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

TRUST BOARD
28 January 2016

Agenda item number		
Title of paper	Quality Report	
Sensitivity of this paper		
• Commercial in confidence?		
• Patient confidential?		
• Suitable for public access?	✓	
Any other papers which this particular paper relates to?		
Strategic objective(s) that this paper relates to		
• Best outcomes	✓	
• Excellent experience	✓	
• Skilled & motivated teams		
• Top productivity		
ASPH value(s) which this paper relates to		
• Patients first	✓	
• Personal responsibility	✓	
• Passion for excellence	✓	
• Pride in our team	✓	
Executive summary	Scorecard: Commentary for each exception is detailed on the dashboard.	
Recommendation	Review the paper and discuss the contents seeking additional assurance as necessary.	
Specific issues checklist		
• Quality and safety issues?	✓	
• Patient impact issues?	✓	
• Employee issues?	✓	
• Other stakeholder issues?		
• Equality & diversity issues?	✓	
• Finance issues?		
• Legal issues?	✓	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non-compliance with the Health and Social Care Act 2008 (Regulated Activities)

		Regulations 2014. Compliance with these regulations is a legal requirement and failure to do so could affect the Trust's Care Quality Commission registration and Monitor licence.
• Risk issues? Link to relevant BAF item number if so		
Author name/role	Dr Erica Heppleston, Assistant Director Regulation and Improvement	
Presented by director name/role	Dr David Fluck, Medical Director and Mrs Heather Caudle, Chief Nurse	
Date	28 January 2016	
Board action	Assurance	

