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

TRUST BOARD
24th February 2011

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for the month of January 2011.
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. The Balanced scorecard features no red ratings. The Clinical Quality Predictor Dashboard continues to be developed and is presented for Board comment. The Clinical Strategy Dashboard is presented. This dashboard is more directly aligned to outcomes for patients. A full report on Care Quality Commission (CQC) Essential Standards of Quality and Safety is provided. Compliance with the Essential Standards ensures maintenance of our registration with the CQC and the report provides information on the current process, progress and current position, and actions to improve for the coming year. The CQC Quality and Risk Profile (QRP) for January has not been published in time for inclusion in the Board papers.
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.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to the equality on access taking into consideration disability, age and that all matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health Act (2009) and failure to do so could affect the Trust's registration and Monitor licence.
The Trust Board is asked to:	Review the paper and seek further assurance if required
Submitted by:	Dr Mike Baxter, Medical Director & Suzanne Rankin, Chief Nurse
Date:	16th February 2011
Decision:	For noting

Contents

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: **31 Jan 2011**

1. To achieve the highest possible quality standards for our patients, exceeding their expectations, in terms of outcome, safety and experience.

	Patient Safety & Quality	Annual Target	Forecast	Actual	Change			YTD
1-01	Standardised mortality (Relative Risk)*	82	82	105.8**	▲	▲	▼	89.3**
1-02	Crude mortality	2.6%	2.0%	1.9%	▼	▼	▲	1.6%
1-03	MRSA (Hospital only)	5	5	0	◄►	◄►	◄►	5
1-04	C.Diff	67	38	2	▼	◄►	▲	32
1-05	Patient Satisfaction (Your Feedback)	90%	81%	76.4%	▼	▼	▲	76.6%
1-06	Formal complaints	361	359	41	▼	▲	▼	291
1-07	SUIs	14	15	1	◄►	▲	▼	13
1-08	Falls - resulting in significant injury (grade 3)	29	16	1	▲	◄►	◄►	14
1-09	Hip fractures treated within 36 hrs	85%****	85.0%	97.3%	▲	▼	▲	90.3%
1-10	Readmissions within 14 days	3.7%	3.7%	2.6%	▲	▼	▲	3.1%
1-11	VTE Assessment	90%	90%	90%	▼	▲	▲	83.4%
1-12	Summated Adverse Report Index (SARI)	1924	1844	106	▲	▲	▼	1410

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

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

1.01-1.02 The Dr Foster SMR is reflective of the Trust's mortality over the last three months. This includes the increase in mortality in December which was previously reported to the Board. The crude mortality for January shows the Trust's performance is within targets. A more detailed discussion on mortality is presented in section three.

1.03-1.04 The Trust's hospital acquired infection rates remain good with no MRSA and only two cases of C Difficile.

1.07 Records that there has been one reported SUI which is discussed in more detail in part one of the Board papers.

1.08 There has been one fall resulting in a grade three injury.

1.09 The hip fracture operative rate is above 90% for the third consecutive month and the Trust is on course to deliver the PCT target.

1.11 This shows that the Trust has now achieved the national target value of 90% compliance with the VTE target.

1.12 The SARI has shown the first increase for three months, the general trend however remains positive. The increase in this parameter is driven by the increase in patient complaints (1.06).

1.3 Clinical Quality Predictor Dashboard

The dashboard is attached at appendix 1.

The aim of the dashboard is to enable triangulation of indicators that give early warning of a ward or clinical areas deteriorating delivery of clinical quality. This will assist in quickly identifying an area in need of support and enable the Trust to respond.

The dashboard is in development and data verification is not yet robust. The dashboard is therefore only to be used as a signpost for clinical quality monitoring and deeper investigation.

2. Clinical Effectiveness

2.1 Crude Mortality Rate by Directorate

	CMR NOV 2010	ABSOLUTE NUMBERS	SEPT 2010	OCT 2010	NOV 2010
ALL	1.70%	116	▲	▼	▼
MEDICINE	5.38%	105	▼	▲	▼
SURGERY	0.45%	6	▲	▼	▲
ORTHO	0.36%	2	▲	▼	▲
PAEDIATRICS	0.00%	0	▲	▼	▲

Mortality review identifies no areas of concern.

