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

Council of Governors
20th February 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for February 2012.
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 gender, 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 David Fluck, Medical Director & Suzanne Rankin, Chief Nurse
Date:	3rd February 2012
Decision:	For Noting

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 7 columns namely:

1. Description of Measure - self-explanatory.

2. Outturn 10/11 – this denotes the performance / outcome for last financial year 2010 /11 and is sourced from Dr Foster.

3. 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.

4. Forecast - the calculation is as follows:

   - For month 9 (December we divide 2011/12 Total by 2011/12 YTD at month 9 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 69(SUM(2011_12 up to m7)/SUM(2011_12 Total)) x 2011_12 YTD x (2011_12 Ave/Last 12 Months Ave)

5. Actual - this is the actual achievement for the month.

6. 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.

7. 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 one: Quality Performance Dashboard

BALANCED SCORECARD — **Position as at:** **31 Dec 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	Dec Actual	Performance			YTD 11/12
						Oct	Nov	Dec	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	93	109.4	▼	▲	▼	99.1*
1-02	Crude mortality	1.60%	1.60%	1.56%	1.90%	▼	◄►	▼	1.57%
1-03	MRSA (Hospital only)	5	4	3	0	▲	◄►	◄►	2
1-04	C.Diff (Hospital only)	36	33	25	1	▼	▲	◄►	16
1-05	Mortality from C.Diff (Hospital Acquired)	10.3%	6.3%	8.5%	0.0%	◄►	▲	◄►	11.4%
1-06	Mortality from VTE	0.4%	0.35%	0.30%	0.0%	◄►	◄►	◄►	0.4%
1-07	Mortality from Hip fractures	4.8%	4.6%	5.7%	4.0%	▲	▲	▼	5.8%
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)			62%	63%	▲	▲	▲	57%
1-10	Formal complaints	360	320	423	42	▼	▲	▼	343
1-11	SUIs	14	14	25	5	▼	▲	▼	22
1-12	Falls - resulting in significant injury (grade 3)	16	14	11	1	◄►	▲	▼	7
1-13	Hip fractures treated within 36 hrs	93.0%	85%	95%	100%	◄►	◄►	◄►	97%
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	1657	160	▼	▲	▼	1,243
1-15	Average Bed Occupancy-Actual beds	94%	94%	96%	95%	▲	▼	◄►	97%
1-16	Average Bed Occupancy-Planned beds				106%	New	◄►	▼	

Delivering or exceeding Target		Improvement Month on Month
Underachieving Target		Month in Line with Last Month
Failing Target		Deterioration Month on Month

1-01/02/07/10/11/13/15/16/3-01/3-08/3-09
The Crude Mortality Rate and Standardised Mortality Rate show an increase to 1.90% from 1.48% in November and 109.4, 88.8 in November, for the month of December. The year to date level still remains at 1.57% and 99.1. Looking at table 2.1 this appears to reflect an increase in crude mortality in August from Medicine. Some of this may be explained by seasonal variation, which will be investigated. However, this was also mirrored by operational pressures which included an increase in bed occupancy rate, an increase in the readmission rate with little change in the Length of Stay, which sits at 0.36 days higher than last year. An increase in the number of emergency admissions during December, nearly 200 more compared to November, added to the operational pressures, with elective activity being maintained. This has also resulted in an increase in the number of complaints and Serious Incidents.

A review of all deaths that occurred in December has been arranged and progress will be reported at Trust Board.

The mortality from hip fractures has remained static after the improvement last month and again all patients with hip fractures were operated on within 36 hours.

1-03/04/05
Hospital acquired infection rates remain on target with no further MRSA cases and only one case of C.Diff.

1-15/16
Currently all escalation areas are open with additional capacity in the community. From Monday 16th January 2012 the day surgery unit cannot be used for escalation unless agreed by the Chief Executive. The occupancy rates are still too high and above the target of 85%; they currently sit at 95% of our current bed stock and would be 106% of planned bed stock.

1.3 The Quality Account

Appendix 2 presents the Quality Account Dashboard. The aim of this dashboard is to inform the Council of Governors of progress against commitments made in the Trust Quality Account.

Quality Account Dashboard
The Quality Account Dashboard (Appendix 2) provides a visual high level summary of the Trust's performance in Q1, Q2 and Q3 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 (- 13.3%). Despite the underachievement, there was a significant improvement between November and December from 57 % to 63% and month on month improvement since July.