1 Scorecard

Table 1: Quality Performance Dashboard

REF	Quality Scorecard Measures	Outturn 14/15	Monthly Target	Annual Target	Nov	Dec	6 month trend	YTD 15/16	Current month commentary
1.01	In-hospital SHMI	58	<72	<72	63	62		66	Mortality indices in line with expectation.
1.02	RAMI	60	<70	<70	62	63		65	Mortality indices in line with expectation.
1.03	In-hospital deaths	1111	86	<1033	80	97		820	No update available.
1.04	Proportion of mortality reviews (measured at the cut-off date for Board reporting)	38%	>90%	>90%	54%	54%		53%	TASCC have maintained 100% completion of mortality reviews. MES have made a slight improvement, completing 47% of reviews this month. Red mortality boxes are in place on all the wards and consultants are being sent reminders of outstanding forms at the end of the month. Process reiterated at Junior Doctors induction in December. DTTO had no mortality reviews to complete this month; WH&P reviews are outstanding.
1.05	Number of cardiac arrests not in critical care areas	72	-	-	7	4		42	These 4 cases all occurred on medical wards. Case reviews are underway to determine if there are areas of improvement to be learned from.
1.06	Methicillin Resistant Staphlococcus Aureus (MRSA) - hospital	1	0	0	0	0		0	On track with zero cases.
1.07	C. Difficile (hospital only)	18	1.4	17	1	0		9	On track with zero cases this month.
1.08	Falls (per 1000 beddays)	3.29	3.00	3.00	2.16	1.93		2.54	The rate of falls continues to decline.
1.09	Pressure ulcers (per 1000 beddays)	2.03	1.19	1.19	2.16	1.86		2.06	The Trust had one hospital acquired stage 3 pressure ulcer and 19 hospital acquired stage 2 pressure ulcers in December 2015; there were no stage 4s. The Trust has an agreed target with the CCG: zero tolerance to avoidable hospital acquired stage 3 pressure ulcers and to reduce stage 2 and above pressure ulcers to less than 22.4 per month. Root cause analysis has been completed for the stage 3 pressure ulcer and the outcome is pending regarding whether it was avoidable. The affected patient does have an extensive vascular history and was admitted with necrotic left leg ulceration requiring angioplasty and stenting. All appropriate pressure relieving strategies were implemented, however some omissions in pressure ulcer care plan documentation were noted. All permanent and bank staff have now been updated on pressure ulcer documentation due to the omissions found from the RCA. Swan and Swift ward staff are to attend forthcoming pressure ulcer study days provided by the Tissue Viability Nurse. It was highlighted that Swift ward had a high number of palliative care patients on the ward in December which coincided with a high number of stage 2 hospital acquired pressure ulcers.
1.10	Readmissions within 30 days - emergency only	12.60%	12.2%	12.2%	12.60%	14.10%		12.7%	Readmissions were 12.7% in Q1, 12.0% in Q2 and 13.3% in Q3, with 14.1% in the month of December. A review of Q2 readmissions by specialty was undertaken by divisions in December 2015. By volume the largest readmissions were in general medicine. Therapies is actively promoting pre-discharge planning and Pharmacy is assisting with medication change management.
1.11	Stroke patients (% admitted to stroke unit within 4 hours)	52.80%	90%	90%	75.80%	71.80%		64.1%	The main reason for missed cases was lack of ring-fenced beds.
1.12	Medication errors (rate per 1000 beddays)	2.04	2.01	2.01	3.06	2.69		3	Increased reporting is being encouraged.
1.13	Sepsis screening audits undertaken - Percentage of eligible patients that were screened	-	-	-	68.0%	74.0%		62.0%	The target for Q3 is 70% .
1.14	Sepsis antibiotic administration audits undertaken - Percentage of eligible patients that had antibiotic administration within 1 hour				79.0%	65.0%		71.0%	The target for Q3 is 80%.
3.03	Serious Incidents Requiring Investigation (SIRI) reports overdue to CCG	-	-	-	22	18			Reports are now being submitted in line with the required trajectory.
3.04	Serious Incidents Requiring Investigation (SIRI) reports submitted to CCG	-	-	-	2	9			
3.07	Friends and Family Satisfaction Score - Inpatients including Daycase	93.9%	95%	95%	97.1%	95.3%		96.3%	Inpatient feedback remains consistent and above the national average recommended score. However the response rate in December is low due to two tracked packages being undelivered to the service provider. Unify have been informed and agreed that if the packages are recovered then the feedback will be added to January's submission.
3.08	Friends and Family Satisfaction Score - Accident and Emergency including Paediatrics	83.6%	87%	87%	86.5%	82.4%		85.6%	A&E satisfaction has dropped in December. Much of the negative feedback describes long waiting times and capacity concerns. These issues will be discussed at the Patient Experience Monitoring Group in February.
3.09	Friends and Family Satisfaction Score - Maternity touchpoint 2 score	95.8%	TBC	TBC	100.0%	82.6%		96.4%	There has been a low response in December due to two tracked packages being undelivered via Royal Mail. This has led to a skew in result as a negative score impacts the recommended score to a greater degree. The process for collating FFT is currently under review and the Trust is considering scanning all paper onsite to prevent such potential for loss of feedback.
3.09a	Friends and Family Satisfaction Score - Outpatients	NEW	92%	92%	95.8%	91.6%		94.4%	Outpatients remains consistent and has a good response rate via text messaging and postcards.
3.10	Follow-up complaints (measure of quality of response)	85	7	81	4	1		25	Follow-ups remain low and are discussed at complaints panels to ensure robust learning when we don't resolve concerns the first time.
3.11	Dementia screening (composite score) - each of the 3 components must exceed 90% to pass the overall criteria	96.6%	>90%	>90%	93.50%				Measure 3.11a case finding scored 98.20%. Component 3.11b diagnostic assessment remains at 100%. Component 3.11c referral to General Practitioner was 92.85%. The reporting of the composite score is under review and is discontinued from this month.