2.2 Data on Outcome from Aortic Aneurysm Surgery (Elective and Non-Elective)

AAA Repair	YEARS			
	08	09	10	08-10 CUMULATIVE
Total Ops	35	44	35	114
Total Deaths	4	9	5	18
Total Mortality	11.4%	20.4%	14.3%	15.8%
Total Elective	24	25	21	70
N° Elective Deaths	1	0	0	1
Elective Mortality	4.2%	0%	0%	1.4%
Total Emergency	11	19	14	44
N° Emergency Deaths	3	9	5	17
Emergency Mortality	27.2%	47.4%	35.7%	38.6%

A recent report by South Central had suggested that ASPH NHS FT had a higher emergency Aortic Aneurysm mortality.

We have reviewed the situation in the last three years. The national average mortality is quoted as 50%, the international benchmark is 40%. The best series in the world reports a mortality of 21%. ASPH cumulative data shows an emergency mortality of 38.6% which compares well with national/international mean.

2.3 Clinical Strategy Dashboard

Ashford & St Peter's Hospitals NHS Trust
Clinical Quality Report

Position as at: 31 Jan 2011

Delivering or exceeding Target
Underachieving Target
Failing Target

1. Improvement of clinical outcomes

		Annual Rolling Improvement Increment 2010-15	2009-10 Outturn	Apply Rolling Improvement Increment 2010-15	2009-10 Apr-Jan	2010-11 YTD	Jan-10	Jan-11	Change		
Clinical Outcomes	Reduced Mortality for Pneumonia	4%	188	180	157	186	25	26	▲	▼	▼
	Reduced mortality for Hip fractures patients	3%	24	23	20	19	2	3	▲	▼	↔
	Reduced mortality from C.Diff	4%	11	11	9	5	1	0	▲	▼	↔
	Reduced mortality in stroke	4%	99	95	87	90	10	0	↔	▲	▲
	Reduced mortality in VTE diagnosic categories	4%	6	6	6	13	1	0	↔	▲	▼
	Reduction in Hospital Acquired C.Diff	6%	50	47	38	32	4	2	▲	↔	▼
	Reduction in Hip fractures LOS	6%	22.9	22.0	22.6	21.0	26.4	7.7	▲	▲	▲
	Reduction in admitted from a nursing home	10%	1474	1327	1224	1278	148	126	▲	▼	▲
	Reduction in admitted from a nursing home LOS	4%	5.9	5.7	5.8	6.4	6.53	2.87	▲	▼	▼
	Increase % Hip Fractures treated with in 36 hrs target	2%	71.9%	73.9%	71.9%	76.5%	71.9%	97.3%	▲	▼	▲
	Reduction in Readmissions with 30 days of discharge	4%	4541	4359	3717	4022	405	367	▲	▼	▲
Patient Safety	Reduction in patient falls related to harm	4%	29	28	24	14	2	1	↔	↔	▲
	Reduction in fractured neck of femur admissions	4%	481	462	393	380	42	11	▲	▼	▲
	Direct audit of surgical check list activity	4%	95%	99%	95%	97.2%	95%	95.0%	↔	↔	▼
	Reduction on theatre unexpected return	50%	63	32	53	28	5	1	↔	▲	▲
	Elimination of Never Events	0	0	0	0	0	0	0	▲	▲	▲
	Reduce in theatre related SIRIs	0	0	0	1	0	0	0	▲	▲	▲
	Reduction in all drug errors Grd 3,4,5	0	6	5	0	1	0	0	▲	▲	▲
Patient Experience	Your Feedback Composite Score	90%			90.0%	76.8%		76.2%	▲	▼	▼
	Reduction in Complaints	0%	361	361	301	291	30	15	▲	▲	▼
	Patient representation										
	Bed news stories reported in local press										
	Reduction in PALS contact	4%	1262	1212	886	1190	108	135	▼	▲	▲

SUI (Serious Untward Incidents are now termed SIRI (Serious Incidents Requiring Investigation)

The Clinical Strategy Dashboard has been presented previously to the Board. The dashboard tracks the objectives of the Clinical Quality Strategy and is very closely aligned to the NHS Outcome Framework.

This dashboard is much more directly aligned to outcomes than the Quality Report and serves to provide further information about the Trust's performance.

The targets and rag rating are set on an annualised improvement calculated from the five year objectives set in the strategy document.

The mortality from hip fractures, stroke and C.Difficile shows the Trust is delivering improvement in performance.

The mortality from pneumonia is amber rated. This is the Trust's biggest cause of mortality and although there is some improvement in outcome over the last year there is still scope for improvement. The Enhancing Quality Programme is designed to reduce the mortality from pneumonia and its effectiveness will be tracked against this metric.

