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

TRUST BOARD
28 July 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for June 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:	20 July 2011
Decision:	For Noting

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indicator Definitions

1.2 Quality and Safety Balanced Scorecard and Commentary

2. Clinical Effectiveness

2.1 Mortality and Morbidity

3. Safety update

3.1 National Patient Safety Alerts (NPSA)

3.2 Ensuring the Provision and Safety of General Paediatric Surgery

3.3 Levels of Paediatric Training

4. Patient Experience

4.1 Complaints/Ombudsman Reports

4.2 Ward Quality Indicators (WQI) Commentary

4.3 Discharge Destinations

5. Appendices

Appendix 1 WQI explanations

Appendix 2 WQI scorecard

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 2010/11 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 3 (June) we divide 2011/12 Total by 2011/12 YTD at month 3 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 3/(SUM(2011_12 up to m7)/SUM(2011_12 Total)) x 2011_12 YTD x (2011_12 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).

BALANCED SCORECARD

Position as at: **30 Jun 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	Jun Actual	Performance			YTD 11/12
						Apr	May	Jun	
1-01	**Standardised mortality (Relative Risk)***	90.7*	82	**94.1**	**102.7(Apr)**	▲	▼	▼	**102.7***
1-02	**Crude mortality**	1.60%	1.60%	**1.59%**	**1.11%**	▼	▲	▲	**1.61%**
1-03	**MRSA (Hospital only)**	5	4	**3**	**0**	◄►	◄►	◄►	**0**
1-04	**C.Diff (Hospital only)**	36	33	**32**	**0**	▲	▼	▲	**8**
1-05	**Mortality from C.Diff (All cases)**	10.3%	6.3%	**9.6%**	**33.3%**	▼	▼	▼	**17.4%**
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%	**4.4%**	**0.0%**	▼	▲	▲	**5.3%**
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	**Patient Satisfaction (NetPromoter Score)**	77.3%	90.0%	**79.0%**	**78.9%**	▼	▼	▼	**79.7%**
1-10	**Formal complaints**	360	320	**335**	**35**	▲	▼	◄►	**95**
1-11	**SUIs**	14	14	**17**	**3**	▼	▼	◄►	**8**
1-12	**Falls - resulting in significant injury (grade 3)**	16	14	**12**	**0**	◄►	◄►	◄►	**0**
1-13	**Hip fractures treated within 36 hrs**	93.0%	85%	**93%**	**97.1%**	▼	▼	▲	**91.6%**
1-14	**Summated Adverse Report Index (SARI)**	1,799	1,552	**1659**	**108**	▲	▲	▲	**405**
1-15	**Average Bed Occupancy-Actual beds**	94%	94%	**94%**	**92%**	▼	▲	▼	**93%**
1-16	Average Bed Occupancy-Planned beds	Work in progress							

1.2 Commentary on Quality and Safety Balanced Scorecard

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Table one: Quality Performance Dashboard

1.01 and 1.02: The SMR which is reflective of mortality 2 months ago has shown an increase to 102.7. There are no specific signal triggers or areas for concern. This figure does reflect performance in April when the Trust's crude mortality figure was over 2%. We are exploring ways of more directly linking SMR and current month mortality to avoid the confusion and apparent conflicts.

In marked comparison the Trust's crude morality rate was 1.1% which is the lowest rate that we have recorded in the Quality Report. In absolute terms this represents 69 deaths which is a 38% reduction on the Trust's average performance.

1.02 and 1.04: The Trust has now exceeded a year since the last MRSA infection. This is the longest period the Trust has ever gone without an MRSA case.

There were no cases of hospital acquired *C.Difficile* in June.

1.05: Mortality from *C.Difficile* appears to have increased from last month's figures, despite no further cases, this is because of the death of 1 patient who was reported with *C.Difficile* in the last Board report. This case has been discussed elsewhere in the Board report.

