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

TRUST BOARD
16th December 2010

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report brings together the • Dash Board, with associated commentary for exceptions • Ward Metrics, with associated commentary for exceptions • Quality overview Items to note in the December Quality report include an excellent result from the National Mothers Survey where Women's services have demonstrated a move from the worst 20% of services in the country to being in the middle of the average 60%. This is a significant improvement as all Trusts would also have been working to improve their services and to move out of the lower 20% and to move into a higher position in the average category is excellent news. In addition, the Picker paediatric inpatient survey results have been received which also demonstrate improvement in a number of questions where the Trust scored worse than average in the 2004 survey. The Quality and Risk Profile (QRP) in November showed an increase in our risk rating for care and welfare from green to amber resulting in ASPH profile registering as amber risk ratings for all areas. This is in part to the data set changing month on month, with some data items remain static for a period of a year despite improvements made, due to annual reviews e.g. patient and staff surveys. The Trust has been benchmarked against other Trusts within SEC for 4 metrics relating to safety as part of the 'safety thermometer' initiative run by the SEC. ASPH is 4th out of the 17 trusts participating.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The Quality report provides assurance that Quality indicators are being monitored and assessed and that actions are being put in place when required
STAKEHOLDER / PATIENT IMPACT AND VIEWS	None sought
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	None identified

The Trust Board is asked to:	Review the paper and discuss the contents
Submitted by:	Dr Mike Baxter ,Medical Director & Susan Osborne, Interim Chief Nurse
Date:	13th December 2010
Decision:	For Noting

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1 Quality Performance Monitoring

1.1 Dashboard Definitions

The table is made up of 6 columns namely:

1. Description of Measure - self explanatory.

2. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2008/09 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

3. Forecast - the calculation is as follows:

    - For month 7 (Oct) we divide 2008/09 Total by 2008/09 YTD at month 7 to give us the proportion of activity that historically took place as a guide to how much more activity will take place during the rest of 2009/10. This is then multiplied out by the YTD figure for 2009/10. To further account for recent up or downward trends we have divided the average monthly figure for 2008/09 by the most recent 12 months average and multiplied this by the first figure. If we are improving this will better forecast that improvement, conversely if we are getting worse the forecast will reflect this also.

    - The formula is this 1/(SUM(2008_09 up to m7)/SUM(2008_09 Total)) x 2009_10 YTD x (2008_09 Ave/Last 12 Months Ave)

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

5. Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, worse than the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an up arrow as higher numbers may be worse and thus will be represented by a down arrow.

6. Year to Date - The sum of the activity from the beginning of the financial year (April).

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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: **30 Nov 2010**

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	88**	▲	▼	▲	85.8**
1-02	Crude mortality	2.6%	1.5%	1.7%	▲	▲	▼	1.5%
1-03	MRSA (Hospital only)	5	5	0	◄►	◄►	◄►	5
1-04	Cdiff	67	44	3	▲	▲	▼	27
1-05	Patient Satisfaction (Your Feedback)	90%	90%	76.9%	▲	▲	▼	76.8%
1-06	Formal complaints	361	348	32	▼	◄►	▼	233
1-07	SUI's	14	16	3	▼	▼	◄►	12
1-08	Falls - resulting in significant injury (grade 3)	29	20	1	▼	▼	▲	12
1-09	Hip fractures treated within 36 hrs	85%****	85.0%	93.5%	▲	▼	▲	75.0%
1-10	Readmissions within 14 days	3.7%	3.5%	3.4%	▼	▼	▲	3.4%
1-11	VTE Assessment*****	90%	90%	71.2%	▲	▲	▼	79.7%
1-12	Summated Adverse Report Index (SARI)	1924	1885	127	▼	▼	▲	1207

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

*** Actual = Sep 2010/11 YTD =Apr-Sep 2010/11 ****Q3 = 85%

***** Based on wards where full VTE data is available

1.2.1 The SMR and crude mortality rate remain unchanged. A detailed analysis of the September mortality data is discussed in section 2.0. There are no areas of concern highlighted.