The mortality related to VTE (pulmonary embolism) has not shown a trend for improvement. This metric will be tracked to show any improvement, which would be the predicted outcome from the high level of compliance with VTE prophylaxis.

The Trust has identified the importance of 30 day readmissions. This is seen as an index of the quality of care but will also be the focus of a new financial risk. The Trust is showing an improvement in performance over last year but is behind the target of effecting a 4% reduction in readmissions. The national target is to achieve a 25% reduction in readmission rates. The introduction of the medical virtual ward project, funded by re-enablement monies, is designed to deliver an improvement in readmission rates. This project will be reported to the Board in two months.

The Trust is involved in a project to reduce the admissions from nursing homes. Although the early data suggests that in the six pilot nursing homes there has been a 50% reduction in admissions. However there are sixty five nursing homes in the Trust's catchment. Therefore to affect the absolute numbers of admissions, this project will need to be scaled up to involve at least 30-50% of the nursing homes. Funding has been secured to support this project and the results will be reported to the Board in two months.

The safety domain is reported as green rated. The exception relates to the quality of the WHO surgical check list. The validity of this data is being reviewed and plans are being discussed with the surgical and anaesthetics divisions to strengthen this intervention.

Patient experience metrics are still being developed. The red rating reflects that more work is required to improve the metrics as well as the performance in this domain.

3. Safety 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	Following the recent SUI a number of actions have been agreed that will put in place. These are detailed below. Work is ongoing to move towards an IT solution using the Communicator software.

There is "3 loop fixes" using less sophisticated technology that have been identified. The initial period for these arrangements would be for three months with review.

A test order sheet is to be attached to the front of the patient's notes. All tests ordered are recorded on the sheet and ticked off when the results are reviewed. No patient will be discharged without all ordered tests being reviewed (or arrangements made to do so). The completion of the checklist will be formally recorded in the discharge summary. This will be implemented by the Divisional Directors.

Radiology will employ a clerical assistance whose role will be to make contact with the consultant in charge of any patient/cases in whom a code 5 priority report has been generated. Contact will be by phone and e-mail. Confirmation of receipt and understanding of requirement for action will be recorded. This will be implemented by the General Manager and Divisional Director for Diagnostics and Therapeutics supported by the other Divisional Directors.

The PAS system recording of responsible consultant will be improved, recognising that as patients move through the system, the responsible consultant may change and this needs to be updated to give accurate attributable data This will be taken forward by the Associate Director for Informatics and the Chief Nurse.

19-Sep-09	Risk to Patient Safety of not Using the NHS Number as the National Identifier for all Patients	Donna Jarrett	The iSOFT (PAS) new release (4.3) is planned for Jan 2011. 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.

3.2 Falls

'Safer Smarter Nursing Metrics' benchmarked data indicates that ASPH has a higher fall rate than other Trusts in the South East Coast area (although not consistently the highest). The data reviwed covers the period until July 2010. This has been discussed at the Trust Falls Group meeting and further analysis will be undertaken to understand our position against others and an improvement trajectory and plan implemented. The Falls Group is now reporting to the Safety and Risk Committee and these action plans will be reviewed at the next Committee meeting in March 2011.

4. Patient Experience

4.1 Your feedback Inpatient Results Quarter 3

The overall results for quarter three show improvements on Q2, in particular:

- layout of the ward being explained
- having someone to talk to about worries and fears
- new medicines being explained clearly.

Questions where patient satisfaction levels have decreased in Q3 relate to:

- availability of nurses
- noise at night (also identified in national survey 2010)
- overall care.

The percentage of patients who would recommend the Trust to family and friends is used to calculate our Net Promoter Score, NPS, which is a measure of patient advocacy. For Q3 the overall NPS score for all wards (67%) is reduced compared to quarter two (70%).

- Highest scoring wards: Chaucer (100%), Dickens (86%), Aspen (80%), Birch (80%)
- Lowest scoring wards: Wordsworth (26%), Elm (51%), MAU (54%).

There has been a slight increase from 46% to 48% in the number of forms completed against the target returns: MAU, Holly and Maple achieved highest returns against the targets and May, Aspen and Wordsworth had the lowest returns.

