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

TRUST BOARD
31st March 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for February 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. The Balanced Scorecard features no red ratings.
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 the equality on access taking into consideration disability, age and that 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.
	Review the paper; discuss the contents seeking additional assurance as necessary.
The Trust Board is asked to:	Agree that the Quality Account Priorities proposed by the Trust's key stakeholders are used as the basis for the completion of the Quality Account.
Submitted by:	Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse
Date:	18th March 2011
Decision:	For Noting and Decision

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

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1 Quality Performance Monitoring

1.1 Dashboard Definitions

The table is made up of 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).

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1.2 Commentary on Quality and Safety Balanced Scorecard

Ashford & St Peter's Hospitals NHS Trust

BALANCED SCORECARD

Position as at: **28 Feb 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	Annual Target	Forecast	Actual	Change			YTD
1-01	**Standardised mortality (Relative Risk)***	82	**82**	**107.3****	▲	▼	▼	**90.7****
1-02	**Crude mortality**	2.6%	**1.8%**	**1.5%**	▼	▲	▲	**1.6%**
1-03	**MRSA (Hospital only)**	5	**5**	**0**	◄►	◄►	◄►	**5**
1-04	**C.Diff**	67	**36**	**1**	◄►	▲	▲	**33**
1-05	**Patient Satisfaction (Your Feedback)**	90%	**84%**	**79.1%**	▼	▼	▲	**76.9%**
1-06	**Formal complaints**	361	**351**	**31**	▲	▼	▲	**322**
1-07	**SUI's**	14	**15**	**1**	▲	▼	◄►	**14**
1-08	**Falls - resulting in significant injury (grade 3)**	29	**16**	**1**	◄►	◄►	◄►	**15**
1-09	**Hip fractures treated within 36 hrs**	85%****	**85.0%**	**96.8%**	▼	▲	▼	**92.0%**
1-10	**Readmissions within 14 days**	3.7%	**3.7%**	**3.8%**	▼	▲	▲	**3.5%**
1-11	**VTE Assessment**	**90%**	**90%**	**91%**	▲	▲	▲	**84.3%**
1-12	**Summated Adverse Report Index (SARI)**	1924	**1724**	**171**	▲	▼	▼	**1581**

* Source data from Dr Foster ** Actual = Dec 2010 YTD =Apr-Dec 2010/11

*** Actual = Dec 2010/11 YTD =Apr-Dec 2010/11 ****Q2=70% Q3 = 85%

1-01 The SMR has increased to the highest value recorded this year at 107.3.
The Dr Foster data base does not identify any areas of concern or indicate any alerts. The data points to the increase in SMR being related to the general increase in emergency activity and also reflects that during this period there was a peak in acutely sick younger people. This data will continue to be monitored and reviewed but there is assurance to the Board that the CMR for February had returned to the previously low value of 1.5%.

1-02 The increased SMR is reflected in the higher CMR rate in this period (see mortality and morbidity table 2) at 2.25% and the higher numbers of deaths 141 vs. 119. The Trust is still on course to achieve the target of 82 for the whole year.

1-03 The Trust continues to perform well against HAI targets and has now recorded 247 days without an MRSA infection, making this the Trust's best ever performance.

1-06 Formal complaints received by the Trust have increased. Initial analysis suggests that these are being driven by the very high operational pressures that the Trust is experiencing.

1-07 There has been 1 SUI this month.

1-09 The rate of hip fracture repair within 36hrs continues to exceed 90%, a performance that places the Trust in the top quartile nationally. Furthermore, the in-hospital mortality from fractured neck of femur at 5% is well below the national average of 7.7%.

1.12 There was a small increase in the SARI value this month; this is driven exclusively by the increase in complaints.

2. Clinical Effectiveness

2.1 Mortality and Morbidity

Table 2

CRUDE MORTALITY RATE BY DIRECTORATE

	CMR DEC 2010	ABSOLUTE NUMBERS	OCT 2010	NOV 2010	DEC 2010
ALL	2.25%	141	▼	▼	▼
MEDICINE	6.34%	119	▲	▼	▼
SURGERY	1.27%	15	▼	▲	▼
ORTHO	1.11%	6	▼	▲	▼
PAEDIATRICS	0.00%	0	▼	▲	◄►

The data relates to Dec 2010, which is in the period covered by the SMR recorded in the Quality Report.

