The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	24th October 2011
Title:	Review of Quality & Safety Dashboard
Executive Summary:	This report provides the Board with an update on the review of the Quality & Safety dashboard. It gives an overview of the process involved and identifies the proposed recommendations for the new scorecard.
Action Requested:	To Approve: The Q&S Dashboard review process and proposals.
Report of:	Chief Nursing Officer
Author: **Contact Details:**	Head of Performance & Compliance Tel 01902 694366 Email simon.evans8@nhs.net
Resource Implications:	None
Public or Private: **(with reasons if private)**	Public Session
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

Background Details

1	**Background**

	The aim of the Quality and Safety (Q&S) dashboard is to provide the Board members with some level of detailed knowledge about directorate performance against a set of agreed indicators which may reflect the quality and safety of a patient's experience here at RWHT. The dashboard was introduced following feedback from Monitor who suggested that the quality of the services delivered by the groups within the divisions should be explicit to the Trust Board, enabling the Non-Executive Directors to consider the relative quality of care delivered at group and divisional level. As agreed when the Q&S dashboard was first introduced, the process for collating and reporting the information has been reviewed after the first 3 months in operation. This report seeks to share with the Board the process through which the Q&S dashboard has been reviewed and, present the proposals for a revised scorecard that, having gone through the required governance process, will be presented to the Trust Board in November.
2	**<u>Comments to Date</u>** Whilst the dashboard has provided a structured one page overview of the quality of services being delivered across the trust, there have been several comments received, both directly from the Board and from operational managers, about its application. These comments relate to the look of the document, trying to comprehend the data and how difficult it has been to read the information contained. The difficulty in applying trust wide targets to specific group performance and suggestions about how the information could be displayed differently in order to draw conclusions around groups of information.
3	**<u>Proposed Changes</u>** Following the feedback several changes have been considered and are currently being developed into the re-designed scorecard. The Board will have noted that the current version of the Q&S dashboard contains a selection of Performance Indicators (PIs) that cover the whole organisation; the trust wide target for the PI is then applied across all of the groups. One of the difficulties associated with this approach is that certain departments, by nature of their work, will never achieve the trust wide target. For example; average length of stay in Cardiac is 7 times greater than that in Ophthalmology yet both are assessed using the trust wide target which is an average across the trust. As a result of this anomaly, it is proposed that all of the indicators will be re-assessed and a *profiled* indicator be used at group level. This method of monitoring enables the overall trust target to be monitored at specific group level and ensures the required performance is being assessed and monitored accordingly.

4	The second area for review concerns the PIs themselves. Broadly speaking the PIs are representative and provide an assessment of the quality of services that patients can expect to receive at the trust; however, all of the PIs have been reviewed to ensure they are fit for purpose and to explore whether other PIs could be included. This process has included benchmarking against other trusts and getting inputs from the patient safety team, patient experience team and reviewing patient survey data. From this a number of new PIs are being considered for inclusion. An example being the number of inappropriate delayed discharges. As part of this review the PIs have also been reviewed in terms of the balance they provide as part of a total view of quality, this point is also considered in the review of the look of the document.
5	The third part of the review process is to reflect on how the document looks and how the information is portrayed. The new approach will present a scorecard of Quality and Safety for each Division, with 4 domains being covered, these are: • Patient Experience • Patient Safety • Patient Outcomes • Resources Each of the 4 domains will be appropriately balanced and contain a similar number of PIs. This provides a more even view of the quality of services being provided. An overall score will also be provided for each domain. A breakdown at Group level will also be provided. Whilst this approach provides greater clarity it should also allow for scrutiny at Divisional, Group, Domain and individual PI levels. The domains have also been chosen as they reflect an integrated view of quality which incorporates the Department of Health's measures of quality and represents the trusts new vision.
6	**<u>Next Steps</u>** Following approval of this process, the revised approach will be presented to the Quality and Safety committee in early November with the first draft of the refreshed Q&S Scorecard coming to the November trust board. Longer term, the aim is to develop the scorecard further to allow more detailed interrogation of data down to Ward level. However, this may require additional resource; a business case may be developed to support this proposal as the Q&S dashboard evolves.

