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

COUNCIL OF GOVERNORS
13th September 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	Delivering quality patient care and an excellent patient experience is a top priority for the Trust Board and this paper sets out how we approach this. 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 Council is asked to:	Discuss
Submitted by:	Suzanne Rankin, Chief Nurse and Mike Baxter, Medical Director
Date:	6th September 2011
Decision:	For Discussion

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Quality Report

1 INTRODUCTION

The NHS has coalesced around the definition set out by Lord Darzi[1] who stated that care provided by the NHS will be of high quality if it is

- **Safe**,
- **effective** and
- with a positive **patient experience**

Patient safety. The first dimension of quality must be that we do no harm to patients. This means ensuring the environment is safe and clean, and that there are processes and policies in place to prevent avoidable harm such as medication errors and patient injury following a fall. These were initially measures of process effectiveness e.g. Venous Thrombo Embolism (VTE) compliance, which measures the rate of the risk assessment achievement but are now becoming outcome measures e.g. numbers of deaths from VTE events.

Patient experience. Quality of care includes quality of caring. This means understanding our patients' perception and experience of their care including the compassion, dignity and respect with which patients are treated. This can only be improved by analysing and understanding patient satisfaction and response to their experiences of healthcare alongside the approach and behaviours of care givers and clinicians.

Effectiveness of care. This means understanding success rates from different treatments for different conditions and using appropriate comparators to benchmark clinical outcomes. Assessing this will include clinical measures such as mortality (death rates) and morbidity (complication rates) and measures of clinical improvement. Very important in this domain is the effectiveness of care as experienced and measured by the patient which will be measured through patient-reported outcomes measures (PROMs). An example of a PROM is the measurement of patient outcome, including improvement in pain free movement, following a joint replacement. This will not only measure outcome but also the effectiveness of pre-operative discussion and shred decision making and to what extent patient expectations and desired outcomes are met.

Delivering quality patient care and an excellent patient experience is a top priority for the Trust Board and this paper sets out how we approach this.

2 REGISTRATION

From 1 October 2010, all health and adult social care providers are legally responsible for making sure they meet essential standards of quality and safety and must be licensed with CQC. The Trust is fully registered with no conditions attached to its Registration.

The Trust is required to monitor on-going compliance with the CQC 16 Essential Standards of Quality and Safety and secure and give assurance against these standards.

Evidence of CQC compliance is underpinned by a data base – 'Performance Accelerator'-

[1] Department of Health. High Quality Care For All: NHS Next stage review Final Report 2008

that supports the Trust's self-assessment of performance against the 16 Essential Standards. Each standard has an executive sponsor identified together with a senior manager who is responsible for driving improvement in that area as well as for ensuring the collation of robust evidence for each standard. Corporate responsibility for overseeing compliance with Essential Standards is monitored through various governance groups where responsibility is assigned and confirmed through the Group's Terms of Reference.

The Trust recognises that CQC compliance is so much more than evidence that policies and procedures are documented. Effective implementation of the standards into practice at the bedside that it is evident on observation of care and treatment and in documentation is essential. To support this, the Trust is developing a new and innovative "layered" approach to Ward to Board assurance that will support review of clinical quality performance at different levels of detail through a variety of clinical perspectives and peer reviews. This will include a detailed CQC 16 Essential Standards Compliance in Practice Review.

3 ASHFORD AND ST PETER'S APPROACH

ASPH's commitment to the delivery of quality services is at the core of all that we do, it is embodied in our values and is at the heart of our vision to be one of the best healthcare Trust's in the country.

Our proactive approach to Quality Governance aligns fully with Monitor's recently published Quality Governance Framework:

- Strategy
- Capabilities and Culture
- Processes and Structures
- Measurement.

Strategy
The Trust has a Clinical Quality Strategy which sets out in detail the approach to achieving the highest possible quality standards for our patients, meeting and exceeding their expectations in terms of outcome, safety and experience. The Strategy, alongside the Trust's Integrated Governance and Risk Management Strategy and Quality Account, support the Trust in ensuring full compliance with core regulatory and national and local standards for quality.

