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

COUNCIL OF GOVERNORS
7th December 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	Delivering quality patient care and an excellent patient experience is a top priority for the Trust Board. The definition of Quality, now used across the NHS was set by Lord Darzi and focuses on 3 components: Safety, effectiveness and patient experience. The Trust is fully registered with the Care Quality Commission. The Board adopts a Ward to Board approach, triangulating hard and soft intelligence to understand the quality provided across our services. The Report covers ▪ Care Quality Commission- compliance with 16 Essential Standards ▪ Patient experience ▪ Quality dashboard ▪ Quality Accounts
The Council is asked to:	Discuss
Submitted by:	Suzanne Rankin, Chief Nurse and Mike Baxter, Medical Director
Date:	28th November 2011
Decision:	For Discussion

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Quality Report

1 Care Quality Commission Compliance with 16 Essential Standards

The 16 Essential Standards form the core element of an organisation's registration with the Care Quality Commission (CQC). The Trust assures compliance with the CQC 16 Essential Standards through triangulation of three perspectives:

- the CQC prepares a Quality Risk Profile (QRP) that gives a view on the Trust's position with regard to compliance with the standards
- and two internal processes:
  - documentary evidence of policy and procedure collated by a software package called Performance Accelerator
  - the CQC Essential Standards Baseline in Practice Review, completed on a six monthly basis.

The triangulation is overseen and monitored by the Trust Integrated Governance and Assurance Committee which in turn reports to Trust Board.

Each standard is sponsored by an Executive Director and is owned by a Senior Manager. The Standard Owner is responsible for ensuring that there is compliance with the standard and that there are up-to-date evidence and improvement plans, where necessary.

Trust's Assessment of Compliance

In assessing the Trust's compliance against the CQC Essential Standards the Trust uses the CQC Judgment Framework. This framework is defined by the CQC to identify a Trust's compliance status with regard to each of the Standards as either:

- compliant
- minor concern
- moderate concern
- major concern.

The level of compliance is derived from a view of the impact on the users of service alongside the likelihood.

	IMPACT		
Likelihood:	**Low**	**Medium**	**High**
Unlikely	Minor Concern	Minor Concern	Moderate Concern
Possible	Minor Concern	Moderate Concern	Major Concern
Almost Certain	Moderate Concern	Major Concern	Major Concern

The current internal triangulation indicates that we have work to do in a number of areas.

The Trust's view is that the CQC preference is for robust assurance associated with realistic judgements and pragmatic plans for improvement. Historically the CQC has been particularly concerned with those Trusts which fail to recognise or acknowledge weaknesses in delivery of the standards since the first step of improvement is to recognise and understand the issue.

Clearly the desirable position is to consider the Trust to be fully compliant with all standards but in terms of assurance and the associated improvement work it is important to take a realistic, if slightly pessimistic view. Each of the areas identified benefits from additional focus for improvement and plans that are monitored for progress.

Care of Older People in Hospital

Very high on the national agenda, and a specific focus for the CQC, is the care in acute hospitals of older people. The issue has arisen as the result of a number of high profile national reports and the results of CQC unannounced visits specifically aimed to review the care of older people in hospitals looking in detail at nutrition management, privacy and dignity and respect.

To date ASPH has not been subject to a CQC visit of this kind but of course an unannounced inspection visit by the CQC can happen at anytime. The Trust approach is aim to give high quality care and treatment to all in a way that would always be compliant with the CQC Essential Standards because that is the right thing to do; not because a CQC visit is likely.

The Trust is keen to continue to improve the care given to older people and those with dementia especially as the proportions of these patients grow as an element of the Trust's patient population.

Work already underway in this area includes:

- protected meal times
- Care Rounding
- The "Best Care" Programme
- Re-focusing of Matrons to "value and role model essential care".

In addition to these in-house initiatives the Trust has also sought external peer review and has recently undergone two visits:

- Surrey and Sussex Hospital Trust conducted a peer review last month focusing on observation of "Care and Compassion"
- and Professor David Oliver (National Clinical Director for Care of Older People) accompanied by an experienced Director of Nursing.

The findings of both were largely positive and gave us some very helpful points to consider for the future in the way we design and deliver care to older people.

2 Patient Experience

The Trust uses a number of measures to support both qualitative and quantitative understanding of the patient experience. Alongside reporting of safety and clinical effectiveness measures, analysis supports delivery of quality improvements for our patients.

