Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
28th October 2010

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report brings together the • Dash Board, with associated commentary for exceptions • Ward Metrics, with associated commentary for exceptions • Quality overview The Quality Dashboard for September shows a positive picture with no red rated indicators. A comprehensive analysis of re admission to hospital is provided. Child Protection training is 100% compliant for staff who require level 3 training but further training is being provided to achieve 100% compliance for level 2 training for all other staff across the Trust. A range of actions is identified to achieve this by November 2010. The 'Your Feedback' initial report is provided.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Board need to be aware of the actions to ensure Child Protection training compliance being at 100%
STAKEHOLDER / PATIENT IMPACT AND VIEWS	The 'Your feedback' process and results are being implemented. This aims to bring real time patient views into the clinical areas to enable staff to address quickly concerns and to improve our patient experience.
EQUALITY AND DIVERSITY ISSUES	None known
LEGAL ISSUES	None identified
The Trust Board is asked to:	Review the paper and discuss the contents
Submitted by:	Dr Mike Baxter Medical Director & Susan Osborne Interim Chief Nurse
Date:	21th October 2010
Decision:	For Noting

Ashford and St. Peter's Hospitals NHS
NHS Trust

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1 Quality Performance Monitoring

1.1 Dashboard Definitions

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).

1.2. Commentary on Quality and Safety Balanced Scorecard (Table 1)

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

	Patient Safety & Quality	Annual Target	Forecast	Actual	Change			YTD
1-01	Standardised mortality (Relative Risk)*	**82**	82	86.3**	▼	▲	▼	83.9**
1-02	Crude mortality	2.6%	1.5%	1.5%	▲	▼	▲	1.4%
1-03	MRSA (Hospital only)	5	5	0	▼	▲	◄►	5
1-04	C.Diff	**67**	48	3	▼	▲	▲	24
1-05	Patient Satisfaction (Your Feedback)	90%	90%	77.0%	New	▼	▲	76.7%
1-06	Formal complaints	361	348	27	▲	▲	▼	174
1-07	SUIs	14	12	0	◄►	▼	▲	6
1-08	Falls - resulting in significant injury (grade 3)	29	18	1	▼	▲	▼	9
1-09	Hip fractures treated within 36 hrs	**70%****	85.0%	83.4%	▲	▼	▲	70.0%
1-10	Readmissions within 14 days	3.7%	3.3%	2.6%	▲	◄►	▼	3.2%
1-11	VTE Assessment*****	90%	90%	89.0%	▲	▼	▲	82.6%
1-12	Summated Adverse Report Index (SARI)	1924	1884	126	▲	▲	▼	942

1.01- 1.02

The Trust SMR shows a small but non-significant rise in September. The crude mortality continues to provide assurance and has shown a small improvement. Mortality rates remain stable with no areas of concern. More detail is available in section 2.

1.03 The Trust has had no further cases of MRSA. The compliance with all aspects of the agreed MRSA action plan is over 90%. The Trust has projected a target of 5 cases for the year outturn stressing the Trust's position of zero tolerance for HCAI.

1.04 The Trust's performance against the Cdiff target remains very reassuring. The Trust has recently been informed of a new "stretch" target for Cdiff of 67 cases which has been applied (down from 90). The Dashboard has been amended accordingly. The Trust continues on a trajectory to deliver a performance showing a 30% improvement on this new target.

1.05 Patient satisfaction as assessed through "Your Feedback" is reported and becoming established in Trust practice. This month reported value at 77% is still lower than target.

Individual wards have now been set clear targets for the number of patient questionnaires that need to be completed, and this and the trends in scores will be monitored weekly by the matrons. A detailed report from "Your Feedback "is attached at Appendix 1.

1.06 The number of formal complaints shows an increase for the first time in 2 months, however the number of complaints received YTD represents a decrease of 13% compared with the same period 2009/10. Details will be provided as a verbal update.

1.07 No SUIs have been recorded this month

1.08 1 fall resulting in grade 3 injury has been recorded this month. This supports the assertion that there has been a real improvement in practice which will deliver a sustained decline in the rate of falls in the Trust. This action is being monitored closely.

1.09 Hip fractures treated within 36 hrs of admission have shown an improvement this month and is recorded at 83.4%. The T&O division has worked hard to achieve this target and have completed an EQUIP event which gave insight to a number of interventions to improve this

pathway, and these have been implemented immediately. The next quarter target is 85% and the Board is assured that this will be delivered.

1.10 Readmission rates at 14 days are recorded as green against target. The board have been informed that more work has now been focused on 28 day readmission rates and this will be discussed in section 2.3.

1.11 VTE assessment rates have shown a further and sustained improvement and are now approaching the 90% target. The Trust has recently been informed that the SHA considers the Trust to be an exemplar organisation for the delivery of this initiative and has been asked to provide guidance for other SEC organisations.

1.12 The Trust SARI has increased this month, which is the first increase in 4 months. The overall trajectory is still on target to deliver a 10% improvement in this metric of avoidable harm over last year but the in month performance will be kept under review.

