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

TRUST BOARD
27th October 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for September 2011.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Quality Report provides assurance that Quality indicators are being monitored and assessed and that mitigating actions are being put in place as required.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience is occurring. Stakeholder views have been sought as part of the Quality Account development process.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health Act (2009) and failure to do so could affect the Trust's registration and Monitor Licence.
The Trust Board is asked to:	Review the paper; discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse
Date:	October 2011
Decision:	For Noting

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

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1 Quality Performance Monitoring

1.1 Dashboard Definitions

The table is made up of 7 columns namely:

1. Description of Measure - self explanatory.

2. Outturn 10/11 – this denotes the performance / outcome for last financial year 2010 /11 and is sourced from Dr Foster.

3. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2010/11 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

4. Forecast - the calculation is as follows:

   - For month 6 (September we divide 2011/12 Total by 2011/12 YTD at month 6 to give us the proportion of activity that has taken place as a guide to how much more activity will take place during the rest of 2011/12. This is then multiplied out by the YTD figure for 2011/12. To further account for recent up or downward trends we have divided the average monthly figure for 2011/12 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 6/(SUM(2011_12 up to m7)/SUM(2011_12 Total)) x 2011_12 YTD x (2011_12 Ave/Last 12 Months Ave)

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

6. 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.

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

1.2 Commentary on Quality and Safety Balanced Scorecard

Table one: Quality Performance Dashboard

BALANCED SCORECARD

Position as at: **30 Sep 2011**

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

	Patient Safety & Quality	Outturn 10/11	Annual Target 11/12	Annual Forecast 11/12	Sep Actual	Performance			YTD 11/12
						Jul	Aug	Sep	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	**90**	**76.6**	▼	▲	▲	**99***
1-02	Crude mortality	1.60%	1.60%	**1.58%**	**1.36%**	▼	▲	▲	**1.54%**
1-03	MRSA (Hospital only)	5	4	**4**	**1**	◄►	▼	◄►	**2**
1-04	C.Diff (Hospital only)	36	33	**30**	**1**	▼	▼	▲	**12**
1-05	Mortality from C.Diff (All cases)	10.3%	6.3%	**8.8%**	**0.0%**	▲	▼	▲	**17.1%**
1-06	Mortality from VTE	0.4%	0.35%	**0.00%**	**0.0%**	◄►	◄►	◄►	**0.0%**
1-07	Mortality from Hip fractures	4.8%	4.6%	**4.5%**	**2.4%**	▼	▼	▲	**4.3%**
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)			**60.0%**	**54.0%**	▲	▼	▲	**55.5%**
1-10	Formal complaints	360	320	**380**	**47**	◄►	▼	▼	**219**
1-11	SUIs	14	14	**20**	**1**	▲	◄►	▲	**13**
1-12	Falls - resulting in significant injury (grade 3)	16	14	**14**	**1**	▼	◄►	▲	**5**
1-13	Hip fractures treated within 36 hrs	93.0%	85%	**96%**	**100.0%**	▲	▼	▲	**94.8%**
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	**1590**	**133**	▼	▲	▼	**811**
1-15	Average Bed Occupancy-Actual beds	94%	94%	**94%**	**92%**	▲	▼	▲	**92%**
1-16	Average Bed Occupancy-Planned beds	Work in progress							

***Source from June Dr Foster**

1.2.1 Dr Foster has applied a new calculation to all trusts' SMR. A value of 100 represents the level of expected mortality. The Trust's value of 76.6 represents an excellent performance. More detailed information on the Trust's national position will be available shortly. The Trust has been contacted by Dr Foster and informed that ASPH has performed at a very high level, indeed has performed at the expected level or above on all but 3 parameters. These are hospital acquired pneumonia post stroke, % stroke patients discharged home and the Trust's response to NPSA alert closure. The first 2 items are clinical issues with acquired pneumonia potentially reflect clinical care. These observations will be reviewed. The Trust's position on the closure of NPSA alerts has been discussed and approved by the Board at a previous meeting.

1.2.2 The Trust's CMR of 1.36% is an improvement on last month's value and is discussed in more detail elsewhere.

1.2.3 The Trust's C.Diff performance is still impressive with an in month figure of 1 case, with a ytd number of 12. The Trust is predicted to deliver under the Trust target of 30.

1.2.4 The Trust is reporting a second MRSA case. This actually reflects a second positive sample in the same patient and does not reflect a true second case. The Trust is contesting the attribution of this "second case" to the Trust's figures. The Trust remains confident in its HAI processes and performance.

1.2.5 The Trust has recorded a 100% delivery of the fractured neck of femur operative target. The Trust's mortality is 2.4% which as has been previously represents the lowest rate in the country. The Trust is also recording rates of approaching a 100% for time to review by orthogeriatrician, falls assessment and bone health assessment. This testifies to the high quality of the whole service with clear benefits to the patient.

1.3 Quality Account Dashboard

The Quality Account Dashboard (Appendix 1) provides a visual high level summary of the Trust's performance in Q1 and Q2 against plans set in the Quality Account 2010/11. Overall performance is better than trajectory and reflects the wide variety of improvement work underway across the Trust. Where indicators are not being met action are in train to improve performance and progress will be reported again at the end of Q3.

Improving our Patient Experience
Priority 1 – To Provide safe, high quality discharge for patients

Patient Satisfaction
The Net Promoter Score (NPS) is off-plan YTD (- 34.5).

National Patient Survey
This is an annual measure being sampled currently.

Discharge Related Complaints.
A strong result against this trajectory which can be attributed in part to the I*mproving Discharge Management* programme.

Priority 2 - To provide high quality experience relating to nutrition and hydration
Essence of Care Nutritional Audit. The Nursing Staff have redesigned and completed the Best Care audits. They have collected the data and results will be ready in time for the next reporting cycle.

Maintaining High Safety Standards
Priority 3 – To provide confidence and reassurance for patients on infection and other preventable infections
All indicators in this category are on, or better than, trajectory.

Priority 4 - To improve the quality of nursing care by setting and measuring a number of nursing indicators

Falls
Strong performance (20-30% better than plan) against these indicators validates the work of the Falls Group and the Falls Lead Nurse in conjunction with ward and clinical teams.

Prevention of Pressure Ulcers (hospital acquired)
Another success story as the data indicates the Trust YTD has outperformed the trajectory on preventing pressure ulcers by 10%.