Patient experience measures include:

- National patient surveys – while limited in terms of their reach (sampling 850 patients for each survey annually) results are benchmarked and enable the Trust to track progress over time
- 'Near real time' feedback through local surveys – 'Your Feedback' including Net Promoter Score
- Patient concerns raised through the Patient Advice and Liaison Service – all concerns are logged in detail on the Trust risk management database

- Formal complaints – both written and verbal complaints are logged in detail on the Trust risk management database
- Incident reporting and associated risk management;
- Audit
- Ward 'spot checks'
- Walkabouts.

The Net Promoter Score (NPS)

The NPS is a widely used tool in the commercial sector to support profitable growth based on the behaviours of loyal customers and has been developed on the fundamental perspective that every company's customers can be divided into three categories: Promoters, Passives, and Detractors. By asking - *'How likely is it that you would recommend [Company X] to a friend or colleague?'* - it is possible to track these groups and get a clear measure of a company's performance through its customers' eyes. Customers respond on a 0 to 10 point rating scale and are categorised as follows:

- **Promoters** (score 9-10) are loyal enthusiasts who will keep buying and refer others, fuelling growth.
- **Passives** (score 7-8) are satisfied but unenthusiastic customers who are vulnerable to competitive offerings.
- **Detractors** (score 0-6) are unhappy customers who can damage a brand and impede growth through negative word of mouth.

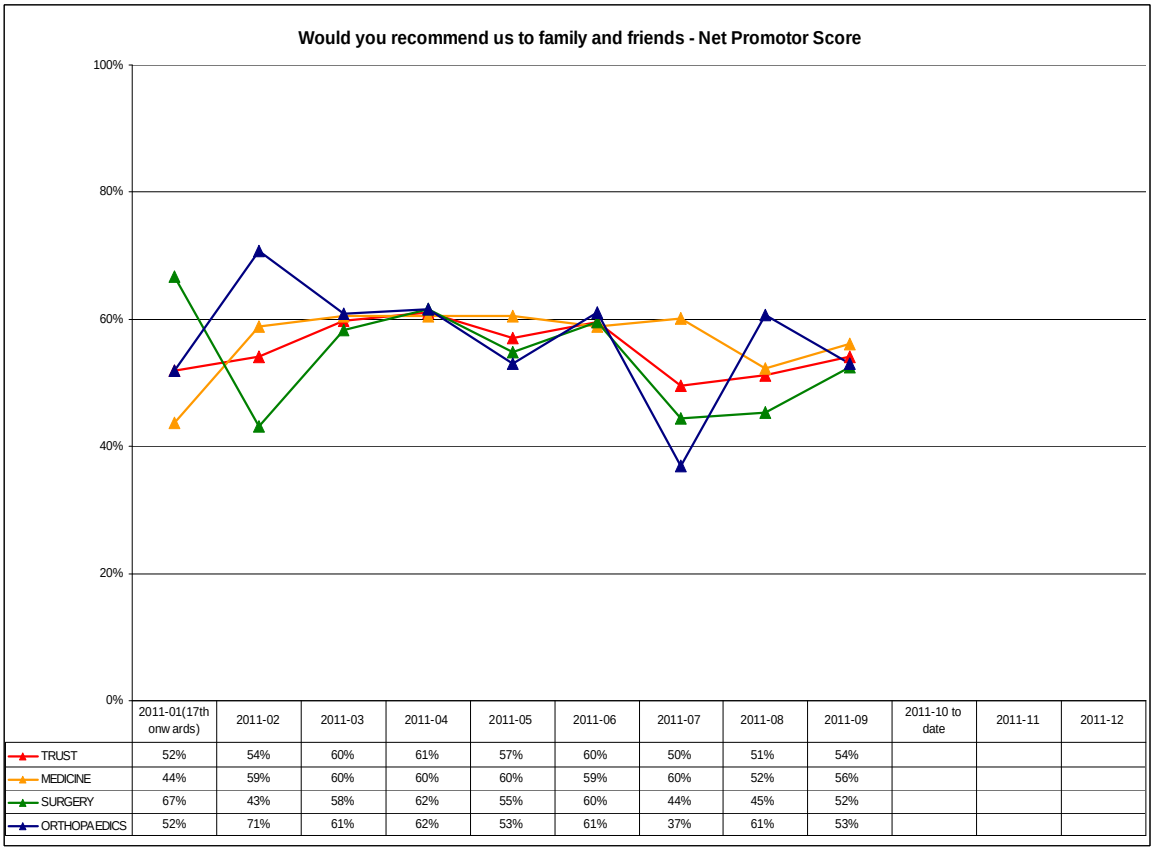
The NPS is calculated as follows:

NPS = % of promoters - % of detractors

As part of the 'Your Feedback' questionnaire the Trust invites patients to respond to the question *'Would you recommend us to family and friends?*' on a rating scale of 0 – 10

The Trust results since January 2011 are presented in Graph one below.

