Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
30th September 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 August shows areas which will require a continued effort into improvement measures. • MRSA: there has been no MRSA case during August • VTE Assessment (Venous Thromboembolism assessment is progressing; work is in place to ensure complet data capture Other areas worthy of noting include the continued improvement in hip fractures within 36 hours. A briefing on the Enhancing Quality Programme is attached as appendix 3. The paper gives an overview of the programme and the benefits anticipated for the pathways involved. Current performance on CQUIN targets is 100% for Quarter 1 and on target for Q2.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The major risk to the Trust remains MRSA. A full action plan is in place and monitored. No further cases have been reported.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Good Quality services are essential. The quality metrics are benchmarked by the Strategic Health Authority and nationally. .
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:	22nd September 2010
Decision:	For Noting

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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)

	Patient Safety & Quality	Annual Target	Forecast	Actual	Change			YTD
1-01	Standardised mortality (Relative Risk)*	82	82	80**	▲	▼	▲	82**
1-02	Crude mortality	2.6%	1.6%	1.6%	▲	▲	▼	1.4%
1-03	MRSA (Hospital only)	5	5	0	▲	▼	▲	5
1-04	C.Diff	90	50	5	▲	▼	▲	21
1-05	Patient Satisfaction (Your Feedback)	90%	90%	76.3%	New Survey		▼	76.5%
1-06	Formal complaints	361	357	19	▼	▲	▲	147
1-07	SUIs	14	14	1	◄►	◄►	▼	6
1-08	Falls - resulting in significant injury (grade 3)	29	20	4	▼	▲	▼	8
1-09	Hip fractures treated within 36 hrs	70%****	83.5%	76.5%	▼	▲	▼	67.7%
1-10	Readmissions within 14 days	3.7%	3.2%	2.4%	▼	▲	◄►	3.1%
1-11	VTE Assessment*****	90%	90%	70.0%	New System		▼	78.2%
1-12	Summated Adverse Report Index (SARI)	1924	1848	108	◄►	▲	▲	816

Line by line explanation of each measure

1-01-1-02:

The Trust August SMR is 80. This an improvement on last month's figure of 89. The crude mortality rate is 1.6% which is a small rise on last month's value of 1.4%. Both figures show a very good performance by the Trust and this is discussed in more detail in section

1-03-1-04:

The Trust performance with respect to Hospital acquired infections shows no cases of MRSA and 5 cases of C.Diff. The Trust is clearly on course to deliver the year-end C.diff target but is also on course to show a 5% improvement on last year's outturn and a 50% reduction in c.dif mortality rates.

1-05: Trust continues to develop the use of new patient feedback report. The figure for patient satisfaction of 76.3% is similar to last month's figure of 76.7%. The challenge is to increase the rate of completion of the new forms in all clinical areas, so that the data accurately reflects the general experience of patients across the whole Trust. Ensuring that this real time, patient experience metric sucessful captures the Trust performance remains a key objective of Programme 1 and is under regular review and scrutiny.

1-06: Formal complaints has shown a fall for the second consecutive month and means that the Trust is on target to show a 10% reduction in complaints across the year.

1-07: There has been 1 SUI reported this month. This is discussed else where in the Trust papers.

1-08: There were 4 falls resulting in grade 3 injury this month. This shows a detoriation on last month's figure of 0. All of these are in the process of having root cause analysis to determine if anything could have prevented this. The Trust remains committed to achieving its internally set target of a 10% reduction in falls over last year's performance.

1-09: Hip fractures treated within 36 hrs shows a value of 76.5% which is a reduction on the excellent performance of last month (86.2%). This does however meet the PCT trajectory of 70% in Q2. The August performance has been analysed further; there were 32 admissions compared to 29 in July. There was also a peak of admissions on Friday and Saturday which created capacity and operational pressures. There continues to be refinement of systems and process of capacity management to ensure the Trust can cope with activity peaks.

1-10: The Trust 14 day readmission rates remain on target but as has previously been discussed this figure may not be robust or clinically significant. More detailed data and analysis on 30 day readmission is being collected and will be presented at the next Board meeting.

1-11: The Trust VTE figure assessment figure is below target. All areas are aware of the importance of this and theatres have introduced a safety mechanism to prevent any patient entering theatre without assessment. Trauma and Orthopaedics assured CGC that compliance was in fact 98% that the issue is entering data into the In Patient List system which is where the data is captured from. A new process has been put in place to ensure data is recorded.

1-12 The SARI represent the absolute number of adverse events reported in the the Trust's dashboard. This figure is a locally developed index of "avoidable" harm. This figure has shown improvement in 2 successive months.The Trust is on target to deliver a 10% reduction (improvement) in reported harmful events.

1.3 WQI (Ward Quality Indicators) commentary

The WQI definitions can be found at Appendix 2

The WQI scorecard can be found at Appendix 3

2 Mortality and Morbidity

2.1 Dr Foster Report

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

1.2 Trust Mortality and Morbidity Meeting (June 2010)

There were 86 deaths in June giving the Trust a CMR 1.27%.

- 73 of the deaths were in medicine (84%, CMR 3.81%),
- 9 deaths in surgery (10%, CMR 0.7%),
- 3 in orthopaedics (3.4%, CMR 0.47%)
- 1 in paediatrics (CMR: 0.17%).

To benchmark the mortality data for acute medicine we have used the SHA quality observatory tool. In the 3 main acute diagnostic groups: Cardiology, thoracic (chest) medicine and care of the elderly, the Trust has a mortality rate in all three groups which is below the SEC mean, and a performance that shows mortality rates which are 50% below national mean. Acute surgical performance is also below the national and SEC mean.