Achieving High Quality Clinical Care
Priority 5 – To reduce the hospital emergency and elective readmission rate

Readmission in 28 days – Elective
This is significantly off plan at 54.5%.

Readmission in 28 days – Emergency
This is 3.5% off trajectory.

Work to improve these indicators is underway through a number of programmes mostly sitting within the Improving Unscheduled Care Programme and the Home from Hospital Project. Work to understand and address the elective rate of re-admissions in more detail is underway.

Priority 6 – To improve the effectiveness of care for those with conditions most commonly associate with death in hospital and hear failure
SMR for Heart Failure
Very slightly off plan (by 0.029%). The Enhancing Quality (EQ) Programme continues to focus on improvement in this area with particular attention to ensuring that patients have a clear management plan and that they are provided with safe discharge instructions and access to community heart failure services where appropriate. Forthcoming interventions include; the proposal to employ a heart failure nurse working across organisational boundaries (effective January 2012) and the implementation of an Integrated care Pathway.

SMR Pneumonia
Currently on trajectory (by 0.004%). This very high volume pathway will benefit from EQ Programme work focused on community acquired pneumonia. Key practice interventions are early antibiotic therapy and the delivery of smoking cessation advice activities which are being implemented and monitored across the Trust.

Priority 7 – to improve the experience and clinical outcomes for those with long term conditions
Admission Rate for Chronic Obstructive Pulmonary Disease (CODP) is slightly below trajectory (YTD figure of 0.77% against a trajectory of 0.78%). Success in this are will reflect our ability to impact on the wider health community and effectively work in partnership with other health and social care agencies across organisational boundaries.

The definitions and data streams will be defined alongside the Quality Account Dashboard at the end of Q3

Clinical Effectiveness

2.1 Mortality and Morbidity

Table two: Crude Mortality rate by Specialty

	CMR SEPT 2011	ABSOLUTE NUMBERS	JULY 2011	AUG 2011	SEPT 2011
ALL	1.35%	83	▼	▲	▲
MEDICINE	3.39%	64	▼	▲	▼
SURGERY	1.20%	15	▼	▼	▼
ORTHO	0.33%	2	▼	▼	▲
PAEDIATRICS	0.00%	0	◄►	◄►	◄►

The mortality review has shown no real change from last month with a 3% reduction in total mortality. This has been generated by a fall in orthopaedic mortality (reflecting the very impressive fractured neck of femur mortality rate). There was a small but insignificant increase in the mortality in acute medicine and emergency surgery.

The review of diagnosis specific (HRG 4) mortality is proceeding. A more detailed report will follow next month.

3.0 Safety Update

31NPSA Safety Alerts

There are no new alerts.

Overdue Alerts

Two alerts remain overdue as follows:

Table three

Description	Deadline	Lead
Early identification of failure to act on	05-Feb-07	**Associate Director of Informatics**
STATUS		
A&E, Respiratory Medicine, Rheumatology, Upper GI, Surgery, Vascular Surgery, Colorectal Surgery & Gastroenterology specialties have agreed to participate in piloting our new Code 5 Tracker system. Arrangements to provide training for staff in the use of the system and the new process for tracking Code 5 alerts is progressing.		
Description	**Deadline**	**Lead**
Risk to Patient Safety of not Using the NHS Number as the	19-Sep-09	**Associate Director of Informatics**
STATUS		
The Trust has been waiting a considerable amount of time for iSOFT to release version 4.2 of their software to resolve this issue. Other Trusts with the same CliniCom PAS are in the same position. The Trust has now formally complained to iSOFT about the unacceptable lack of progress and is meeting with representatives of iSOFT on 24th October 2011. Please note that iSOFT was acquired by CSC in the summer and this may hamper further progress as the new organization decides upon its future product path		

4. Patient Experience

4.1 Patient Experience Measures

The Trust uses a number of measures to support both qualitative and quantitative understanding of the patient experience. Alongside reporting of safety and clinical effectiveness measures, analysis supports delivery of quality improvements for our patients. Patient experience measures include:

- National patient surveys – while limited in terms of their reach (sampling 850 patients annually) results are benchmarked and enable the Trust to track progress over time;
- 'Near real time' feedback through local surveys – 'Your Feedback' including Net Promoter Score;
- Patient concerns raised through the Patient Advice and Liaison Service – all concerns are logged in detail on the Trust risk management database;
- Formal complaints – both written and verbal complaints are logged in detail on the Trust risk management database;
- Incident reporting and associated risk management;
- Audit;

- Ward 'spot checks';
- Walkabouts.

The Net Promoter Score (NPS)

The NPS is a widely used tool in the commercial sector to support profitable growth based on the behaviours of loyal customers and has been developed on the fundamental perspective that every company's customers can be divided into three categories: Promoters, Passives, and Detractors. By asking - *'How likely is it that you would recommend [Company X] to a friend or colleague?'* - it is possible to track these groups and get a clear measure of a company's performance through its customers' eyes. Customers respond on a 0 to10 point rating scale and are categorised as follows:

- **Promoters** (score 9-10) are loyal enthusiasts who will keep buying and refer others, fuelling growth.
- **Passives** (score 7-8) are satisfied but unenthusiastic customers who are vulnerable to competitive offerings.
- **Detractors** (score 0-6) are unhappy customers who can damage a brand and impede growth through negative word of mouth.