1.2.2 The Trust has recorded 3 cases of hospital acquired Cdiff. These have been in complex patients with multiple antibiotic therapies. The patients were rapidly isolated and the infection contained. The Trust performance remains good against target. There have been no MRSA cases, this now marks 130 days without a case.

1.2.3 The patient satisfaction data is presented in more detail in the ward metrics.

1.2.4 The number of complaints has increased from 27 to 32. There is a trend of an increase in the number of complaints over the last 3 months. A review of themes has been undertaken. The YTD position remains at a 13% decrease on complaints compared with last year.

1.2.5 There were 3 SUI which have been discussed elsewhere in the Board papers. It is worth noting that all SUI investigations are following the new procedure which includes early contact with patients and families involved in SUI investigations.

1.2.6 The number of significant, grade 3 falls remains low with only 1 event this month.

1.2.7 Patients with fractured Hips operated on within 36 hrs have shown a marked improvement in Nov with a 93.5% completion rate compared with 81% last month.

1.2.8 14 day readmission remains on target. The more important work on 30 day readmission is proceeding and the board will receive an update at the next meeting

1.2.9 VTE assessment has shown a dip in performance. This is reflective of the roll out to wards who have been now adopted the IPL system of recording compliance. The Trust manual audit confirms performance of over 85%. There has recently been a national directive on group exclusions. It is still anticipated that the Trust will record 100% compliance with the VTE initiative.

1.2.10 SARI measure shows a reduction from 138 to 127. This marks 11 less adverse outcomes in the Trust in November compared to October.

1.3 Triangulated Data Dashboard

An initial draft of the triangulated dashboard is presented at appendix 3 for discussion.
This dashboard would be utilised as a tool for General Managers to enable then to quickly see where issues may lie. It would also be issued for the matrons and ward sisters to have a clear visual of quality indicators in their area.

It is our intention to consider how we might develop targets for incident reporting and complaints and PALS, and to give further consideration to providing a local weighting for the total of each measure per ward, similar to the SARI. It is important to note that in some cases indicators are not universal for example CMR would be expected to be higher in some areas than others dependant on type of patient cared for.

The dashboard is presented for discussion as to whether this would be a useful dashboard to enable more triangulating of information and to be an effective tool to promote higher quality care.

2 Mortality and Morbidity

2.1 Dr Foster update:

There are no Dr Foster alerts. ASPH was identified as one of 3 Trusts with SMR significantly below expectation. The Trust had the 5th best SMR in the country.

2.2 Mortality and Morbidity Review Group

Work has been started to look at Crude mortality rate by ward and directorate to start to triangulate data and to be able to better support the Directorates with information.

Below is the crude mortality rate for the Divisions.

	CMR	CMR LAST MONTH	ABSOLUTE NUMBERS
ALL	1.50%	1.58%	100
MEDICINE	4.28%	4.17%	82
SURGERY	1.05%	1.32%	14
ORTHO	0.00%	0.38%	0
PAEDIATRICS	0.30%	0.57%	2

This is presented in a new format to aid review. The current CMR is presented in column 1, broken down by speciality. Column 2 offers a comparison to the previous month. Column 3 shows the absolute numbers of patients involved.

The Trust's mortality figures remain stable, with no significant changes. The slight increase in CMR in acute surgery and paediatrics which was noted in last month's report has improved and this is reflected in an improvement in the Trust's overall CMR.

A report on last month's mortality figures from surgery is awaited. There were 4 deaths recorded as being related to elective procedures in surgery.

The report from paediatrics showed that the increase in mortality reflected stillbirths.

Review of the national perinatal mortality statistics for 2009 shows that the rate of still births and perinatal and neonatal mortality at ASPH is below the national average for all 3 categories with no suggestion of adverse trends over the years 2005-2009.

There were no deaths in orthopaedics in September.

3 Quality Update

3.1 NPSA Safety alerts

Overdue Alerts
Two alerts remaining overdue as follows.