Graph one: The Net Promoter Score by Division and Trust



	2011-01(17th onw ards)	2011-02	2011-03	2011-04	2011-05	2011-06	2011-07	2011-08	2011-09	2011-10 to date	2011-11	2011-12
TRUST	52%	54%	60%	61%	57%	60%	50%	51%	54%			
MEDICINE	44%	59%	60%	60%	60%	59%	60%	52%	56%			
SURGERY	67%	43%	58%	62%	55%	60%	44%	45%	52%			
ORTHOPAEDICS	52%	71%	61%	62%	53%	61%	37%	61%	53%			

A review of the internet reveals evidence that the NPS is being used by other NHS Trusts as a measure of patient satisfaction. In terms of benchmarking ASPH scores, two other Trusts have recently published results:

Croydon Health Services NHS Trust April 2011: NPS = 61%
The Royal Free Hampstead NHS Trust April 2011: NPS = 85%

This is a helpful but incomplete analysis but certainly indicates that continued focus and effort is necessary to achieve the desired improvements to patient experience.

Patient Experience Summary

Overall improving the patient experience continues to be a tough challenge. Review of the indicators (including complaint numbers and themes) does not yet give robust assurance that the desired improvements are being achieved. Whilst disappointing, it is the experience of many other organisations and the advice given by experts such as the Picker Institute, that progress in this area is a long term aspiration and that improvement work must be given time to succeed.

Improvement of patient experience is dependant upon a great many things but mostly dependant upon the quality of individual interactions that reflect the organization's cultures and values. This requires a "cultural shift" which is clearly not a short term objective.

Wide ranging work continues to be done across the Trust with the intention of shifting the culture, improving the environment and creating a great place for staff to work, all of which aim to improve the patient experience. All the evidence and experience indicates that the approach that the Trust is taking is the right one but must be given support and time to be fully effective.

3 QUALITY DASHBOARD

Every month the Board of Directors receives the full Quality Report which includes the quality section from the Balanced Scorecard. This is available to the public via the Trust web site.

This dashboard is underpinned by each Division having its own Quality dashboard which is discussed in monthly performance meetings.

The September Quality quadrant of the Balanced Scorecard is given below with some of the explanations.

Table one: Quality Performance Dashboard

BALANCED SCORECARD — **Position as at:** 31 Oct 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	Oct Actual	Performance			YTD 11/12
						Aug	Sep	Oct	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	90	85.7	▲	▲	▲	97.9*
1-02	Crude mortality	1.60%	1.60%	1.55%	1.48%	▲	▲	▼	1.53%
1-03	MRSA (Hospital only)	5	4	4	0	▼	◄►	▲	2
1-04	C.Diff (Hospital only)	36	33	29	2	▼	▲	▼	14
1-05	Mortality from C.Diff (All cases)	10.3%	6.3%	9.0%	11.1%	▼	▲	▼	15.9%
1-06	Mortality from VTE	0.4%	0.35%	0.30%	0.0%	◄►	◄►	◄►	0.7%
1-07	Mortality from Hip fractures	4.8%	4.6%	6.0%	9.1%	▼	▲	▼	6.1%
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)			60.0%	57.0%	▼	▲	▲	57.0%
1-10	Formal complaints	360	320	400	50	▼	▼	▼	269
1-11	SUIs	14	14	23	4	◄►	▲	▼	17
1-12	Falls - resulting in significant injury (grade 3)	16	14	13	1	◄►	▲	◄►	6
1-13	Hip fractures treated within 36 hrs	93.0%	85%	96%	100.0%	▼	▲	◄►	95.0%
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	1672	146	▲	▼	▼	957
1-15	Average Bed Occupancy-Actual beds	94%	94%	96%	98%	▼	▲	▼	97%
1-16	Average Bed Occupancy-Planned beds				105%	New			

*Source from August Dr Foster

Commentary on Quality and Safety Balanced Scorecard

1.01/1.02 The SMR has risen from last month's value of 76.6 to 85. CMR has also shown an increase from 1.36% to 1.48%. This 9% increase in mortality is reflected in a small increase in mortality in all divisions (table 1) but actually reflects a relatively small change in the absolute numbers of events recorded within the Trust (89 vs 83).