REF	Reference items	Target description & limit		Nov	Dec	6 month trend	YTD 15/16	Current month commentary
1	Overdue safety alerts	<1 overdue	<1	1			n/a	New safety alerts received in December which have been actioned and are underway include the monitoring of vital signs before and after restrictive interventions and manual restraint received on 3 December and the alert received on 15 December on the risk of using different airway devices simultaneously. The latter alert describes the risk of using a Heat and Moisture Exchanger and a Heated Humidifier Filter simultaneously which can cause lung damage and airway and lung obstruction. Regarding the AKI safety alert, clinicians have been receiving results since December 2015 although the alerting function on VitalPAC was not available until the second week of January for Ashford Hospital.
2.1	NHS Safety Thermometer - % of patients on spot day with new harms	< National av.	2.11%	1.50%	0.84%		1.17%	New harms of 0.84% are below the national average of 2.11%.
2.2	NHS Safety Thermometer - % of patients on spot day with new CAUTIs	< National av.	0.30%	0.21%	0.63%		0.23%	New CAUTIs of 0.63% are above the national average of 0.30% and relate to new CAUTIs on Chaucer, MAU and Swan wards.
2.3	NHS Safety Thermometer - % of patients on spot day with new pressure ulcers	< National av.	0.93%	0.21%	0.00%		0.35%	There were no new pressure ulcers.
2.4	NHS Safety Thermometer - % of patients on spot day with falls with harm	< National av.	0.56%	0.85%	0.21%		0.41%	Falls with harm at 0.21% were below the national average of 0.56%.
2.5	NHS Maternity Safety Thermometer - % of patients with combined harm free care (physical harm and women's perception of safety)	> National av.	70.20%	78.3%			75.0%	December 2015 data not yet available.
3	Best care audits undertaken this month	Level 3 ward count	-	-	-	-	n/a	The next Quarterly Best Care Audits are in progress and results will be available for the February written report.
4	WOW awards	-	n/a	64	31		n/a	Medicine and Emergency Services received 15 WOW nominations and Theatres, Anaesthetics, Surgery and Critical Care received 5. Women's Health and Paediatrics and Trauma and Orthopaedics, Diagnostics and Therapies divisions were both nominated for 4. Estates and Facilities had 3 nominations.
5.1	Complaints % Responded to timescale (pre April 2015)	Timeliness	>95%	100.0%	89.0%			35 complaints were closed in December of which 4 were over the agreed time frame. These pertain to MES division. Attempts were made to contact complainants in all cases to advise of the delay.
5.2	Complaints % Responded to timescale (Grade 1 & 2 in 25 days)	Timeliness	>95%	85.60%	56.00%			This is used as an internal measure as we strive to turnaround grade 1 or 2 complaints within 25 days. All grade 1 and 2 complaints in Medicine and Emergency Services will be signed off centrally until performance is integral.
5.3	Complaints % Responded to timescale (Grade 3 & 4 in 35 days)	Timeliness	>95%	60.0%	20.0%			8 complaints out of 10 graded 3 or 4 took longer than 35 days to complete. 2 of these complaints were also classed as SIRIs and therefore would not be expected to be completed within 35 days. The remaining 6 complaints all required complex and thorough investigations. 5 of these complainants agreed to extended dates, however 1 complainant could not be reached. The divisions for which these complaints relate to are: 5 for MES, 2 for TASCC and 1 for TODT.
5.4	Complaints mean response time in days: variance from 25 day target (Grade 1 & 2)	Responsiveness	<0	0	-4	-		Despite 44% of grade 1 or 2 complaints being responded to in more than 25 days, the majority are responded to in less than this, giving an overall average days to respond of 21 days.
5.5	Complaints mean response time in days: variance from 35 day target (Grade 3 & 4)	Responsiveness	<0	6	25	-	-	This average includes those complaints that have also undergone a SIRI process and can be skewed due to this.
5.6	PHSO (Ombudsman) cases open - total number	Quality of response	nil	14	12			2 cases were closed in December and were partially upheld. No new cases were received.
5.7	PHSO (Ombudsman) cases not upheld	Quality of response	All	1	0			2 cases partially upheld.

Scorecard notes:

Rating table

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

2.1 Patient Experience

Parliamentary and Health Service Ombudsman (PHSO) Cases

2 cases were closed in December both of which have been partially upheld.

1 case pertains to the TASCC division where the Ombudsman found that during the patient's hospital stay they received appropriate and reasonable clinical care; however there were failings in provision of after care on more than one occasion and a delay in follow-up after initial surgery. The recommendation which the Trust has accepted was to offer a financial remedy and further apology which the Trust has accepted.

1 case pertains to the MES division where the Ombudsman found that the Trust had managed the patient clinically appropriately, however due to a lack of clarity and unclear records leading to the patients loved ones being unable to understand how much information the patient had to base their decision on, meant this was partly upheld. The recommendation is that the Trust acknowledges the failings relating to the lack of information available to determine the extent of discussion between the patient and the clinical team and to use this for learning and improvement. The Trust is to provide an appropriate apology to the patient's relative. The Trust has accepted these recommendations.

1 new case has been accepted for investigation pertaining to the TASCC division and specifically the Ophthalmology Department.

Claims

New claims reported:

1 new claim pertaining to MES division.

Intimated claims:

7 claims intimated. 3 pertain to TASCC, 2 pertain to MES, 2 pertain to TODT. 3 of these are previous complaints / concerns.