1.3 WQI (Ward Quality Indicators) commentary

1.3.1. The WQI definitions can be found at Appendix 3 and the WQI scorecard at Appendix 4. The submission for September demonstrates considerable improvement across the Trust although there are some areas where there needs to be further action taken.

1.3.2. In comparison to last month's figure of 5 areas with C.diff there were 3 areas with C.diff infection

1.3.3 Insertion and management of peripheral cannula identified improvement in a reduction of 5 red scores to 3 red scored areas.

1.3.4. Blood traceability is consistently showing improvement in compliance as there were 18 Green scores compared to 15 the previous reporting month. It should be noted that unless 100% compliance is achieved this indicator will be RAG rated red.

1.3.5. Falls were down from 64 in August to 52 in September with 1 resulting in injury.

1.3.6. VTE assessment compliance has also slightly improved from 7 green areas to 8 green areas for September. The Trust is seen as a best performer across the region for this indicator.

1.3.7. Medication errors have increased slightly this month from 11 to 13 reported errors. This is actioned and reported through local Clinical Governance meetings and also through intervention by pharmacy.

1.3.8. Pressure ulcers acquired at Grade 3 were related to a patient from Elm ward and Aspen ward. The patient on Elm has been very frail and has been in hospital for several weeks with incontinence and other medical problems. However, she is now improving and mobilising and her acquired pressure ulcer is healing.

1.3.9. The patient on Aspen was receiving Bi-level Positive Airway Pressure (BIPAP) related due to pressure from the mask. This is being further investigated by the Tissue Viability Nurse Specialist.

2 Mortality and Morbidity

2.1 Trust Mortality Group

2.1.1. The Trust mortality meeting runs 2 months behind current month due to the completion of the note audit. Trust mortality for July 2010 was recorded as 1.38% and represents 94 deaths in the Trust. This represents a stable situation for the Trust and benchmarks favourably against local and SEC Trusts.

2.1.2. 74 deaths (80%) of the Trust deaths were in acute medicine. 10 (10%) were in acute surgery and 3 deaths (3%) in orthopaedics and paediatrics. This is consistent with previously reported patterns

2.1.3 The Crude mortality rate in general medicine was 3.88% which is comparable to the rates recorded last month.

2.1.4. It has been noted that the Trust has recorded 4 deaths in patients classified as "elective" patients. This is an unusual situation and further enquiry has identified all 4 cases were medical (2 cardiology and 2 gastroenterology). All were explicable and all were wrongly classified as elective. This is being taken up with Informatics to improve data quality.

Although pneumonia continues to be the highest mortality HRG (as previously reported in detail), there has been an increase in mortality classified under the diagnostic category of urinary tract infection. This is of interest as the most common diagnosis for the patients readmitted within 30 days of discharge is reported as uro-sepsis (see section 4). These cases, the diagnostic criteria, treatment protocols and care pathway for uro-sepsis will be reviewed. The Board will be receiving an update when further review has been completed.

2.1.5. The Trust remains double green for mortality with no new alerts identified.

2.2 Colorectal surgical site infection

2.2.1 The Surgical site surveillance conducted by the Health Protection Agency Centre for Infections re-audit of colorectal surgical wounds has been reported. The national reported rate for wound infection in this speciality is 10%. In the 2008 survey ASPH was reported as having a wound infection rate of 25.8%. The 2009 survey gave a result of 24.6% against a national average of 9.7%. This prompted a rigorous review of practice, which was supported by, and the actions agreed with, the Health Protection Agency. The action plan from 2009 is attached and has addressed a variety of issues including surgical scrub technique, timing and type of prophylactic antibiotic administration, double glove operating and a change of gloves prior to closure. The remaining items on the action plan will be rolled into the 2010 action plan, which will be established following a group review of the results, and discussion at CGC in November.

2.2.2. The recently published surveillance module has demonstrated an improvement in ASPH performance with infection rate now at 17.1% against a national result of 10.8%. Although this represents an improvement in performance it also demonstrates that there is still more to do. There has been a meeting chaired by the medical director between the colorectal team and anaesthetics. Agreed further actions include an urgent a re-audit of peri-operative antibiotic administration and surgical scrub technique with shared review and actions based on the results.

2.2.3. There is also going to be an immediate switch to the use of a 2 % chlorhexidine skin preparation, which is a major change in practice, which has recently been suggested to be best practice. The effect of this intervention will be re-audited monthly and will be reviewed by the divisions, CEAG and the CGC.

2.2.4. The Board will be informed of the results of these re-audits and the results of our internal wound infection reports. The Trust is confident that it will demonstrate further improvement in this metric, to meet the best national benchmarked performance.

