The Royal Wolverhampton Hospitals NHS Trust

NHS

Trust Board Report

Meeting Date:	25 July 2011
Title:	Quality & Safety Report
Executive Summary:	The current Quality & Safety Report is presented to the Board on a quarterly basis. Monitor have recommended the Board should receive more frequent information on quality & safety therefore the attached paper sets out the options and includes a recommendation to move to monthly reporting of the Quality & Safety Report.
Action Requested:	For decision: The Board to discuss options and confirm the timing and frequency of the Quality & Safety Report
Report of:	Cheryl Etches, Director of Nursing & Midwifery
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Resource Implications:	
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	
Appendices/ References/ Background Reading	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

1. Background Details

The Quality & Safety Report has been presented to the Quality & Safety Committee and Trust Board on a quarterly basis for the last two years. Following a review by Monitor, as part of Foundation application, it was recommended that the Board should receive more frequent information on quality and safety.

As of July 2011 the Board receives a monthly Trust Dashboard, which includes quality and safety indicators. The Quality & Safety Report, covering Quarter 1 (April to June 2011) is due to go to Board in September 2011.

2. Options

Four options for future reporting to Trust Board on quality and safety are:

2.1 Trust Dashboard monthly and Quality & Safety Report quarterly (Table of Contents - Appendix 1)

The Trust Dashboard includes some of quality and safety indicators that are included in the Quality & Safety Report. The Trust Dashboard however includes data at Directorate level whereas the Quality & Safety Report is Trust level data. Whilst the Trust Dashboard is a new report this option would not significantly increase the amount of information the Board receives on quality and safety and, therefore, may not fully address Monitor's recommendation.

2.2 Trust Dashboard (extended) and the Quality & Safety Report remains quarterly

The Trust Dashboard could be extended to include most of the indicators currently included in the Quality & Safety Report. A small number of the indicators rely on data collected via monthly nursing audits and, therefore, are not currently available monthly.

This option would provide the Board with the most current data available in the Dashboard however; while the information will be current it may not be completely accurate. Trust Board deadlines do not allow sufficient time for data flow, analysis and validation via Directorates/Divisions & Governance; this includes the requirement to sign off and validate incident reports.

A quarterly Quality & Safety Report would however provide both the Quality & Safety Committee and the Board with the validated and accurate data on all indicators and include quarterly indicators, provide further analysis of monthly indicators and details of actions taken.

2.3 Trust Dashboard monthly and Quality & Safety Report also monthly (first to Quality & Safety Committee, then to Trust Board) (Reporting schedule – Appendix 2)

The Trust Dashboard would remain the same and the Quality & Safety Report would move to monthly reporting. The Quality & Safety Report would go to the Quality & Safety Committee before Trust Board therefore the Board would receive this monthly report as per the schedule attached in Appendix 2. A monthly Quality & Safety Report would provide the Quality & Safety Committee with current, accurate and more frequent information on which to act however the report to the Trust Board would not reflect the last completed month.

2.4 As option 2.3 but reporting schedule brought forward one month (would therefore not go to Quality & Safety Committee first)

If the Quality & Safety Report moved to monthly reporting and did not go to the Quality & Safety Committee first then it would be possible to report to Trust Board on the last completed month. Issues regarding the accuracy of the data would remain as described in 2.2. In addition, the Board would receive the report before any organisational committee.

3. Recommendation

Option 2.3 is recommended. This would provide the organisation, via the Quality & Safety Committee, with current, accurate and more frequent information on which to act and also provide the Board with mitigating actions.

Appendix 1

Table of Contents for Quality & Safety Report

1 Executive Summary

2 Trust Safety & Quality Overview

2.1 Incident rate
2.2 Serious complaints
2.3 New litigation
2.4 Inquests
2.5 Safeguarding Incidents
2.6 Radiation Incidents

3 Preventing Harm, Improving Safety Measures

3.1 Mortality (HSMR)
3.2 Patient Falls
Number of inpatient falls
Number of falls resulting in serious injury
3.3 Pressure Ulcers by Grade
3.4 Recognition of the Deteriorating Patient
% late observations
Number of cardiac arrests
3.5 Healthcare Acquired Infections (HCAIs)
3.5.1 Clostridium Difficile – hospital Acquired for ages > 2
3.5.2 MSSA Bacteraemia
3.5.3 Device Related Hospital Acquired Infections
3.6 Venous Thrombo Embolism
% inpatient VTE risk assessment completed on admission
Number of hospital acquired VTE
Number of community acquired VTE
3.7 Nutritional assessment
3.8 Clinical Handover

4 Patient Experience

4.1 Formal Complaints
4.2 PALS Concerns
4.3 Management of Complaints
4.4 Formal Complaints Trends
4.5 Ombudsman
4.6 Patient Experience Tracker