Division 1 - Quality & Safety Scorecard

Patient Experience	This Month	Last Month	Trend
Patient Complaints as a percentage of activity	A	G	↓
Number of complaints accepted for investigation by Ombudsmen	G	G	↔
Number of serious complaints received	G	G	↔
Percentage of complaints responded to within 25 working days	G	G	↔
Percentage of patients who rated overall satisfaction good/excellent	A	A	↔
Number of cancelled/rescheduled outpatient appointments	A	R	↔
Number of cancelled operations on the day of surgery for non-medical reasons			↔
% of people responding "yes" to the question - Are you being involved as much as you want to be in decisions about your care and treatment?		A	↔
Overall Rating	R		↔

Patient Safety	This Month	Last Month	Trend
Number of red incidents	G	G	↔
Number of healthcare/inpatient falls	G	G	↔
Number of healthcare/inpatient falls - resulting in serious injury	G	G	↔
Number of healthcare acquired pressure ulcers acquired/deteriorated	A	G	↓
Percentage of inpatient MUST assessments completed within 24 hours of admission	A	R	↑
MSSA Bacte	A	G	↓
Clostridium ficile - l tal acquired for ages >2 years	G	G	↔
e rela bacter as	A	R	↑
ntage VitalPA E risk assessments on admitting ward	G	A	↑
ntage ate obs tions (VitalPAC wards only)	G	A	↑
Overall Rating	A		↔

Patient Outcomes	This Month	Last Month	Trend
Length of stay (elective)	G	G	↔
Length of stay (non-elective)	A	G	↓
Percentage of emergency re-admissions within 30 days	A	A	↓
Outpatient DNA rate (New)	G	G	↔
Outpatient DNA rate (Review)	A	A	↔
Delayed discharges - coded	G	G	↔
18 week RTT - admitted	G	G	↔
18 week RTT - non-admitted	G	G	↔
Clinical correspondence turnaround within 48 hours	A	R	↑
Overall Rating	A		↑

Resources	This Month	Last Month	Trend
Activity against contract	A	A	↔
S ness absence	A	R	↑
Pe ntage of staff who have undergone an annual appraisal	G	G	↔
Percentage of trained nursing vacancies per funded establishment	A	A	↔
Percentage of medical training grade vacancies per funded establishment	G	G	↔
Pay budget (ward pay budget only)	A	A	↔
WTE budgeted against actual (ward WTE only)	A	A	↓
Overall Rating	G		↓

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Report to:	Trust Board
Date:	24 October 2011
Subject:	Quality & Safety Report
Report by:	Chief Nurse
Author:	Patient Safety Manager
Purpose of Report	To provide the Trust Board with information regarding performance and progress with Trust quality and safety.

Report

The report relates to August 2011 and includes progress of the Trust's campaign to prevent harm and improve patient safety in addition to an organisational overview of incidents, complaints, inquests, and claims. It also provides information on issues that fall outside of the campaign but contribute to the quality and safety agenda.

Review Committee Approval

Recommendation(s)

The Board is asked to note the content of the report

Contents

1) EXECUTIVE SUMMARY

This report on Quality and Safety includes progress on the Campaign for Preventing Harm, Improving Safety. The report refers to the period August 2011.

Section 2 provides an overview of organisational quality and safety.

Section 3 details progress with the Preventing Harm, Improving Safety harm prevention initiatives.

Section 4 reports on the patient experience.

Section 5 includes performance on areas that impact on patient safety and quality.

The areas to note regarding progress are as follows:

- The percentage of late observations is decreasing but remains above 20%
- Highest monthly total of C Diff for several years
- MSSA bacteraemias high this month putting us above the cumulative target for the first time this year