Capabilities and Culture
The Chief Nurse and Medical Director are the key accountable clinical leaders for the Quality Agenda and actively engage all members of the Trust Board in the promotion of a quality focussed culture throughout the Trust.

Structures and Process
Diagram one (attached) summarises the Trust organisational structure and accountabilities for delivering quality. This structure is supported by a committee structure which can be seen in diagram two (attached).

Measurement
The Trust Quality Report is presented as the first item at each Board meeting (Open and Closed) and contains data and information in a variety of triangulated forms:

- the Quality element of the Trust Balanced Scorecard which contains information on mortality, infection rates (MRSA and C Difficile), patient satisfaction and complaint rates, Serious Untoward Incidents and falls, hip fractures treated within 36 hours, numbers of readmissions within 14 days, Venous Thrombo Embolism (VTE)

assessment rates and the Trust Summated Adverse Report Incident Rate (SARI)
- a mortality and morbidly report
- a Serious Untoward Incident (SUI) report including discussion of learning and change in practice
- a National Patient Safety Agency (NPSA) Safety Alert Report
- the Care Quality Commission (CQC) Quality Risk Profile (as published)
- a patient experience report including more detailed analysis of patient experience indicators and complaints

The Quality Report also includes Trust level national reports and audits such as the National Patient Surveys and the National Sentinel Stroke Audit.

3.1 **Ward to Board**

The first agenda item at each Trust Board meeting is a detailed Quality Report, containing information in a variety of complementary forms as described above.

The Trust Board meets ten times per year and at alternate meetings receives patients and carers who share their experiences of treatment and care at the Trust. This enables the Trust Board to engage with patients and stakeholders and to fully understand, and challenge, the Trust's approach to quality delivery.

In addition, the Board regularly hears from the matrons and multi disciplinary teams.

The Integrated Governance and Assurance Committee (IGAC) is a formal Trust Board sub committee, and is chaired by a Non-Executive Director and attended by the Chief Executive, Chief Nurse and Medical Director. This is a robust form of assurance for the Board.

ASPH's framework of integrated governance ensures that patient safety and clinical risk has a high profile throughout the Trust. All Committees and Groups report through one of two parent Committees: Clinical Governance Committee and Non Clinical Risk Management Committee, both of which report to the Integrated Governance Assurance Committee (IGAC) every two months. The Clinical Governance Committee (CGC) chaired by the Medical Director and attended by the whole executive team, operates a bi-annual schedule of reporting for each Clinical Division.

The Trust Board members routinely visit the wards and clinical areas meeting with patients and staff to discuss the experience of receiving and giving care within the organisation. The Executive Directors have a weekly schedule of clinical and departmental visits.

Essential Care Spot Checks are scheduled throughout each week and involve senior clinicians, managers, executive and non-executive directors. These spot checks involve structured visits to ward and clinical areas where care is reviewed and discussed.

3.2 **Quality management systems**

The Chief Nurse and Medical Director share responsibility for the Quality Agenda. The Chief Nurse is accountable for maintaining the Trust's CQC compliance with the Essential Standards of Care and the CQC Registration which is currently secured without condition. The Medical Director is accountable for the Clinical Governance structures and processes and Chairs the Clinical Governance Committee.

Divisional Directors, General Managers and Heads of Nursing are responsible for the operational delivery of clinical quality through a triumvirate leadership approach. Heads of Nursing have specific accountability for clinical quality and Divisional Directors of quality governance. Heads of Nursing are also responsible for operational delivery of clinical quality, whilst Matrons focus on quality improvement and enablement of the ward and clinical areas to respond to quality information and to drive continuous improvement.

Robust and documented structures and processes are in place to enable regular analysis and challenge of quality information. These include the Integrated Governance Committee (quarterly); Clinical Governance Committee (bi-monthly); Safety and Risk Committee (bi-monthly) and Divisional Performance Reviews (monthly).