During this period there were 141 deaths which is a 22% increase in mortality on the Trust's November figures.

This rise is seen in all specialities, the most significant spikes were however seen in surgery, 150% increase (6 to 15) and orthopaedics and trauma with a 300% (2 to 6). These figures are also reflected in the mortality rates for these divisions with surgery's mortality rate increasing from 0.45% to 1.27% and orthopaedics from 0.35% to 1.11%. Although the numbers of patients involved is small and almost certainly insignificant with no clear trend emerging from the month on month figures, the surgical and orthopaedic directorates have been asked to review and monitor their performance.

Medicine showed a small rise in mortality of 13% (105 to 119) in this period with the CMR increasing from 5.385 to 6.34%.

All divisions are reviewing deaths through their Mortality and Morbidity meetings which form part of the divisional reports to the Clinical Governance Committee.

The Trust Mortality Meeting continues to review the mortality data for the whole Trust. The group also reviews a summary of the notes on a 50% sample of the Trust's deaths.

Last month's review has shown there is a significant improvement in death certification (creating a strong and reliable link between death certificate, clinical notes and coding).

The communication of information concerning deaths to GPs has also improved. GPs are now notified by letter and a clinical summary of a patient's death at exactly the same time that the death certification is completed at the Trust.

There has also been a marked improvement in the review of all deaths in each of the divisions. All identified cases of unexpected death had been referred for review at the divisional Mortality and Morbidity meetings and are now part of the divisional report to the clinical governance committee.

3. Safety Update

3.1 NPSA Safety alerts

Overdue Alerts
Two alerts remain overdue.

Deadline	Description	Lead	Status
05-Feb-07	Early identification of failure to act on radiological imaging reports	Jonathan Glover	Overdue
Work is ongoing to move towards an IT solution using the Communicator software. Action plan in place to ensure robust interim measures; Radiology Department has employed a clerical assistant and the new manual system is in place, clinicians are signing to acknowledge they have received the report, the test order sheet and subsequent process must be embedded and reviewed to ensure it is working before closure of alert. The PAS system recording of responsible consultant is also being improved and this needs to be completed prior to closure of alert.			
19-Sep-09	Risk to patient safety of not using the NHS Number as the National Identifier for all Patients	Donna Jarrett	No change in status. The iSOFT (PAS) new release (4.3) is required and not yet available. 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. In the meantime and to mitigate the risk the patients' hospital number and usual demographics are used in accordance with the patient identification policy.

3.2 'Never Event' Update

The new list of Never Events is attached at Appendix 1.

In April 2009 the Department of Health (DH) published a 'Never Events' list. This list has now been extended, from 9 'never events' to 25 covering all health care areas, with the aim of maintaining and increasing NHS focus on safety.

'Never events' are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

Implications for the Trust:

- increased risk of a serious incident falling within the category of a never event
- following a 'never event' commissioners can recover the costs of any procedure in which a 'never event' occurred and if appropriate the costs associated with treating the consequences of that 'never event'.

Between April 2010 and February 2011 the Trust has had one incident which would clearly have been classed as a 'never event'. The majority of incidents listed in the new 'never event' list would previously have been regarded as serious untoward incidents.

Trust response to publication:

- amend Incident Reporting Policy to include the extended list
- Publish DH report and 'Never Event' list via Aspire to alert all health care professionals of the amended guidance
- discuss at Clinical Governance Forum
- e-mail to all Divisional Directors/Speciality Leads/General Managers/Clinical Governance Managers/Matrons to ensure they have clear guidelines and procedures in place to mitigate any risks associated with the published list
- position following divisional response reported to Safety and Risk Committee for consideration of training requirements and/or further actions.