Deadline	Description	Lead	Status
05-Feb-07	Early identification of failure to act on radiological imaging reports	Jonathan Glover	This alert remains an issue for the Trust. The software system called Communicator which should have addressed all the issues described but is still not functioning well and has not been fully rolled it. The imaging department have been liaising with the company to address these issues. Software is currently being tested. This has been added to the CRR. An SUI has occurred due to failure to act on a result and further actions are being put in place to support his process including consideration of a form to identify all tests requested which will be held with the notes and Drs will be required to ensure all results viewed prior to discharge.
19-Sep-09	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	Donna Jarrett	Our planned solution is to use iSOFT (PAS) there is a new release (4.3) due in Jan 2011 that will enable us to validate the correct NHS number with the correct patient. This will enable us to move forward with this alert. Other Trusts that use the same PAS software are in a similar position in that they have to wait for the IT software to be completed and implemented.

New Alerts

Date of Issue	Description	Deadline	Lead	Status
25 November 2010	Preventing fatalities from medication loading doses	25 November 2011	Victoria Griffiths	On target

Alerts due for completion in next month

Date of Issue	Description	Deadline	Lead	Status
16 June 2010	Safer administration of Insulin	16 December 2010	Debbie Hindson	On target for closure – awaiting final report for system closure, actions in place.
1 December 2009	Safer lithium therapy	31 December 2010	Victoria Griffiths	On target
30 July 2010	Reducing treatment dose errors with low molecular weight heparins	26 January 2011	Heidi Galang	On target

3.2 Patient Feedback

All inpatient areas now have a local mechanism for patient feedback. Paediatrics and Outpatients feedback processes are currently being developed and expect to be rolled out in the New Year.

Net Promoter Scores (NPS)

Each ward is asking patients to report on the question 'Would you recommend this trust to your friends and family'. This score is being utilised as a key performance indicator to establish whether improvements in patient experience are delivering an outcome that supports the Trust objectives.

The NPS has been revised; we are classifying the 'probably' group as 'passives' and not including these in the calculation. The net promoter score is calculated using the methodology introduced by Reichheld (2003) in a Harvard Business review article 'The One number you need to grow'
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 [Company X] to a friend or colleague? — you can track these groups and get a clear measure of your company's performance through its customers' eyes.

Customers respond on a 0-to-10 point rating scale and are categorized as follows:

- **Promoters** (score 9-10) are loyal enthusiasts who will keep buying and refer others, fueling 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 your brand and impede growth through negative word-of-mouth.

To calculate your company's Net Promoter Score (NPS), we take the percentage of customers who are Promoters and subtract the percentage who are Detractors.

Would you recommend this Trust to friends and family?

Ward	Net Promoter Score	Definitely	Probably	Not Recommend	No. Forms
Medicine SPH					
Aspen	**75%**	75%	25%		57
Birch	**80%**	83%	14%	3%	69
May	**77%**	82%	14%	5%	22
Cedar	**77%**	79%	19%	2%	47
Holly	**70%**	73%	24%	3%	59
Maple	**57%**	63%	31%	6%	35
MAU	**70%**	73%	23%	3%	30
Medicine ASH					
Chaucer	**91%**	91%	9%		11
Fielding	**58%**	58%	42%		26
WWW	**52%**	59%	34%	7%	29
Orthopaedics					
Dickens	**84%**	85%	15%	1%	131
Elm	**68%**	68%	32%		47
Juniper	**68%**	70%	28%	2%	60
Surgery					
Falcon	**67%**	70%	28%	3%	40
Heron	**74%**	76%	22%	2%	55
Kingfisher	**60%**	63%	34%	3%	176
SAU	**85%**	85%	15%		40

3.3 Complaints/Ombudsmen reports

Divisions with highest complaints were Medicine & Emergency Care with 12 complaints and Surgery with 9.

Examples from the themes for November are detailed below:

Communication - Accuracy/completeness: (9 issues)
A patient's wife raised concerns regarding the cancellation of appointments and not being advised, nurses not being able to provide any further information, clinic attendances being incorrect and a letter from a doctor thought to be inaccurate.

Clinical decisions/treatment (medical) (7 issues)
A patient's daughter was unhappy with the treatment and care her mother received and delay in the decision to undertake surgery. Concerns included a failure to list the patient for an upper GI endoscopy given symptoms; delay in reviewing the patient following second referral from GP. Following discharge the patient was readmitted the following day. The patient's daughter feels there was additional delay in undertaking further surgery. Daughter feels that an earlier diagnosis should have occurred.