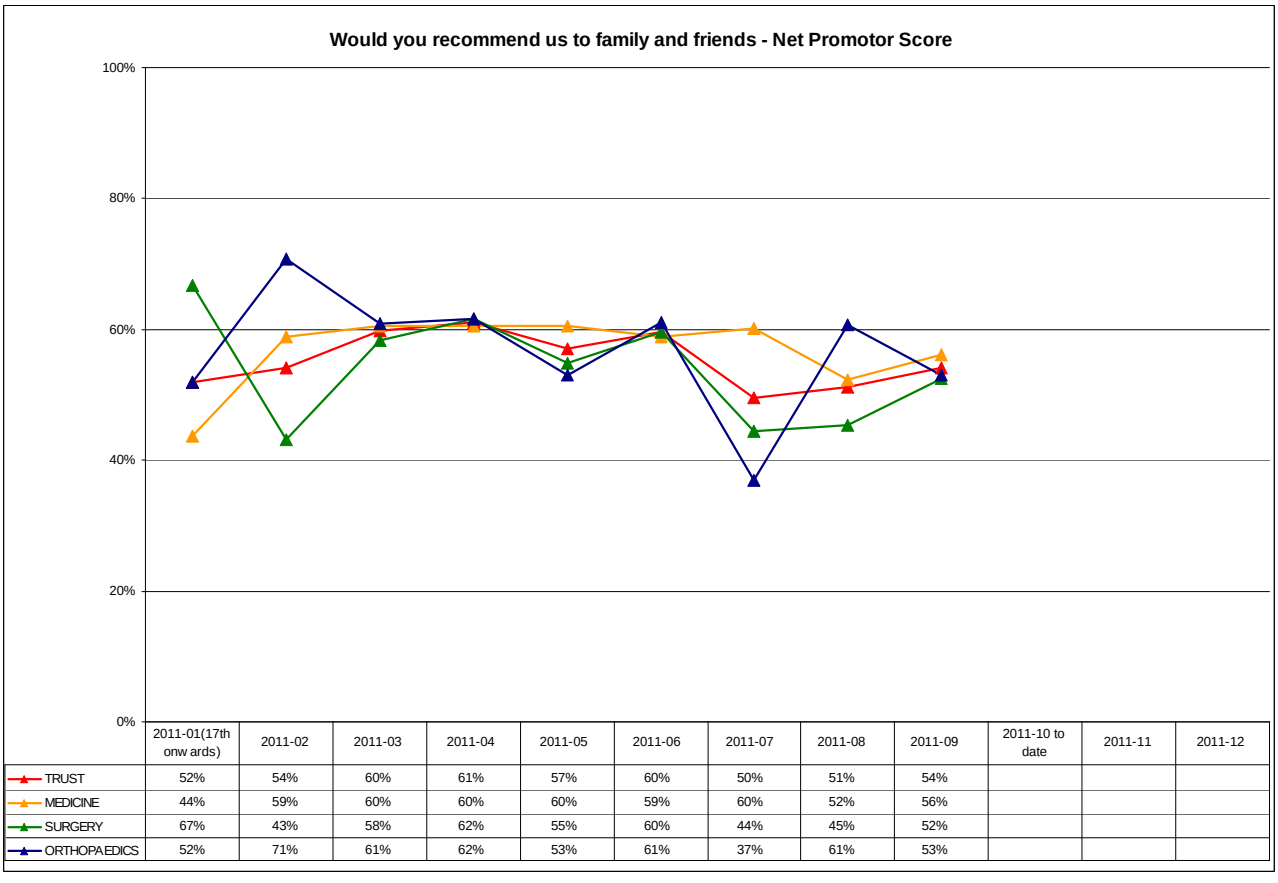
The NPS is calculated as follows:

NPS = % of promoters - % of detractors

As part of the 'Your Feedback' questionnaire the Trust invites patients to respond to the question *'Would you recommend us to family and friends?*' on a rating scale of 0 – 10

The Trust results since January 2011 are presented in Graph one below.

Graph one: The Net Promoter Score by Division and Trust



	2011-01(17th onw ards)	2011-02	2011-03	2011-04	2011-05	2011-06	2011-07	2011-08	2011-09	2011-10 to date	2011-11	2011-12
TRUST	52%	54%	60%	61%	57%	60%	50%	51%	54%			
MEDICINE	44%	59%	60%	60%	60%	59%	60%	52%	56%			
SURGERY	67%	43%	58%	62%	55%	60%	44%	45%	52%			
ORTHOPAEDICS	52%	71%	61%	62%	53%	61%	37%	61%	53%			

A review of the internet reveals evidence that the NPS is being used by other NHS Trusts as a measure of patient satisfaction. In terms of benchmarking ASPH scores, two other Trusts have recently published results:

Croydon Health Services NHS Trust	April 2011: NPS = 61%
The Royal Free Hampstead NHS Trust	April 2011: NPS = 85%

This is a helpful but incomplete analysis but certainly indicates that continued focus and effort is necessary to achieve the desired improvements to patient experience.

Your Feedback

A detailed report by ward and area of Your Feedback survey returns and associated scores is at Appendix 3. There is a relatively high degree of consistency in the scores across the Trust and by ward area, at around the 80% mark. This would be very encouraging but it is clear that ward areas are failing to collect sufficient survey responses for the scores to be fully validated. Ward areas have been advised that failure to achieve the targets set for survey collection will result in a recording of "no score" for that month. The Heads of Nursing are working with ward sisters to improve achievement in this area. In addition, an in-house technical solution is being scoped and is to be defined before the end of November 2011. In the meantime, and to assist wards, volunteers are being approached. Many Trusts work with volunteers to collect patient feedback and this may prove a useful interim solution.

Living our Values

A key aim of the Living our Values Programme is to ensure that all staff attend a workshop before March 2012, preferably with their MDT/functional team. A good example of this format was the joint Wordsworth & Chaucer Ward Workshop, held at the end of September 2011, which was attended by the Ward Manager and two Consultants.