Although Trauma and Orthopaedics' mortality rate is slightly higher than the SEC mean (3.2% vs 3.8%), it should be stressed that ASPH is a centre for Trauma and the numbers of deaths in trauma are extremely low (in June was 3 cases) making accurate, and clinically significant, comparisons very difficult. All 3 trauma and orthopaedic cases have been reviewed at the directorate M&M and no areas of concern were raised.

One of the surgical deaths was an elective patient. This case has been presented, by the consultant involved, to the surgical M&M, and learning has been identified and shared. I have asked that this case should be logged as an incident, and a report presented and shared at the CGC.

The single paediatric death was reviewed at the Paediatrics M&M, no concerns were identified.

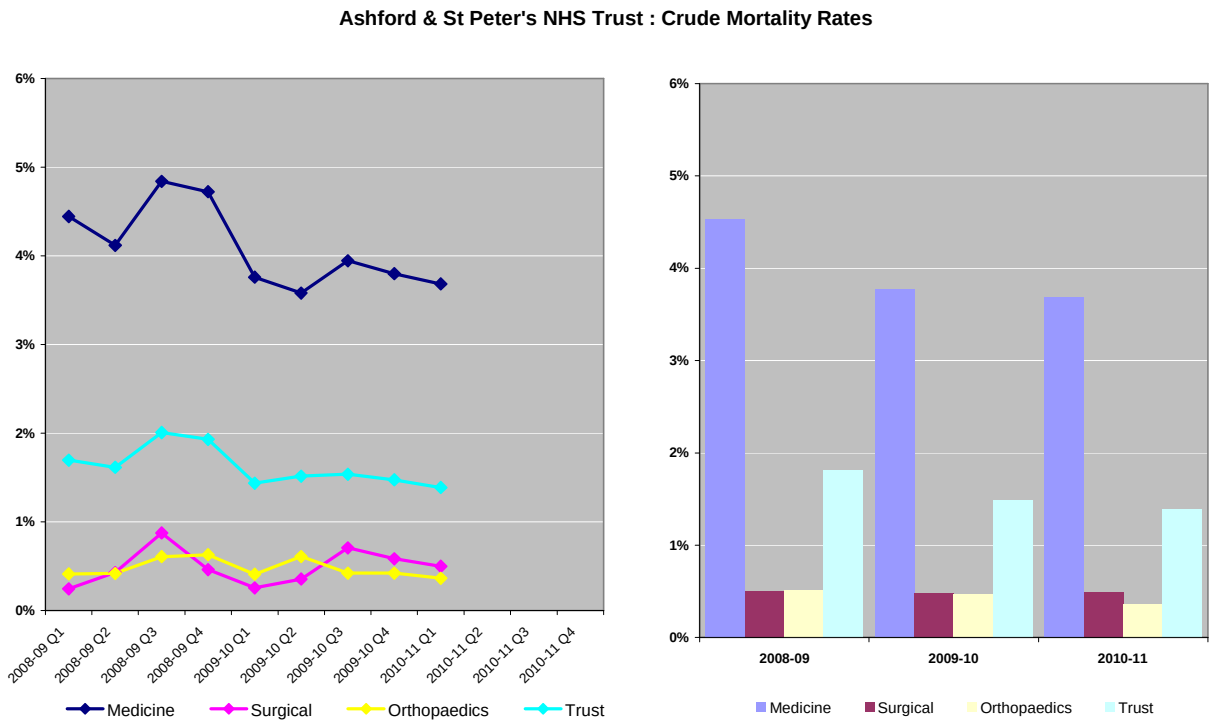
The demographic data identified pneumonia as the highest represented HRG in line with previous reports. There were no issues of concern generated by the review of the demographic data. 48 sets of notes were reviewed by the named consultants (57%) cohort. No additional concerns were identified.

Medicine will review all deaths under 50 years and all deaths within 24 hrs of admission at their next M&M this will be reported to CGC.

A 20% sample of the notes audited was re-reviewed by the MD against the Trust's proforma. No discrepancies or areas of concern were identified

2.3 Trust mortality statistics 2008/09 to 2009/10

Figure 1 :ASPH CMR Quarters from 2008/09 to date



The data shows, as reported to the Board in previous quality reports, that the Trust's CMR is driven primarily by acute medicine. The CMR for medicine has progressively fallen from a value of 4.4% in Q1 2008/09 to the current value of 3.8%. This reduction represents approximately 200 less deaths in the Trust from 2008/09 to 2009/10. This reflects the large changes in the practice of acute medicine which have included much greater direct consultant involvement in early patient assessment and care planning and improved patient pathways. There has also been great improvement in the early identification of physiologically compromised patients with involvement of critical care services in the assessment of the use of non-invasive ventilation, medical HDU and ITU.

The Trust's overall CMR shows a similar profile of improvement, (as it closely tracks the mortality in medicine). This is reflected in the Trust's excellent SMR performance.

Surgical and Orthopaedic mortality remains very low. There is a trend over the last year for a reduction in mortality, particularly in Orthopaedics. This may reflect the improved performance the Trust has seen in early trauma interventions such as fractured neck of femur treatments.