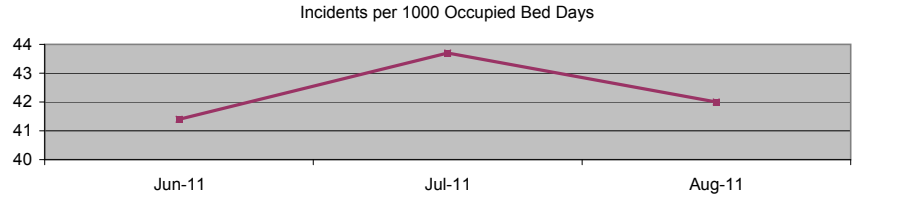
- No serious complaints in August and no safeguarding adult incidents
- There were no falls resulting in serious injury this month and no Grade 3 or 4 healthcare acquired pressure ulcers in the acute setting
- Overall compliance with VTE risk assessment remains above 90% although it has dropped slightly this month
- Formal complaints remain below target based on activity. All complaints were responded to within 25 working days or had agreement to extend.
- No breaches in single sex accommodation.

2) TRUST SAFETY & QUALITY OVERVIEW

2.1 Incident Rate

Key to providing high quality care is having good systems in place for staff to report when patients have, or could have been harmed. Organisations with good levels of reporting are able to set safety priorities and direct investment, anticipate problems and reduce costly claims, identify problems and take actions. High reporting of incidents is a mark of high reliability organisations and therefore incident reporting is to be encouraged. It is essential that staff receive feedback, there is a focus on learning, frontline staff are engaged, incident reporting is easy, reporting systems focus on improving safety rather than blaming individuals and appropriate action is taken.

	Jun-11	Jul-11	**Aug-11**
Div 1	410	401	351
Div2	427	458	448
Total	837	859	799
Per 1000obd	41.4	43.7	42



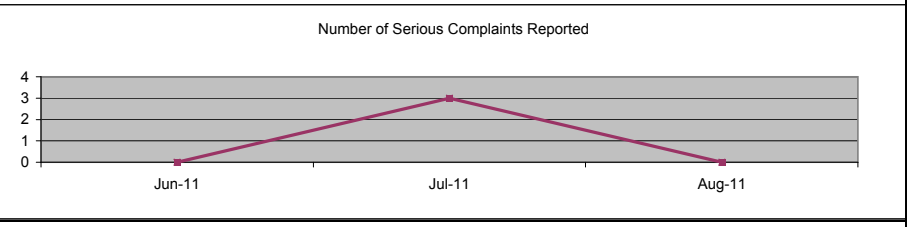
Analysis: The number of incidents reported during August has increased by 7% from the previous month. The majority of incidents are reported by nursing and midwifery staff and the largest category of incidents is patient falls (further information on patient falls in section 3.2).

Actions: The reporting of incidents continues to be encouraged and the use of online reporting of incidents via DatixWeb is extending. All directorates are working to achieve a sustained reduction in patient falls.

2.2 Serious Complaints

A serious complaint includes complaints graded amber and red on the Trust's risk matrix. These complaints are reported and monitored by the Quality & Safety Committee on a quarterly basis and the Trust Board receives a summary report of red/amber complaints on a quarterly basis.

	Jun-11	Jul-11	**Aug-11**
Div 1	0	1	0
Div2	0	2	0
Corp	0	0	0
Total	0	3	0



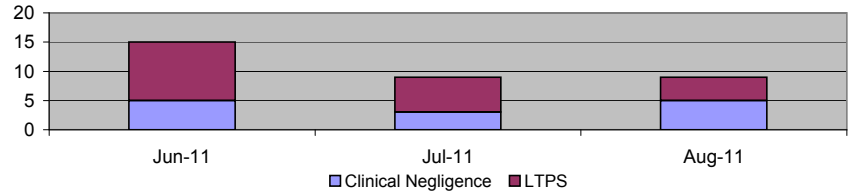
Analysis: No serious complaints received in August.

Actions:

2.3 New Litigation

The numbers of new clinical negligence claims and liabilities to third party (LTPS) claims received during the quarter are detailed below. A detailed report is provided in the confidential section of the Trust Board every 6 months.