Actions Include:

- essential care spot checks initiated and to continue
- noise at night 'deep dive' and observation initiative (late Feb and early March) where senior staff clinical and non-clinical will be observing ward areas overnight and establishing an action plan in response to the issues identified
- "How we can work together to improve the patient experience" workshops are being run from January to May to engage with staff and establish actions that can improve the ward areas position
- divisions to identify five actions taken in response to patient feedback (quarterly)
- development of a "Your Feedback" poster campaign for patients to demonstrate to patients that their views are heard and acted upon - "you said – we did".

4.2 Complaints/Ombudsman reports

There were forty two complaints received in January compared with seventeen in December. The divisions with highest complaints were Medicine and Emergency Care (twenty-two) and Surgery (six).

The Trust received one notification of a complaint having been referred to the Ombudsman for review during January. The complaint was investigated within the Medicine and Emergency Care Divisions and the complainant did not feel satisfied or assured by the Trust's response and declined offers to carry out a further investigation or meeting.

Papers have been provided to the Ombudsman and, in addition an action plan developed to address failings identified. The case is currently being assessed by the Ombudsman for procedure to full review.

A case dating from 2007 has been outlined in the Ombudsman Annual Report; Care and Compassion? A detailed paper is for presentation to Board later in the agenda of this meeting.

4.3 Ward Quality Indicators

The ward Quality Indicators are found at Appendix 3

In the month of January, the WQI indicate that:

- complaints for the wards have increased from twelve in December to twenty-nine for January.
- MAU has seven complaints for this month and has also had two medication medication errors and four prescribing medication errors. MAU is also demonstrating red rating around "Your Feedback" returns and VTE compliance. To address this the Deputy Chief Nurse will be undertaking Essential Care spot checks of MAU in order to improve this quality picture and provide support and facilitation.
- falls have reduced to sixty for the month of January from eighty in December.
- apart from Kestral ward, MUST assessment completion rates are improving. The recent baseline Nutrition Audit has been undertaken which has identified shortfalls in the quality of nutrition care and is being addressed through an action plan facilitated by the Nutrition Steering Group. To address the red rating on Kestral, the specialist nutrition nurse will visit and discuss the results of this indicator with the ward sister and agree a response. This indicator for Kestral ward will be closely monitored.
- the Discharge Checklist has been measured for the first time with some disappointing results. This is being addressed through the Discharge Project which is being accelerated to bring about focused and rapid improvements to internal systems and processes and safe discharge.
- "Your Feedback" has been rolled out to Kestral ward and initial returns are encouraging but in general the number of returns has worsened over the January period.

4.4 Care Quality Commission

The Care Quality Commission (CQC) has not published a January Quality and Risk Profile (QRP) in time for inclusion with this report.

A full report on progress and compliance with Care Quality Commission Essential Standards of Quality and Safety is provided.

4.4.1 Overview

The Trust is currently registered without conditions to provide the following services:

- Diagnostic and Screening Procedures
- Family Planning
- Maternity and Midwifery Services
- Surgical Procedures
- Termination of Pregnancies

- Treatment of Disease, Disorder or Injury.

In order to maintain this registration the Trust must be compliant with regulations set out in the Health Act (2009). To help providers comply with these regulations the CQC provide guidance to organisations, this is in the form of the Essential Standards of Quality and Safety.

4.4.2 Inspection process

The CQC will conduct a planned review of each organisation every two years. ASPH has not received a review since the start of Registration. The Trust will therefore receive a planned review between now and March 31st 2012.

The review will be unannounced and will take the form of a day visit in a similar way to the Hygiene Code inspections. The inspectors will ask staff questions as well as request evidence of compliance with standards such as policies and procedures.

'Setting the bar' is the process by which the CQC will assess compliance and may issue conditions or improvement notices as a result.

- Major Concerns will be 'below the bar' and compliance action will be taken. This will be in the form of conditions being placed on the Trust
- Minor and Moderate Risks will be considered alongside the organisations ability to improve.

4.4.3 Process for monitoring the sixteen Essential Standards of Quality and Safety

There are sixteen essential standards which are reviewed through governance mechanisms in the Trust. Each essential standard has a senior manager who reviews the standard requirements, reviews evidence, establishes action plans and provides a quarterly risk rating. Each standard has an executive sponsor who receives a quarterly update from the standard owner. Most standards have an overseeing Committee or Group where the relevant standard is identified on their Terms of Reference as a responsibility. The standard owners are members of the Committees or Groups and this provides a forum for discussion of compliance and action plans.