2.3 28 day Readmission Rates

Table 1 Readmissions at 28 days which include data from all trust admissions including Day Cases

Month	Admissions	Re-admissions	Readmission Rate
10-01	4970	391	7.9%
10-02	4823	365	7.6%
10-03	5727	432	7.5%
10-04	5000	385	7.7%
10-05	4938	364	7.4%
10-06	5211	405	7.8%
10-07	5124	375	7.3%

Table 1 shows the rate of readmissions of patients to the Trust within 28 days of discharge. The denominator in this table is all admissions to the Trust, including all elective and day case patients. This is in line with other Trust (and national) reports and as previously described we perform well on this metric with readmission rates below the SEC and national mean. The rate has been stable over the last 7 months and comparable to the values recorded 09/10.

Despite this good performance the absolute numbers of readmissions are surprisingly high at 350-400 patients which equates to 10 plus admissions per day. This does not fit comfortably with a good patient experience and is also placing a very high burden of work on the Trust's unscheduled care activity. Furthermore, if the new guidelines reported in the White Paper are enacted this activity will not be funded (the Trust will not receive payment) for this activity.

There is a clear imperative to understand this data in more detail and put actions in place to reduce the readmission rate.

We have therefore investigated this data further.

Table 2 represents the data related to the readmission rates for patients whose primary (and secondary) admission was related to an emergency admission.

Table 2 Any patient who was admitted as an emergency admission and then readmitted as an emergency within 28 days

Month	Admissions	Re-admissions	Readmission Rate
10-01	2048	328	16.0%
10-02	1970	275	14.0%
10-03	2306	330	14.3%
10-04	2220	315	14.2%
10-05	2164	292	13.5%
10-06	2117	326	15.4%
10-07	2099	305	14.5%

This allows a number of conclusions to be drawn.

The first is that the majority of readmissions are related to a primary emergency admission. For July comparing table 1 and 2 there were 375 (total) vs. 305 (emergency).

Therefore 75 of the readmissions (20%) are related to primary elective procedures (surgery), while 305 (80%) are related to primary emergency admissions (medical). The cause of surgical readmissions requires a separate analysis but it is clear that a majority of the readmission burden is generated by medicine.

The rate of readmission related to emergency primary admissions diagnosis is 13-16%.
Table 3 shows that of the total 375 patients , 55 (15%) were readmitted within 2 days of discharge, 70% within 14 days and 30% between 14 and 28 days.

Table 3 Days between discharge and readmission

No. of days between the readmission	Readmissions	Total Admissions
2 Days	55	5124
14 DAYS	204	5124
28 DAYS	116	5124
Grand Total	**375**	**5124**

This suggests that a majority, but not all, readmissions follow a fairly rapid time period from discharge and therefore a question concerning the appropriateness of discharge, or the support mechanisms in place to support the discharge, should be reviewed.

Table 4 Length of stay for primary admission in patients readmitted within 28 days of discharge

LOS of the 1st Admission and the outcome of the readmission			
LOS GROUP	**Died**	**Discharged**	**Grand Total**
Less than 2 Days	9	227	236
Less than 1 Week	3	72	75
Greater than a Week	3	61	64
Grand Total	15	360	375

Table 4 shows the duration of the primary admission in patients who were subsequently readmitted.

The data provides the very striking observation that 336 of 375 patients who were readmitted stayed less than 2 days on their first admission (90%).

Of these patients the mortality rate was 3.9% which is comparable to the acute medicine CMR suggesting that there was not excessive mortality which is reassuring but this is clearly a situation which needs to be better understood.

The most common diagnosis for the primary admission was uro-sepsis (10.8%).

There was no link between readmission and day of discharge and as yet no association with individual clinical practice although this continues to be reviewed.

2.3.1 Summary and Actions

This data clearly shows that the 30 day readmissions represents a large number of patients (up to 400 per month), that 20% are related to primary elective admissions (surgery), while 80% are related to primary emergency admissions (medicine). A majority of readmissions had primary admission duration of less than 2 days. A significant number of readmissions occur within 1 day of discharge (15%) and the majority are admitted within 2 week (70%). The most common diagnosis relates to uro-sepsis.

The Trust is reviewing the treatment protocol for uro-sepsis and the discharge support arrangements for patients admitted for less than 2 days

The readmission data is being re-analysed to focus on the cohort of patients discharged within 2 days of primary admission.

The analysis will look within this cohort at time to readmission and diagnostic profile.

There appears to be an issue with regards to end of life care and whether those patients who died in hospital following re admission chose the hospital to be the place of choice for their death. Further analysis will be undertaken on those patients who died in hospital.

This data is being used in the NWS transformation program 2 and will give some insight in how to reduce the readmission which could potentially have the impact of reducing unscheduled care activity by 10-15 patients per day.

3 Quality Update

3.1 NPSA Safety alerts

Overdue alerts
Two alerts remaining overdue as follows.