3.3 National Health Service Litigation Authority (NHSLA) Trust Rating Update

The NHSLA handles negligence claims and works to improve risk management practices in the NHS. The Clinical Negligence Scheme for Trusts (CNST) is a voluntary membership scheme, to which all NHS Trusts in England currently belong. The Clinical Negligence Scheme for Trusts handles all clinical negligence claims against member NHS bodies. The costs of meeting these claims are met through members' contributions.

The core NHSLA risk management programme is provided by a range of NHSLA standards and assessments. Healthcare organisations are regularly assessed against these risk management standards which have been developed to reflect issues which arise in the negligence claims reported to the NHSLA. There is a set of risk management standards for each type of healthcare organisation incorporating organisational, clinical, and health & safety risks. All NHSLA Standards are divided into three "levels": one, two and three. NHS organisations which achieve success at level one in the relevant standards receive a 10% discount on their CNST contributions, with discounts of 20% and 30% available to those passing the higher levels.

The NHSLA has confirmed that following a recent period of assessment against the relevant risk management standards **ASPH will be accorded Level 2 CNST status** with immediate effect. The Trust reassessment will likely occur sometime in 2013.

4. Patient Experience

4.1 Complaints/Ombudsman Reports

There were 31 complaints received in February compared with 42 in January. This is within our usual variance with an average of 36.6 per month. The divisions with highest complaints were Acute and Emergency Medicine (fifteen), Surgery (five) and Trauma and Orthopedics (five). Acute and emergency medicine have had high rates of complaints in Jan and Feb: 22 and 15 respectively, compared with previous 3 months Oct – Dec when rates were 9, 12 and 7.

The Trust received notification of the outcome of initial assessment of a complaint within Acute and Emergency Medicine that was referred to the Ombudsman for review in January. The Trust has been provided with an opportunity to continue local resolution by undertaking a further investigation. An action plan is being developed to address failings identified and will be shared with the complainant.
This complaint related to care at end of life. Issues included delay and miscommunications in arranging an oncology referral for palliative care, lack of communication with family, concerns regarding inadequate information on transfer from St Peter's hospital to Ashford, and standards of nursing care – e.g. availability of call bells, and the meeting of hygiene needs. The action plan will be reviewed at the Complaints Monitoring Group by the Divisional General Manager for Acute and Emergency Medicine at the meeting on 6th May, and progressed through the division's clinical governance meetings.

4.2 Quality Account 2011/2012

The approach to the development of the Quality Account for 2011/2012 has previously been shared with the Board. A stakeholder engagement event took place on Tuesday 8th March which was

attended by representatives from the Council of Governors, a member of LINks, and two members of the Patient Panel alongside Trust subject matter experts. The Patient Panel had met previously to discuss potential indicators for the Quality Account, and the information from this meeting has been fed into the proposal below.

Those at the stakeholder event discussed progress on last year's priorities, the context within which the NHS and the Trust will be operating in the coming year. The group then worked with staff members in 3 groups to consider recommendations under the headings of Patient Experience, Patient Safety, and Clinical Effectiveness.

The following have been recommended by our key stakeholders as their significant priorities for the Trust for 2011/2012 and would like to see the Trust's Quality Account setting out the action and associated metrics for these priorities:

Patient Experience	Priority 1	To provide **safe and high quality discharge for patients.**
	Priority 2	To provide high quality experience relating to **nutrition and hydration.**
Patient Safety	Priority 3	To provide confidence and reassurance for patients around **infection control.** This should include MRSA and C. Difficil as well as wider preventable infections.
	Priority 4	Improve the quality of nursing care through measurement of nursing sensitive indicators and consequent improvement focus. Two key areas of focus should be - **pressure ulcers** - **falls.**
Clinical Effectiveness	Priority 5	Reduce the hospital emergency and elective **readmission rate**
	Priority 6	Improve **effectiveness of care for those with conditions most commonly associated with death in hospital** - **pneumonia** - **heart failure** The Trust's Enhancing Quality Programme is framing improvement work along these pathways.
	Priority 7	Improve the **experience and clinical outcomes** for those with **long term conditions** by enhancing outpatient management and collaborative working with primary and community services.