1.06: VTE mortality relates to deaths from Thromboembolic complication (e.g. Pulmonary Embolism) which are potentially avoidable by the use of VTE Prophylaxis (compliance recorded in ward quality indicators). The Trust is currently recording no deaths indicating the success of our VTE Compliance Strategy.

1.07 and 1.13: The Trust has delivered the 36 hr target with 97.1% of patients achieving surgery within 36 hrs. The mortality for # neck of femur is 0% for June and 5.3% YTD. The Trust has been officially recognised as having the lowest mortality for this condition in the whole country. This national report also identifies ASPH as being the top Trust in the country for falls and bone health assessment, 5th in the country's Best Practice Tariff performance (1st in South East Coast) and in the top 10% for cancellations of patients based on clinical conditions.

1.14: The Trust SARI has seen the third consecutive month of improvement and is a reflection of a positive improvement in the Trust's Quality agenda.

2. Clinical Effectiveness

2.1 Mortality and Morbidity

Table two: Crude Mortality rate by Specialty

	CMR JUNE 2011	ABSOLUTE NUMBERS	APRIL 2011	MAY 2011	JUNE 2011
ALL	1.11%	69	▲	▲	▲
MEDICINE	3.28%	62	▲	▲	▲
SURGERY	0.57%	7	▼	▼	▲
ORTHO	0.00%	0	▼	▼	▲
PAEDIATRICS	0.00%	0	◄►	◄►	◄►

The Trust has recorded its lowest crude mortality rate ever in June with a 38% reduction over the figures in May (69 deaths vs 110).

The Crude Mortality Rate has been reduced in all of the emergency service directorates: Medicine (24%), Surgery (52%) and Orthopaedics (1.1% to 0%) and represents the Trust's best ever global performance with respect to mortality.

3. Safety Update

3.1 NPSA Safety Alerts

There are no new alerts.

Overdue Alerts

Two alerts remain overdue as follows:

Description	Deadline	Lead
Early identification of failure to act on radiological imaging reports	05-Feb-07	**Associate Director of Informatics**
STATUS		
Andrew Davis from IT has confirmed that the application has been completed and will be transferred to a live environment by 22 July 2011 with a 'roll-out' to all users by the end of August 2011. Other project management-type tasks which remain to be completed are as follows: Compilation of a list of email addresses for the alerts Creation of a user manual and/or training package Compilation of initial user list (with required access level)		
Description	**Deadline**	**Lead**
Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	19-Sep-09	**Associate Director of Informatics**
STATUS		
The Trust is still awaiting the release of version 4.3 from iSOFT to resolve this issue. iSOFT has confirmed that this version is currently in testing but no confirmed date has been provided for this version to become available on general release. Other Trusts with the same CliniCom PAS are in the same position.		

3.2 Ensuring the Provision and Safety of General Paediatric Surgery

In May the Board received an update against the Healthcare Commission Report published in 2007, *Improving the Services for Children in Hospital*, and the current Trust position with regard to the levels of paediatric general surgery and anaesthetics undertaken within the Trust and an outline plan for securing the ongoing safety of general paediatric surgery.

Since that time work has continued to develop a robust arrangement for the monitoring of levels of paediatric surgical and anaesthetic activity as well as to put in place the necessary professional and practice policy guidance. The Children and Young Peoples Action Group, chaired by the Chief Nurse, has been taking this work forward. Progress to date includes:

- the establishment of a General Paediatric Surgery and Anaesthetic Activity Database that collects information by practitioner, procedure and age of child using the Operating Theatre Blue Spier software. The database will be reviewed monthly by the identified Paediatric General Surgical and Anaesthetic Clinical Leads who will be reviewing activity to ensure the cohorting of paediatric procedures to those practitioners known to undertake paediatric activity and who will be subject to completion of the agreed clinical competency framework.
- identification of clinical leads for Paediatric General Surgery and Anaesthetics
- the development of a Trust General Paediatric Surgery and Anaesthetic Policy
- the development of a Paediatric Anaesthetic Competency Framework for inclusion within the Policy
- identification of the key components and reference material to develop the Paediatric General Surgical Competency Framework.