Deadline	Description	Status	Lead
05-Feb-07	Early identification of failure to act on radiological imaging reports	The potential closure of this alert was discussed at Safety and Risk Committee. Clinicians present required further communication on process. This needs to be addressed prior to closure and the clinical specialist lead has taken responsibility for this action.	Dr Jonathan Glover
19-Sep-09	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	Our planned solution is to use soft (PAS). There is a new release (4.3) due in Oct 2010 that will enable us to validate the correct NHS number with the correct patient. This will enable us to move forward with this alert. Other Trusts that use the same PAS software are in a similar position in that they have to wait for the IT software to be completed and implemented.	Barbara Capaldi

New Alerts

Date of Issue	Description	Deadline	Lead	Status
23 September 2010	Laparoscopic surgery: failure to recognise post-operative deterioration	24 March 2011	Elliot Chisholm	On target

Current Alerts
There are currently 6 other alerts open. Work is underway to ensure these are completed before the deadline.

3.2 Your Feedback Appendix 1

An initial report has been produced from 'Your Feedback' and is attached as Appendix 2. It is evident that wards need to reach their target for completed forms to enable the information to reflect the patient experience in the clinical areas. The question "would you recommend us to relatives and friends" will be used as the key metric to measure patient experience in clinical areas. The Customer

Affairs Department will follow up those clinical areas that are not reaching their target on a weekly basis.

3.3 PROMS

The PROMS (patient reported outcome measures) results are now published. PROMS comprise of 2 questionnaires completed by the patient pre and post op and cover four common elective procedures: hip and knee, groin hernias and varicose veins.

The information delivers a measure of 'health gain' for patients and to add to the value of the PROMs questionnaire data, it is linked routinely with Hospital Episode Statistics (HES) episode-level information and, in the case of hip and knee replacement operations, National Joint Registry (NJR)

Once we have a number of data points we will be able to triangulate this information with length of stay data and other clinical data i.e. result data from the Enhancing Quality programme, to provide a fuller picture of clinical and service delivery linked to outcomes for patients.

When interpreting the results it is important that the trends are taken to be a starting point for further investigation rather than giving a definitive conclusion on organizational performance. Currently there is only one result so this is not statistically significant for us to draw any immediate conclusions however the Trust is making plans to discuss the outcomes of PROMS with relevant teams to consider how we utilise this information and start to think about the impact on patients and service for the future.

A benchmark of our outcomes against the national figures and the Royal Surrey County Hospital demonstrates that we are close to the national average.

3.4 NHS Maternity Survey 2010

The NHS Maternity Survey 2010 was published under embargo on 23rd September. This survey is a Picker survey and will provide information that benchmarks our Trust against the national picture and will also allow comparison with the 2007 maternity survey. A planning workshop has been set for 9th November by the maternity team to analyse the information and set out the action plan.

3.5 Child Protection

It has been identified that the Trust has a shortfall in the number of staff with up to date Child Protection training. 86% (3018 of 3500) of staff have attended level 2 training. There is a deficit in all areas including emergency services, ward areas, other clinical areas and non-clinical areas. There is an issue with completeness of data retrieved from ESR database but key areas including Maternity and Paediatrics are known to be100% compliant.

An action plan has been put in place to ensure 100% is achieved by end of November, and a fortnightly position report is being delivered to all managers.

Key actions include:

- Review at weekly service delivery group with General Mangers and interim Deputy Chief Operating Officer
- General Managers and AD's of discrete areas have been given the responsibility of validating the data for their areas and developing action plans to achieve 100% compliance and to feed back weekly until achieved

.

- Child Protection training figures will feature on directorate performance reports.
- Training has been set and dates have been circulated to General Managers and advertised on Aspire

- Bespoke training requirements are being identified to enable targeted training to be established.

Submitted by: Susan Osborne, Interim Chief Nurse and Dr Mike Baxter, Medical Director

Date: 21st October 2010

Appendix 1

Ashford and St. Peter's Hospitals NHS
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Surgical Site Surveillance – Colorectal Action Plan September 2009 to date

Problems identified	Action to be taken	Progress	By whom	Review date	RAG
Lack of review & discussion with HPA per national guidelines re antibiotic prophylaxis	JW to contact HPA and request up to date antibiotic prophylaxis guidelines	19/09/09 DG E-mailed JW requesting this information 21/10/09 Antibiotic prophylaxis information given to CG	Jenny Wilson & Dawn Gantley	October 09 Complete	G
Lack of information regarding practice of centres with low infection rates.	DG to obtain information from JW regarding these centres	19/10/09 DG contacted Addenbrookes who are collating required information 13/11/09 Waiting for clean dirty protocol to arrive from Addenbrookes End of November DG forwarded Addenbrookes clean dirty protocol to KE	Dawn Gantley	Beginning of November 09 Complete	G
Unable to identify if all patients shower prior to theatre, (on same day or day before)	Surgical ward managers to ensure all staff are aware of importance of this action, including SAU	Reminder in Surgical Newsletter	Barbara Doyle Vicky Powell	November 09 Complete	G
Unable to confirm if all hair removal, (if required is performed using clippers)	Matron to liaise with ward managers and ensure that appropriate clippers are available on all wards (if required). Include SAU	Hair clippers are available in theatres	Barbara Doyle & Alison Lambert	November 09 Complete	G
Unable to identify that prophylactic antibiotics are given 45 minutes preoperatively – (1/2 to 1 hour window)	Identify junior colorectal Drs to perform audit to provide this information	01/11/09 Rebecca Curtis & Taiba Javaid to perform retrospective audit. Audit registered and to be completed by 01/12/09. Audit results presented 18/02/10 at SSI meeting	Dawn Gantley	November 09 February 2010 Complete	G