The essential standards are reviewed by the Integrated Governance and Assurance Committee (IGAC). IGAC receive a compliance report from the Performance Accelerator Assurance Tool which identifies the risk rating, most recent achievements and any concerns.

4.4.4 Current position

Sixteen essential standards for quality and safety

Involvement and Information			QRP risk rating Green
Outcome	**Trust rating**	**QRP rating**	**Improvement actions in place**
Outcome 1 Respecting and involving people who use services	Minor concern	Amber	
Outcome 2 Consent to care and treatment	Green	No information available to CQC	Fully compliant
Personalised care, treatment and support			QRP risk rating Green
Outcome 4 Care and welfare of people who use services	Minor concern	Green	

Outcome 5 Meeting nutritional needs	Moderate concern	Green	Improvement in MDT communication is required, and assurance that escalation of concerns is quick and effective particularly for vulnerable patients. This needs to be embedded into practice and is a focussed action for this standard.
Outcome 6 Co-operating with other providers	Minor concern	Amber	Discharge processes remain a focus for improvement.
Safeguarding and Safety			QRP risk rating
Outcome 7 Safeguarding people who use services from abuse	Green	No rating	Provision of training for safeguarding adults, and ensuring all staff receive this training
Outcome 8 Cleanliness and infection control	Green	Amber	Fully compliant
Outcome 9 Management of medicines	Green	Amber	Fully compliant
Outcome 10 Safety and suitability of premises	Green	Green	Fully compliant
Outcome 11 Safety availability and suitability of equipment	Green	No information available to CQC	Medical device training for doctors is being reviewed in particular to establish a robust assurance process for junior doctors.
Suitability of staffing			QRP risk rating
Outcome 12 Requirement relating to workers	Green	No rating	Ensuring all staff receive local and Trust induction. Ensuring CRB 3 year checks are completed
Outcome 13 Staffing	Green	Amber	
Outcome 14 Supporting workers	Minor concern	Amber	Training needs analysis is under review as part of the work required to achieve NHS LA level 2. Attendance at mandatory training is a risk and work is in place to review the policy and implement a process to improve the management of staff attendance by line managers.
Quality and management			QRP risk rating
Outcome 16 Assessing and monitoring the quality of service provision	Minor concern	Amber	Establishing adequate monitoring of the standards particularly to assure against outcomes is a focus.
Outcome 17 Complaints	Green	No rating	Fully compliant
Outcome 21 Records	Green	Amber	Fully compliant

Overall position

There are five minor concerns and one moderate concern as assessed by the Performance Accelerator tool.

The moderate concern relates to the Meeting Nutritional Needs Standard. The Chief Nurse will investigate further in order to fully understand the issue and determine the appropriate response. This will be reported to the Board.

No major concerns have been identified.

No concerns have required notification to CQC.

4.4.5 Assurance from Divisions

The Divisions are required to present their assurance for each standard, for both Ashford and St Peter's Hospital, as part of the six monthly reviews to the Clinical Governance Committee (CGC). The Divisions use the Judgement Framework (JF) to rate the standard for their area identifying minor, moderate or major concern. This JF is provided by the CQC to assist Trusts to make judgements about the level of risk for each standard.

All Divisions have provided assurance during the 2010/2011 CGC meetings.

There has been one major concern identified against Outcome 1 relating to the non-compliance of the endoscopy area and refurbishment of the area has been put in place to address that.

A further major concern was raised in relation to the availability of sessions for mandatory training which was addressed by utilising the additional 'bonus' days which also include the relevant training.

There is still work to be done to ensure Divisional outcomes and the assurance for the standards are robustly linked together and this is part of the ongoing review of governance.

4.4.6 Improving Monitoring and Assessment

The system of registration is still relatively new and the CQC have now completed a number of organisational reviews which have been published. These reviews have been helpful in ascertaining the level of assurance required by the inspectors and the standard owners have met to discuss this.

Inspectors raised concerns against a number of items including poorly fitting latches on toilets that could compromise privacy and dignity, policies in draft, and staff not being able to describe how to raise a safeguarding concern. It is clear from the reviews that the level of assurance and evidence required to meet the standards is extremely high and that robust assessment using the JF is required to give assurance and where appropriate challenge and identification of weaknesses requiring focus and improvement.

4.4.7 Conclusion

All need to be vigilant, especially standards owners and executive sponsors in understanding the requirements of the CQC and in the meeting of the sixteen essential standards. The risk to CQC registration and the Monitor compliance is significant if achievement of the sixteen standards cannot be demonstrated through robust evidence, governance and outcomes.