National Patient Survey
This is an annual measure taken in July 2011. Publication of results is awaited.

Discharge Related Complaints.
Off plan by 13%, which is deterioration from last quarter. Attention and focus on the management of discharge continues and will be informed by the thematic analysis of these complaints.

Priority 2 - To provide high quality experience relating to nutrition and hydration
Essence of Care Nutritional Audit. This audit was carried out on December and the results are being collated and analysed.

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
On trajectory (-38%). In Quarter three our performance on falls demonstrates small yet steady improvements.

Prevention of Pressure Ulcers (hospital acquired)
On trajectory (-1%). Improvements in quarter three were unfavourably affected by a challenging month in November. Early indications suggest that the corporate plan devised in November is reaping results with stark reduction in December. The data shows that the Trust is 1% better at preventing harm induced by pressure sores than planned.

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

Readmission in 28 days – Elective
This is significantly off plan at 58.8%.

Readmission in 28 days – Emergency
This is on trajectory (-4%) compared to last quarter which told us that we had some way to go and this quarter demonstrates that we are on our way to getting there.

Work to improve these indicators is having an impact.

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 0.048%) and an improvement from last quarter. The Enhancing Quality (EQ) Programme continues to drive the performance and is now secure in going forward in the next 15 months. This work will now be supported by the Trust's subscription to a national Integrated Care Pathway Audit, which will help with pace and focus on the next phase of this work.

SMR Pneumonia
Currently on trajectory and a marginal improvement from last quarter (by 0.316%).

Priority 7 – to improve the experience and clinical outcomes for those with long term conditions
Admission Rate for Chronic Obstructive Pulmonary Disease (CODP) is now on trajectory (YTD figure of 0.66% 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.

Quality Account External Assurance

In accordance with the governance arrangements for the maintenance of Quality Accounts the Trust is required to nominate one of the mandatory measures for data stream validation by the external auditor. The Trust has selected the C Difficile measure for scrutiny.

2. Clinical Effectiveness

2.1 Mortality and Morbidity

Table two: Crude Mortality Rate by Specialty

	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
TRUST TOTAL	▲	◄►	▼	◄►	▼
Percentage reported	1.37	1.36	1.48	1.48	1.9
Actual Number of deaths	80	82	89	94	111
Total Admissions All (EL/DC/NEL)	5854	6054	5992	6329	5840
MortalityRateAll	1.37%	1.35%	1.49%	1.49%	1.90%
MEDICINE	▲	▲	▼	◄►	▼
Actual Number of deaths	62	62	71	80	88
Total Admissions All (EL/DC/NEL)	1568	1596	1401	1596	1608
MortalityRateAll	**3.95%**	**3.88%**	**5.07%**	**5.01%**	**5.47%**
SURGERY	▼	▼	▲	▲	▼
Actual Number of deaths	13	14	13	8	13
Total Admissions All (EL/DC/NEL)	1203	1240	1254	1378	1196
MortalityRateAll	1.08%	1.13%	1.04%	0.58%	1.09%
ORTHOPAEDICS	▼	▲	◄►	◄►	▲
Actual Number of deaths	3	2	2	2	1
Total Admissions All (EL/DC/NEL)	586	605	587	599	522
MortalityRateAll	0.51%	0.33%	0.34%	0.33%	0.19%
PAEDIATRICS	◄►	◄►	▼	▲	◄►
Actual Number of deaths	0	0	1	0	0
Total Admissions All (EL/DC/NEL)	187	229	269	299	267
MortalityRateAll	0.0%	0.0%	0.4%	0.0%	0.0%

Table two demonstrates the crude mortality within the Trust. As can be seen, there is little change in crude mortality rates from August to December in Surgery, Orthopaedics and Paediatrics. The total crude mortality rate has increased to 1.9% which is reflected in a rise in crude mortality rate to 5.47% in medicine. There has been a steady rise in crude mortality within medicine which may reflect seasonal variation. An audit of all deaths for December is being arranged and comparison with previous year's seasonal changes will be made.

2.2 Dementia Care Update

The report of the National audit of dementia care in general hospitals was publicly released in December 2011; this is a generic report on findings across England and Wales. Only 26% of Trusts took part in the enhanced, detailed audit; within this part of the report the non-participation of Holly ward refers to obtaining responses for the carer/patient questionnaire. The difficulty in obtaining this involvement is acknowledged with one third of participating wards unable to submit any surveys; Maple and Elm wards did return questionnaires. Results for this part of the enhanced audit are not included in the national report due to low response rates.