Unable to demonstrate hand washing technique of colorectal team in theatre	Discuss use of 2 minute timer 16/11/09 Distribute results of scrub technique audit to surgeons.	Eidens to have timers mounted to walls in theatre for scrubbing prior to theatre. Not implemented as currently not required. Theatre scrub technique audit was performed July 2010, results currently being analysed. Results to be disseminated to Surgery once available In progress during October / November	Kate Eidens Kate Eidens	November 09 End September 2010 End of Nov 2010	A
Ensure skin prep is NICE compliant	M F to identify appropriate skin prep, 2% Chlorhexidine with 70% alcohol.	05/11/09 Betadine/providene currently used is NICE compliant New product soon available 2% chlorhexidine with tincture. Matron for Theatres (SPH) is currently preparing a business case to support the implementation of "new Chlor prep product"	Mo Farish Julie Hand	November 09 Spring 2010 October 10	A
Steri-drapes not used	KE to identify appropriate steri-drapes	05/11/09 In stock iodine impregnated drapes. In use	Kate Eidens	November 09 Complete	G

Unable to ensure that all dressings and wound care is standardised	Use of island dressing – opsite post op. Original theatre dressings to remain insitu for 48 hours (unless visible exudate)	05/11/09 Opsite post op in stock updated on surgeons preference Cards 01/03/10 message in Surgical newsletter	Kate Eidens All medical and nursing teams	November 09 March 2010 Complete	G
General documentation of wound infections in patients notes is poor	Documentation of wound infections to be improved. Teaching at junior doctors forum To be added to electronic summaries DG to contact Andrew Davis	TBA for Dec 09 New intake of juniors doctors agree & arrange teaching for September 2010 junior doctors forum Re-scheduled for October Contacted IT re possibility of changing IPL template.	Mo Farish Dawn Gantley & Barbara Doyle Dawn Gantley & Andrew Davis	November 09 September 2010 September 2010 October 2010	A
Need to raise awareness of wound infection classifications	Posters of wound classifications to be placed in nurses and Doctors offices. Information leaflet on wound infections to be given to patients on admission.	Insitu Information given on discharge	Barbara Doyle/Mo Farish Nursing staff	November 09 Complete	G
Lack of data regarding hand washing technique prior to examining surgical wounds	Audit to demonstrate compliance	01/11/09 Rebecca Curtis & Taiba Javaid to audit. Registered to be completed 01/12/09 Audit results presented 18/02/10 at SSI meeting	Dawn Gantley	November 09 February 2010 Complete	G

Ensure documentation reflects that patient temperature is maintained above 36C	To review theatre documentation as intra-operative Temperature is not always documented Ensure ward staff understand the importance of patient temperature in wound infection	Pardeep Gill is in process of implementing NICE guidance re hypothermia in theatres Audit in progress November 09 Audit completed June 2010 has identified further actions required 16/08/10 actions identified 1) Thermometers to be placed in anaesthetic room and in theatres 2) Changes to WHO safety checklist, to capture if patient has been "warmed" prior to theatre and initial temperature at start of procedure Complete, education by CPE	Pardeep Gill Alison Lambert	November 09 Complete October 2010 November 09 Complete	A
Ensure gloves are changed for closing	Ensure theatre staff are aware, update surgeon preference card	05/11/09 Updated in surgeons preference cards, all staff are aware.	Kate Eidens	November 09 Complete	G
Lack of a separate tray for closure	Ensure closure trays are available and used	05/11/09 Separate trays for closure to be introduced asap. Discussed with surgical team. February 2010 Surgery purchased additional theatre equipment to enable additional closure trays to be available	Kate Eidens	November 09 February 2010 Complete	G
Lack of data in theatre to demonstrate clean dirty technique	Clean dirty technique audit to be performed Clean dirty protocol to be updated	05/11/09 Audit to be written August 10 Lesley Law has written clean/dirty protocol to be ratified	Kate Eidens Lesley Law & Kate Eidens	Planned to be completed once protocol has been ratified October 2010	A

Provide additional support with data collection for SSI audit in Jan 2010	Additional staff members to be identified to undertake training on 10/12/09 Arrange in house training to update staff who have received original data collection training	13/11/09 Four training places Secured and training completed Arranged with Pauline Harrington January 2010in house training not required	Dawn Gantley & Barbara Doyle Dawn Gantley	November 09 Complete	G

Appendix 2

Ashford and St. Peter's Hospitals NHS
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Findings from "Your Feedback" Pilot Report October 2010

The Trust has been running a pilot project, the "**Your Feedback"** survey from 1 July in adult, inpatient areas with the expectation that all patients will be offered an opportunity to complete a questionnaire prior to discharge. Carers are able to complete the form on behalf of patients; the form takes just a few minutes to complete.