Discharge - Arrangements on the day (5 issues)
A patient's son raised concerns relating to his mother being in the discharge lounge for 8 hours after suffering a mild stroke.

Treatment – medication (5 issues)
A patient was sent home without the long term treatment for a medical condition, and communication with family regarding patient's condition was poor.

All complaints are investigated by the Divisions and actions put in place to improve situations that have ended in a complaint.

In October 2010 the Trust provided a copy complaints file to the Ombudsman who has now carried out an initial assessment and has decided not to investigate. This complaint dates back to March 2010 and a full investigation was carried out by the Complaints team with several detailed responses provided. The Ombudsman has confirmed there is no further action for the Trust.

It is important that the Trust ensures the continued robust management of complaint investigations to ensure any case file provided to the Ombudsman demonstrates a thorough and comprehensive investigative process and response. Complaints performance against agreed timescales is currently being monitored by Division and ongoing training and support for Managers is being provided.

3.4 Update on 2010 National Mothers Survey

The Picker report on our maternity services was produced in September and reported at the Trust Board in October stating that action plans were in progress. The CQC maternity survey results have been received in December 2010 and recommendations from both of these surveys have been incorporated into one action plan as attached.

The CQC report uses data from all 144 maternity units in the country. In the previous Healthcare Commission report the Trust was placed in the least well performing group and in the bottom 20%. The ratings have since been changed and trusts are grouped into the bottom 20%, the average 60% and the top 20%.

ASPH maternity services has been placed in the middle of the average 60% of all maternity units which is a marked improvement from previous patient satisfaction results and demonstrates a real achievement for Women's services.

There are still areas for improvement and there have been slightly different recommendations from each survey with room for improvement in community services and labour services, both of which are being taken forward from now until April 2011.

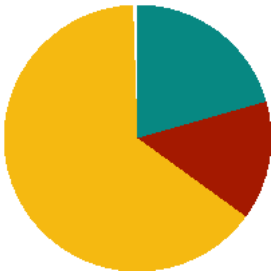
3.5 Picker Paediatric Inpatient survey

The Paediatric Directorate opted to participate in the optional Paediatric Inpatient Survey 2010, along with 30 other Trusts. The results summary is identified below however the time frame of 6 years between surveys makes it difficult to attribute improvements to specific actions. The Directorate has reviewed key issues and preliminary issues for addressing include accessibility of hot drinks for parents and somewhere confidential to talk to parents. Both of these issues were discussed at the local Clinical Governance meeting last week and the team are exploring further improvements. The wider Trust issues of poor provision of patient diet and accessibility of hot meals for parents will be shared with the Estates and Facilities Division.

These issues will be added to the questions monitored on 'Your Feedback'.

An action plan is being established and an action planning day organised by Picker in February, will be attended by members of the team.

2004

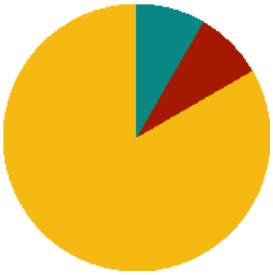


A total of 34 questions were used in both the 2004 and 2010 surveys. Compared to the 2004 survey, your Trust is:

- Significantly BETTER on 7 questions
- Significantly WORSE on 5 questions
- The scores show no significant difference on 22 questions

How do we compare to other Trusts?

2010



The survey showed that ASPH Trust is:

- Significantly BETTER than average on 6 questions
- Significantly WORSE than average on 6 questions
- The scores were average on 60 questions

3.6 Cardiac arrests

Completion of cardiac arrest logs is now much improved.

There are approximately 10 cardiac arrests a week and around 8 out of the 10 logs are completed at the time of the cardiac arrest. The outstanding 2 are being chased up to ensure 100% completion.

The cardiac arrest logs have been amended to ensure the senior clinician is identified as the responsible person for completing the log.

Now robust information is provided, the resuscitation service is able to analyze and instigate investigations and/or debriefs as necessary. Themes identified include use of MEWS score and subsequent actions, Ashford Hospital teams have been identified as needing additional support. Outreach team has instigated 1:1 training in Ashford in relation to MEWS escalation and work has been undertaken to improve form completion at Ashford.