2.4 Elective vs. emergency Caesarean Section rate

The Board has been tracking the reduction in elective LSCS rate during the year, in line with the national and PCT targets. The Trust is now showing a rate of 22% against the target of 25%.
A question was raised at the last Board meeting about the possibility that the reduction in elective CS might be mirrored by a rise in the emergency CS rate. This would be an unpredicted, adverse outcome.
The data shows that the emergency LSCS rate 2009/10 was 16.2% and YTD 2010/11 is 15.4%. This illustrates that the overall rate of both emergency and elective LSCS has fallen. This is also reflected in an increase in the spontaneous vaginal delivery rate from 57.9% to 60.7%. This shows the Trust is showing the intended outcome of the national directive, namely to increase the number of women experiencing normal childbirth without surgical intervention.

3 Quality Update

3.1 NPSA Safety alerts

Overdue alerts
Two alerts remain overdue due to lack of software availability.

Deadline	Description	Status
05-Feb-07	Early identification of failure to act on radiological imaging reports	The software is now in place and being tested and it is anticipated that this alert will be closed imminently..
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 iSOFT (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.

New Alerts issued this month

Date of Issue	Description	Deadline	Lead	Status
26 August 2010	Prevention of over infusion of intravenous fluid and medicines in neonates	28 February 2011	Audrey Elmore	On target

3.2 NPSA organisation feedback 1st October 2009 – 31st March 2010

The NPSA organisation feedback has been issued from the NPSA for the period 1st October 2009 – 31st March 2010. The Board may recall the trust had a data glitch which

resulted in inaccurate data being pulled by the national reporting and learning system (NRLS) from our Datix system which highlighted the Trust as a low reporter. This has been rectified and the report indicates the Trust is in the upper quartile of reporters for similar organisations.

ASPH reporting rate is 7.2 incidents reported per 100 admissions indicating a strong reporting culture.

Full interpretation of the report will be discussed at the Safety and Risk Committee.

3.3 PROMS

The National Publication of PROMS (Patient Related Outcomes) has been released on September 16th. The detail of this report will be brought to the next Board meeting. For the four procedures involved, hips and knees, varicose veins and the groin hernia. The data will provide valuable information to support patient care, helping clinicians to understand how procedures are impacting on the patient, and how patients perceive the surgery has improved their quality of life. The data may also help support improved management of patient expectation and patient information.

3.4 Patient Feedback

'Your feedback' forms have been established in all adult inpatient areas. Wards are being set targets to encourage a larger number of patients to complete the forms in order to enable us to maintain a process of continuous feedback and improvement. This will be monitored and is also reported in the WQIs. . Noise at night continues to be an issue and work is ongoing to treat this. The main issues identified so far fall into 2 groups; patients with dementia who are disturbed at night, and secondly , staff footwear.

3.5 Enhancing Quality Programme

A full report is provided at Appendix 1

3.6 Ward Quality indicators

Ward Quality Indicators Report for August 2010

There was a non submission for Hand Hygiene Compliance from the Eye Unit at Ashford. This has been discussed with the Matron for the area who is aware that this is not acceptable practice and will be discussing further with her team.

Peripheral cannula care this month demonstrates some underperforming areas. Within these areas this has been found to be lack of documentation by the medical staff and a lack of daily checking by the nursing staff. Action has been taken by the matrons and extra training put in place. The Matron has discussed the issues at the orthopaedic clinical governance group and the divisional meeting.

Blood Traceability on return of tags has improved further this month from13 areas achieving 100% in July to 15 areas achieving 100% compliance in August. Further improvement is still required to ensure all areas attain 100%.

Patient falls have decreased in overall number in most areas. There are 4 that resulted in injury.

Complaints have risen in MAU and Accident &Emergency and NICU. These are being actioned by the relevant matrons.

Medication administration errors and prescribing errors have decreased.

VTE assessment is a new indicator that has been added and 7 areas are achieving compliance. Further work is ongoing to improve this score.

Your Feedback is also a new indicator and only 2 areas are achieving above 90%. Further work is ongoing to improve this score.

Two further indicators are to be included for the month of October those being MUST (Malnutrition Universal Screening Tool) and Discharge checklists

3.7 The Role of Boards in Improving Patient Safety- **Monitor**

The Board received the Monitor Publication *The Role of Boards in Improving Patient Safety* at its July Meeting. The then Chief Nurse prepared an initial action plan a number of aspects of which have already been taken forward , for example enhancing the remit and terms of reference of the Clinical Governance Committee, increasing the use of patient feedback within consultant appraisal and continuing the focus on Board visibility.

Further work on agreeing next steps will be taken forward once the permanent Chief Nurse has taken up appointment and familiarised herself with the Trust**.**

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

Date: 29th September 2010

Appendix 1

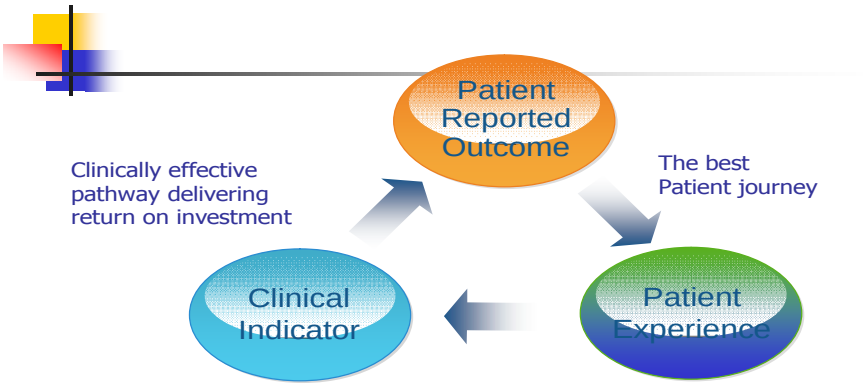
Enhancing Quality Programme Briefing Paper
September 2010

1. Overview

Enhancing Quality is a PCT Alliance sponsored Programme taking its starting point from the innovative work done in North West SHA. We will be collaborating with them and other SHA areas to join up our learning and development.