The questionnaire (Appendix 1) contains questions about the patient experience and also asks questions on patient satisfaction; the back page provides the patient with the opportunity to write personal comments about their experience. The questions were chosen from the analyses of the national patient satisfaction surveys in which the Trust showed high problem scores.

The survey form is produced by the Clinical Audit department and is specific to the ward; completed forms are returned daily to the Audit department for analysis. Reports are provided weekly and monthly to wards and monthly to Trust Board in the form of a dashboard.

This first, quarterly, analytical report considers the benefits of using this mechanism to obtain patient feedback and looks closely at the type of information available to drive actions and improvements to the patient experience. It focuses, in particular, on whether patients would recommend the Trust to relatives and friends and how they rated the overall care provided to them in hospital.

Your Feedback Summary

Table1 below presents scores for wards for July, August and September (for calculation of scores refer to Appendix 2). Score % relate to patients perceptions of the service. It is important to consider the number of forms for a ward together with the score as higher returns will give more representative scores. In some cases there will be good reason for low numbers of forms being completed by patients e.g. wards with elderly, demented patients (note that carers are able to complete the form on behalf of the patient) and wards where there is a low discharge rate for patients. Target numbers for each ward to achieve monthly were set at the beginning of September.

Table 1: Monthly Scores by Ward Showing Perception of Patients as a % and Number of Forms Submitted

		July		August		September	
Ward	**Target**	**Score %**	**Forms**	**Score %**	**Forms**	**Score %**	**Forms**
Aspen	40	**74.6%**	14	**76.7%**	30	**85.9%**	24
Birch	20	**83.4%**	19	**83.8%**	23	**85.1%**	31
Cedar	24	**75.5%**	13	**73.0%**	16	**82.7%**	21
Chaucer	4	**76.9%**	5	**97.6%**	1	**91.5%**	5
Dickens	76	**86.0%**	33	**84.5%**	48	**85.6%**	58
Elm	32	**71.2%**	17	**79.6%**	11	**72.3%**	22
Falcon	40	**66.5%**	18	**80.8%**	10	**71.8%**	13
Fielding	20	**74.1%**	15	**79.1%**	3	**76.1%**	10
Heron	76	**84.5%**	9	**77.1%**	18	**79.7%**	33
Holly	24	**74.2%**	10	**66.3%**	29	**73.3%**	31
Juniper	60	**81.9%**	18	**69.0%**	16	**76.7%**	30
Kestrel	TBA		0		0		0
Kingfisher	96	**72.7%**	72	**76.2%**	61	**67.1%**	60
Maple	28	**80.1%**	9	**64.6%**	14	**68.4%**	16

MAU	200	**75.6%**	28	**100%**	1	**88.1%**	2
May	24	**72.7%**	2	**87.9%**	5	**73.7%**	17
SAU	140	**79.4%**	27	**0%**	0	**75.8%**	13
Wordsworth	24	**65.7%**	5	**64.4%**	12	**66.8%**	17
All Wards	**920**	**76.7%**	**314**	**76.3%**	**298**	**77.0%**	**403**

Note that for wards achieving high scores with insufficient numbers of forms the scores are considered unreliable and these have been highlighted in grey. Increasing numbers of forms completed gives improved accuracy of the result which is seen with the overall figures for all wards where there is close consistency of feedback over the 3 months. Kestrel ward has not existed as a separate ward over this period.

Kingfisher and Dickens wards have achieved the highest returns; both MAU and SAU are areas under review, requiring support from the implementation team to discuss issues and improve target returns. Wards caring for elderly patients and rehabilitation wards: Chaucer, Fielding and Wordsworth have relatively low discharge rates.

The overall top 3 positive scores are:

- Feeling welcomed
- Controlling pain
- Resolving concerns

Overall the areas where patients are less happy are:

- Level of noise at night
- Being involved in decisions
- Cleanliness of toilets
- Someone explaining the layout of the ward
- Someone explaining when the patient might go home
- Staff introducing themselves
- Discharge planning

Staff have suggested that patients do not fully equate the question on ward layout with being shown toilets, facilities; how to use the call bell etc and poor results probably reflect the phrasing of the question. Note that food is an area of high personal preference and low scores across all areas require more understanding of this measure.

The following tables compare responses across the wards over the quarter July to September for:

- Recommending the Trust to family and friends;
- Overall care.

Table 2: Quarterly Results for: Recommend to Family and Friends

Ward	Definitely	Probably	Not Recommend	Responses
Aspen	75%	25%		57
Birch	83%	14%	3%	69
Cedar	79%	19%	2%	47
Chaucer	91%	9%		11
Dickens	85%	15%	1%	131
Elm	68%	32%		47
Falcon	70%	28%	3%	40
Fielding	58%	42%		26
Heron	76%	22%	2%	55

Holly	73%	24%	3%	59
Juniper	70%	28%	2%	60
Kingfisher	63%	34%	3%	176
Maple	63%	31%	6%	35
MAU	73%	23%	3%	30
May	82%	14%	5%	22
SAU	85%	15%		40
Wordsworth	59%	34%	7%	29

Note that the number of responses needs to be considered together with the scores. Higher satisfaction is seen on: Birch, Cedar, Chaucer, Dickens and May wards; lower satisfaction is seen on: Elm, Fielding, Kingfisher, Maple and Wordsworth wards.