	Jun-11	Jul-11	**Aug-11**
Clinical Negligence	5	3	5
LTPS	10	6	4
Total New	15	9	9



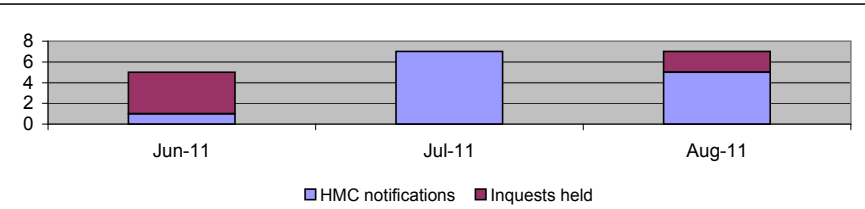
Analysis: During August 2011 there were 5 new clinical negligence claims received relating to diagnosis, treatment, and failure to admit to hospital. LTPS claims relate to needle stick and slip, trips and falls

Actions: The divisions continue to receive a quarterly report of all new claims in the period and concluded claims with any lessons learned.

2.4 Inquests

The purpose of the inquest is to determine how, when and where the deceased died. Her Majesty's Coroner (HMC) may give a narrative verdict or one of a number of standard verdicts. HMC may also make recommendations on the provision of care/treatment or service provided or, issue a Coroner's Rule 43 which allows him to report the findings to an individual or body who may have the power to prevent a similar death occurring in the future.

	Jun-11	Jul-11	**Aug-11**
HMC notifications	1	7	5
Inquests held	4	0	2
HMC Recommendations	0	0	0
% Recommendations per FCE	0	0	0



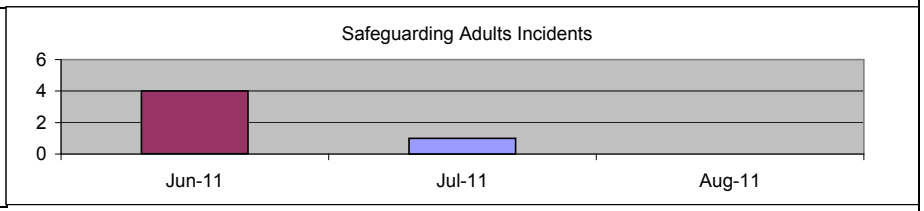
Analysis: During August 2011 there were 2 inquests held which were given verdicts of natural causes and accidental death

Actions: The divisions receive quarterly reports on all newly notified inquests and concluded with any lessons learned

2.5 Safeguarding Adults Incidents

A vulnerable adult is defined in 'No Secrets' (the Government's Guidance on Adult Abuse) as "a person aged 18 years or over, who is in receipt of or may be in need of community care services by reason of 'mental or other disability, age or illness and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation." It is recognised that certain groups of people may be more likely to experience abuse and less able to access services or support to keep themselves safe. The following incidents are those that have been reported under the Wolverhampton Safeguarding Adults policy and procedure 2010.

Safeguarding Adults	Jun-11	Jul-11	**Aug-11**
Div 1	0	1	0
Div2	4	0	0
Total	4	1	0



Analysis: There were 3 safeguarding referrals during the month of August however following initial investigation 1 referral was found not to be a safeguarding incident and 2 are related to step down beds, which are not RWHT beds.

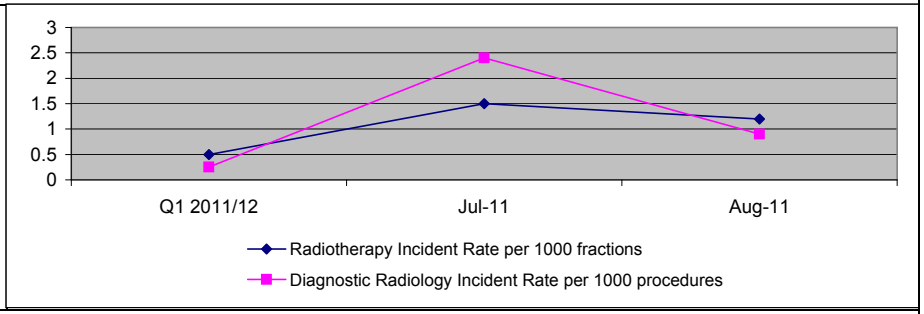
Actions: No action required.