1.1 What is EQ?

Essentially it is a clinical change Programme which triangulates information to drive quality improvements in clinical interventions, patient reported outcomes and patient experience. An incentive system through CQUIN will recognise and reward providers to improve their patient care consistently, just as QoF has done in General Practice.



1.2 Programme Desired Outcomes

The vision for the Programme is to drive up the standards of hospital and community care by benchmarking and supporting clinical leadership to change them. This will be regardless of where patients live, what their local hospital or community provider is or who their GP is.

From 2010/11 the Programme will be a significant component of the local approach towards Commissioning for Quality and Innovation (CQUIN) and will:

- save lives and improve care ;
- improve the quality of life for patients;
- provide world class health services
- establish a quality improvement process focused on world class results for patient
- improve the patients experience of healthcare

The Programme will deliver this by:

- Clinicians using information they have generated to improve their results.

- Developing improvement skills in clinicians and managers; using data to improve care; promulgate techniques in changing 'hands on practice'; engaging patients in the change process.
- Encouraging all units towards delivering current upper decile performance through incentives and celebrating achievements.
- Extending the scope of clinical metrics, performance and benchmarking driven by clinicians, patients and stakeholders

1.3 Programme Benefits

Through improving the quality of services, financial benefits will be delivered, including:

- a reduction in complications;
- a reduction in re-admissions;
- avoidance of hospital admissions;
- a reduction in hospital days.
- Improved patient experience
- Improved health outcomes for patients
- Safer care
- Stimulating an environment for innovation and quality improvement
- Improved World Class Commissioning competency assessments for PCTs

1.4 Why is it important?

The baseline information from elsewhere shows that many patients don't always receive the interventions that would maximise their recovery and health. We already know from the work of the SHA Quality Observatory that there are huge variations across the SEC patch.

EQ aims to streamline care, improve documentation and generally make the care provision more consistent and reliable – every time for every patient. We know that reliable care will yield higher quality clinical care, better outcomes and lower costs.

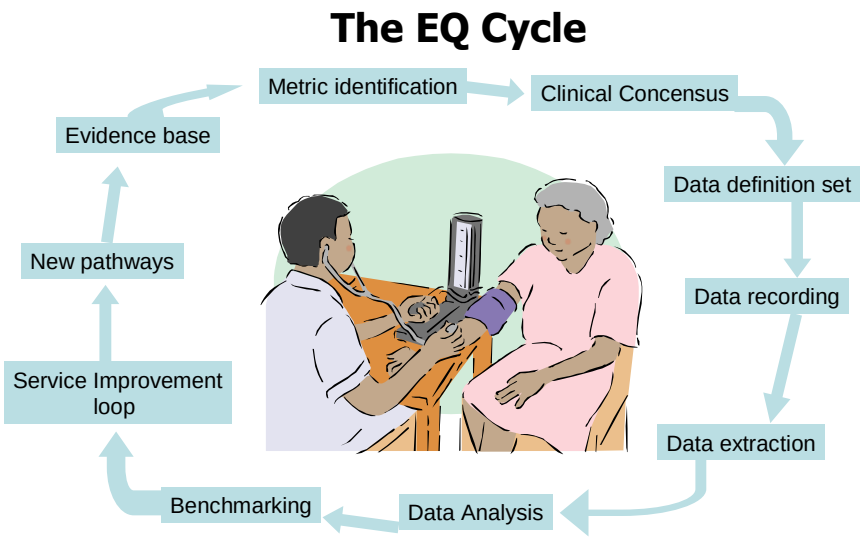
There are 5 Acute work streams in EQ

- Hip and Knee replacement
- Acute MI
- Pneumonia
- Heart Failure
- Dementia

It will form 0.5% of the Commissioning for Quality and Innovation (CQUIN) payments – a potential total of £10.9 million across SEC for acute Trusts.

1.5 How does it work?

It's very similar to QoF!
Using international evidence, a set of clinical indicator metrics are agreed with clinicians across SEC. These are the interventions known to have the greatest impact on optimising patient outcome. NICE, National Service Frameworks and other initiatives have also provided us with evidence based guidance but EQ takes this a step further – it goes on to measure and report whether each and every patient received that appropriate care at the right time – each and every time.



Once the required metrics are defined and agreed, all providers must have an efficient mechanism to collect and submit the data and then review individual and comparative results. To do this, a standardised data collection and reporting tool will be made available to all provider organisations. We are looking to see if we can find innovative solutions to data collection to make it easier for clinicians to record the necessary information as part of their clinical care in exactly the same way as GP systems do. Patients meeting the criteria for each pathway can be identified using algorithms from a Monthly Trust Data upload direct to the standardised data collection tool. At any time, the Trusts can review their performance in the tool.

Once the information is collected and validated it is benchmarked against other providers, nationally and internationally, enabling clinical teams to see where they can improve their patient care.

1.6 Shaping Clinical Audit for the future

This programme is seen as a successful model for Clinical Audit and how to change practice to improve patient care. It shows how current Clinical Audit practices could be developed in the future to use this approach.