Table 3: Quarterly Results for Overall Care

Ward	Very Happy	Happy	Not Happy	Responses
Aspen	87%	13%		61
Birch	86%	13%	1%	72
Cedar	76%	24%		49
Chaucer	91%	9%		11
Dickens	80%	19%	2%	133
Elm	72%	28%		46
Falcon	63%	38%		40
Fielding	63%	37%		27
Heron	79%	17%	3%	58
Holly	63%	34%	3%	67
Juniper	74%	23%	3%	61
Kingfisher	60%	37%	2%	182
Maple	61%	37%	3%	38
MAU	65%	31%	4%	26
May	67%	33%		21
SAU	63%	37%		38
Wordsworth	55%	45%		33

Higher satisfaction is seen on: Aspen, Birch, Chaucer, Dickens and Heron wards; lower satisfaction is seen on: Falcon, Fielding, Holly, Kingfisher, Maple, MAU, SAU and Wordsworth.

Actions

The intention for introduction of the “Your Feedback” inpatient survey is to support wards in understanding the patient experience within their area and to respond quickly to any issues and drive actions and improvements at the local level.

Each area is monitoring their results and identifying local actions. Results and actions are being reported as part of the local performance monitoring and discussed at ward meetings and monthly Matron meetings.

Each area has been tasked with identifying up to 3 main actions and reporting to the Clinical Effectiveness Manager at the end of each quarter to enable production of feedback posters for the

ward and reports to the Improving Patient Experience Group and the Patient and Public Engagement Group.

Conclusions and Recommendations

The "Your Feedback" inpatient survey was implemented very quickly from discussions at the beginning of June 2010 with aim of introduction to wards by 1 July 2010. "Your Feedback" supports Trust objectives around improving the patient experience and improving future results from the national inpatient survey programme. Results from the annual, national survey are not received until early in 2011 leaving little time before actions can be identified in response to findings and before the next national survey.

The process was designed to be as close to real time as possible with forms being scanned and analysed daily to provide weekly reports. The value of the process is not only in receiving near real-time reporting but also in the manner of the reporting which is both quantitative and qualitative. "Your Feedback" contains questions about the patient experience and also allows patients to provide written comments on their particular experience; these comments are scanned in to the "Your Feedback" folder on the teams, shared drive and can be accessed by all staff.

During this trial 3 month period, 1015 patients completed forms in the 17 adult inpatient wards across the Trust; the national annual inpatient survey is sent to 850 patients. The "Your Feedback" system provides a rich source of patient feedback.

The challenges faced during this 3 month period include the need for more support for areas to understand their results and to provide reports in a more user-friendly manner. It is recognised that some changes to the questionnaire are required; staff have responded that patients do not always understand the implication of some of the questions e.g. low responses to patients being shown the layout of the wards. Staff have explained that patients are shown where toilets and other facilities are and how to use call bells but this is not explicit with the wording of the question.

Recommendations are:

- To continue with the inpatient survey;
- To review and improve questions with a focus on outcome measures that raise standards with a rating of '7' (good) being the new zero measure;
- To focus multi-professional teams on improving outcomes using the feedback;
- To improve reporting for wards and provide support for staff to interpret their results;
- Raise awareness among staff through dedicated sessions to enable understanding and usefulness of the mechanism;
- Publicity internally and externally and using results more directly for positive publicity liaising closely with the Communications team;
- Developing a near real-time system for outpatients / other areas.

Appendix 3 WQI definitions

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.