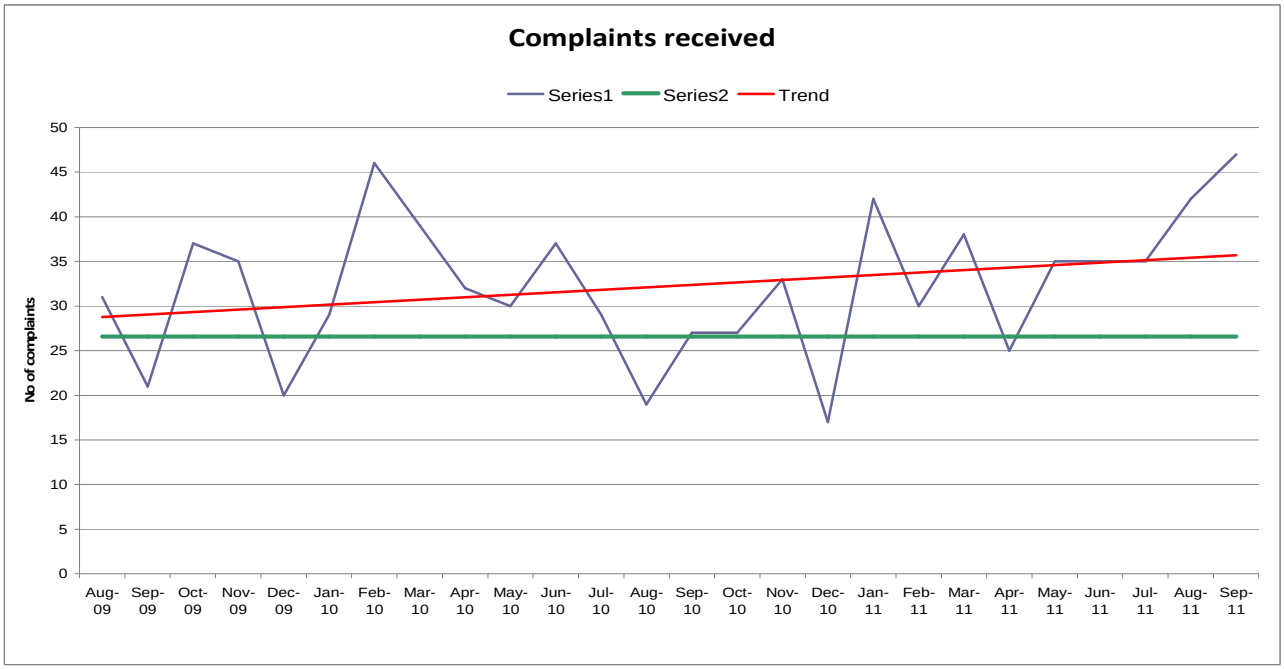
Mindful of the impact of capacity issues on the ability of teams to attend a Workshop, half day sessions are now being offered and the Living our Values Project Managers will ensure that "intelligence" is used to prioritise areas where the patient experience appears less good.

A further aim of the programme is to embed a front line cycle of listening and improvement. To support this, it is planned that areas will have a display board, a "Living our Values Board", to include presentation of the agreed Team Standards for Patient Experience, high level patient feedback information (PALS, Complaints, NPS and AQS) as well as a "You said, We did" area. The materials for this are currently being developed.

4.2 Complaints/Ombudsman reports

There were 47 complaints received in August compared with 42 in August and 35 in July. The Trust aims to reduce the number of formal complaints by 30% during 2011/12 with an overall target of 320. A total of 219 complaints have been received year to date, +36% over target (160). Chart one shows a breakdown of complaints received by month (Series 1), the monthly target (Series 2) and the overall trend line.

Chart One



The reason for the increase in complaints is not well understood and requires further exploration. Two areas will be explored in the first instance:

1. the effectiveness of the PAL Service. Last FY the PAL Service resolved 86% of issues raised thus preventing potential formal complaints. The in year rate of resolution is to be reviewed and will be reported at the next Board.
2. "Complainant Experience" – it is proposed that a method be designed, (focus groups, telephone surveys), in order to gain a real understanding of the complainant issues and motivations. This is to be developed and implemented quickly (Nov 11).

It is anticipated that these examinations will prove helpful in identifying key improvement work.

There were 44 responses due in September, of these, 8 responses were sent within the agreed timescale, this equates to a monthly performance of 18% with agreed timescales for response in comparison to 43% performance in August. Whilst this performance is far from satisfactory, it is important to note that during September and October the Divisional and Corporate teams have been focused on recovering the backlog of complaint responses. This has resulted in 50+ complaints being closed within the last 6 weeks. Teams have been advised to focus on both current performance as well as recovery in parallel to give a more balanced performance going forward.

The Corporate Team has been augmented by a member of staff whose sole role is to support and mentor the Divisions in their complaint management. Other improvement approaches include direct telephone contact with complainants and individual negotiations of timescales for response dependent on the complexity of the concerns.

Chart two details complaints received monthly by Division. The chart demonstrates a sharp increase (+36%) in Acute & Emergency Care, with seven complaints relating to Accident & Emergency (A&E).

Trauma & Orthopaedics also saw a significant increase with 10 complaints received in September compared to 5 in August.