Although the data represents an overall good performance, work is underway to improve outcome (reduce mortality) in community acquired pneumonia, hospital acquired pneumonia, COPD and heart failure.

In addition, and in line with recommendations from a national report, the Trust is looking at improving the provision for emergency surgery and a report will be brought to the Board from the Division of Surgery in the New Year.

1.04/1.05 The Trust has no cases of MRSA, and only 2 cases of hospital acquired C.Diff. The Trust has had no deaths related to hospital acquired C.Diff.

1.07. Mortality for patients receiving hip fracture surgery has increased in month from a nationally low figure of 2.4% to a value of 9.1%. This figure represents 3 deaths in a

cohort of 33 patients receiving treatment in October. These individual cases have been reviewed by the division of trauma and orthopaedics (and will be presented at the division's M&M meeting and to the Trust CGC). No concerns have been identified in these cases.

It is worth noting that for the second consecutive month 100% of # NOF were operated on within 36 hrs (1.13).

1.15/1.16 Are data points that relate to bed occupancy. These are important surrogate measures of patient flow, bed capacity and patient experience. It has also been suggested that there is a relationship between bed occupancy and HAI rates.

Line 1.15 shows the bed occupancy rate of the beds in use within the Trust. The current in month figure of 98% reflects a very high occupancy rate and is higher than the target set on the dashboard of 94% (reflecting 10/11 outturn)

1.16 Indicates that the Trust has bed capacity, over and above its core bed stock, currently open. If the patients currently in the Trust were accommodated within the "core bed allocation" the bed occupancy would be 105%. The Trust target, in line with national best practice, would be to have a bed occupancy rate (within the core bed stock) of 85%.

4 QUALITY ACCOUNTS

The Quality Account Dashboard (Appendix 1) provides a visual high level summary of the Trust's performance in Q1 and Q2 against plans set in the Quality Account 2010/11. Overall performance is better than trajectory and reflects the wide variety of improvement work underway across the Trust. Where indicators are not being met actions are in train to improve performance and progress will be reported again at the end of Q3.

Improving our Patient Experience
Priority 1 – To Provide safe, high quality discharge for patients

Patient Satisfaction
The Net Promoter Score (NPS) is off-plan YTD (- 34.5).

National Patient Survey
This is an annual measure being sampled currently.

Discharge Related Complaints.
A strong result against this trajectory, which can be attributed in part to the I*mproving Discharge Management* programme.

Priority 2 - To provide high quality experience relating to nutrition and hydration
Essence of Care Nutritional Audit. The Nursing Staff have redesigned and completed the Best Care audits. They have collected the data and results will be ready in time for the next reporting cycle.

Maintaining High Safety Standards
Priority 3 – To provide confidence and reassurance for patients on infection and other preventable infections
All indicators in this category are on, or better than, trajectory.

Priority 4 - To improve the quality of nursing care by setting and measuring a number of nursing indicators

Falls
Strong performance (20-30% better than plan) against these indicators validates the work of the Falls Group and the Falls Lead Nurse in conjunction with ward and clinical teams.

Prevention of Pressure Ulcers (hospital acquired)
Another success story as the data indicates the Trust, for the first two quarters, is doing better than projected in preventing harm from pressure ulcers.

Achieving High Quality Clinical Care
Priority 5 – To reduce the hospital emergency and elective readmission rate

Readmission in 28 days – Elective
Readmission in 28 days – Emergency
These indicators (based on a re-admission rate) appear slightly off trajectory but actual numbers demonstrate improvement.

Work to improve these indicators is underway through a number of programmes mostly sitting within the Improving Unscheduled Care Programme and the Home from Hospital Project. Work to understand and address the elective rate of re-admissions in more detail is underway.