2. Summary Position at Q2

2.1 Summary Position

Table 1 below summarises the position for each milestone. SEC PCT Alliance is commencing work towards Milestone 1.7 ‘Participation in PROMS & Patient Experience’. Equally milestone 1.8 work stream has not yet been launched with Trusts.

Table 1 Summary position for Q1 and Q2

	Work streams/Quality Pathways	Target	Period	Current Position	Issues and Risks
1.1	9 Leads appointed by April 2010 (Q1)	100%	Apr 10-Jun 10	100%	Achieved
1.2	Complete data submission into QMR (Q1, Q2, Q3, Q4)	95%	Apr 10 - Mar 11	100%	Meeting deadlines always very tight (prioritisation?)
1.3	Clinical metrics signed off (Q2)	100%	Apr 10-Jun 10	100%	Achieved
1.4	Programme Lead attendance and reports delivered on time (Q4)	80%	Apr 10-Mar 11	100%	Achieved
1.5	Complete Review Questionnaire and full contribution to the performance review day (Q2)	100%	Jul 10-Sept 11	100%	Achieved
1.6	Successful QMR/SUS data pilot by July 2010 (Q2)	100%	Jul 10-Sept 11	100%	Achieved
1.7	Participation in PROMS & Pt experience research and measures development events (Q4)	85%	Apr 10-Mar 11	N/A	PCT Alliance to launch work stream Q3
1.8	Quality audits carried out (external audit programme) (Q4)	100%	Jul 10-Mar 11	N/A	PCT Alliance to agree process with Trusts for Q4
1.9	Attendance & Involvement in EQ Programme events and Collaboratives (Q2, Q4)	80%	Apr 10-Mar 11	100%	Milestone Q2 achieved however risk identified with Clinical Engagement and continuing commitment to the Programme. Need attendance at all Collaborative dates by Clinical Lead and key staff in team to meet CQUIN Q4.
1.10	Improvement from baseline position for each patient specific pathway (Q4)	100%	Oct 10-Mar11	N/A	To be measured Q4

3. Programme Structure, Governance and Assurance

A governance structure and assurance programme has been established to support the programme and the Clinical Leads to deliver the programme milestones. The post of Programme Manager was established in mid April, and Frances Scott has been appointed on a secondment basis until December 2011.

The EQ Programme was launched in January 2010, SEC PCT Alliance has provided extremely positive feedback to advise the Trust has moved from a poor performing Trust in March to now performing as one of the forerunner Trusts in the Programme.

4. Data Management and Coding

Agreement has been made with external partner Premier and the PCT Alliance for our Trust to send on a monthly basis direct to them the audit data set information, which will be uploaded to the Audit Management Software, Quality Measures Reporter (QMR) database. Information services have fully supported the programme. Testing has commenced to ensure this data transfer is

robust, secure and correctly reflects the patient data set for the programme. Additionally validation has commenced to verify the information.

Key staff have been trained to use the QMR tool, including the ward clerks in Orthopaedics who will be responsible for the inputting of the Hip and Knee pathway data.

Clinical Coding staff are fully informed and briefed of their role in the programme and supporting the Clinical Leads with improving the documentation and recording of diagnosis. This underpins the identification of patients who qualify for inclusion in the EQ programme.

A 10 Patient case note audit for each pathway has been completed in order to test the process and to gain familiarity of the QMR audit tool.

5. Clinical Focus Groups and Clinical Engagement

Clinical Focus Groups	Clinical Lead
AMI	Dr Peter Wilkinson
Dementia	Dr Raad Nari
Heart Failure	Dr Ian Beeton
Hip and Knee	Mr Constant Busch
Pneumonia	Dr Paul Murray

Each of the four pathways have appointed Clinical Leads and two of the four have established EQ pathway improvement teams as a prerequisite to the forthcoming series of Collaborative Learning events to be held from 30th September 2010 to 31st March 2011. Clinical leadership and active involvement in the Collaborative events are seen as key to delivering benefits to patients. Attendance of events is a required demonstration and significant contribution to our CQUIN milestone achievement.

Early adoption of a team approach has been taken forward by both Hip and Knee and AMI Clinical Leads. Clinical Engagement with Heart Failure Lead has been challenging as this Clinician has a 'stand alone' approach to fulfilling the requirements of the programme. Pneumonia Clinical Lead has not been fully engaged in the programme from onset and time commitment to the programme has been challenging with other key commitments. The Programme Lead is currently working with Clinical Leads and the Directorate Managers to ensure and improve the Clinical Engagement for these two pathways.

It is recommended that the Enhancing Quality Programme and CQUIN milestone achievement features as part of the Directorate performance reviews and also as part of the Clinical Leads PDR performance reviews.

5.1 Hip and Knee

Prospective audit on the Ashford site has been implemented on 1st July. All the ward clerks have been trained to use the QMR tool and they will be responsible for the input of the audit data. A plan to rollout the prospective audit model is in place following the Collaborative session on 7th October. In the mean time retrospective audit process is being used to capture the data at SPH.

5.2 AMI

A trial for prospective audit took place led by the Lead Clinician. This proved unsuccessful so a retrospective audit process is in place completed by the Medical Support Worker on CCU to extract the data and the Trust Clinical Audit department to input results. This process needs to be

reviewed and alternative solutions are being sought, an on-line electronic data capture idea using the same process as Heart Failure is preferred.