Chart Two

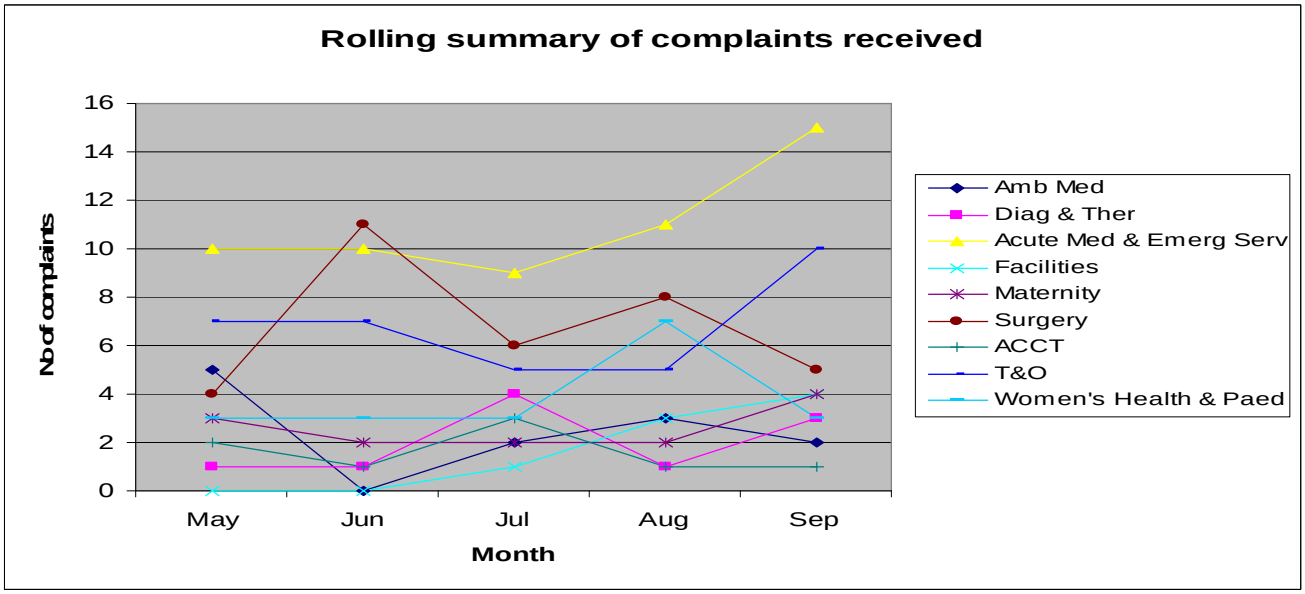


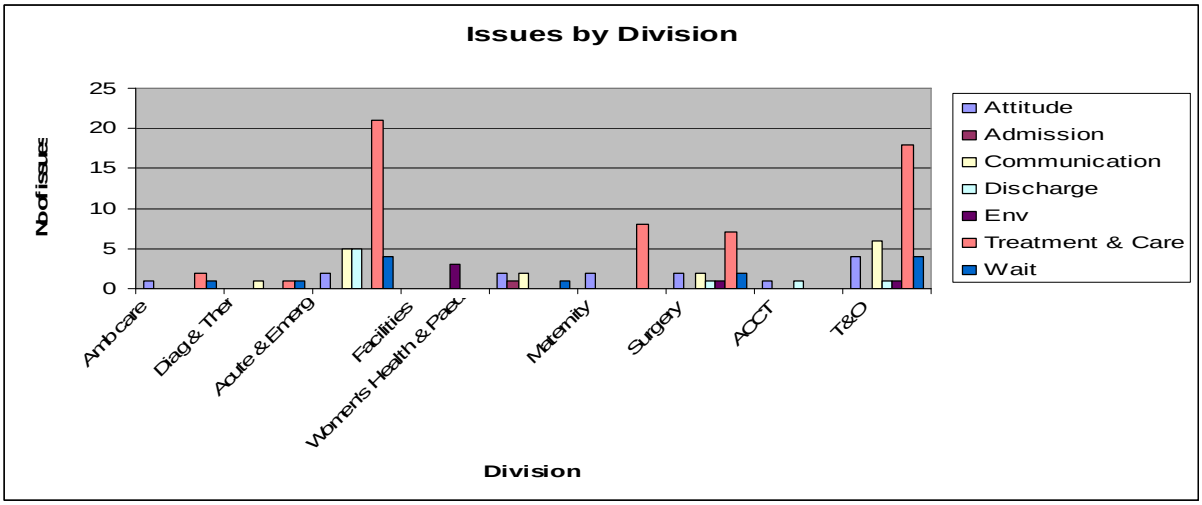
Chart three provides further breakdown of the types of issues raised by Division in September.

Within Acute & Emergency Medicine 21 issues relate to Treatment and Care of which 7 issues relate to nursing care and 13 relate to medical care. Four complaints relate to treatment care in the Accident & Emergency Department. No clear sub-trends are evident.

Within Trauma & Orthopaedics, there were 34 separate issues, 17 of these relate to Treatment and Care. Ongoing trend analysis of the issues reveals themes that are now being addressed:

- wait for pre-operative assessment – dedicated nurse now in place
- information given by central booking team – booking service has been streamlined within division.

Chart Three



Ombudsman Cases

4.3 Ombudsman Cases

The Trust has received one notification of a complaint referred to the Ombudsman. This case was investigated in 2009 and is a surgical complaint. Copy papers have been provided and the case is currently under initial assessment.

There is still currently one case under initial assessment, papers were provided to the Ombudsman in Quarter 4, 2010/11 and we await the outcome of this assessment.

4.4 Patient Experience Summary

Overall improving the patient experience continues to be a tough challenge. Review of the indicators outlined above does not yet give robust assurance that the desired improvements are being achieved. Whilst disappointing, it is the experience of many other organisations and the advice given by experts such as the Picker Institute, that progress in this area is a long term aspiration and that improvement work must be given time to succeed.

Improvement of patient experience is dependant upon a great many things but mostly dependant upon the quality of individual interactions that reflect the organization's cultures and values. This requires a "cultural shift" which is clearly not a short term objective.

The Board is aware of the wide ranging work that continues to be done across the Trust with the intention of shifting the culture, improving the environment and creating a great place for staff to work, all of which aims to improve the patient experience. All the evidence and experience indicates that the approach that the Trust is taking is the right one, the Board should be confident that the appropriate work is being conducted.

Clearly, continued monitoring and evaluation is required and this will be strengthened over the coming months as described earlier in this report in order to ensure that the Trust direction remains on course.

4.4 Ward Quality Indicators (WQI)

The Ward Quality Definitions are found at Appendix 1 and the Ward Quality Indicators are found at Appendix 4.

The following narrative is provided by the relevant Head of Nursing for the month of September 2011.

Division of Women's Health and Paediatrics Service
Paediatrics

Scores for September 2011 are overall very encouraging, scoring between 95 -100%. It is expected with the commencement of the Essence of Care Benchmarking project improvement in the quality and outcome of care will be realised.

For the month of September 2011, the main themes of concern are the number of complaints.

Maternity

In Maternity, the hygiene and high impact audits remain 100%. The Matron's audit for Joan Booker and Labour Ward are marked down (95%) because the large waste bins are stored in the sluice which are not locked at present and is accessible to the public. Keypad locks are to be fitted to the doors of the sluices to reduce this risk.

There continues to be sustained improvements in the recording of the VTE assessment which is 100% for Joan Booker this month and 93% for Labour Ward. This has improved as we have ensured that clinical staff have passwords for clininet and are recording more of these personally, rather than relying on data entry by clerical staff.

Medicine and Emergency Services:

Falls – There is a discrepancy between data for falls collected by the Falls Nurse and data collected through incident reporting, this is being addressed. The correct protective measures are being used (low bed with crash mats and sensor alarms). Ten nurses have attended a teaching session on falls.

Medication errors- there have been a number of medication errors and root cause analysis has been completed. Within the Division, the Clinical Governance Manager has developed a "medication error points system" for keeping a record of staff that have been involved in any medication errors. Early indications highlight that there have been a number of errors over non consecutive months; analysis of this error has revealed that there are no trends.

Discharge checklists- the Discharge Checklist has continued to be an issue on CCU. However, new quality indicators for the ward indicate a significant improvement.

Infection Control- CCU's score for compliance with intravenous cannula care has worsened. Matrons will be spot checking this indicator to ensure compliance.

VTE Assessment
VTE- CCU/MHDU and May ward have a downward trend for compliance with VTE assessment. Improvement plans are to be audited for effect and progress.

Complaints- There has been an increased number of complaints for the Accident and Emergency Department and MAU. Action plans are in development to address concerns identified. Trend analysis shows no correlation between complaints.