2.2 Enhancing Quality and Enhanced Recovery Programme

Both colorectal surgery and orthopaedic surgery have remained above target and the previous year's performance; gynaecological surgery has scored slightly below, primarily due to a dip in results for provision of patient information and discharge advice. This is a low volume pathway with an average of ten patients per month.
In the community acquired pneumonia pathway performance exceeded the level achieved in 2014/15.
Data collection for the Heart Failure pathways has merged with the National Heart Failure Audit and new measures are included. A new baseline will be set using July to December 2015 discharges.
The Trust is also participating in new pathways for emergency laparotomy, COPD and fractured neck of femur.

Table 2 Q3 Quality Account Priorities Dashboard

Q3 Quality Priority Dashboard 2015-16

REF	Quality Account Measure	Q1	Q2	Q3	Quarter 3 Narrative
	Safety - Improving harm free care				
1.1	Medication safety thermometer implemented by end of Q1				This is partially implemented at Dec. 2015. Some wards are yet to join and data completeness has not been achieved owing to capacity limitations. The phased rollout is continued in Q4.
1.2	Maternity safety thermometer implemented by end of Q1				Achieved.
1.3	Falls trajectories agreed with divisions by end of Q1				Achieved.
1.4	Pressure ulcer trajectories agreed with divisions by end of Q1				Achieved.
1.5	Maintain Safety Thermometer performance better than national average				Safety Thermometer performance in Q3 for new harms and new pressure ulcers was below the national average. However, falls with harm for November 2015 were above the national average, and in December New CAUTIs were higher.
1.6	Risk assessed 97% of adult inpatients for VTE on admission				Over 97% of adult inpatients have been VTE Risk Assessed on admission for Q3: October - 98.46%; November - 98.56%; December - 98.02%.
1.7	Root cause analysis (RCA) of 100% of identified cases of hospital associated thrombus (HAT)				All RCAs for cases of HAT identified in Q3 are either completed or in progress. However, some cases have exceeded the customary 2 month completion period that the Trust is continuing to aim for.
1.8	Audited documentation of the prescription of appropriate chemical thromboprophylaxis with the aim of achieving 85%				There has been an increase in % during Q3: October - 86%; November - 75%; December - 88%. A review of the audit tool is planned for 16/17 to ensure data validity.
1.9	Achieve VTE Exemplar Centre Status by 31 March 2016				VTE Exemplar Centre Status is awarded by VTE Prevention England, which is a programme of NHS England. There are six requirements that need to be fulfilled, each with their own indicators. As a Trust we have two indicators yet to achieve, with work ongoing.
	Partially achieved at Q3				
	Safety - Embedding and measuring safety culture				
2.1	Duty of candour programme included in Trustwide induction by April 2015				Achieved in Q1.
2.2	Disseminate duty of candour training programme to other staff groups by Q2				Whilst the campaign is continuing the Training Tracker update is yet to be finalised.
2.3	Quarterly audits of duty of candour with exeception reporting to IGAC				Rollout of the detailed duty of candour audit for cases other than serious incidents is not yet in place.
2.4	Complete Manchester Patient Safety Framework rollout by end of Q2, feedback via Team Brief				Achieved in Q2
2.5	Divisional actions plans for MaPSaF, including heatmaps, in place by end of Q3				Achieved in Q2
2.6	Progress implementation of MaPSaf improvement work in Q4				On track.
	Partially achieved at Q3				
	Safety - Preventing death and promoting recovery (sepsis)				
3.1	Sepsis measure to be formulated based on CQUIN				In Q3 62% of eligible patients were screened for sepsis which is below the target of 70%.
	Partially achieved at Q3				
	Clinical Effectiveness - Diagnosis and treatment of diabetes				
4.1	Screen 98% eligible inpatients for diabetes (spot audit)				In Q3 the percentage of patients tested within 24 hours is still below the target of 98%, although results have increased steadily from 88% in October, to 91% in November and 96% in December.
4.2	Insulin prescribing documentation audits undertaken quarterly from Q2				Q2 audit has been undertaken.
4.3	Action plan to improve insulin prescribing to be rolled out by Q3				No update available.
4.4	Diabetes pathway working with external stakeholders - review and implementation trajectory by Q3				No update available.
	Partially achieved at Q3				
	Clinical effectiveness - Readmissions				
5.1	Readmissions project led by the Medical Director is to continue				Readmissions are now divisionally monitored.
5.2	Target 30 day emergency readmissions will be no greater than 12.2% by Q4				Readmissions were 12.7% in Q1, 12.0% in Q2 and 13.3% in Q3, with 14.1% in the month of December. A review of Q2 readmissions by specialty was undertaken by divisions in December 2015. By volume the largest readmissions were in general medicine. Therapies is actively promoting pre-discharge planning and Pharmacy is assisting with medication change management.
5.3	Review post discharge contacting patients pilot and consider expansion by end Q2				This is not currently being expanded.
5.4	Input to Woking hub pilot feedback, continue external dialogue re. expansion				The Trust actively participated in the Woking hub pilot through the Provider Reference Group for individual pathways.
	Partially achieved at Q3				