The Trust has an appointed lead for dementia and a Dementia Steering Group has been working to develop the service ensuring that dementia care has a 'whole' Trust focus. The dementia strategy was approved in Jan 2011 and a range of achievements have been made since then including the Patient Passport (or 'ME') document, recruitment of a consultant geriatrician and training and education of staff across all areas.

3. Safety Update

3.2 Pressure Ulcers

The number of Trust acquired pressure ulcers (stage 2 and above) from April – December 2010 was 75, compared to April – December 2011, which was 81.

Chart one below outlines comparative data collated via the two existing methods of pressure ulcer data collection, the ward quality indicators (WQI) and Datix, the Trust risk management data collection system, for 2010/2011.

The figures on the WQI record pressure ulcers by stage/grade on their first appearance and by number of pressure ulcers presenting not number of patients with pressure ulcers.

Chart one

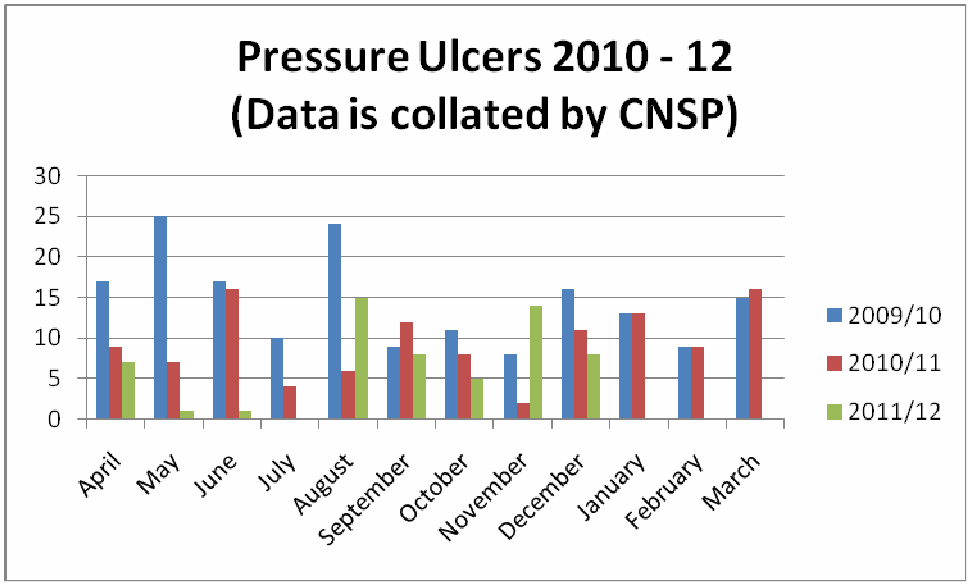


Chart two

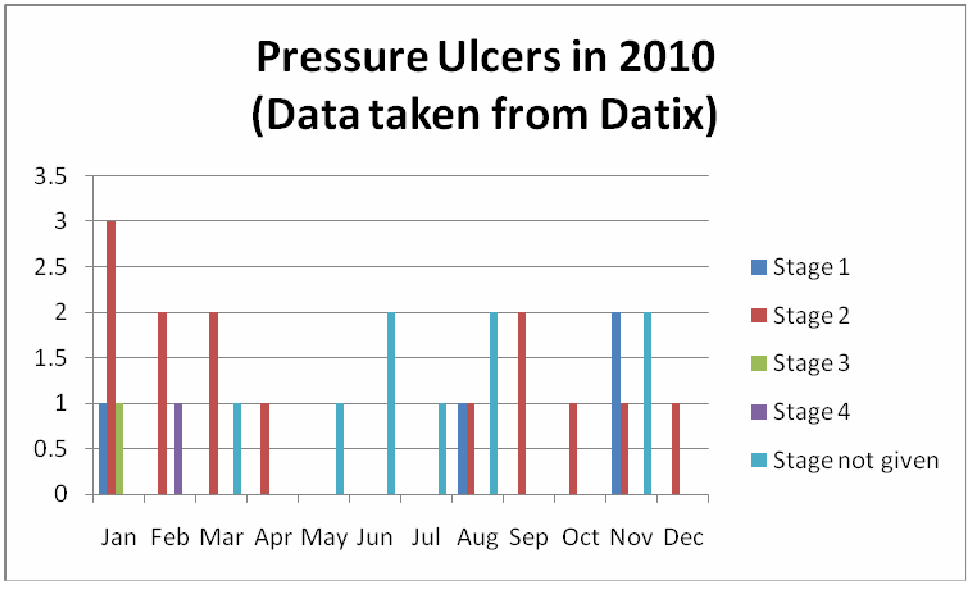
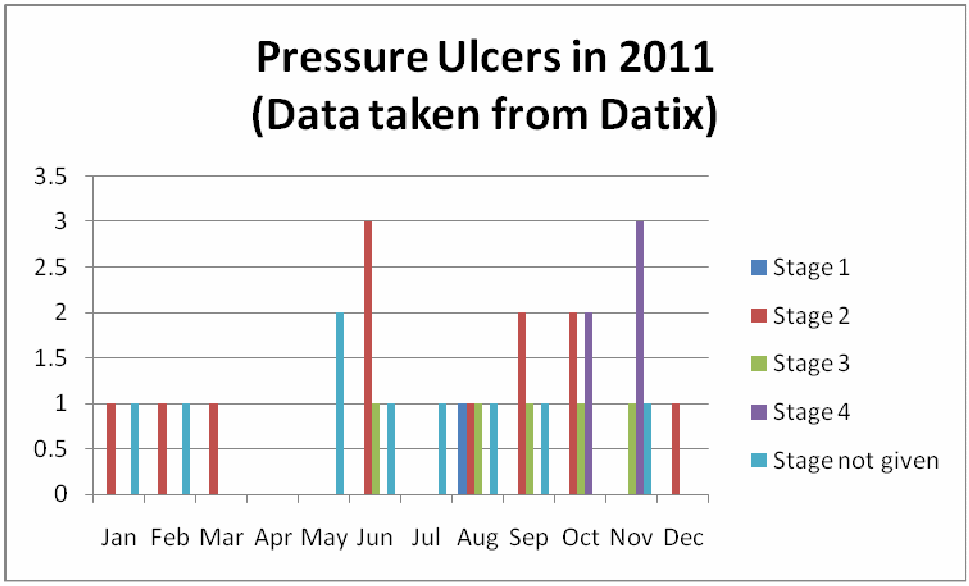


Chart three



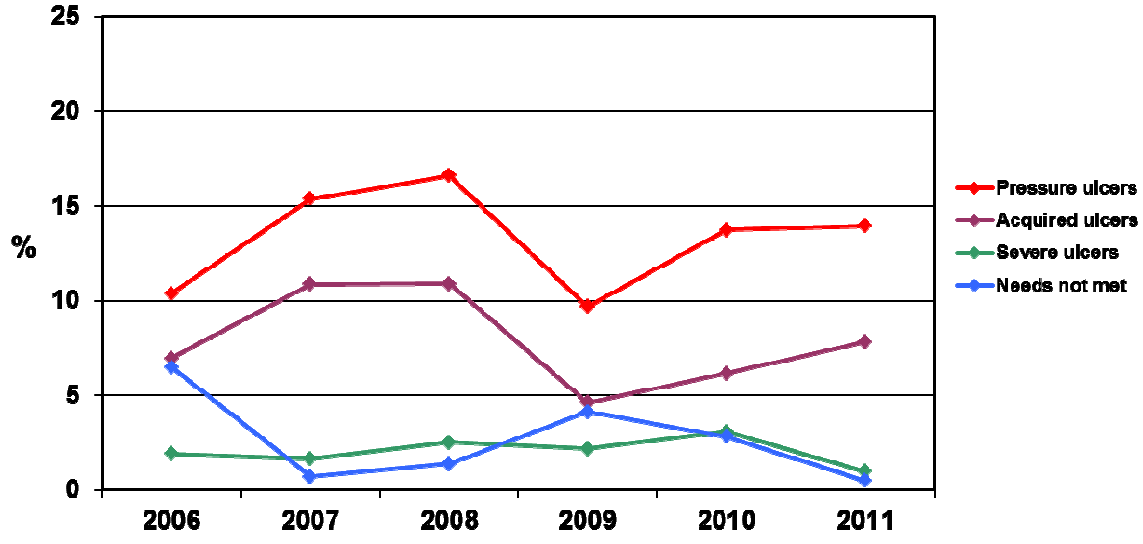
Analysis

As of April 2011 all Trust acquired stage 3 and stage 4 pressure ulcers have to be reported as Serious Incidents. This has resulted in an increase in the numbers reported.