The formal processes are supported by an emphasis on visible, tangible senior clinical leadership and presence in the clinical areas, led by the Chief Nurse and Medical Director. This results in speedy and proactive identification, escalation and response to clinical quality and performance issues as they arise.

Clinical governance has recently been strengthened through the appointment of thirty Clinical Speciality Leads and Divisional Heads of Nursing who will work alongside Divisional Directors to embed clinical leadership and ownership of the quality agenda across the Trust.

3.3 Our current risk management systems

The monthly formal Trust Executive Committee also reviews the Quality Report. The report is further reviewed at monthly Divisional Performance Meetings. A clinical risk group discusses clinical risks from each area alongside wider organisational clinical risk. An incident working group concentrates on rapid management of grade 3/4 incidents and serious untoward incidents (SUIs), and reports into the clinical risk group. A clinical governance forum also operates as a learning forum for the clinical governance managers where practical operational issues can be shared and actions agreed.

Service improvement activity is driven in response to analysis of the quality information and is reported alongside the data to enable the Trust Board to be confident that the appropriate response and mitigation is taken.

The Corporate Risk Register is reviewed bi-monthly by the Board and Trust Executive Committee (TEC). Each risk has a clearly identified executive sponsor and a senior management owner, who are responsible for reviewing risks and ensuring that appropriate corrective action is taken within an agreed timeframe.

4 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 July 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 Jul 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	Jul Actual	Performance			YTD 11/12
						May	Jun	Jul	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	91.8	90.4(May)	▼	▼	▲	98.4*
1-02	Crude mortality	1.60%	1.60%	1.60%	1.71%	▲	▲	▼	1.63%
1-03	MRSA (Hospital only)	5	4	3	0	◄►	◄►	◄►	0
1-04	C.Diff (Hospital only)	36	33	30	1	▼	▲	▼	9
1-05	Mortality from C.Diff (All cases)	10.3%	6.3%	8.6%	0.0%	▼	▼	▲	15.3%
1-06	Mortality from VTE	0.4%	0.35%	0.00%	0.0%	◄►	◄►	◄►	0.0%
1-07	Mortality from Hip fractures	4.8%	4.6%	4.6%	5.1%	▲	▲	▼	5.2%
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)	77.3%	90.0%	80.0%	80.6%	▼	▼	▲	79.9%
1-10	Formal complaints	360	320	335	35	▼	◄►	◄►	130
1-11	SUIs	14	14	18	2	▼	◄►	▲	10
1-12	Falls - resulting in significant injury (grade 3)	16	14	12	2	◄►	◄►	▼	2
1-13	Hip fractures treated within 36 hrs	93.0%	85%	94%	97.3%	▼	▲	▲	93.1%
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	1670	143	▲	▲	▼	548
1-15	Average Bed Occupancy-Actual beds	94%	94%	94%	94%	▲	▼	▲	93%
1-16	Average Bed Occupancy-Planned beds	Work in progress							

1.01 & 1.02:
The SMR is a standardised measure of hospital mortality devised by Professor Sir Brian Jarman of Imperial College London, and published every year by Dr Foster in the Hospital Guide The SMR figures are reflective of mortality 2 months ago. It shows a decrease to 90.4 with an improvement in the annual forecast to 91.8, but a YTD of 98.4. The forecast remains above the target of 82. It has to be noted that it is hard to compare the previous years and current SMR, as it is periodically rebased;

The Crude Mortality Rate is 1.71 and above our target of 1.6 and shows an increase from last month. This will be looked at by the Trust Morbidity Group. However, the absolute number of deaths was 102

1.03 - 1.05
No reported MRSA this month, but unfortunately in August one has been reported and a Root Cause Analysis is being carried out. There has been one case of *C-Difficile* which has had a positive effect on the mortality rate from this condition.

1.06 – 1.07
No issues

1.08-1.11
There were 35 complaints received in July compared with 35 in June. The Trust aims to reduce the number of formal complaints by 30% during 2011/12 with an overall target of 320. A total of 130 complaints have been received year to date, +22% over target (106).