Surgery & Orthopaedics:
Scores for September remain static and there are still areas to improve on. The introduction of the Best Care Project and in particular the Essence of Care will have a rapid impact on the future of quality metric and also the way in which actions and root causes will be identified. These are just being been implemented in Surgery and Trauma & Orthopaedics (T&O) following being piloted on the medical wards.

For the month of September 2011, the WQI indicate that the main themes are:

Trauma & Orthopaedics

Falls- Rowley Bristow East and Dickens Ward had 1 fall within the month remaining static. Rowley Bristow West had a total of 5 falls despite only showing 4 on the indicators. Within the month there has been an increase in the number of patients that are confused and 'specials' are requested to provide extra support.

The wards are supported by a falls prevention nurse who has now implemented a post fall protocol in line with best practice and we are one of the first trusts within the SHA to have implemented this fully.

Complaints – Rowley Bristow West had 3 complaints attributed in month but are now seeing a downward trend. However, Dickens Ward has seen an increase in month by 1. Complaints themes and trends are shared at both Sister and Ward meetings and action plans for improvement are implemented.

Discharge checklists- Overall the division has seen an improvement in month with Dickens Ward scoring 91% and Rowley Bristow East West scoring 100%. The MDT Discharge training has had appositive effect. However, Rowley Bristow West only scored 70%. This has been discussed with the Ward Sister and the Matron who will continue to monitor and support in order to see an improvement next month.

Peripheral Cannula- Both Rowley Bristow West and East scored 80% in month and this is being addressed by the Sisters and Matron. The ward sister will ensure that the VIP score is documented for every shift and that cannulae are removed as quickly as possible. This will be monitored by the Matron who now works 2 rostered clinical shifts per week providing a more visible clinical presence. This will also be part of the shift leader documentation checks.

Pressure Ulcer Prevention- Overall the orthopaedic wards are 100% compliant in the monitoring of pressure ulcers but Rowley Bristow East have 2 hospital acquired Grade 2 Pressure ulcers (incorrectly shown as Rowley Bristow West on the indicators) and Dickens Ward have 1 hospital acquired Grade 3 Pressure ulcer for the month of September. There is a root cause analysis being undertaken for Dickens Ward and the Matron is checking documentation to ensure that the Waterlow scores are being calculated correctly, that care plans and the appropriate interventions are in place.

Your Feedback – The Division has failed to achieve on the target set for return rate and further work need to be undertaken by the Ward Sister and Matron to see an improvement.

Surgery

Saving Lives – SDU scored 90% in month for both central line aftercare and peripheral aftercare. This is due to documentation not being fully completed in theatres and not all lines being labelled correctly. The Sister will liaise with theatres to ensure that the documentation after insertion of cannulae prior to anaesthesia induction is clearly documented. The Ward Sister will also ensure that the VIP score is documented for every shift and that cannulae are removed as quickly as possible. This will be monitored by the Matron who now has a more prominent clinical role.

VTE Assessment Compliance- In month SDU scored 80%, Heron 79% and SAU 61%. The score across the division remains low on a monthly basis and this has been highlighted at both the medical and sisters divisional meetings to raise awareness and education. Care Rounding and shift leader checks will monitor this going forward.

Falls- Kingfisher had 3 falls in month and Falcon Ward 2 with no harm to patients concerned. The increased rate is being monitored by the Ward Sisters. With the support of the lead falls nurse the wards have been using the Tabs Voice mattress and seat cushions which appear to be having a positive effect as an early warning indicator.

Your Feedback – The Division has failed to achieve on the target set for return rate and further work need to be undertaken by the Ward Sister and Matron to see an improvement.

ACCT, Ambulatory Care, Diagnostics & Therapeutics

Within Outpatients, the ward quality indicators remain consistently green. Hand washing audit is of a consistently high standard and all disciplines are audited. Matron's environment audit for Outpatients is carried out and remain 96%-98%. Ambulatory care Division is now merged with specialist surgery and the quality indicators for Ophthalmology and Maxillo Facial remain good. Within the Ambulatory Division as from this month, the Matron's environment audits will include X-Ray, Neurophysiology, Blanch Herriot and Stephanie Marks.

Submitted by: Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse

Date: October 2011

Appendix 1

Quality Account Dashboard – Q1 and Q2

	Apr	May	Jun	Jul	Aug	Sep	YTD 11/12	YTD 11/12 Plan	Actual v Plan	Annual 11/12 Plan	10/11 Outturn	11/12 Outturn
Improving our Patient Experience												
Priority 1 - To provide safe, high quality discharge for patients												
Patient Satisfaction (NetPromoter Score)	61.0%	57.0%	60.0%	50.0%	51.0%	54.0%	55.5%			90.00%	77.30%	55.5%
National Patient Survey>Avg responses	Annual											
Discharge Related Complaints	3	8	4	0	5	7	27	***31***	-11.5%	61	87	27
Priority 2 – To provide high quality experience relating to nutrition and hydration												
Essence of Care Nutritional Audit: Quarterly												
1. Ward Environment results	Quarterly Audit										67.5%	NA
2. OCS service											82.2%	NA
3. Service to Patients											69.5%	NA
4. Patients nutritionally at risk											53.4%	NA
Maintaining High Safety Standards												
Priority 3 - To provide confidence and reassurance for patients on infection control and other preventable infections												
Prevention of peripheral acquired infections	100.0 %	97.2%	97.3%	97.0%	96.6%	98.0%	97.7%	*95.0%*	2.7%	95.0%	NA	97.7%
Prevention of central line acquired infections	97.2%	97.8%	99.4%	100.0%	100.0%	100.0%	99.1%	*95.0%*	4.1%	95.0%	NA	99.1%
Hand hygiene	98.7%	98.6%	99.0%	99.0%	97.1%	99.0%	98.6%	*90.0%*	8.6%	90.0%	NA	98.6%
C.Diff (hospital acquired)	2	6	0	1	2	1	12	***15***	-20%	33	36	12
MRSA Bacteraemia (hospital acquired)	0	0	0	0	1	1	2	***2***	0%	4	5	2
Priority 4 – To improve the quality of nursing care by setting and measuring a number of nursing inicators												
Total Falls	48	31	37	51	34	47	248	***310***	-20%	619	688	248
Falls - resulting in harm (grade 3 or above)	0	0	0	2	2	1	5	***8***	-33%	15	17	5
Prevention of Pressure Ulcers (hospital acquired grade 2 above)	14	5	5	8	6	8	46	***51***	-10%	103	108	46
Achieving High Quality Clinical Care												
Priority 5 - To reduce the hospital emergency and elective readmission rate												
Readmission in 28 days - Elective	60	71	55	56	74	64	380	***246***	54.5%	492	984	380
Readmission in 28 days - Emergency	290	294	278	243	257	260	1622	***1567***	3.5%	3134	3687	1622
Priority 6 - To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure												
SMR for Heart Failure	0.087 %	0.066%	0.032%	0.122%	0.034%	0.121%	0.077%	*0.048%*	0.029%	0.048%	0.050%	0.077 %
SMR for Pneumonia	0.399 %	0.280%	0.224%	0.538%	0.270%	0.208%	0.320%	*0.316%*	0.004%	0.316%	0.320%	0.320 %
Priority 7 - To improve the experience and clinical outcomes for those with long term conditions												
Admission Rate for Chronic Obstructive Pulmonary Disease (COPD)	0.78%	0.92%	0.67%	0.95%	0.63%	0.66%	0.77%	*0.78%*	-0.01%	0.78%	0.8%	0.77%