The Arjo Huntleigh audits 2006 – 2011

In addition, an audit of the prevalence of pressure ulcers has been conducted annually since 2006 within the Trust by an independent company called Arjo Huntleigh Getinge Group. The Arjo Huntleigh audit is a snap shot audit performed on one day in a year and as such is a valuable benchmark over time.

Chart four: The Arjo Huntleigh audit 2011



Source: Arjo Huntleigh-Healthcare Audit of ASPH 2011

Chart four depicts results from the Arjo Huntleigh audit for annual snapshot reviews of pressure ulcer prevention from 2006 to 2011. An average of 420 patients was audited each year; results are presented as % patients. Both prevalence and rates of hospital acquired pressure ulcers have varied over time; prevalence has increased by approx 4% since 2006 whilst hospital acquired numbers are

static with 2006. Incidence of severe ulcers appears to be reducing but this trend must be sustained before this can be verified. On a positive note the number of patients recorded as 'needs not met' has shown a positive reduction over 2 consecutive years.

The Arjo Huntleigh audit for 2011 showed a case mix adjusted facility acquired prevalence (excluding stage 1 pressure ulcers) of 3.4% against a rate of 3.3% in 2010. Both figures demonstrate that the local pressure ulcer rate is lower than observed in the national reference data held by Arjo Huntleigh.

Conclusion

Focused improvement work to drive down the rate of hospital acquired pressure ulcer must continue. The Chief Nurse held a seminar before Christmas which has led to the production of a Corporate Pressure Ulcer Reduction Action Plan. The plan focuses on education and training of the nursing workforce alongside pressure ulcer prevention and management strategies. A focus on high quality documentation is also included. The action plan's progress will be monitored via the Senior Nursing and Midwifery Leadership Committee.

4. Patient Experience

In December 2011, 45 patients lodged formal complaints about their care and or experience in our hospitals compared to 32 in November and 50 in October.

A pilot telephone survey of complainants was undertaken in mid-December and an early indicator of cause of complaint is the lack of early intervention to resolve patients' concerns during their hospital stay (although 97.2% of PALS do not become formal complaints). Main themes leading to complaints have been poor communication, not being listened to and perceived unsafe discharge. The survey will continue and fuller results will be reported to the Complaints Monitoring Group on 10 February 2012. Immediate actions in response to the survey will be:

- Map NPS Ward performance – January.
- Awareness campaign of PALS service February/March
- Current pilot of patient diaries will be extended – evaluation early February.
- Complaints relating to discharge to be fed into current Discharge Improvement Programme

The Net Promoter Score has improved from 57% to 63% during the reporting period. A technological solution for capturing 'Your Feedback', Net Promoter Score and patient compliments is under development. The Trust received 10 positive comments via NHS Choices, a recent comment was: '**Lived up to its mission statement'.**

Quality Account Dashboard Definitions

Priority 1: To provide safe, high quality discharge for patients

1. Patient Satisfaction (Net Promoter Score (NPS)
   Internal measure at Trust level provided from continuous "Your Feedback" survey of adult inpatients. The NPS is a measure of patient loyalty, patients are asked: "Would you recommend the Trust to family and friends?" and asked to give a score between 0 and 10.

   Respondents are classified as:

   - 0-6 = "Detractors"
   - 7-8 = "Passives"
   - 9-10 = "Promoters"

   NPS = % of Promoters – % of Detractors

2. National Patient Survey
   Results relating to discharge from the annual, national survey of July inpatients available March 2012.
3. Discharge Related Complaints
   The number of complaints received by the Trust that relate to discharge issues and practice
   Number of complaints received during the month relating to patient discharge.

Priority 2 – To provide high quality experience relating to nutrition and hydration

Essence of Care Nutritional Audit (quarterly) – Measures refer to 2010/11 are under revision

1. Ward environmental results
   Results from the observation of the ward environment relating to patient care for nutrition and hydration.