1.07 & 1.13
The exceptional June mortality figure for hip fractures was not maintained but rose to 5.1% with a YTD figure of 5.2%, which is still extremely good. Hip fractures treated within 36hours rose to 97.3%.

1.15-1.16
Bed occupancy was static at 94%.

(The data definitions are given in the attachment)

5 QUALITY ACCOUNTS

From 2008-9 Foundation Trusts have formally included Quality Reports within their Annual Reports. The content of the Quality Report is based on the separate requirement for all NHS organisations to produce and publish a Quality Account.

Governors are involved in the identification and prioritising of quality indicators and are also presented with the Quality Report/Account after the financial year has ended. ASPH Governors have helped select the priorities for 2011/12 and these will routinely be reported back to the Patient Experience Group.

The Priories chosen for 2011/12 are :

- Priority 1 – To provide safe, high quality discharge for patients
- Priority 2 – To provide high quality experience relating to nutrition and hydration
- Priority 3 – To provide confidence and reassurance for patients on infection control, including MRSA and clostridium difficile as well as other preventable infections

- Priority 4 – To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators
- Priority 5 – To reduce the hospital emergency and elective readmission rate
- Priority 6 – To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure
- Priority 7 – To improve the experience and clinical outcomes for those with long term conditions by improving outpatient management and collaborative working with primary and community services.

It is important that the Trust monitors its progress against the commitments set out in the Quality Account and it is anticipated that future Quality Reports to the Trust Board will include a Quality Account dashboard to support monitoring of progress. This will also be discussed at the Council ‘s Patient Experience Group

Suzanne Rankin, Chief Nurse and Mike Baxter, Medical Director

Diagram one: ASPH organisational structure and accountabilities for delivering quality