Discussions have been held with the Specialist Commissioner for Paediatric Services in Surrey with regard to the establishment of a local paediatric network. In the first instance the Specialist Commissioner will discuss with NHS Surrey the possibility of establishing a network using a model already in place in Sussex. ASPH has made it clear that this would be actively supported by the Trust and would build on relationships already established. ASPH is well placed to lead a network of this kind and will continue to pursue this approach.

3.3 Levels of Paediatric Training

The 08/09 Follow up review by the CQC on *Improving the Services for Children in Hospital* indicated that the Trust was performing well overall but in a number of specific skills related areas there was further work to do.

In order to update assurance in these areas the new Head of Nursing has been tasked with conducting a skills level review and will report back on this to the Children's and Young Peoples Action Group**.**

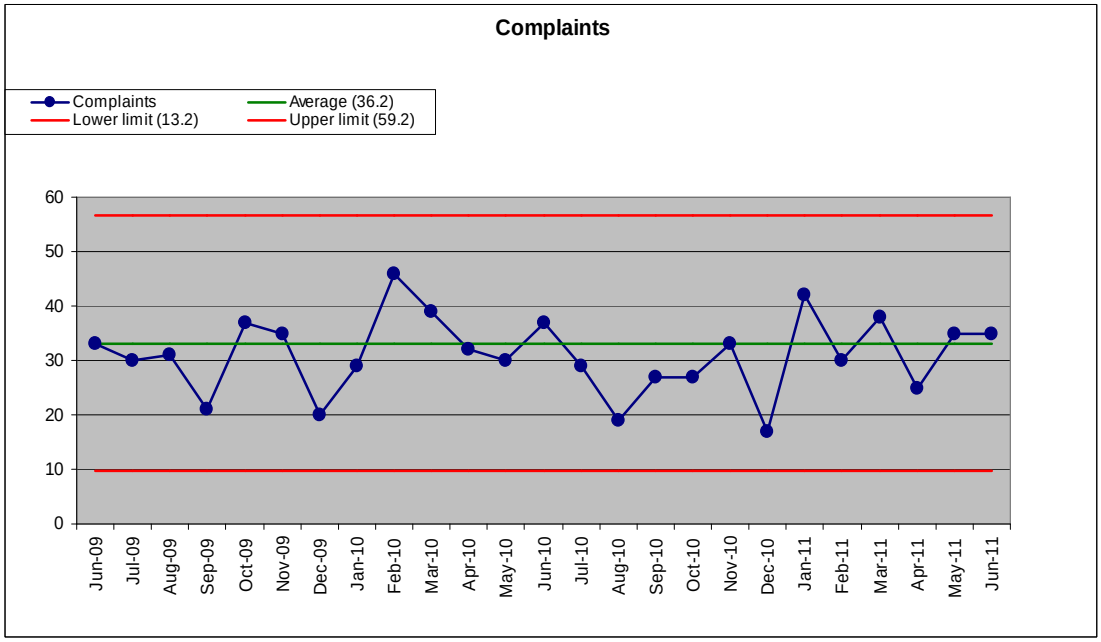
4. Patient Experience

4.1 Complaints/Ombudsman Reports

4.1.1 Complaints

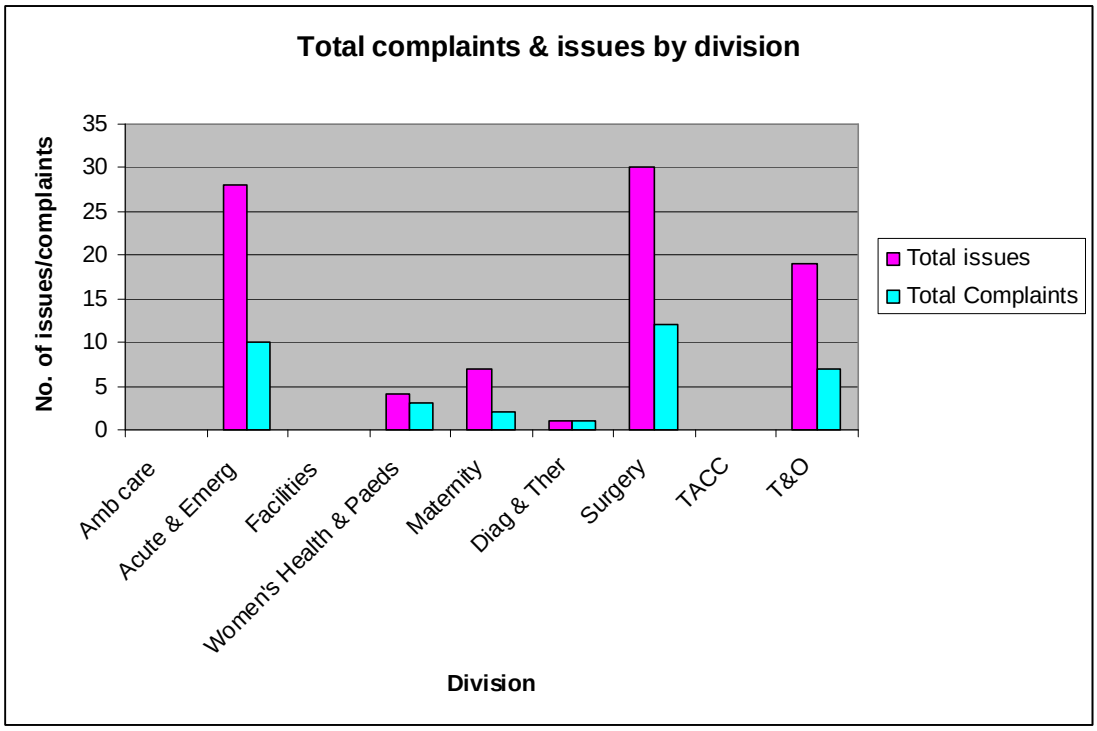
There were 35 complaints received in June compared with 35 in May. The Trust aims to reduce the number of formal complaints by 30% during 2011/12 with an overall target of 320. A total of 95 complaints have been received year to date, +18% over target (81). Graph one shows a breakdown of complaints received by month and shows that the average number of complaints received each month remains at 36.