Three arrests are being investigated further this month.

3.7 Quality Risk Profile (QRP) November

The QRP is now being delivered on a monthly basis from the Care Quality Commission (CQC). The dataset used to calculate the risk ratings changes each month as new items become available. This makes the tool difficult to use to demonstrate improvement as an improvement in one area may be counteracted by the addition of a new data item.

The QRP is best used as a tool to indicate our key risk areas and ensure that as a trust we are focussing on our key priorities in relation to outcomes for patients. It is not a judgement of our compliance with regulations.

Our key risk area is the Outpatient Survey. A number of items are identified specifically from the Outpatient Survey that we were unable to demonstrate actions for improvement – in particular around Doctors communication. The outpatient action plan is being reviewed and amended by the Deputy Chief Nurse.

Red (worse than expected ratings) and dark amber ratings (tending towards worse than expected ratings) are being addressed with standard owners and actions being identified to improve.

Awareness session has been delivered to Executive Directors and General Managers. The QRP is delivered on a monthly basis for information with the key changes identified. General Managers are being informed of areas within their remit that need improvement or monitoring.

Current risk ratings

Ratings for the 5 'sections' all mid amber which indicates a change for section 2 'Care and welfare' which was rated green in October.

Risk ratings for the essential standards are below

Outcome	Rating from QRP Nov 2010	Rating from QRP Oct 2010	Comments
Respecting and involving users	Low Amber	Low Amber	
Consent	No information	No information	
Care of welfare of users	Very Low Green	Very low Green	
Nutrition	Very Low green	Very low Green	
Co-operating with other providers	Mid amber	No risk rating	
Safeguarding	No risk rating	No risk rating	
Cleanliness and infection control	Low amber	Green	Addition of data item - The proportion of respondents to the adult inpatient survey who stated there were no hand-wash gels available for patients and visitors to use – discussed with infection control – suggestion that patients do not understand what the foam sanitizers are – LF to take to infection control for discussion on new was to address this. No risk identified re actual provision of hand gels
Management of medicines	Mid amber	Mid Amber	
Safety and suitability of premises	Very low green	Green	Down 1 notch – no apparent rationale for this – seeking advice from CQC
Safety and suitability of equipment	No information	No information	
Requirements relating to workers	No risk rating	No risk rating	
Staffing	Mid amber	Amber	
Supporting staff	Mid amber	Amber	Up two notches towards higher amber – addition of 3 data items relating to positive educational audit on newborn screening.
Assessing and monitoring quality	Mid amber	Amber	
Complaints	No risk rating	No risk rating	
Records	Mid amber	Green	Addition of 3 new data items relating to data quality, ethnic coding data and maternity data quality, and completeness of heart disease audits for the 2009/2010 period. All items were rated as similar to expected. Data sets are being reviewed to understand how improvements can be made.

3.8 Safety Thermometer Census

This is the first national survey of patient safety. NHS South East Coast is working in partnership with the national QIPP Safe Care Work stream, the Chief Nursing Officer, NPSA and the NHS Institute to facilitate NHS SEC organisations participation in the survey.

The survey comprises an audit of 4 areas:

- Medical/ older people (Holly Ward)
- Trauma and orthopaedic (Elm Ward)
- Stroke/ Rehabilitation (Chaucer Ward)
- A generic 'other' to be determined locally (Aspen Ward – Respiratory)

The census occurs quarterly on 1 day starting on the 15 September and comprises four key metrics for the Safer Care QIPP work stream and the 3 key HIA metrics:

- Pressure ulcers
- Falls
- Catheter associated urinary tract infection
- VTE

The census is being repeated on 15 December 2010. The safety thermometer tool is still under development and a final tool will be published by February 2011. It is likely that this tool will be one of the recommended instruments for regular data collection on key safety metrics.

The table below shows results for 'no harm' to patients for all 4 metrics for Trusts across Surrey, Kent and Sussex for the first census on 15 September; note that our sample size was 51 patients.