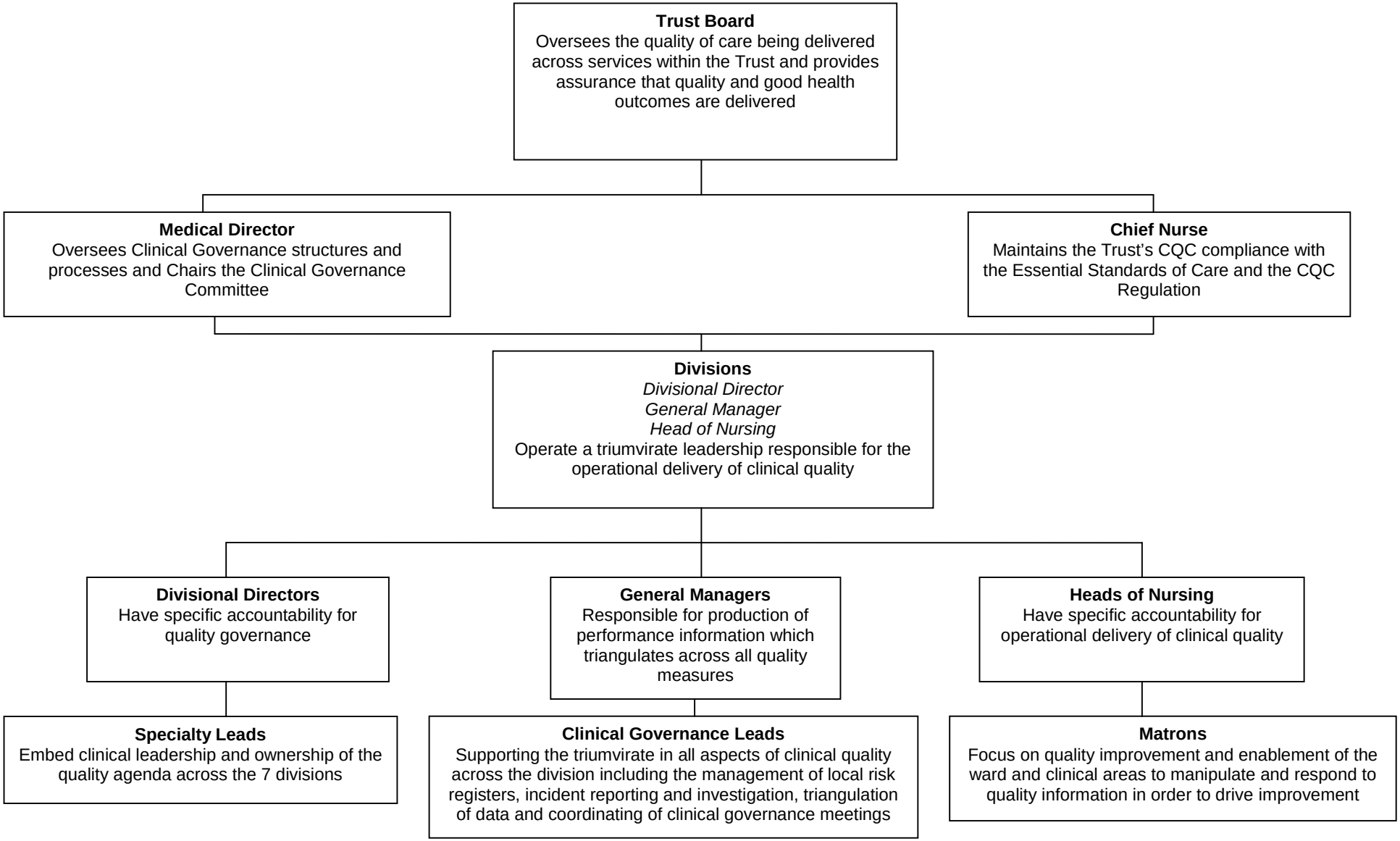
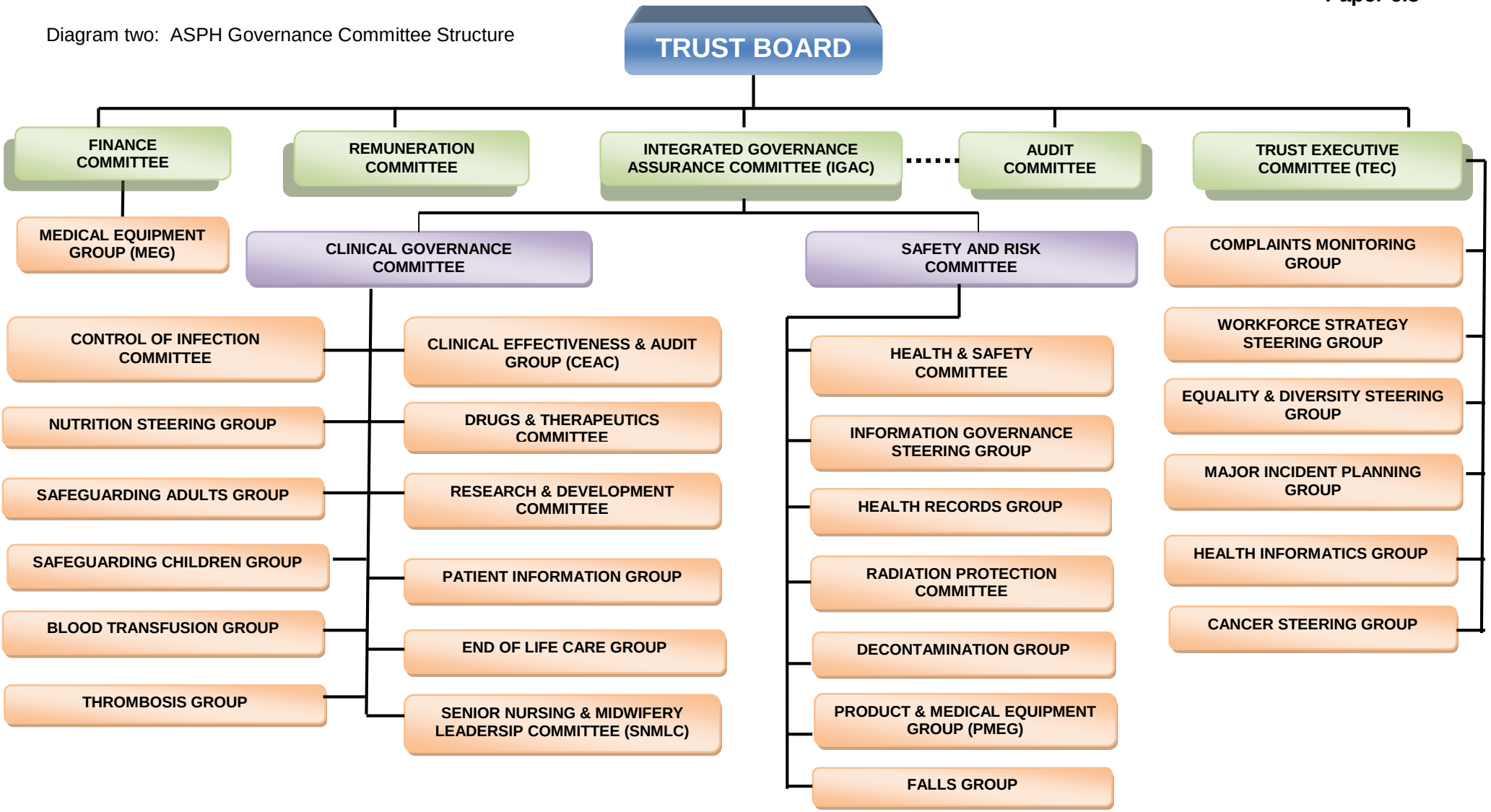