Priority 6 – To improve the effectiveness of care for those with conditions most commonly associate with death in hospital and hear failure
SMR for Heart Failure
Very slightly off plan (by 0.029%). The Enhancing Quality (EQ) Programme continues to focus on improvement in this area with particular attention to ensuring that patients have a clear management plan and that they are provided with safe discharge instructions and access to community heart failure services where appropriate. Forthcoming interventions include; the proposal to employ a heart failure nurse working across organisational boundaries (effective January 2012) and the implementation of an Integrated Care Pathway.

SMR Pneumonia
Currently on trajectory (by 0.004%). This very high volume pathway will benefit from EQ Programme work focused on community acquired pneumonia. Key practice interventions are early antibiotic therapy and the delivery of smoking cessation advice activities which are being implemented and monitored across the Trust.

Priority 7 – to improve the experience and clinical outcomes for those with long term conditions
Admission Rate for Chronic Obstructive Pulmonary Disease (CODP) is slightly below trajectory (YTD figure of 0.77% against a trajectory of 0.78%). Success in this area will reflect our ability to impact on the wider health community and effectively work in partnership with other health and social care agencies across organisational boundaries

Suzanne Rankin, Chief Nurse and Mike Baxter, Medical Director

Appendix 1

Quality Account Dashboard – Q1 and Q2

	Apr	May	Jun	Jul	Aug	Sep	YTD 11/12	YTD 11/12 Plan	Actual v Plan	Annual 11/12 Plan	10/11 Outturn	11/12 Outturn
Improving our Patient Experience												
Priority 1 - To provide safe, high quality discharge for patients												
Patient Satisfaction (NetPromoter Score)	61.0%	57.0%	60.0%	50.0%	51.0%	54.0%	55.5%			90.00%	77.30%	
National Patient Survey>Avg responses	Annual											
Discharge Related Complaints	3	8	4	0	5	7	27	***31***	-11.5%	61	87	
Priority 2 – To provide high quality experience relating to nutrition and hydration												
Essence of Care Nutritional Audit: Quarterly												
1. Ward Environment results	Quarterly Audit										67.5%	NA
2. OCS service											82.2%	NA
3. Service to Patients											69.5%	NA
4. Patients nutritionally at risk											53.4%	NA
Maintaining High Safety Standards												
Priority 3 - To provide confidence and reassurance for patients on infection control and other preventable infections												
Prevention of peripheral acquired infections	100.0 %	97.2%	97.3%	97.0%	96.6%	98.0%	97.7%	*95.0%*	2.7%	95.0%	NA	
Prevention of central line acquired infections	97.2%	97.8%	99.4%	100.0 %	100.0 %	100.0%	99.1%	*95.0%*	4.1%	95.0%	NA	
Hand hygiene	98.7%	98.6%	99.0%	99.0%	97.1%	99.0%	98.6%	*90.0%*	8.6%	90.0%	NA	
C.Diff (hospital acquired)	2	6	0	1	2	1	12	***15***	-20%	33	36	
MRSA Bacteraemia (hospital acquired)	0	0	0	0	1	1	2	***2***	0%	4	5	
Priority 4 – To improve the quality of nursing care by setting and measuring a number of nursing indicators												
Total Falls	48	31	37	51	34	47	248	***310***	-20%	619	688	
Falls - resulting in harm (grade 3 or above)	0	0	0	2	2	1	5	***8***	-33%	15	17	
Prevention of Pressure Ulcers (hospital acquired grade 2 above)	14	5	5	8	6	8	46	***51***	-10%	103	108	
Achieving High Quality Clinical Care												
Priority 5 - To reduce the hospital emergency and elective readmission rate												
Readmission in 28 days - Elective	60	71	55	56	74	64	380	***246***	54.5%	492	984	
Readmission in 28 days - Emergency	290	294	278	243	257	260	1622	***1567***	3.5%	3134	3687	
Priority 6 - To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure												
SMR for Heart Failure	0.087 %	0.066 %	0.032 %	0.122 %	0.034 %	0.121%	0.077%	*0.048 %*	0.029%	0.048%	0.050%	
SMR for Pneumonia	0.399 %	0.280 %	0.224 %	0.538 %	0.270 %	0.208%	0.320%	*0.316 %*	0.004%	0.316%	0.320%	
Priority 7 - To improve the experience and clinical outcomes for those with long term conditions												

Admission Rate for Chronic Obstructive Pulmonary Disease (COPD)	0.78%	0.92%	0.67%	0.95%	0.63%	0.66%	0.77%	*0.78%*	-0.01%	0.78%	0.8%	