Board Action

The Board is asked to approve the priorities outlined above as those upon which the Quality Account should be shaped. The priorities do represent a good fit with the Trust's business planning and internally identified priorities for the forthcoming year. Whilst these priorities might receive particular attention within the Quality Account they do not replace or sideline the other many and varied pieces of Trust work underway to improve the quality of care.

4.3 Ward Quality Indicators (WQI)

The ward Quality Indicators are found at Appendix 2.

Action to implement the Essential Care Spot checks has been taken and these have commenced. The checks have demonstrated some very positive observations, the opportunity to address patient and staff issues in real-time as well as emphasising the role modelling and visible leadership role for senior clinical and nursing staff across the Trust.

Care Rounds, where patients' clinical condition, comfort and needs are actively checked and recorded on an hourly basis have been implemented in the Medical Assessment Unit (MAU). This proactive approach has already had an impact on reducing falls and the use of nurse call bells (patients do not need to call as their needs have been proactively addressed). This proactive model of nursing will be implemented across all ward areas from the 28th March 2011.

For the month of February 2011, the WQI indicate that:

- complaints are reduced on January figures at 22 for the month, the highest area ward or clinical area being A/E which has received 5 complaints
- falls have reduced to 51 for the month continuing a downward trend (80 Dec, 60 Jan)
- MUST compliance has improved on Kestrel ward through input from the nutritional support nurse
- the Discharge Checklist has not been completed this month due to amendments to the audit tool to reflect the new Single Assessment document
- wards that demonstrate 5 or more areas of concern (out of 26 areas of focus reported on the WQI) for February are Kestrel, Falcon, Kingfisher, Maple, Cedar, Holly, Birch and Aspen. The appropriate Matron and Ward Sister have been asked to provide an action plan which will be monitored for progress by the Deputy Chief Nurse.

The tables below outline quarterly trends for the number of non-compliant recordings (breaches) against the WQI targets of 5 key areas of focus out of the 26 WQI. It can be seen that improving trends (reducing numbers of breaches) are emerging for:

- Maple, Holly, Kestrel, May, Elm, Heron and Juniper wards

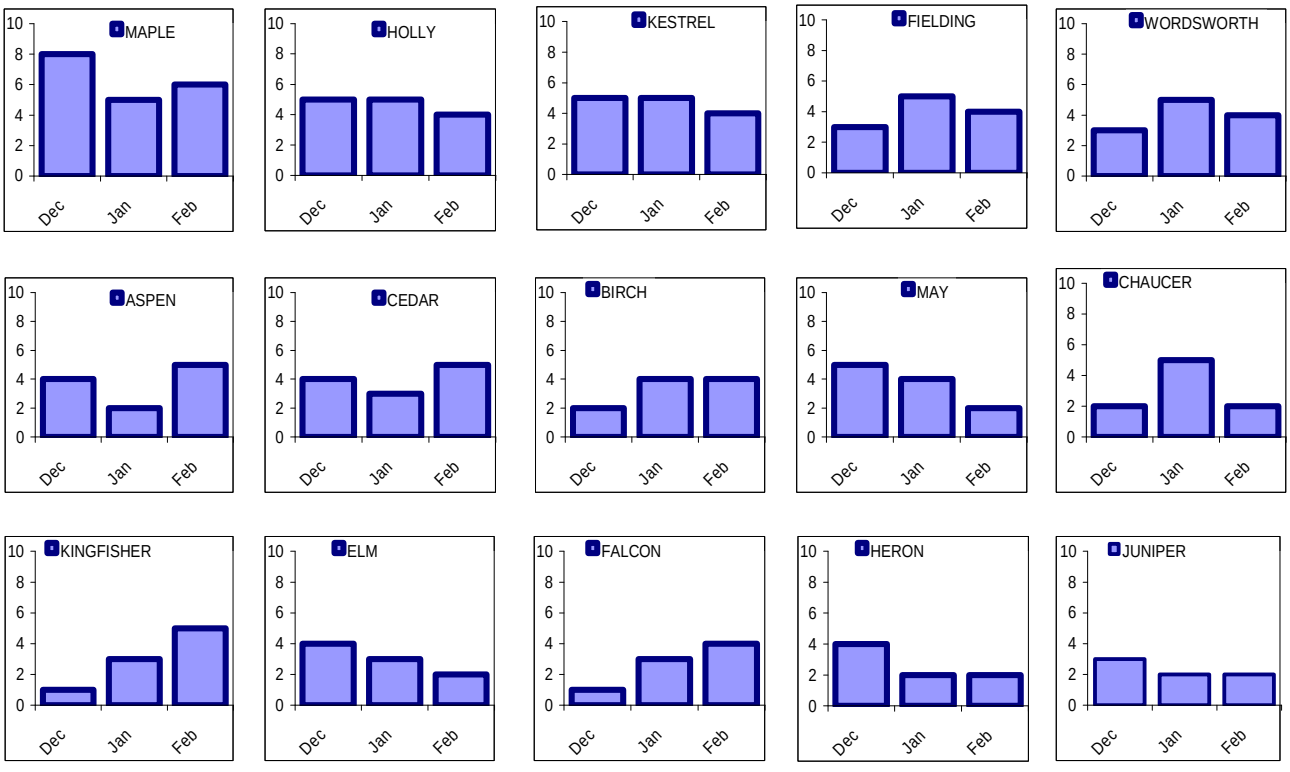
Equivocal trends are apparent for:

- Fielding, Wordsworth and Chaucer wards

Declining trends are apparent for:

- Aspen, Cedar, Birch, Kingfisher and Falcon wards. As detailed above more focused review of these ward areas will be undertaken by the Deputy Chief Nurse with the relevant Matrons and Ward Sisters to both understand these trends and take responsive action.

Ashford and St Peter's Ward Quality Scorecard - Number of Breaches



This kind of trend analysis is useful and will be further developed and tri-angulated with other data and information to enable a robust and reliable view of the quality of care received by patients in these wards areas as well as appropriate and speedy intervention in poor practice and recognition and sharing of good practice.

Blood Traceability

This indicator monitors the number of blood bag tag labels returned to the Blood Bank against the number of blood bags used. The purpose of this monitoring is to enable a robust system whereby the recipient of individual blood products can be traced should an issue with the donor blood quality come to light at a later date. This has become increasingly important with the rise of blood borne infections such as HIV and Hepatitis as well as other infectious diseases such as Variant CJD.

The Medicines and Healthcare Products Agency requires 100% traceability and so anything less becomes a red indicator on the WQI Dashboard.

Many of the red indicators are due to poor completion or incomplete completion of the traceability tags rather than non-return but a decision not to record this would hide the ward areas where more focus on this is required.

The current system for recording is manual and subject to human error which does make a 100% rate a challenge which the Trust must continue to strive for. An electronic system is in development through process mapping of the requirement and is outlined within the Trust IT Strategy but implementation dates are certainly into the future and unconfirmed at present.

In terms of patient risk this indicator is not a measure of the quality or safety of blood product administration and practice and does not indicate a patient risk originating in this way. The risk relates to a less straight forward contact and follow-up process as patients administered individual blood products would have to traced through other systems and records if an issue with the donor blood quality is subsequently identified.

In order to raise the profile of this issue and drive ward level ownership return rates are reported to ward managers, matrons, divisional directors, governance managers and practice educators on a monthly basis. Returns are also published in the monthly transfusion newsletter 'Blood Drops' which is distributed electronically, in print format and also hosted on the intranet.

Where there are areas with persistently poor results the Blood Transfusion Specialist Nurse visits to reiterate requirements and seek named contacts to take responsibility for their teams in the promotion of improved returns.

For the month of March all blood bags have been tagged with a reminder to fill in and return traceability tags and this does appear to be having an impact which will be reported next month.

4.4 <u>Clinical Quality Predictor Dashboard Update</u>

Last month, the Board was presented with the Clinical Quality Predictor Dashboard seeking to share with the Board its development phase.

The purpose of this dashboard is to triangulate clinical, operational and staffing indicators in order to aid early identification of clinical areas in difficulty so that speedy intervention can be initiated.