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

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

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

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	Blood Traceability	Pressure Ulcer Prevention: Compliance with monitoring of Pressure	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%	=100%	=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%		99% - 76%	1- 2	1- 2	1- 2	1- 2							89%-75%
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<100%	<=75%	>3	>=3	>=3	>=3	>=1	>=1	>=1	>=1	>=1	<90%	<75%
MEDICINE 1,2,3	ASPEN	94 %	0	0	N/A	N/A	100 %	N/A	100 %	100 %	95 %	93 %	49/50	100 %	0	0	1	0	0	5	0	0	2	0	70 %	86 %
	CCU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	98 %	95 %	6/6	100 %	0	0	0	0	0	2	0	0	0	0	97 %	N/A
	BIRCH	100 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	95 %	95 %	6/6	100 %	0	0	0	0	0	2	0	0	0	0	79 %	85 %
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	90 %	93 %	12/12	100 %	0	0	0	0	0	0	0	0	0	1	52 %	N/A
	HOLLY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	95 %	97 %	4/4	100 %	0	0	0	0	0	2	0	0	1	2	95 %	73 %
	CEDAR	100 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	96 %	95 %	8/10	100 %	0	0	0	0	0	4	0	0	0	0	80 %	83 %
	MAY	100 %	0	0	N/A	N/A	N/A	100 %	75 %	100 %	97 %	97 %	44/44	100 %	N/A	0	0	0	0	5	0	0	0	1	100 %	74 %
	MAPLE	97 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	96 %	100 %	21/21	100 %	0	2	0	0	0	5	0	1	0	2	79 %	68 %
ASHFORD	CHAUCER	100 %	0	1	N/A	N/A	100 %	100 %	N/A	100 %	96 %	93 %	N/A	100 %	0	0	0	0	0	4	0	0	0	0	100 %	92 %
	WORDSWORTH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	95 %	95 %	7/7	100 %	0	0	0	0	0	3	1	0	0	0	100 %	67 %
	FIELDING	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	91 %	95 %	3/3	100 %	0	1	0	0	0	1	0	0	0	0	100 %	76 %
TRAUMA & ORTHOPAEDICS	DICKENS	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	99 %	93 %	5/5	100 %	0	0	0	0	0	0	0	0	0	0	89 %	86 %
	ELM	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	95 %	20/21	100 %	0	1	1	0	0	0	0	0	0	0	70 %	72 %
	JUNIPER	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	95 %	95 %	27/27	100 %	2	3	0	0	0	0	0	1	0	0	94 %	77 %
	ROWLEY BRISTOW	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	0	0	0	0	0	0	N/A	N/A
SURGERY	KINGFISHER	98 %	0	1	N/A	100 %	100 %	100 %	90 %	100 %	N/A	90%	29/29	100 %	2	0	0	0	0	2	0	0	0	0	7 %	67 %
	FALCON	100 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	94 %	90%	31/33	100 %	1	1	0	0	0	0	0	0	0	0	17 %	72 %
	SDU	99 %	0	0	N/A	90 %	100 %	100 %	90 %	80 %	93 %	95%	14/16	100 %	0	1	0	0	0	0	0	0	0	0	50 %	N/A
	ADMISSIONS LOUNGE	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	95%	3/6	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	10 %	N/A
	HERON	100 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	95 %	85%	7/7	100 %	0	0	0	0	0	0	0	1	0	0	25 %	80 %
	MAXFACS CLINICS AH	92 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100 %	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	KESTREL	Closed	0	0	N/A	N/A	N/A	N/A	N/A	N/A	92 %	Closed	14/16	100 %	0	0	0	0	0	1	0	1	0	0	100 %	N/A
EMERGENCY SERVICES	MAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	90 %	125/129	100 %	0	0	0	0	0	8	0	0	0	3	48 %	88 %
	SAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	92 %	29/29	100 %	0	0	0	0	0	0	0	0	0	0	8 %	N/A
	A&E	98 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	93 %	100 %	68/72	N/A	0	0	0	0	0	5	0	6	0	0	N/A	N/A
PAEDIATRICS	OAK	100 %	0	0	N/A	100 %	N/A	N/A	N/A	N/A	99 %	95 %	14/14	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	ASH	96 %	0	0	N/A	100 %	N/A	N/A	N/A	100 %	96 %	94 %	14/14	N/A	0	0	0	0	0	0	0	1	0	0	N/A	N/A
	PAED A/E	96 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	96 %	93 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	NICU	99 %	0	0	N/A	100 %	N/A	N/A	N/A	100 %	92 %	90 %	22/24	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
THEATRES	THEATRES SPH	100 %	0	0	100 %	N/A	N/A	100 %	100 %	N/A	96 %	97 %	46/49	N/A	0	0	0	0	0	0	0	0	0	0	29 %	N/A
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	96 %	100 %		N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	DSU SPH	99 %	0	0	N/A	N/A	N/A	N/A	N/A	100 %	99 %	100 %	3/3	N/A	0	0	0	0	0	0	0	0	0	0	83 %	N/A
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	96 %	100 %	7/7	N/A	0	0	0	0	0	0	0	0	0	0	48 %	N/A
IMAGING/END OSCOPY	ENDO	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	96 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0	4 %	N/A
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	96 %	98 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	93 %	97 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
CRITICAL CARE	ITU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	87 %	98 %	29/35	100 %	0	0	0	0	N/A	0	0	0	0	0	64 %	N/A
MATERNITY	JOAN BOOKER	100 %	0	0	N/A	N/A	N/A	100 %	90 %	N/A	93 %	93 %	12/12	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	1	55 %	N/A
	LABOUR WARDS	96 %	0	0	N/A	N/A	100 %	N/A	80 %	N/A	95 %	95 %	39/44	N/A	N/A	N/A	N/A	N/A	0	1	0	1	0	0	44 %	N/A
	MATERNITY ULTRASOUND/ANC	80 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	93 %	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	N/A	N/A
OUTPATIENTS	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	89 %	88 %	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	94 %	96 %	N/A	N/A	N/A	N/A	N/A	N/A	0	2	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	94 %	96 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	EYE CLINIC/UNIT AH	99 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	100 %	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A