2. OCS service
   OCS is the external contractor providing a professional staff and patient meal service to the Trust

3. Service to patients – patient survey of mealtimes

4. Patients nutritionally at risk
   Patients at risk are identified by the red tray system and appropriate support is provided to patients at mealtimes

Priority 3 – To provide confidence and reassurance for patients on infection control and other preventable infections

1. Prevention of peripheral acquired infections
   Prevention of central line acquired infections
   % patients without evidence of infection

2. Hand hygiene
   Audits of members of staff cleaning/decontaminating their hands between procedures.

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

4. MRSA Bacteraemia (hospital acquired)
   Number of MRSA bacteraemia isolated in a blood culture therefore present in the patient's blood stream

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

1. Total Falls
   Total number of falls

2. Falls – resulting in harm (grade 3 or above)
   Number of falls resulting in serious harm to the patient

Prevention of Pressure ulcers (hospital acquired grade 2 and above)
Number of pressure ulcers acquired in hospital of grade 2 and above

Priority 5 – To reduce the hospital emergency and elective readmission rate

1. Readmission in 28 days – Elective
   Reduction in readmissions following an elective procedure within 28 days of discharge

2. Readmission in 28 days – Emergency
   Reduction in readmissions following an emergency admission within 28 days of discharge

Priority 6 – To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure

1. SMR for Heart Failure
2. SMR for Pneumonia

The Standardised Mortality ratio (SMR) compares the expected rate of death with the actual rate of death taking into account patient demographics and severity of illness etc.

Priority 7 – To improve the experience and clinical outcomes for those with long-term conditions

Admission rate for Chronic Obstructive Pulmonary Disease (COPD)
Reduction to the rates of attendance and subsequent admission for patients with COPD.

Appendix two

Quality Account Dashboard - Q1 - Q3

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD 11/12	Trend	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%	57.0%	57.0%	71.0%	57.6%	↑	*70.0%*	-13.3%	70.0%	-	57.6%
National Patient Survey>Avg responses	Annual															
Discharge Related Complaints	3	8	4	0	5	7	12	4	9	52	↓	*46*	13.7%	61	87	52
Priority 2 - To provide high quality experience relating to nutrition and hydration																
Essence of Care Nutrational Audit: Quarterly																
1. Ward Environment results	Quarterly Audit														67.5%	
2. OCS service															82.2%	
3. Service to Patients															69.5%	
4. Patients nutritionally at risk															53.4%	
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%	100.0%	98.0%	98.0%	98.0%	↑	*95.0%*	3.0%	95.0%	-	98.0%
Prevention of central line acquired infections	97.2%	97.8%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	99.3%	↑	*95.0%*	4.3%	95.0%	-	99.3%
Hand hygiene	98.7%	98.6%	99.0%	99.0%	97.1%	99.0%	97.2%	98.0%	99.0%	98.4%	↑	*90.0%*	8.4%	90.0%	-	98.4%
C.Diff (hospital acquired)	2	6	0	1	2	1	2	1	1	16	↑	*24*	-33%	33	36	16
MRSA Bacteraemia (hospital acquired)	0	0	0	0	1	1	0	0	0	2	↑	*3*	-33%	4	5	2
Priority 4 - To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators																
Total Falls	48	31	37	51	34	47	50	46	43	387	↑	*464*	-17%	619	688	387
Falls - resulting in harm (grade 3 or above)	0	0	0	2	2	1	1	0	1	7	↓	*11*	-38%	15	17	7
Prevention of Pressure Ulcers (hospital acquired grade 2 above)	14	5	5	8	6	8	8	14	8	76	↓	*77*	-1%	103	108	76
Achieving High Quality Clinical Care																
Priority 5 - To reduce the	0.0219	0.0253	0.0157							0.0207				0.014	0.029	
Readmission in 28 days - Elective	60	71	55	56	74	64	72	73	61	586	↓	*369*	58.8%	492	984	586
Readmission in 28 days - Emergency	290	294	278	243	257	260	223	215	197	2257	↑	*2351*	-4.0%	3134	3687	2257
Priority 6 - To improve	0.2701	0.2458	0.2178							0.2447				0.149	0.298	
SMR for Heart Failure	0.087%	0.066%	0.032%	0.100%	0.034%	0.066%	0.067%	0.047%	0.059%	0.062%	↑	*0.048%*	0.014%	0.048%	0.050%	0.062%
SMR for Pneumonia	0.398%	0.279%	0.223%	0.383%	0.290%	0.264%	0.267%	0.332%	0.195%	0.292%	↑	*0.316%*	-0.024%	0.316%	0.320%	0.292%
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%	0.48%	0.52%	0.30%	0.66%	↑	*0.78%*	-0.12%	0.78%	0.8%	0.66%

Delivering / exceeding target		Improvement from last Quarter	↑
Underachieving Target		In Line with Last Quarter	↔
Failing Target		Deterioration from last Quarter	↓