5 Patient Safety and Quality (other)

5.1 Hand Hygiene Practice
5.2 Environmental standards
5.3 Essence of Care standards
5.4 Single sex accommodation
5.5 Nursing & Midwifery staffing levels
5.6 Medication Incidents

Appendix 2

Reporting Schedule for Dashboard and Quality & Safety Report

Monthly Reporting Schedule Trust Dashboard

Reporting period	Data Entry Deadline	Director Deadline	Trust Board
June	8 July	12 July	25 July
July	17Aug	13 Sep	26 Sept
Aug	9 Sep	13 Sep	26 Sept
Sep	7 Oct	11 Oct	24 Oct
Oct	11 Nov	15 Nov	28 Nov
Nov	19 Dec	10 Jan	23 Jan
Dec	6 Jan	10 Jan	23 Jan

Monthly Reporting Schedule Quality& Safety Report				
Reporting period	Data Entry Deadline	QSC Report Deadline	QSC Meeting	Trust Board
Apr, May & June	15 July	22 July	2 August	26 Sept
July	17 Aug	26 Aug	6 Sept	26 Sept
Aug	16 Sep	23 Sep	4 Oct	24 Oct
Sep	14 Oct	21 Oct	1 Nov	28 Nov
Oct	18 Nov	25 Nov	6 Dec	23 Jan
Nov	19 Dec	30 Dec	10 Jan	23 Jan
Dec	20 Jan	27 Jan	7 Feb	27 Feb

Trust Dashboard: June 2011

Directorates with any indicator that is red on 3 occasions during any 3 month rolling period is required to submit an exception report on the third occasion.

Trends:
↔ No change
↑ Improvement on previous month
↓ Deterioration on previous month

Division 1

Indicator	Target	Tolerance	Data Source	Cardio-thoracic	Gen Sur/ Urology	Head & Neck/ Ophthal	Trauma/ Ortho	Critical Care	Obs & Gynae
Patient Experience									
Patient complaints as a percentage of activity	<0.5%	Green = <0.5, Red = 0.5+	Nina Dunmore	G 0%	G 0.07%	G 0.14%	R 0.5% ↓	R 1.0% ↓	G 0.16%
New investigations accepted by Ombudsman	0	Green = 0,Amber = 1,Red = >1	Nina Dunmore	G ↔	G ↓	G ↔	G ↔	G ↔	G ↔
Percentage patients who rated overall satisfaction good/excellent	90%	Green = >90,Amber = 80-89, Red = <80	Nina Dunmore	G 100% ↑	A 88%↓	A 88%↓	G 90%	N/A	G 96%
Patient Safety									
Number of red incidents	0	Green = 0,Amber = 1,Red = >1	Sukhy Khunkhuna	G ↔	G ↔	G ↔	A ↓	G ↔	G ↔
Number of operational red risks	0	Green = 0,Amber = 1,Red = >1	Sukhy Khunkhuna	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔
Number of inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	0	*Green = 0,Amber = 1-4, Red = 4+	Sukhy Khunkhuna	A 5 ↑	A 8 ↓	A 5 ↓	A 8 ↓	G 0 ↑	A 1 ↑
Number of hospital acquired pressure ulcers acquired/deteriorated (Grade 2, 3 & 4) * RAG= tolerance multiplied by the number of inpatient wards reporting	0	*Green = 0,Red = 1+	Sukhy Khunkhuna	R 2 ↑	R 6 ↓	R 2 ↓	R 6 ↓	R 9 ↓	R 1 ↔
Percentage completed inpatient MUST assessments	100	Green = 100,Amber = 75-99 Red = <75	Rose Baker Zena Young	A 95 ↑	A 76↓	A 93↔	A 95.5↓	G ↔	G ↔