Trust	No Harm Score	No. Patients
East Kent Hospitals NHS Foundation Trust	91.30%	46
East Sussex Hospitals NHS Trust	91.30%	46
Queen Victoria NHS Foundation Trust	90.30%	31
Ashford & St Peter's Hospitals NHS Trust	**86.30%**	**51**
Frimley Park NHS Foundation Trust	82.50%	40
Maidstone & Tunbridge Wells NHS Trust	80.50%	41
Brighton & Sussex University Hospitals NHS Trust	79.10%	43
Western Sussex Hospitals NHS Trust	77.10%	48
Surrey & Sussex Healthcare NHS Trust	76.90%	52
Royal Surrey County NHS Trust	76.80%	56
Surrey Community Hospitals	74.60%	67
South Downs Health NHS Trust	73.90%	46
Dartford & Gravesham NHS Trust	69.70%	76
Eastern & Coastal Kent Community Hospitals	66.70%	18
Medway Community Hospitals	54.50%	11
West Kent Community Health	52.50%	59
Medway NHS Foundation Trust	49.00%	51

3.9 WQI (Ward Quality Indicators) commentary

The WQI definitions can be found at Appendix 2

The WQI scorecard can be found at Appendix 4
Peripheral Cannula and after Care: Documentation still needs improvement.

Cleanliness: The recent refurbishment resulted in a higher than usual amount of dust and clutter and this issue has now improved on the matron's environment audit

Blood Traceability: Further actions have been implemented to improve blood traceability.
The porters are now required to document which ward the blood has been taken to. Nursing staff are required to document the name of the ward and sign the relevant documentation as soon as the blood bag is taken down from the patient.

MUST tool: This is the second month that this measure has been recorded. There are concerns around the accuracy around how the tool is being used. The professional development lead for the Trust has arranged training sessions to address this and a nutritional audit being undertaken on 16th December.

Pressure Ulcers: There is focussed training being provided by the Wound Care Specialist Nurse on Aspen and May to support these areas.

Falls: Most areas have seen a decrease but there is still ongoing work

Complaints**:** Most areas have seen a decrease

VTE: Ongoing work still required.

Medication Errors**:** These relate to prescribing errors and will be discussed with the Divisional director for Medicine & Emergency Services.

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

Date: 13th December 2010

Appendix 1

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

National Mothers Survey 2010
Action Plan

(incorporating both CQC and Picker feedback)

Introduction
This action plan incorporates actions from issues highlighted in the Picker report received end September 2010 and the CQC report received end November 2010. Both reports use data from the national mothers survey undertaken in February 2010. The Picker report compares data from all maternity units which used Picker as the data collection company (40 maternity units) while the CQC report uses data from all maternity units in the country (144 units).

The CQC report deems the maternity service at ASPH to be within the average 60% of all maternity units in all categories of care.

No	Problem area	Action since Feb 2010 and comments	Further Action required	Lead	Timescale
1	**Antenatal care** with particular attention to: • information and choice of place of birth • choice of place of check-ups • receiving *The Pregnancy Book* • information and explanations • making a birth plan • being involved in decision making • being treated with kindness and respect • parent education classes at a convenient time and venue • parent education class content • continuity of carer	Care has been and will continue to be constrained by low community staffing levels. Recruitment and retention action plan in place since April 2010 with ongoing monitoring. As recruitment and retention improves, restructuring of teams to increase community establishment and develop more continuity.	Set up community working party to review all community care pathways & staffing and formulate action plan.	TS/JF/LM	End April 2011
			Emphasise all midwives to discuss choice of place of birth at booking interview: use of place of birth leaflet to reinforce choices.	TS/Band 7 team leaders	Ongoing
			Midwifery led birth centre business plan currently at TEC for approval. If awarded goes to Board in December 2010 for final approval.	EN/PC	Dec 2010
			Every CMW team to consider possibility of using a local Children's Centre for antenatal appointments.	TS/all CMW team leaders	Ongoing
		Increased order of *The Pregnancy Book* to include multiparous as well as primigravid women.	Discuss possible inclusion of *The Pregnancy Book* on Tempest DVD.	TS	January 2011
			Ongoing reminders to all CMWs to give *The Pregnancy Book* to all women at booking.	TS/Team Leaders	Ongoing
			Introduce effective communication teaching	JF/JH	January