Appendix 2 WQI definitions

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

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

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

6 Peripheral Cannula care
Ensures peripheral cannula insertion and after care undertaken in line with good practice to reduce cannula 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 Blood Traceability
Numbers of labels returned against number of blood bags used.

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

11 Mixed Sex Wards
Number of patients that were in a mixed sex environment for more than 2 hours

12 Total number of falls

13 Number of falls resulting in significant injury,
Falls graded 3, 4 or 5 which indicates harm as reported via incident reporting

14 Complaints
Actual number of complaints registered to the clinical area in reporting month.

15 Medicine administration errors
Number of errors reported via incident reporting

16 Medication prescribing errors.
Number of errors reported via incident reporting

Appendix 3 Your feedback

Week Ending	Target No. of forms to be completed	April 2011				May 2011				June 2011			
Ward		Score	Avail Score	Score %	Forms	Score	Avail Score	Score %	Forms	Score	Avail Score	Score %	Forms
Birch	20	694	770	90.1%	17	866	1026	84.4%	23	1076	1218	88.3%	29
Cedar	24	694	868	80.0%	20	864	1086	79.6%	26	796	1004	79.3%	23
Dickens	72	1291	1518	85.0%	33	617	710	86.9%	16	1823	2116	86.2%	47
RBW (Elm)	32	760	1032	73.6%	23	360	520	69.2%	12	1238	1536	80.6%	35
Fielding	20	313	394	79.4%	9	35	46	76.1%	1	0	0		0
Holly	24	848	1018	83.3%	27	753	890	84.6%	23	931	1180	78.9%	27
RBE (Juniper)	72	431	516	83.5%	12	735	1028	71.5%	23	1075	1462	73.5%	33
Kingfisher	96	1733	2368	73.2%	61	1612	2082	77.4%	52	1471	1824	80.6%	43
MAU	20	296	418	70.8%	10	556	720	77.2%	17	480	718	66.9%	16
SAU	60	1874	2254	83.1%	51	1463	1816	80.6%	45	1692	2120	79.8%	50
Aspen	52	500	608	82.2%	16	203	216	94.0%	5	518	662	78.2%	15
Wordsworth	24	31	44	70.5%	1	173	294	58.8%	7	395	598	66.1%	14
Chaucer	4	0	0		0	0	0		0	106	138	76.8%	3
Falcon	40	1161	1438	80.7%	33	625	804	77.7%	18	248	312	79.5%	7
Maple	28	409	600	68.2%	15	431	536	80.4%	14	400	658	60.8%	20
Heron	40	327	374	87.4%	8	43	50	86.0%	1	450	528	85.2%	12
Kestrel	60	29	40	72.5%	1	0	0		0	0	0		0
May	40	832	974	85.4%	22	815	966	84.4%	21	665	768	86.6%	18
All Wards	728	12223	15234	80.2%	359	10151	12790	79.4%	304	13364	16842	79.3%	392

Week Ending	Target No. of forms to be completed	July 2011				August 2011				September 2011			
Ward		Score	Avail Score	Score %	Forms	Score	Avail Score	Score %	Forms	Score	Avail Score	Score %	Forms
Birch	20	826	934	88.4%	20	709	824	86.0%	19	871	1028	84.7%	17
Cedar	24	688	870	79.1%	21	1436	1768	81.2%	40	817	972	84.1%	22
Dickens	72	1400	1592	87.9%	37	1009	1120	90.1%	24	1361	1766	77.1%	30
RBW (Elm)	32	1184	1634	72.5%	39	485	638	76.0%	14	327	406	80.5%	4
Fielding	20	320	504	63.5%	11	261	354	73.7%	8	572	814	70.3%	18
Holly	24	790	860	91.9%	22	655	734	89.2%	18	748	852	87.8%	15
RBE (Juniper)	72	197	272	72.4%	6	505	638	79.2%	14	713	896	79.6%	10
Kingfisher	96	1513	1782	84.9%	42	1575	2020	78.0%	45	1736	2120	81.9%	48
MAU	20	344	436	78.9%	10	154	172	89.5%	5	0	0		0
SAU	60	1832	2426	75.5%	64	992	1310	75.7%	30	1055	1430	73.8%	32
Aspen	52	0	0		0	242	322	75.2%	8	489	546	89.6%	10
Wordsworth	24	398	522	76.2%	13	640	878	72.9%	21	360	472	76.3%	8
Chaucer	4	177	220	80.5%	5	169	186	90.9%	4	176	192	91.7%	4
Falcon	40	934	1154	80.9%	25	710	916	77.5%	21	1054	1280	82.3%	16
Maple	28	974	1172	83.1%	28	883	1088	81.2%	24	1004	1326	75.7%	21
Heron	40	192	260	73.8%	7	593	736	80.6%	17	621	756	82.1%	12
Kestrel	60	33	46	71.7%	1	317	358	88.5%	8	0	0		0
May	40	1001	1210	82.7%	29	435	574	75.8%	13	33	44	75.0%	1
All Wards	728	12803	15894	80.6%	380	11770	14636	80.4%	333	11937	14900	80.1%	268