Graph one



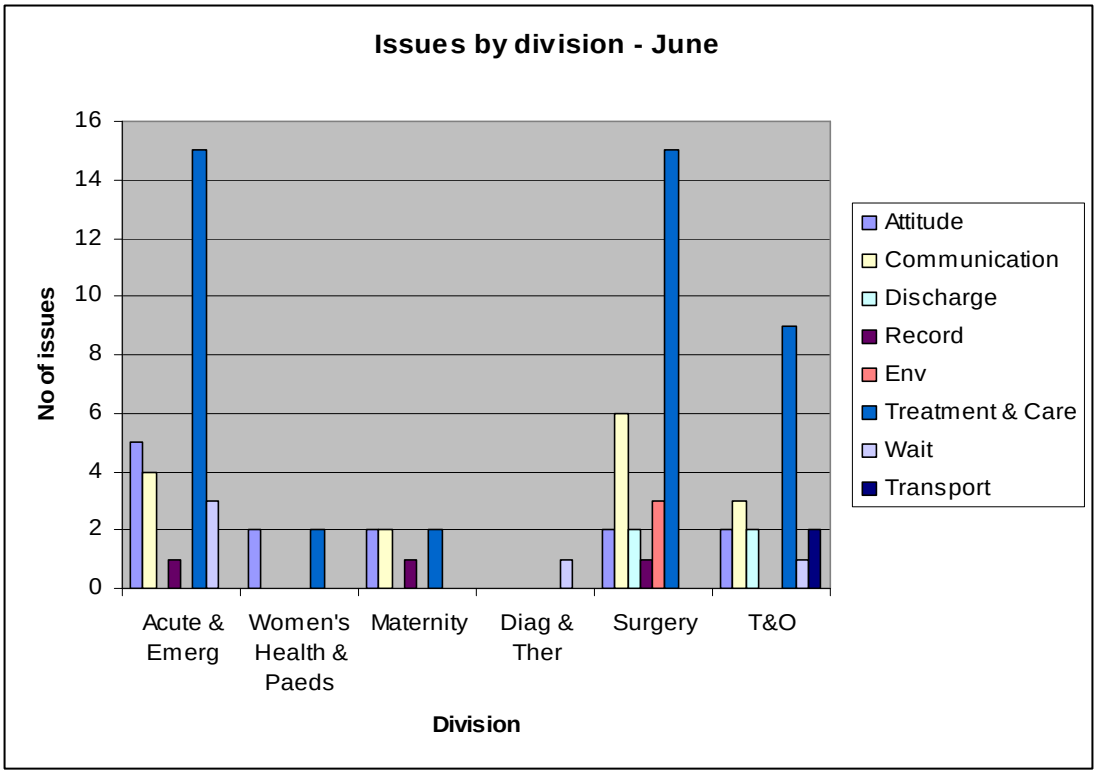
Graph two details total complaints and issues received by Division in June. The most complaints were received in Surgery (12) compared with 4 in May, Acute & Emergency Services received the same number as the previous month (10). Ambulatory Medicine and Anaesthetics, Critical Care and Theatres received no complaints during June.

Graph two



Graph three provides further breakdown of the types of issues raised by Division in June. Within Surgery, 15 issues related to 'Treatment and Care' of these, 10 issues were around 'Clinical decisions and treatment'. In Acute and Emergency Services, 15 issues related to Treatment and Care, of these 5 related to Clinical decisions and treatment' and the remainder of issues were low in numbers, widely spread across sub-categories with no trend of note.

Graph three



4.1.2 Ombudsman cases

The Trust received notification of the outcome of an initial assessment of a complaint, initially investigated in 2008, in relation to a patient's emergency and medical care pathway. Having sought independent clinical advice, the Ombudsman has advised the Trust that insufficient evidence of learning has been provided. The Ombudsman recommended the Trust provide a further, detailed response to the complainant upon actions taken in response to the matter raised in the complaint and evidence of monitoring the effectiveness of these. Following this, the complainant will have the right of appeal to the Ombudsman should they remain dissatisfied.

4.2 Ward Quality Indicators (WQI)

The Ward Quality Indicators are at Appendix 2 and the narrative is provided by the relevant Heads of Nursing.

Indicators for June are encouraging overall but improvement work will continue to ensure improvements are sustained. Clinical Practice Educators across the Divisions are becoming increasingly involved in the response to poor indicators, supporting ward and clinical areas with targeted support, training and education.

For the month of June 2011 the WQI indicate that the main themes by Division are:

Medicine and Emergency Services

Falls - Maple Ward has a high number of falls but the trend analysis indicates a decreasing fall rate. The Trust's Falls Group is developing a falls strategy and the Division has set a target of 18% reduction in falls for 2011-12. Falls reduction is an element of Safety Express, a national QIPP campaign and continued focus will support achievement of the national QIPP objectives as well as local quality of care improvements.

Medication errors - there have been a number of medication errors last month on a number of wards. A root cause investigation has taken place and action plans are being developed. A draft tool kit has been developed to look at trends and to create a "passport of errors" for each registered nurse. The tool kit will be presented to the Senior Nursing and Midwifery Leadership Team for ratification.