A review of this data revealed that:

1. Turnover was seen to be highest on Paediatric A&E (29.27%) and Heron ward (26.7%) against a target of < 13%
2. Vacancy factors were seen to be highest on MHDU (27.7%), Wordsworth (25.56), Kestrel (36.49%), Heron (20.34%) and SAU (26.9%) a vacancy rate > 20% is red rated
3. Lowest appraisal figures were seen to be Aspen (66.7%), Chaucer (62.5%) and MAU (79.1%) against a target of 95%.

In relation to the red rated turnover rates noted for Paediatric A&E and Heron Ward, it is clear that action to understand and address the rate must be taken. The relevant Matrons and been directed to work with their HR Business Partner and the Ward Sister to undertake a review to understand the issue and develop action plans to address. This will be monitored by the Deputy Chief Nurse alongside the Divisional General Managers.

The Divisions are all recruiting to the areas of vacancy through an Open Day for Trained Nurses (2 April 2011) combined with a focus on HCA recruitment. Encouragement to focus on active and speedy recruitment has been discussed at a variety of forums; Nursing and Midwifery Committee, Ward Sisters Meeting, Ward Sisters Leadership Development Programme, Matrons Feedback Sessions and during the course of Chief Nurse and Deputy Chief Nurse ward visits and one to ones with Ward Sisters. Progress will be monitored by the Deputy Chief Nurse and Heads of Nursing once in post.

With regard to appraisal rate, there is corporate focus on achieving 95% which is being delivered through the Divisional Leadership and supported by the Corporate Nursing Team. The requirement to achieve the appraisal target has been communicated by the Chief Nurse to all nursing staff.

The clinical quality predictive dashboard is being further developed and refined in accordance with the following recommendations:

1. There should be HR ward level matrix for all wards
2. The RAG rating criteria should be modified
3. There should be a summary of actions undertaken
4. This should be produced ten days in advance of the Trust Board.

On completion of this work the dashboard will be presented to Board for further review and comment.

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

Date: 18th March 2011

Appendix 1

	The "NEVER EVENTS" List 2011/12
1.	**Wrong site surgery**
2.	**Wrong implant/prosthesis**
3.	**Retained foreign object post-operation**
4.	**Wrongly prepared high-risk inject able medication**
5.	**Maladministration of potassium-containing solutions**
6.	**Wrong route administration of chemotherapy**
7.	**Wrong route administration of oral/enteral treatment**
8.	**Intravenous administration of epidural medication**
9.	**Maladministration of Insulin**
10.	**Overdose of midazolam during conscious sedation**
11.	**Opioid overdose of an opioid-naïve Patient**
12.	**Inappropriate administration of daily oral methotrexate**
13.	**Suicide using non-collapsible rails**
14.	**Escape of a transferred prisoner**
15.	**Falls from unrestricted windows**
16.	**Entrapment in bedrails**
17.	**Transfusion of ABO-incompatible blood components**
18.	**Transplantation of ABO or HLA-incompatible organs**
19.	**Misplaced naso- or oro-gastric tubes**
20.	**Wrong gas administered**
21.	**Failure to monitor and respond to oxygen saturation**
22.	**Air embolism**
23.	**Misidentification of Patients**
24.	**Severe scalding of Patients**
25.	**Maternal death due to post partum haemorrhage after elective caesarean section**

Appendix 2 WQI definitions

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

1 Hand Hygiene Compliance
Audits of members of staff cleaning/decontaminating their hands between procedures

2 Number of MRSA bacteraemia
MRSA isolated in a blood culture therefore present in the patient's blood stream

3 Number of C Diff cases (Hospital post 72 hours)
Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.

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

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

6 Peripheral Cannula care
Ensures peripheral cannula insertion and after care undertaken in line with good practice to reduce cannula infections

7 Cleanliness
Audit undertaken by facilities on a monthly basis related to cleaning standards

8 Matrons Environmental Audit
Matrons environmental audit undertaken weekly of the ward and department and the mean taken for the month

9 Blood Traceability
Numbers of labels returned against number of blood bags used.

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

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

12 Total number of falls

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

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

15 Medicine administration errors
Number of errors reported via incident reporting

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