Ashford and St Peter's Ward Quality Scorecard - September 2011

N/S: No submission

		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Saving Lives: Central Lines Insertion	Saving Lives: Central Lines After Care	Saving Lives: Urinary Catheter Insertion	Saving Lives: Urinary Catheter After Care	Saving Lives: Peripheral Cannula	Saving Lives: Peripheral Cannula After Care	Cleanliness	Matron Environment Audit	Discharge Check List	Malnutrition Universal Screening Tool	Pressure Ulcer Prevention: Compliance with monitoring of Pressure Ulcer	Pressure Ulcer Prevention: Hospital Acquired Grade 1	Pressure Ulcer Prevention: Hospital Acquired Grade 2	Pressure Ulcer Prevention: Hospital Acquired Grade 3	Pressure Ulcer Prevention: Hospital Acquired Grade 4	Mixed Sex Wards Compliance	Patient Falls: Number of falls	Patient Falls: Resulting in Injury	Complaints	Medication Errors: Administration	Medication Errors: Prescribing	VTE Assessment Compliance	Your Feedback
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	>=85%	>=85%	=100%	<=3	<1	<1	<1	=0	=0	=0	=0	=0	=0	>=90%	>=90%
		89% - 80%			94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	84% - 75%	89% - 80%	84% - 70%	84% - 70%	99% - 76%	1- 2	1- 2	1- 2	1- 2								89%-75%
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<70%	<70%	<=75%	>3	>=3	>=3	>=3	>=1	>=1	>=1	>=1	>=1	<90%	<75%
MEDICINE 1,2,3	ASPEN	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	93 %	98 %	93 %	94 %	100 %	0	2	0	0	0	0	0	1	4	100 %	
	CCU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	80 %	94 %	98 %	61 %	100 %	100 %	0	0	0	0	0	1	0	0	3	65 %	N/A
	BIRCH	100 %	1	0	N/A	N/A	100 %	100 %	100 %	100 %	98 %	98 %	100 %	100 %	100 %	1	0	0	0	0	3	0	1	0	100 %	
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	96 %	98 %	N/A	91 %	100 %	0	0	0	0	0	0	0	0	0	80 %	N/A
	HOLLY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	95 %	100 %	100 %	100 %	1	1	0	0	0	0	0	0	2	100 %	
	CEDAR	97 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	93 %	97 %	100 %	100 %	100 %	0	0	0	0	0	2	0	0	0	100 %	
	MAY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	92 %	92 %	83 %	97 %	100 %	0	1	0	0	0	5	0	1	9	61 %	
	MAPLE	98 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	93 %	95 %	96 %	98 %	100 %	0	0	0	0	0	3	0	0	2	100 %	
	SHORT STAY UNIT	N/S	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/S	97 %	N/A	100 %	N/A	N/A	N/A	N/A	N/A	0	8	0	0	0	N/A	N/A
ASHFORD	CHAUCER	100 %	0	0	N/A	N/A	N/A	100 %	N/A	N/A	96 %	97 %	83 %	94 %	100 %	0	0	0	0	0	2	1	0	0	100 %	97.7 %
	WORDSWORTH	100 %	0	1	N/A	N/A	N/A	100 %	100 %	100 %	95 %	97 %	83 %	99 %	100 %	0	1	0	0	0	1	0	0	0	100 %	
	FIELDING	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	95 %	100 %	100 %	100 %	1	0	0	0	0	7	0	1	0	100 %	
TRAUMA & ORTHOPAEDICS	DICKENS	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	98 %	98 %	91 %	100 %	100 %	0	0	1	0	0	0	0	1	0	79 %	
	RBW (ELM)	100 %	0	0	N/A	N/A	100 %	100 %	80 %	100 %	92 %	97 %	70 %	96 %	100 %	0	2	0	0	0	4	0	3	0	100 %	
	RBE (JUNIPER)	100 %	0	0	N/A	N/A	100 %	100 %	80 %	100 %	95 %	97 %	100 %	100 %	100 %	0	0	0	0	0	0	0	0	1	100 %	
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	96 %	96 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	4	0	N/A	N/A
SURGERY	KINGFISHER	99 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	92 %	95 %	99 %	99 %	100 %	0	0	0	0	0	3	0	0	0	100 %	
	FALCON	98 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	96 %	90 %	90 %	100 %	100 %	1	0	0	0	0	2	0	0	0	100 %	
	KESTREL	N/A	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	N/A	N/A	0	0	0	0	0	N/A	N/A
	SDU	100 %	0	0	N/A	90 %	100 %	100 %	100 %	90 %	92 %	100 %	N/A	N/A	100 %	0	0	0	0	0	0	0	0	0	80 %	N/A
	HERON	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	96 %	39 %	98 %	100 %	0	0	0	0	0	0	0	0	1	79 %	
	ADMISSIONS LOUNGE	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	97 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
	MAXFACS AH/SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/S	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A
EMERGENCY SERVICES	MAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	95 %	N/S	N/A	100 %	100 %	N/A	0	0	N/A	0	0	0	3	1	66 %	N/A
	SAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	90 %	95 %	83 %	100 %	100 %	0	0	0	0	0	2	0	0	0	61 %	
	A&E	96 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	91 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	4	0	0	1	N/A	N/A
PAEDIATRICS	NICU	95 %	0	0	N/A	100 %	N/A	N/A	100 %	100 %	98 %	96 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
	OAK	98 %	0	0	N/A	100 %	N/A	N/A	100 %	N/A	97 %	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
	ASH	98 %	0	0	N/A	100 %	N/A	N/A	100 %	100 %	96 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
	PAED A/E	99 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	97 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	2	0	N/A	N/A
THEATRES	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	99 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	73 %	N/A
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	98 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
	DSU SPH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	76 %	N/A
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	92 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
IMAGING/ENDOSCOPY	ENDO	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	99 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	1	0	1	0	100 %	N/A
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	90 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	96 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
OTHERS	EYE CLINIC SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	92 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	N/A	N/A
	EYE CLINIC/UNIT AH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	94 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	2	0	0	0	100 %	N/A
CRITICAL CARE	ITU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	95 %	N/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	100 %	N/A
MATERNITY	JOAN BOOKER	100 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	93 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	100 %	N/A
	LABOUR WARDS	99 %	0	0	N/A	N/A	100 %	N/A	100 %	N/A	92 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	2	0	93 %	N/A
	MATERNITY ULTRASOUND/ANC	99 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	90 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A
OUTPATIENTS	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	2	0	0	0	N/A	N/A
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	91 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	N/A	N/A