Discharge Checklists – CCU, whilst still red on this indicator, has shown a month on month improvement. The introduction of the new Single Assessment Document in June will support early initiation of the discharge process on admission. Discharge competency training is underway within the Division. CCU will attend training in the coming weeks.

Surgery & Orthopaedics

The WQI demonstrate an improving trend and in particular in relation to MUST completion.

Central Line after Care - SDU scored amber for Central Line after Care. This is attributed to poor line labelling. The Team Leader has addressed this problem with staff. Line labelling is exclusive to SDU and the HoN will continue to monitor closely.

Peripheral Line after Care

- Both Kingfisher Ward and SDU scored amber for this indicator. This is due to poor documentation post insertion of the cannula.
- Juniper Ward rated red at 80% this month, an improvement from 75%. From

Action - the label associated with the cannula is not being used by practitioners. Discussions and expectations in relation to line labelling and documentation are being underway with all practitioner groups.

Discharge Check List – Heron Ward scored red from a previous green rating for this indicator.
Action – Ward Meeting to appoint individual responsible for leading on this indicator.

VTE Assessment Compliance- Heron Ward VTE score is very low at 35% (red); the HoN is to review the approach to VTE assessment with the Ward Sister.
Matron Environment Audit – non submission for Eye Ward at Ashford
Action – HoN to clarify who the lead auditor is for the area.

ACCT, Ambulatory Care, Diagnostics & Therapeutics

Complaints- one complaint received for Day Surgery at St Peter's Hospital related to lack of privacy & dignity during preoperative preparation.
Action – scoping of potential refurbishment to area to create consulting and changing rooms
Compliments- one compliment for the care in the Day Surgery Unit at Ashford Hospital. "I want to tell you how pleased I was today with the exceptionally good service I received from the nurses and surgeons in Day Surgery at Ashford Hospital…. I am lucky enough to travel and visit very good institutions where allegedly five star service is offered. Your people did exactly what I know to be an excellent five star job. The NHS seems to get very little positive feedback but I know they do a great job and today was a great example".

VTE Assessment Compliance

- Critical Care VTE score is very low at 33% (red); this will be challenged at the next ITU meeting and Care Rounding and Shift Leader checks will monitor this going forward.
- The VTE assessment score for Theatres at St Peter's Hospital is inaccurate as VTE assessments are not completed in the Operating Theatres.

Medication Errors - there were two prescribing medication errors in the Day Surgery Unit at St Peter's Hospital. A "deep dive" of prescribing errors has been requested by the Chief Nurse.

Women's Health and Paediatric Services

Paediatrics NICU
Peripheral Cannula - NICU has achieved amber for the month of June .The NICU Manager will ensure that all practitioners comply with all elements of the cannula insertion procedure by teaching/reiterating the importance of this with the NICU Clinical Practice Educator (CPE).Teaching sessions to be arranged as well as the issue highlighted at induction and infection control updates.

Paediatric A&E
Complaints-there have been two complaints in Paeds A&E. One related to effective communication and the other to a missed diagnosis which is now subject to investigation.

4.3 Discharge Destinations

In response to a question previously raised by a member of the public regarding destinations of discharged patients, Table three summarises patients' discharge destinations for the period April 2011 to the end of June 2011. It can be seen that, in the main, patients are discharged to their 'usual place of residence'.

Table three: Discharge destinations

Discharge destination	**April 2011**	**May 2011**	**June 2011**
Usual place of residence	5421	5719	5919
Patient died	119	107	73
Other NHS provider	86	104	122
Not Known	55	47	62
NHS Nursing Home	48	44	53
Non-NHS Hospital	12	19	12
Temporary place of residence	6	7	9
Non-NHS Hospice	3	5	3
Police Station	1	1	
Total	**5751**	**6053**	**6253**

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

Date: 20th July 2011

5. Appendices

Appendix 1 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