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

Date: 16th February 2011

Appendix 2 WQI definitions

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

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

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

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

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

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

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

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

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

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

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

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

12 Total number of falls

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

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

15 Medicine administration errors
Number of errors reported via incident reporting

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

17 Discharge Checklist audit- compliance with the Nursing Documentation regarding the Discharge Checklist

18 VTE assessment compliance from Inpatient List

19 Your Feedback – Number of completed returns against target set per ward

APPENDIX 1 **JANAUARY 2011** **CLINICAL QUALITY PREDICTER DASHBOARD**

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Net Promoter score 'patient feedback' target 90% (>80% amber) NOTE: QUARTER 3 DATA	Complaints (1 = amber, >1 = red)	PALS Concerns (4 = amber > 4 = red)	Incidents grade 1+2	Incidents grade 3,4,5	C diff infection (1= amber >1=red)	Bed occupancy (In Bed at Midnight)	Discharge checklist	Staff turnover target <13% (13-15 amber, > 15=red)	% vacancy <10% =green, 10-20% amber, >20% = red)	Sickness as a %hours available target <3.5% (3.5-5.5 amber)	Appraisal 95% (>85% amber, <85%=red))	Net Promoter score - 'staff feedback'
Acute Medicine and Emergency care	**AVE = 66%**												
ASPEN	80%	0	1		0	0			14.4			66.7	
CCU		1	0		0	0		28.0	16.5	6.93		88.9	
BIRCH	80%	0	0		0	0			9.9			90	
MHDU		1	0		0	0			5.2	23.07		100	
HOLLY	67%	1	5		1	0		91	18.3	8.59		88.2	
CEDAR	79%	0	0		0	0		83	8.9	0.00		90	
MAY	68%	0	4		0	0			15.1	11.96		92.3	
MAPLE	67%	2	6		0	0			17.3	16.58		100	
MAU	54%	7	8		0	0		87	13.8	17.35		79.1	
A&E		5	9		0	0							
CHAUCER	100%	0	1		0	0		17	12.1	17.55		62.5	
WORDSWORTH	26%	0	1		0	1		0	11.1	25.56		90	
KESTREL		1	5		0	0			0.00	36.49		100	
FIELDING	55%	0	1		0	1		24	5.6			0	
T&O	**AVE = 67%**												
DICKENS	86%	0	0		0	0			0.00	11.40		93.5	
ELM	51%	1	1		0	0		17	2.70	6.71		94.4	
JUNIPER	56%	0	0		0	0		43	8.40	4.35		83.3	
ROWLEY BRISTOW		3	7		0	0							
Surgery	**AVE = 71%**												
KINGFISHER	64%	0	11		0	0		88	17.70	24.66		80.6	
FALCON	77%	0	1		0	0			16.50	8.69		88.9	
HERON	65%	0	5		0	0		76	27.70	20.34		91.7	
SAU	77%	1	0		0	0		73	7.90	26.90		58.8	
Anaesthetics, critical care and Theatres													
THEATRES		1	0		3	0							
DSU		2	5		1	0							
Critical care		0	1		0	0			3.1	8.83		89.6	
Diagnostics and therapeutics													
ENDO		0	0		0	0			3.60	1.18		80.8	
X-ray		0	6		0	0							
Women's													
JOAN BOOKER		2	2		0	0							
LABOUR WARDS		1	0		0	0							
PAEDS													
ASH/OAK		2	1		0	0			10.90	8.69		80.4	
PAED A/E		2	0		0	0			29.27	23.60		94.1	
NICU		1	0		0	0			8.00	11.84		93.5	

DATA SOURCES

NPS	Your Feedback data from wards	Discharge Checklist	
Complaints	Datix	Turnover	HR performance report
PALS	Datix	% Vacancy	HR performance report
Incidents	Datix	Sickness	tbc
C Diff	Infection control data	Appraisal	HR performance report
Bed occupancy	tbc	Staff net promoter score	to be established
Patient turnover	HR performance report		

There are additional clinical areas to be added to the dashboard: discharge lounge, Out Patients Department