5.3 Heart Failure

This pathway has proceeded with an electronic data capture process using the Discharge letter system (Inpatient lists) and junior doctors are responsible for completing the audit data capture. A transfer of the data to QMR is feasible; however the reporting for this pathway will be delayed as a consequence of choosing this delivery method. Information Services have developed the Inpatient List system to support this. Formally launched by Dr Beeton to junior doctors at the beginning of August, take up has been slow. Support, refresher and additional education sessions are being set up to improve the process. Additionally other solutions including patient alert systems are being considered. Dr Beeton has developed a Heart Failure Discharge booklet for patients.

5.4 Pneumonia

This pathway has proceeded with a retrospective audit. Support has been provided initially by the Quality Department's Clinical Audit department. Plan to develop a prospective process for audit capture following learning from the forthcoming Collaborative.

5.5 Dementia

Following a two day workshop led by SEC PCT Alliance, Clinical measures for Dementia have been established and are currently out for consultation. These are not part of the current CQUIN metrics and milestones. Clinical Lead and strategy group established within the Trust.

6. Communications

A series of awareness presentations and cascades have been delivered to key staff in the Trust, together with briefing letters to outline the background to the programme and the implementation plans. Update reports have been produced monthly to the PCT, PCT Alliance and internally to the Trust.

7. Finance

7.1 Actual Quarterly Performance

The achievement of Q1 CQUIN payment of £100,000 is outlined in Table 2 on page 7.

7.2 Predicted Quarterly Performance

Table 3 on page 7 outlines the predicted Q2 performance and income streams expected. Although we are on target to achieve Q2 payments, achievement of 1.2 for Q3 and Q4 and 1.9 in Q4 are considered at risk due to the reasons as previously outlined in Table 2 on page 4.

Table 2

ACTUAL QUARTERLY PERFORMANCE - Q1

	Work streams/Quality Pathways	Target	Q1	Q2	Q3	Q4	Weighting	Target Income	Income
1.1	9 Leads appointed by April 2010 **(Q1)**	100%	100%				10%	£100,000	£100,000
1.2	Complete data submission into QMR **(Q3, Q4)**	95%					15%	£150,000	
1.3	Clinical metrics signed off **(Q2)**	100%		100%			10%	£100,000	
1.4	Programme Lead attendance and reports delivered on time **(Q4)**	80%					10%	£100,000	
1.5	Complete Review Questionnaire and full contribution to the performance review day **(Q2)**	100%		100%			5%	£50,000	
1.6	Successful QMR/SUS data pilot by July 10 **(Q2)**	100%		100%			10%	£100,000	
1.7	Participation in PROMS & Pt experience research and measures development events **(Q4)**	85%					5%	£50,000	
1.8	Quality audits carried out **(Q4)**	100%					10%	£100,000	
1.9	Attendance & Involvement in EQ Programme events **(Q2, Q4)**	80%		100%			10%	£100,000	
1.10	Improvement from baseline position for each patient specific pathway **(Q4)**	100%					15%	£150,000	
							100%	£1,000,000	£1,000,000

Table 3

PREDICTED QUARTERLY PERFORMANCE – Q2

	Work streams/Quality Pathways	Target	Q1	Q2	Q3	Q4	Weighting	Target Income	Potential Income Q2
1.1	9 Leads appointed by April 2010 **(Q1)**	100%	100%				10%	£100,000	Achieved
1.2	Complete data submission into QMR **(Q3, Q4)**	95%					15%		
1.3	Clinical metrics signed off **(Q2)**	100%		100%			10%	£100,000	£100,000
1.4	Programme Lead attendance and reports delivered on time **(Q4)**	80%					10%		
1.5	Complete Review Questionnaire and full contribution to the performance review day **(Q2)**	100%		100%			5%	£50,000	£50,000
1.6	Successful QMR/SUS data pilot by July 10 **(Q2)**	100%		100%			10%	£100,000	£100,000
1.7	Participation in PROMS & Pt experience research and measures development events **(Q4)**	85%					5%		
1.8	Quality audits carried out **(Q4)**	100%					10%		
1.9	Attendance & Involvement in EQ Programme events **(Q2, Q4)**	80%		100%			10%/2	£50,000	£50,000
1.10	Improvement from baseline position for each patient specific pathway **(Q4)**	100%					15%		
							100%	£400,000	£400,000