Diagram two: ASPH Governance Committee Structure



MEDICAL STAFFING COMMITTEE
EMPLOYEE PARTNERSHIP FORUM
PATIENT PANEL

Definitions

Balanced Scorecard - Description of indicators

		Annual Threshold 11/12	Descriptions	Denominator:	Numerator:	Calculation:
1-01	Standardised mortality (Relative Risk)	**82**	The HSMR is a standardised measure of hospital mortality devised by Professor Sir Brian Jarman of Imperial College London, and published every year by Dr Foster in the *Hospital Guide.* It is the observed number of in-hospital spells resulting in death divided by an expected figure, for a basket of 56 diagnoses which represent 80% of hospital mortality in England. Day cases are excluded unless the patient died. The expected figure is derived from a logistic regression model which adjusts for case-mix factors.	Expected number of in-hospitals deaths derived from logistic regression, adjusting for factors to indirectly standardise for difference in case-mix for the 56 diagnosis groups. Adjustments are made for: Sex Age on admission (in five year bands up to 90+) Admission method (non-elective or elective) Socio-economic deprivation quintile of the area of residence of the patient (based on the Carstairs Index) Primary diagnosis (based on the Clinical Classification System - CCS group) Co-morbidities (based on Charlson Score) Number of previous emergency admissions Year of discharge (financial year) Palliative care (whether the patient is being treated in specialty of palliative care) Exclude cases Daycases (where classpat = 2 in the first episode)	All spells culminating in death (method of discharge as death (DISMETH=4), defined by specific diagnosis codes for the primary diagnosis of the spell.56 diagnosis groups which contribute to 80% of in-hospital deaths in England.	The ratio of the observed number of in-hospital deaths to the expected number of deaths, multiplied by 100