MSSA baceteraemia	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔
Clostridium Difficile - hospital acquired for ages >2 years	–	Green = 0,Amber = 1-2, Red = >2	Mike Cooper	G ↔	R 3↓	A ↓	G ↔	G ↔	G ↔
Device related bacteraemias	–	Green = 0,Amber = 1,Red = >1	Mike Cooper	G ↔	R 2↔	G ↔	G ↔		G ↔
Device related bacteraemias (Haem/Onc, Crit Care, Renal, Neonates)	–	Green = 0,Amber = 1- 2 Red = >2	Mike Cooper					G ↔	
Percentage VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	90%	Green = 90%+, Amber = 70-89%, Red = <70%	Paul Franklin	A 81%↑	A 78.5%↑	A 77.8%↑	A 78%↑	R 59.8%↑	R 60.4%↑
Activity									
Number of cancelled/rescheduled outpatient appointments	–	Reduction of 40% in year	Lesley Taff	169 ↓	376 ↓	1026 ↓	928 ↓		93 ↑
Length of stay (elective)	3.06	Green = <3.06 Amber = 3.07-3.19 Red = >3.20	Lesley Taff	R 6.8 ↑	R 3.6↔	G 1.1↑	R 4↑		G 2.7↑
Length of stay (non elective)	3.15	Green = <3.15 Amber = 3.16-3.24 Red = >3.25	Lesley Taff	R 8.7↓	R 4.3↔	R 4.3↓	R 6↓		G 1.1↔
Activity against contract	2%	Green = 2% Amber = 2-5% Red = >5%	Lesley Taff	R 33.49% ↑	R-30.65% ↓	R 8.28% ↓	G 1.63% ↑	N/A	A 4.06% ↓
Percentage of emergency readmissions within 30 days	4.19%	Green = <4.19% Amber = 4.20-5% Red = >5%	Lesley Taff	G 0%↔	G 2.5%↑	G 0.98%↓	G 1.56%↓	G 0%↔	G 2.44%↓
Number of cancelled operations on day of surgery for non medical reasons	0	Green = 0 Amber = </= 4 Red = >/=5	Lesley Taff	R 14↓	R 8↑	R 7↓	A 4↑	G ↔	A 2↑
Radiology reporting (indiator, target & tolerance to be defined)	–	–	–						
Outpatient DNA Rate (New)	<7%	<7% = Green, 7%-10% = Amber, >10% = Red	Lesley Taff	11.1%	7.1%	11.7%	7.1%	N/A	8.8%
Outpatient DNA Rate (Review)	<7%	<7% = Green, 7%-10% = Amber, >10% = Red	Lesley Taff	4.6%	7.9%	8.8%	10.6%	N/A	9.8%
Human Resources									
Sickness absence	<4%	Green = <4%,Amber = 4.1 - 5.9 Red = >6%	Lesley Taff	G 3.1% ↑	G 2.7% ↑	G 3.6% ↑	R 7.3% ↑	G 2.8% ↓	G 2.9% ↑
Percentage of trained nursing vacancies per funded establishment			Lesley Taff	1.28%	0.43%	0.59%	1.58%	0.00%	0.41%
Percentage of medical training grades vacancies per funded establishment			Lesley Taff	0.00%	0.86%	0.00%	0.00%	0.00%	0.00%
Staff feedback (Chat Back results to be reported in September 201)			Caroline Marshall						
Finance									
Pay budget (ward pay budget only, represented by Directorate)	In balance	Green = Yes,Amber = Agreed Red = No	Robert Rainbow	R	R	R	R	R	R
WTE budgeted against actual (ward WTE only, represented by Directorate)	In balance	Green=variance < 5% Amber=variance 5-10% Red=variance >10%	Robert Rainbow	2.81	-2.12	-2.7	-4.2	3.62	-0.06