			into mandatory bonus day training for all maternity staff from January 2011.		2011
			Consider including community on band 6 rotation rotas to increase community staffing g and facilitate development of community interest/expertise amongst midwifery staff.	TS	End April 2011
		All parent education restructured in August 2010	Undertake review of content and timing of parent education classes once the new weekend provision has been evaluated for six months. Make any necessary changes.	TS/JF/RC/ NW	End April 2011
2	**Labour and birth** with particular attention to: • confidence and trust in staff • involvement in decision making • quality of care • being treated with kindness and respect • not being left alone at worrying times	Introduction of new joint preceptorship and supervision programme in May 2010	Introduce effective communication teaching into mandatory bonus day training for all maternity staff from January 2011	JF/JH	Jan 2011
			Ongoing inclusion of communication issues in all new doctors' local induction to highlight the importance of effective communication	EN/GN	Ongoing
			Ongoing evaluation and review of joint preceptorship and supervision programme for all newly qualified and newly recruited junior midwives (programme commenced July 2010)	JF/JH/DC	Ongoing
			Review ongoing maternal satisfaction survey and introduce dissemination of findings at monthly directorate and staff meetings	AH	Jan 2011
			Ongoing use of ASPMAT, staff communication bulletin, Risky Business and staff meetings to highlight issues arising from feedback and/or complaints	All midwifery managers	Ongoing
			Devise and introduce band 6/7 development programme for experienced midwives	JF	End March 2011
			Consider appointing core band 6 midwives as part of development programme to encourage midwifery expertise in the labour	All midwifery managers	End March 2011

			ward setting		
			Recruitment and retention action plan (see midwifery staffing below)	All midwifery managers	Ongoing
			Ongoing regular skills drills to be facilitated and reported and reviewed at quarterly Women's Health Education and Training Group meetings	JF/JH	Ongoing
			Effective performance management	JF/JH/WHETG	Ongoing
			Ensure annual appraisal of all staff to review performance and set personal development goals	EN/JF/all appraisers	Ongoing
3	**Postnatal care in hospital** with particular attention to: • information and explanations • availability of staff to help • quality of food • cleanliness of toilets and bathrooms		Introduce 'group discharge talk' on Joan Booker Ward for postnatal women.	AH	January 2011
			25 hours per week clerical appointment on Joan Booker Ward to assist midwives with discharge paperwork and free up midwives for clinical care: ERF to panel December 2010	AH	Ongoing March 2011
		New food trial undertaken for 3 months from Aug 2010. Received a worse overall review than original food therefore currently back to original food	Hotel Services Manager (WB) engaged with issues surrounding quality of food. Other options being explored including: - A 'younger persons' menu for the bulk service - 'Softer marketing' e.g. packaged cutlery, tray mats - Trust catering out to tender for 2012 start with midwifery managers involved in the steering group - Consideration of 'healthy snacks' to supplement main meals	WB/JF/AH	Ongoing

		Quota of housekeeping staff on Joan Booker Ward doubled since the 2010 surveys	Weekly matron's audit of cleaning and housekeeping with monthly submission of scores to ward quality indicator dashboard/Monthly assessment of cleaning audit with housekeeping team/PEAT inspections	WB/AH	Achieved/ongoing ed/ongoing
4	**Infant feeding** with particular attention to: • full discussion during pregnancy • consistency of advice	Achieved BFI Certificate of Commitment and training programme instigated towards achieving level 1 in March 2011	Explore how women can get individual discussion in antenatal period given the difficult staffing situation	AH/KM[c]H/AB/TS	March 2011
5	**Community care** with particular attention to: • giving appropriate advice and information • explanation of antenatal screening • location of antenatal care		Establish community working party to review all community care pathways & staffing and formulate action plan Screening specialist midwife to emphasise necessity of giving full and appropriate explanations of antenatal screening choices to all women in a way that can be understood; to be conveyed during mandatory bonus day training session	TS/JF/LM AK	End April 2011 January 2011/ongoing
6	**Midwifery staffing**	Regular recruitment and retention meetings with HR staff	Ongoing implementation and regular review of recruitment and retention action plan devised April 2010 Midwifery staffing levels to be reported and reviewed at Trust quarterly workforce planning committee meetings from January 2011 Timely and efficient processing of all midwifery applicants Regular review of midwifery staffing on Trust risk register	All midwifery managers All midwifery managers/JH JH/LH EN/JR	Ongoing Ongoing Ongoing Ongoing