1	Not all areas have 'Your Feedback' established, Dat Surgery and Oak and Ash are currently establishing the process.
4	January data is in complete, incidents are loaded onto the system and currently the process does not allow for all previous months data to be loaded onto Datix in time for papers to the Board
7	This data item is under review and will be available for March Board
8	Discharge checklist audited monthly
9	Missing data items were not able to be interpreted robustly enough to be included in this dashboard and are being reviewed for March Board
10	Missing data items were not able to be interpreted robustly enough to be included in this dashboard and are being reviewed for March Board
11	This will be incliuded in next months data
12	Missing data items were not able to be interpreted robustly enough to be included in this dashboard and are being reviewed for March Board

Ashford and St Peter's Ward Quality Scorecard - January 2011

N/S: No submission

		Saving Lives												Pressure Ulcer Prevention								Patient Falls						
		Hand Hygiene Compliance	Number of MRSA Bacteraemia	Number of C Diff Cases (Hospital post 72 hrs)	Central Lines Insertion	Central Lines After Care	Urinary Catheter Insertion	Urinary Catheter After Care	Peripheral Cannula	Peripheral Cannula After Care	Cleanliness	Matron Environment Audit	Discharge Check List	Malnutrition Universal Screening Tool	Blood Traceability	Compliance with monitoring of Pressure Ulcer	Hospital Acquired Grade 1	Hospital Acquired Grade 2	Hospital Acquired Grade 3	Hospital Acquired Grade 4	Mixed Sex Wards Compliance	Number of falls	Resulting in Injury	Complaints	Medication Errors: Administration	Medication Errors: Prescribing	VTE Assessment Compliance	Your Feedback
		>=90%	=0	=0	>=95%	>=95%	>=95%	>=95%	>=95%	>=95%	>=85%	>=90%	>=85%	>=85%	=100%	=100%	<=3	<1	<1	<1	=0	=0	=0	=0	=0	=0	>=90%	>=90%
		89% - 80%			94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	94% - 85%	84% - 75%	89% - 80%	84% - 70%	84% - 70%		99% - 76%	1- 2	1- 2	1- 2	1- 2								89%-75%
		<80%	>=1	>=1	<85%	<85%	<85%	<85%	<85%	<85%	<75%	<80%	<70%	<70%	<100%	<=75%	>3	>=3	>=3	>=3	>=1	>=1	>=1	>=1	>=1	>=1	<90%	<75%
MEDICINE 1,2,3	ASPEN	98 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	96 %	N/A	N/A	24/32	100 %	0	0	0	0	0	2	0	0	0	0		83.6 %
	CCU	100 %	0	0	100 %	100 %	100 %	100 %	90 %	100 %	99 %	95 %	28 %	100 %	13/14	100 %	0	0	0	0	0	0	0	1	0	0		N/A
	BIRCH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	97 %	N/A	98 %	8/9	100 %	1	2	0	0	0	4	0	0	0	0		81.5 %
	MHDU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	97 %	95 %	N/A	N/A	37/41	100 %	0	0	0	0	0	1	0	1	0	0		N/A
	HOLLY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	96 %	91 %	86 %	14/17	100 %	1	0	0	0	0	7	1	1	0	0		80.0 %
	CEDAR	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	97 %	83 %	100 %	5/11	100 %	1	0	0	0	0	5	0	0	0	0		81.0 %
	MAY	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97%	95 %	N/A	80 %	40/45	100 %	0	2	0	0	0	3	0	0	0	0		69.7 %
	MAPLE	99 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	94 %	96 %	N/A	100 %	3/4	100 %	0	0	0	0	0	3	0	2	0	1		69.9 %
ASHFORD	CHAUCER	100 %	0	0	N/A	N/A	N/A	100 %	N/A	N/A	97 %	86 %	17 %	78 %		100 %	0	2	0	0	0	6	0	0	0	0		73.6 %
	WORDSWORTH	100 %	0	1	N/A	N/A	100 %	100 %	N/A	100 %	96 %	93 %	0 %	78 %	3/5	100 %	0	0	0	0	0	5	0	0	0	0		70.8 %
	FIELDING	100 %	0	1	N/A	N/A	100 %	100 %	100 %	100 %	96 %	93 %	24 %	85 %	3/3	100 %	1	0	1	0	0	7	0	0	0	0		84.3 %
TRAUMA & ORTHOPAEDICS	DICKENS	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	94 %	N/A	N/A	5/9	N/A	0	0	0	0	0	0	0	0	0	0		85.4 %
	ELM	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	93 %	17 %	95 %	9/16	N/A	0	0	0	0	0	1	0	1	0	0		70.9 %