1-02	Crude mortality (Died in hospital)	**1.60%**	Showing the percentage of total died in the hospital over total admissions in a given time period.	Total admitted patients in a given time period.	Total deceased patients in the same time period where died in hospital. Discharge Method was 4 on PAS.	Total deceased/Total admitted
1-03	MRSA (Hospital only)	**4**	Hospital acquired MRSA case i.e. post 48hrs admission.			Count of post 48hrs MRSA case in a given time period.
1-04	C.Diff (Hosptial only)	**33**	Hospital acquired C. Diff case i.e. post 72hrs admission.			Count of post 72hrs C.Diff case in a given time period.
1-05	Mortality from C.Diff (patients with C.Diff who die)	**6%**	The percentage of the observed number of deaths at a given trust to the number of admissions for a particular C.Diff diagnosis.	Every finished inpatient spell at an acute trust for C.Diff diagnosis, ICD 10 code 'A047'.	Total death of every finished inpatient spell at an acute trust caused by C.Diff diagnosis. Discharge method=4 and diagnosis='A047'.	Total C.Diff Deaths/Total C.Diff Admissions
1-06	Mortality from VTE (patients with VTE who die)	**0.35%**	The percentage of the observed number of deaths at a given trust to the number of admissions for a particular, VTE diagnosis.	Every finished inpatient spell at an acute trust for VTE diagnosis, ICD 10 code 'I80*', 'I81*', 'I82*' and 'I83*'.	Total death of every finished inpatient spell at an acute trust caused by VTE diagnosis. Discharge method=4 and diagnosis='I80*', 'I81*', 'I82*' and 'I83*'.	Total VTE Deaths/Total VTE Admissions
1-07	Mortality from Hip fractures - (patients with Hip Fractures who die)	**4.60%**	The percentage of the observed number of deaths at a given trust to the number of admissions for a particular, Hip Fractures diagnosis.	Every finished inpatient spell at an acute trust for hip fractures diagnosis, ICD 10 code 'S72*'.	Total death of every finished inpatient spell at an acute trust caused by hip fractures diagnosis. Discharge method=4 and diagnosis='S72*'.	Total Hip Fractures Deaths/Total Hip Fractures Admissions
1-08	National Patient Survey (Top 20)	**>3**				
1-09	Patient Satisfaction (NetPromoter Score)	**90%**	NPS is based on the fundamental perspective that every company's customers can be divided into three categories: Promoters, Passives and Detractors. By asking one simple question – How likely is it that you would recommend to a friend or colleague? You can track these groups and get a clear	**Promoters:** Currently the NPS is calculated assuming patients that respond 'YES' are promoters	**Detractors:** Detractors: those that respond 'NO' are detractor	**NetPromoter Score=**%Promoters-%Detractors

			measure of your company's performance through its customer's eyes. Currently the NPS is calculated assuming patients that respond 'YES' are promoters, those that respond 'NO' are detractor. The 'Possibly' are passives and therefore removed from the calculation. The band fro Detractors is wide – scoring from 1-6 of the ten possible options. Passives score 7-8 and the Promoters 9-10.			
1-10	Formal complaints	**320**				Straight count of formal complaints of the month
1-11	SUIs	**14**				Straight count of Serious Unwanted incident of the month
1-12	Falls - resulting in significant injury (grade 3)	**14**				Straight count of falls grade 3 and above.
1-13	Hip fractures treated within 36 hrs	**85%**	The percentage of the Hip fractures patients who were treated within 36hr of admission at the trust to the total number of hip fractures admissions.	Total patients with hip fractures.	Total patients with hip fractures treated within 36 hrs plus delayed patients because medical reasons.	Sum(Total hip fractures admitted patients treated within 36 hrs plus delayed patients for medical reasons)/Sum(Total hip fractures admitted patients)
1-14	Summated Adverse Report Index (SARI)	**1552**				Sum (Total Deaths in 1-02/03/04/05/06/07; total complaints, total SUIs, total Falls, total breach of Hip fractures not treated within
1-15	Average Bed Occupancy	**94%**		Count of daily trust beds total.	Count of daily trust occupied beds total	Sum(Count of daily trust occupied beds total)/Sum(Count of daily trust beds total)
1-15-1	*Highest Bed Occupancy on any one*					

	day					
1-15-2	*Median bed occupancy*					
1-15-3	*95th percentile bed occupancy*					
1-16	Patient Moves	**28,566**	To analyse patient moves in depth, following facts need to be taken into consideration:			Total count of patients who were transferred from one ward to another
1-16-1	*Outliers*		Patients are in the inappropriate clinical area/wards i.e. medical patients are in surgical wards.			
1-16-2	*Move of outliers*		Move patients from inappropriate clinical areas/wards to the appropriate clinical areas/wards.			
1-16-3	*Move of patient due to bed/ward closure*					