Appendix 2 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 - August 2010

N/S: No submission

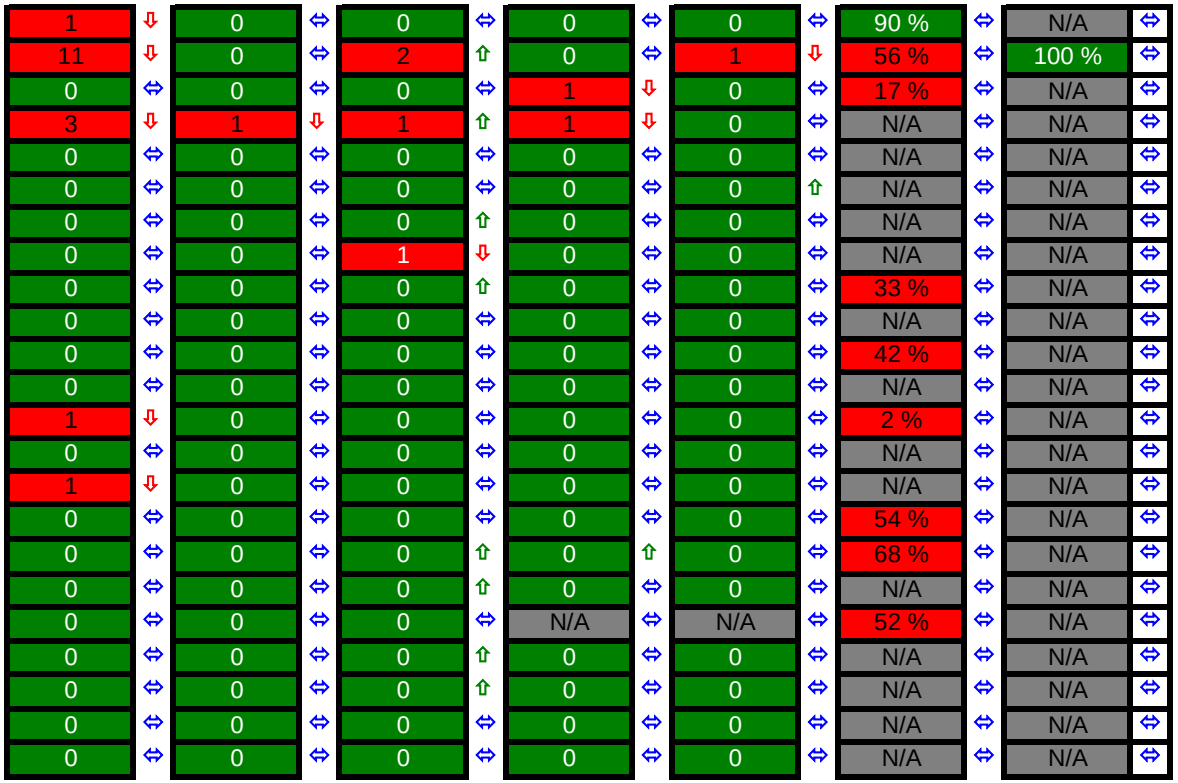
		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Saving Lives			
					Central Lines Insertion	Central Lines After Care	Urinary Catheter Insertion	Urinary Catheter After Care
		>=90%	*=0*	*=0*	*>=95%*	*>=95%*	*>=95%*	*>=95%*
		89% - 80%			*94% - 85%*	*94% - 85%*	*94% - 85%*	*94% - 85%*
		<80%	*>=1*	*>=1*	*<85%*	*<85%*	*<85%*	*<85%*
MEDICINE 1,2,3	ASPEN	100 % ⇔	0 ⇔	0 ⇧	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	CCU	100 % ⇔	0 ⇔	0 ⇔	100 % ⇔	100 % ⇔	100 % ⇔	100 % ⇔
	BIRCH	100 % ⇔	0 ⇔	0 ⇔	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	MHDU	100 % ⇔	0 ⇔	0 ⇔	100 % ⇔	100 % ⇔	100 % ⇔	100 % ⇔
	HOLLY	100 % ⇔	0 ⇔	1 ⇔	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	CEDAR	100 % ⇔	0 ⇔	0 ⇧	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	MAY	98 % ⇧	0 ⇔	2 ⇧	N/A ⇔	N/A ⇔	N/A ⇔	86 % ⇩
	MAPLE	98 % ⇧	0 ⇔	1 ⇩	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
ASHFORD	CHAUCER	100 % ⇧	0 ⇔	0 ⇔	N/A ⇔	N/A ⇔	N/A ⇔	100 % ⇔
	WORDSWORTH	100 % ⇔	0 ⇧	0 ⇔	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	FIELDING	100 % ⇧	0 ⇔	1 ⇩	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
TRAUMA & ORTHOPAEDICS	DICKENS	100 % ⇔	0 ⇔	0 ⇔	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	ELM	100 % ⇧	0 ⇔	0 ⇔	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	JUNIPER	95 % ⇧	0 ⇔	0 ⇧	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	ROWLEY BRISTOW	100 % ⇔	0 ⇔	0 ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔
SURGERY	KINGFISHER	93 % ⇧	0 ⇔	0 ⇧	N/A ⇔	N/A ⇔	100 % ⇔	100 % ⇔
	FALCON	100 % ⇔	0 ⇔	0 ⇔	N/A ⇔	100 % ⇔	100 % ⇔	100 % ⇔
	SDU	100 % ⇧	0 ⇔	0 ⇔	N/A ⇔	90 % ⇩	N/A ⇔	100 % ⇔
	ADMISSIONS LOUNGE	100 % ⇔	0 ⇔	0 ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔
	HERON	100 % ⇔	0 ⇔	0 ⇧	N/A ⇔	N/A	100 % ⇔	100 % ⇔
	MAXFACS CLINICS AH	97% ⇧	0 ⇔	0 ⇔	N/A ⇔	N/A ⇔	N/A ⇔	N/A ⇔

	KESTREL	Closed	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
EMERGENCY SERVICES	MAU	98 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	SAU	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔
	A&E	93 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
PAEDIATRICS	OAK	100 %	⇧	0	⇔	0	⇔	N/A	⇔	100 %	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	ASH	99 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	PAED A/E	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	NICU	99 %	⇧	0	⇔	0	⇔	N/A	⇔	100 %	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
THEATRES	THEATRES SPH	100 %	⇔	0	⇔	0	⇔	100 %	⇔	N/A	⇔	100 %	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	THEATRES ASH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	DSU SPH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	100 %	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	DSU ASH	90 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
IMAGING/ENDOSCOPY	ENDO	99 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	IMAGING ASH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	IMAGING SPH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
CRITICAL CARE	ITU	100 %	⇔	0	⇔	0	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔	100 %	⇔
MATERNITY	JOAN BOOKER	99 %	⇧	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	100 %	⇧				
	MATERNITY/ANC	95%	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	LABOUR WARDS	88%	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
OUTPATIENTS	OUTPATIENT ASH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	OUTPATIENT SPH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
OPHTHALMOLOGY	EYE CLINIC/UNIT AH	N/S	⇩	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔
	EYE CLINIC SPH	100 %	⇔	0	⇔	0	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔	N/A	⇔