	JUNIPER	96 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	95 %	43 %	83 %	37/46	N/A	0	0	0	0	0	0	0	0	0	0		74.5 %
	ROWLEY BRISTOW	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	86 %	92 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
SURGERY	KINGFISHER	100 %	0	0	N/A	100 %	100 %	100 %	100 %	100 %	95 %	87 %	88 %	90 %	19/25	N/A	0	0	0	0	0	2	0	0	0	0		74.9 %
	FALCON	100 %	0	0	N/A	100 %	100 %	100 %	80 %	100 %	96 %	93 %	N/A	80 %	23/23	N/A	0	0	0	0	0	0	0	0	0	0		76.1 %
	SDU	98 %	0	0	N/A	90 %	N/A	100 %	90 %	90 %	97 %	98 %	N/A	N/A	28/32	N/A	0	0	0	0	0	0	0	0	0	0		N/A
	ADMISSIONS LOUNGE	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	85 %	N/A	N/A	4/4	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	HERON	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	99 %	97 %	76 %	95 %	9/12	N/A	0	0	0	0	0	0	0	0	0	0		71.9 %
	KESTREL	100 %	0	0	N/A	N/A	100 %	100 %	90 %	100 %	94 %	93 %	N/A	46 %	5/6	100 %	0	0	0	0	0	8	0	1	0	0		84.2 %
EMERGENCY SERVICES	MAU	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	94 %	88 %	87 %	88 %	67/87	100 %	0	0	0	0	0	4	0	7	2	4		71.0 %
	SAU	98 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	97 %	94 %	73 %	100 %	8/11	N/A	0	0	0	0	0	0	0	1	0	0		74.3 %
	A&E	96 %	0	0	N/A	N/A	N/A	N/A	90 %	N/A	93 %	98 %	N/A	N/A	89/119	N/A	0	0	0	0	0	2	0	5	0	0	N/A	N/A
PAEDIATRICS	OAK	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	100 %	95 %	N/A	N/A	14/17	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	ASH	98 %	0	0	N/A	N/A	N/A	N/A	100 %	100 %	98 %	94 %	N/A	N/A		N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	PAED A/E	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	98 %	92 %	N/A	N/A		N/A	0	0	0	0	0	0	0	2	0	0	N/A	N/A
	NICU	99 %	0	0	N/A	94 %	N/A	N/A	N/A	100 %	98 %	93 %	N/A	N/A	9/17	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
THEATRES	THEATRES SPH	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	96 %	98 %	N/A	N/A	34/55	N/A	0	0	0	0	0	0	0	1	0	0		N/A
	THEATRES ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	95 %	95 %	N/A	N/A		N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	DSU SPH	100 %	0	0	N/A	N/A	100 %	100 %	100 %	100 %	96 %	97 %	N/A	N/A	3/3	N/A	0	0	0	0	0	0	0	2	0	0		N/A
	DSU ASH	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	96 %	98 %	N/A	N/A	1/1	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
IMAGING/ ENDOSCOPY	ENDO	100 %	0	0	N/A	N/A	N/A	N/A	100 %	N/A	98 %	99 %	N/A	N/A		N/A	0	0	0	0	0	0	0	0	0	0		N/A
	IMAGING ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	99 %	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
	IMAGING SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97%	97 %	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A
CRITICAL CARE	ITU	100 %	0	0	100 %	100 %	100 %	100 %	100 %	100 %	96 %	100 %	N/A	N/A	38/49	N/A	0	0	0	0	N/A	0	0	0	2	0		N/A
MATERNITY	JOAN BOOKER	98 %	0	0	N/A	N/A	N/A	100 %	N/A	100 %	95 %	95 %	N/A	N/A	14/18	N/A	N/A	N/A	N/A	N/A	0	0	0	2	0	0		N/A
	LABOUR WARDS	100 %	0	0	N/A	N/A	100 %	N/A	80 %	N/A	95 %	95 %	N/A	N/A	31/41	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	N/A	N/A
	MATERNITY	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	95 %	93 %	N/A	N/A	24/36	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
OUTPATIENTS	OUTPATIENT ASH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	N/A	N/A
	OUTPATIENT SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	90 %	98 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	1	0	0	N/A	N/A
OTHERS	EYE CLINIC SPH	100 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	86 %	94 %	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0		N/A
	EYE CLINIC/UNIT AH	99 %	0	0	N/A	N/A	N/A	N/A	N/A	N/A	97 %	100 %	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0	N/A	N/A