – Summary of Best Care Audit Results for April 2016

Results.

32 wards/areas were audited in April 2016. 7 wards/areas increased their accreditation levels; of note were Cedar, DSU and SDU all of which increased to level 3 from level 1. 17 wards retained their previous accreditation levels, including ITU, HDU, Joan Booker, Labour Ward and Maple. 8 wards/areas decreased in accreditation levels; of these, most significant were ED which decreased to level 0 from level 2 and Swan which decreased to level 0 from level 1. In April 2016, 72% of wards achieved accreditation levels of 2 or above compared with 80% in January and 56% in October 2015.

Quarterly Best Care Surveillance Panels.

The format of the panel meetings from January 2016 onwards will include attendance by the surveillance panel at divisional clinical governance meetings and ward visits for wards achieving level 0 or 1 to encourage engagement of front line staff

Table 2: Best Care Audits Wards & Areas April 2016

Wards/areas	Previous results	October 2015	January 2016	April 2016	Trend
Admissions Lounge	N/A – first audit in October 2015	3	3	3	→
AMU	N/A – first audit in January 2016	N/A – first audit in January 2016	2	2	→
Ash	2	0	2	2	→
Aspen	2	1	2	2	→
BACU	2	1	2	1	↓
Cedar	2	3	1	3	↑
Chaucer	3	3	3	Not done	
Cherry	N/A – first audit in January 2016	N/A – first audit in January 2016	2	3	↑
Dickens	2	3	2	3	↑
DSU	1	2	1	3	↑
ED	3	1	2	0	↓
Falcon	2	1	2	1	↓
Heron	2	1	2	1	↓

HDU	3	3	3	3	→
Holly	3	0	3	3	→
ITU	3	3	3	3	→
Joan Booker	3	3	3	3	→
Kingfisher	2	1	2	1	↓
Labour Ward	2	2	3	3	→
Maple	1	3	3	3	→
May	3	3	2	2	→
NICU	2	3	3	3	→
Oak	3	3	2	3	↑
OPD ASH	3	1	3	3	→
OPD SPH	2	Not done	3	3	→
Paeds ED	2	2	2	1	↓
SAU	2	0	2	2	→
SDU	3	1	1	3	↑
Swan	1	1	1	0	↓
Swift	1	0	3	2	↓
Theatres ASH	1	2	2	3	↑
Theatres SPH	2	1	1	1	→
Urology	N/A – first audit in October	2	1	1	→