		Cleanliness	Matron Environment Audit	Blood Traceability	Pressure Ulcer Prevention					Mixed Sex Wards Compliance
Peripheral Cannula	Peripheral Cannula After Care				Compliance with monitoring of Pressure Ulcer	Hospital Acquired Grade 1	Hospital Acquired Grade 2	Hospital Acquired Grade 3	Hospital Acquired Grade 4	
>=95%	*>=95%*	*>=85%*	*>=90%*	*=100%*	*=100%*	*<=3*	*<1*	*<1*	*<1*	*=0*
94% - 85%	*94% - 85%*	*84% - 75%*	*89% - 80%*		*99% - 76%*	*1- 2*	*1- 2*	*1- 2*	*1- 2*	
<85%	*<85%*	*<75%*	*<80%*	*<100%*	*<=75%*	*>3*	*>=3*	*>=3*	*>=3*	*>=1*
100 %	90 %	93 %	93 %	50/51	100 %	1	0	0	0	100 %
100 %	100 %	100 %	96 %	2/2	100 %	0	0	0	0	N/A
100 %	100 %	99 %	96 %	6/6	100 %	0	0	0	0	100 %
100 %	100 %	95 %	93 %	6/6	100 %	0	0	0	0	N/A
100 %	100 %	96 %	93 %	6/6	100 %	1	0	0	0	100 %
100 %	100 %	96 %	97 %	7/9	100 %	1	0	0	0	100 %
50 %	83 %	98 %	92 %	29/29	100 %	N/A	1	0	0	100 %
90 %	90 %	92 %	95 %	27/27	100 %	0	0	0	0	100 %
100 %	N/A	98 %	93 %	N/A	100 %	0	1	0	0	100 %
100 %	100 %	98 %	95 %	6/6	100 %	0	0	0	0	100 %
100 %	100 %	98 %	89 %	6/6	100 %	0	1	0	0	100 %
100 %	100 %	98 %	97 %	3/6	100 %	0	0	0	0	100 %
83 %	100 %	94 %	93 %	38/38	100 %	0	0	0	0	100 %
67 %	100 %	95 %	95 %	24/26	100 %	2	1	0	0	100 %
N/A	N/A	95 %	97 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
80 %	100 %	Closed	95 %	19/19	100 %	0	1	0	0	100 %
100 %	100 %	91 %	97 %	61/65	100 %	1	1	0	0	100 %
100 %	90 %	99 %	98 %	21/22	100 %	0	0	0	0	N/A
100 %	N/A	96 %	95 %	6/6	N/A	N/A	N/A	N/A	N/A	N/A
100 %	100 %	96 %	95 %	5/5	100 %	0	0	0	0	100 %
N/A	N/A	95 %	95 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A

| | | |

Patient Falls			Medication Errors				
Number of falls	Resulting in Injury	Complaints	Administration	Prescribing	VTE Assessment Compliance	Your Feedback
=0	*=0*	*=0*	*=0*	*=0*	*>=90%*	*>=90%*
						89%-75%
>=1	*>=1*	*>=1*	*>=1*	*>=1*	*<90%*	*<75%*
0	0	0	0	2	32 %	77 %
3	0	0	0	0	89 %	N/A
1	0	0	1	0	74 %	84 %
1	0	0	1	1	35 %	N/A
4	0	0	0	3	100 %	66 %
4	0	0	0	0	79 %	73 %
4	0	0	0	0	90 %	88 %
7	0	0	0	0	92 %	65 %
4	0	0	0	0	100 %	98 %
9	1	0	0	0	100 %	64 %
1	0	0	0	0	100 %	79 %
0	0	0	0	0	81 %	85 %
4	1	0	0	0	70 %	80 %
4	1	0	0	0	74 %	69 %
0	0	0	0	0	N/A	N/A
0	0	0	0	0	2 %	76 %
0	0	0	0	0	70 %	81 %
0	0	0	0	0	67 %	N/A
0	0	0	0	0	N/A	N/A
1	0	0	0	0	40 %	77 %
0	0	0	0	0	N/A	N/A


1 0 0 0 0 90 % N/A
11 0 2 0 1 56 % 100 %
0 0 0 1 0 17 % N/A
3 1 1 1 0 N/A N/A
0 0 0 0 0 N/A N/A
0 0 0 0 0 N/A N/A
0 0 0 0 0 N/A N/A
0 0 1 0 0 N/A N/A
0 0 0 0 0 33 % N/A
0 0 0 0 0 N/A N/A
0 0 0 0 0 42 % N/A
0 0 0 0 0 N/A N/A
1 0 0 0 0 2 % N/A
0 0 0 0 0 N/A N/A
1 0 0 0 0 N/A N/A
0 0 0 0 0 54 % N/A
0 0 0 0 0 68 % N/A
0 0 0 0 0 N/A N/A
0 0 0 N/A N/A 52 % N/A
0 0 0 0 0 N/A N/A
0 0 0 0 0 N/A N/A
0 0 0 0 0 N/A N/A
0 0 0 0 0 N/A N/A