Division 2

Indicator	Dermato-logy	Emergency Medicine	Renal & Diabetes	Resp & Gastro	Elderly Care & Stroke	Haem / Onc & Radio-therapy	Neonatal & Paeds	Rheumat-ology	Community Services*
Patient Experience									
Patient complaints as a percentage of activity	G0%	G 0.05%	G 0%	G 0.03%	G 0%	G 0.07%	G 0.1%	G 0%	G 3↓
New investigations accepted by Ombudsman	G ↔	G ↑	G ↔	G ↔	G ↔	G ↔	G ↔	G ↔	N/A
Percentage patients who rated overall satisfaction good/excellent	N/A	N/A	A 85%↓	G 97%↑	R 69%↓	G 96%	N/A	N/A	N/A
Patient Safety									
Number of red incidents	G ↔	G ↑	G ↔	A ↓	G ↑	G ↔	G ↔	G ↔	R 7↓
Number of operational red risks	G ↔	G ↔	A ↔	G ↔	G ↔	G ↔	G ↔	G ↔	G 1↑
Number of inpatient falls *RAG= tolerance multiplied by the number of inpatient wards	G 0 ↔	A 12 ↑	R 22 ↓	R 31 ↓	R 21 ↑	A 5 ↓	G 0 ↔	A 4 ↓	G 0↔
Number of hospital acquired pressure ulcers acquired/deteriorated (Grade 2, 3 & 4) * RAG= tolerance multiplied by the number of inpatient wards reporting	G 0 ↔	R 2 ↓	R 1 ↑	R 15 ↓	R 3 ↓	R 1 ↑	R 1 ↓	G 0 ↔	G 3↔
Percentage completed inpatient MUST assessments	Incl in Renal & Diabetes	A 90↑	A 92↓	A 92↑	A 97↓	G ↑	G ↔	Incl in Eld Care&Stroke	G 100↑
MSSA baceteraemia	G ↔	G ↔	A ↓	G ↔	A ↓	G ↔	G ↔	G ↔	G 0↔
Clostridium Difficile - hospital acquired for ages >2 years	G ↔	G ↑	R 3↓	R 2↓	A ↑	R 3↓	G ↔	G ↔	G 0↓
Device related bacteraemias	G ↔	G ↔		A↓	A↓				A ↓
Device related bacteraemias (Haem/Onc, Crit Care, Renal, Neonates)			A↑			R 4↓	R 2↔	G ↔	N/A
Percentage VTE risk assessments assessed on admitting ward (VitalPAC wards only represented by Directorate, excludes maternity & low risk cohorts)	Incl in Renal & Diabetes	R 67.8%↑	R 53.6%↑	A 76%↑	A 89.7%↑	R 43.8%↑		Incl in Eld Care&Stroke	N/A
Activity									
Number of cancelled/rescheduled outpatient appointments	0 ↑		38↓	158↓	40↓	64↓	145 ↑	17↓	N/A
Length of stay (elective)			G 1.9↓		N/A	R 6.9↓	G 1.5↓	G 0.6↔	N/A
Length of stay (non elective)			G 2.8↓		R 3.5↔	R 6.6↓	G 0.8↔	G 1.1↓	N/A
Activity against contract	R-34.70% ↓	A 4.25% ↑	R49.51% ↓	G 0.92% ↑	R-16.58% ↓	R 12.7% ↑	A 3.38% ↑	R 5.09% ↓	N/A
Percentage of emergency readmissions within 30 days	G 0%	G 0%	G 0%	G 0%	G 0%	G 0%	G 2.27%	G 0%	N/A
Number of cancelled operations on day of surgery for non medical reasons									N/A
Radiology reporting (indiator, target & tolerance to be defined)									
Outpatient DNA Rate (New)	16.2%	N/A	11.1%	13.7%	9.1%	9.3%	13.2%	3.7%	
Outpatient DNA Rate (Review)	13.8%	N/A	14.4%	11.3%	9.9%	9.2%	12.1%	8.7%	
Human Resources									
Sickness absence	G 0% ↔	R 6.6% ↓	G 3.5% ↑	A 5.6% ↓	R 7.1% ↑	A 4.1% ↑	A 5.1% ↑	R 7.7% ↑	N/A
Percentage of trained nursing vacancies per funded establishment	3.12%	4.27%	0.38%	1.47%	2.69%	0.14%	3.49%	0.00%	N/A
Percentage of medical training grades vacancies per funded establishment	0.00%	1.08%	2.00%	0.91%	1.70%	0.00%	0.82%	0.00%	N/A
Staff feedback (Chat Back results to be reported in September 201)									N/A
Finance									
Pay budget (ward pay budget only, represented by Directorate)	No dedicated ward budget	R	R	R	R	R	R	No dedicated ward budget	N/A
WTE budgeted against actual (ward WTE only, represented by Directorate)		5.19	-4.84	-3.64			4.58		N/A

Narrative explanation on indicators (red on a third occasion within any rolling 3 month period or with a significantly worsening position). N/A=data not available, hash box=not reportable:

- *Definitions, targets and tolerances differ in community services: Number of Complaints - not available as %activity, target is zero, <5 Green; Number of Serious Incidents - target is zero, Red>3 ;Number of Red Risks - target is zero, Green<5 ; Number of Falls with mod/severe injury - target <5 per annum, 1=Red; Number of Hospital Acquired Pressure Ulcers(Grade 2,3&4) - target is 10% reduction in Q4 from Q1, Green<10; Percentage nutritional assessment (not MUST) completed on admission to hospital - target 97%, Green>97%.
- A rapid improvement event targeting falls prevention has commenced involving D18, EAU, ASU, CTW and West Park 3. A plan of spread to other wards is being developed. It is also intended to commence another rapid improvement event for pressure ulcer prevention in the near future.
- **Exception reports** will be required from the following Directorates if they remain red next month: **Falls** - Resp/Gastro, ElderlyCare/Stroke; **Pressure Ulcers** - Cardiothoracic, General Surgery/Urology, Head,Neck&Ophthalmology, Critical Care Services, Obs/Gynae, Renal/Diabetes, Resp/Gastro, ElderlyCare/Stroke, & Haem/Onc/Radiotherapy; **CDifficile** - General Surgery/Urology; **DRHABS** - General Surgery/Urology, Haem/Onc/Radiotherapy & Neonates/Paeds; **Length of Stay** - Cardiothoracic, GenSurgery/Urology, Trauma/Ortho, ElderlyCare/Stroke & Haem/Onc/Radiotherapy; **Cancelled Operations** - Cardiothoracic, GenSurgery/Urology & Head,Neck&Ophthalmology.