Appendix 2 WQI definitions

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

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

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

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

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

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

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

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

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

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

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

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

12 Total number of falls

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

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

15 Medicine administration errors
Number of errors reported via incident reporting

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

Appendix 3

INITIAL DRAFT FOR DISCUSSION

First draft of potential triangulation of Quality data:PLEASE NOTE amber perameters are for demonstration purposes and no amber ratings have been agreed by executive team.

Data Sources	
NPS	Your Feedaback
Complaints	Monthly complaints data, Customer Affairs
PALS	Monthly PALS data, Customer Affairs
CMR	Dr Foster, Information Department
Incidents	Datix database Quality department
HR data	Monthly performance data, HR

	Net Promoter score 'patient feedback' target 90% (>80% amber)	Complaints	PALS	CMR	Incidents grade 1+2	Incidents grade 3,4,5	Turnover target <13% (13-15 amber)	Sickness as a%hours available target <3.5% (3.5-5.5 amber) OCT DATA	Appraisal 95% (>85% amber)	Net Promoter score - 'staff feedback'
Acute Medicine and Emergency care	**70% average**	**12**	**55**	**4.28**	**77**	**3**	**15%**	**3.1**	**89.7**	
ASPEN	75%			17	6	0	16.7	3.3	87.5	
CCU				2.3			11.0	3	100	
BIRCH	80%	1	5	3.6	4	0	14.6	2.3	94.4	
MHDU				39.3	5	0	5.7	0.5	85.7	
HOLLY	70%	2	5	22.1	4	0	21.5	4.1	90.3	
CEDAR				15.8	14	1	3.0	3.3	97.2	
MAY	77%			10.4	8	0	14.9	7.2	92.6	
MAPLE	57%	3	0	21.6	5	0	17.0	3	90.6	
MAU	70%	2	11	2.1	20	0	16.2	1.5	85.4	
A&E		3	19		11	2	25.0			
CHAUCER	91%	0	2	1.4	2	0	17.7	3.8	62.5	
WORDSWORTH	52%			2.4	6	0	16.4	12	94.1	
FIELDING	58%	0	1	3.9	2	0	9.2	3.5	100	
T&O	**73% average**	**3**	**7**	**0**	**12**	**0**	**7.40%**	**3.1**	**84.2**	
DICKENS	84%	1	0	0			0.00	1.99	74.2	
ELM	68%	1	0	4.4	11	0	5.40	1.47	83.8	
JUNIPER	68%	0	2	2.2	1	0	8.40	1.17	77.8	

Surgery	**75% average**	**9**	**30**	**1.05**	**7**	**0**	**19.70%**	**3**	**83.2**	
KINGFISHER		0	1	2.7			21.40	4.1	93.5	
FALCON	67%	1	0	3.5	2	0	17.40	1	91.7	
HERON	74%						26.70	6.3	94.4	
KESTREL		1	9		5	0				
SAU	85%	1	2	0.2	1	0	16.20	1.6	78.6	
Anaesthetics, critical care and Theatres		**0**	**0**		**22**	**2**	**10.50%**	**2.4**	**98.3**	
THEATRES					12	0				
DSU		1	5		5	1				
Critical care				63.7	5	1		3.1	84.6	
Diagnostics and therapeutics		1	8		1	1	11.20%	1.1	91.9	
ENDO				0	0	1	0.00	0.4	92.9	
X-ray					1	0	8.00	3	94.8	
Women's		4	1		22	1	17.09%			
JOAN BOOKER				0	7	1				
LABOUR WARDS		1	0	0.3	14	0				
PAEDS		2	5	0.3	1	0	15.78%			
ASH/OAK				0			5.40		82.1	
PAED A/E		2	3				17.22		88.2	
NICU				6.8	2	0	8.20		88	