No.	Measure	Commentary
	Clinical effectiveness - Learning from audits and NICE guidance	
6.1	100% implementation of NICE Technology Appraisals (TA) within 3 month deadline	For October to December 18 Technology Appraisals were published. Query relating to TA357 being followed up with Pharmacy and response 11.01.16 included in list b as the Trust does not routinely treat skin cancer. All included as appropriate either in the Formulary or in one of the two lists. Published on the Trust website.
6.2	NICE Guideline status report and gap analysis	For October to December 6 Quality standards and 12 clinical guidelines are being reviewed. There is scope for improvement in this area.
6.3	NICE Procedures - status report and audit to evidence safe practice	One new procedure has been approved (IPG466) and is being implemented: Rapid Corneal Cross-linking for Keratoconus.
	Partially achieved at Q3	
	Patient Experience - Experience of vulnerable groups	
7.1	Mental Health Act (MHA) policies and	Achieved in Q2.
7.2	MHA training specific to role by Q4	Achieved.
7.3	Complete Surrey Public Health suicide	This training has been made available to staff.
7.4	Dementia quality priority to be formulated	In place and reported to open board.
7.5	Improve feedback via carers survey, establish memory café by Q2	Achieved.
7.6	50% applicable dementia patients to have This is Me/REACH documents by end Q3	Not achieved - audit carried out and only 25% patients had these documents. Dementia champions are currently being recruited on all wards and will be responsible for taking this forward.
7.7	Dementia friendly environment review by Q2, followed by impact assessment	A review of the dementia friendliness of the environment has been undertaken by the Admiral Dementia Nurse. Plans are in place for improvements, contingent upon the ability to access areas to undertake the improvements.
7.8a	Mandatory level 1 dementia training update (all staff) by Q4	Partially achieved: This has been part of the mandatory update for all clinical staff for almost a year. 48% of staff have been trained as part of an ongoing 3 year plan. Discontinue as priority measure.
7.8b	Level 2 training delivered to all staff frequently working with dementia (Q4)	Dementia awareness training (L2) carried out monthly open to all staff. Working with Training and Development to review compliance for divisions. Plans to receive external accreditation. Part of an ongoing 3 year plan.
7.8c	Level 3 training for specialist staff and Executive Directors to be explored by Q4	Staff have access to the University of Surrey Dementia modules. To develop training strategy with RSCH as part of the merger work.
	Partially achieved at Q3	
	Patient Experience - feedback of outpatient experience	
8.1	System for communication Outpatient Clinic wait time implemented by end Q3	Achieved - an electronic system is in place by Q3, including waiting time in minutes. This measure is achieved so won't be carried forward.
8.2	Implement service user feedback process about new wait time system (Q4)	In progress during Q4. Patients to be surveyed in February 2016.
	Partially achieved at Q3	
	Patient Experience - inpatient experience	
9.1	Orthopaedic Supported Discharge methodology expansion business case by Q2	OSD is up and running. We have recruited into additional posts through business planning, therefore the overall capacity has increased from approximately 8 to 18 patients. Ongoing work includes increasing capacity and identifying appropriate business continuity plans to support the trust when beds are under pressure.
9.2	Ward moves review with trajectory and improvement plan by Q3	Partially achieved: a review has taken place following the co-location of the short stay wards. The initial data analysis indicates that more work is needed regarding patient moves and this is currently being reviewed in Q4.
9.3	Discharge assessment re. return to care homes to be reviewed by Q2	The discharge team has reviewed the process and identified improvement opportunities. The discharge team has attended care home group events and spoken at local events.
9.4	Follow-up complaints < 10% of complaints received, on average. RCA and action plan if exceeded.	Below 10% follow-up rate has been achieved in Q3.
9.5	Continue end of life care outreach partnership working	Collaborative work continues with palliative medicine consultants attending hospice/community/hospital MDT meetings following and supporting patient journeys.
	Partially achieved at Q3	