2.7 Radiation Incidents

All incidents involving radiation are reported on the Datix system following the Trusts Policies: HS05 Ionising Radiation Safety Policy and HS06 Laser Safety Policy. There is a legal requirement that incidents involving a greater than intended exposure or exposure of the incorrect patient are reported to the Care Quality Commission under the Ionising Radiation (Medical Exposures) Regulations 2000 and those involving equipment are reportable to the HSE under the Ionising Radiation Regulations 1999. The term 'greater than intended' is defined in HS05. All radiation incidents are reported to and discussed at the Trusts Radiation Safety Committee.

Radiation Incidents	Jun-11	Jul-11	**Aug-11**
Radiotherapy	1	4	3
Diagnostic Radiology	2	4	1
Nuclear Medicine	0	not available	1
Laser/Non-ionising	0	not available	1

Rates	Q1	Jul-11	**Aug-11**
Radiotherapy Incident Rate per 1000 fractions	0.5	1.5	1.2
Diagnostic Radiology Incident Rate per 1000 procedures	0.25	2.4	0.9



Analysis: There was one incident in Diagnostic Radiology which was reported to the CQC as required.

▪ Diagnostic Radiology – The incident involved an x-ray request form with a different patient details resulting in the exposure of the incorrect patient. The incident is being investigated internally and the outcome will be reported in the next report.

▪ Radiotherapy –There were 3 incidents involving radiotherapy treatment this month 0 were externally reportable or resulted in harm patients. One involved a patient entering a room where treatment was about to commence on another patient. The machine safety interlocks meant that neither patient was actually exposed. The second involved the incorrect images being taken for a particular phase of a patients treatment, the dose from which was insignificant but procedure had not been followed. In the third incident, on day 2 of a 15 day treatment, radiographers queried whether the treatment coverage was sufficient, on discussion with consultant it was decided that the plan should be altered. Therefore one fraction out of 15 was incorrect, however this had insignificant effect to the overall treatment.

▪ Nuclear Medicine – The incident involved the requirement of a 2nd injection of a radiopharmaceutical when the incorrect breast had been injected for a sentinel node biopsy.

▪ Laser/Non-ionising – There was an MRI incident where the clinical information on the request form did not correspond to the patient. The procedure was interrupted to clarify the information.

Actions: The Radiation Safety sub Committee met on the 10 October to review the incidents and actions will be included in the next report.

3) PREVENTING HARM, IMPROVING SAFETY MEASURES

Introduction:

This section includes progress from the Preventing Harm, Improving Safety Group for the period (month/quarter).

The following initiatives are our priority for 2011-13 and will contribute towards achieving our aim to prevent avoidable harm and avoidable death: Pressure Ulcers, Falls Prevention, Infection Prevention, Venous Thromboembolism, Deteriorating Patient, Nutritional Assessment, Device Related Infections and Clinical Handover.

3.1 Mortality

The Hospital Standardised Mortality Rate (HSMR) is an important indicator of the care provided. Figures shown are the monthly average and are the latest data available by Dr Foster.

	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Outturn	Apr-11	May-11	Jun-11	Jul-11	YTD
HSMR	93.4	109.8	107.9	94.2	99.9	97.5	106.4	103.4	103.4	95	102 [113]	91	84	88	89	88
Observed Death Rate (56 CCS	3.20%	4.20%	3.80%	3.50%	4.30%	4.00%	5.10%	4.90%	4.50%	3.90%	4.14%	4.40%	3.50%	3.40%	3.60%	3.7%
Expected Death Rate (56 CCS	3.40%	3.80%	3.50%	3.70%	4.30%	4.10%	4.80%	4.80%	4.30%	4.10%	4.08%	4.80%	4.20%	4.10%	4.00%	4.3%
No of In Hospital Deaths	99	128	116	106	128	126	165	157	128	130	1506	125	98	79	111	413
Expected Deaths	97.8	107.2	97.5	101.6	115.2	116.2	141.6	137.6	112.8	125.4	1343	138	117	108	119	482
Excess Deaths	1	21	19	4	13	10	23	19	15	5	163	-13	-19	-29	-8	-69

Analysis: April- July 2011 is the latest available data as at October 2011. The Trust's YTD HSMR based on 4 months data is 88 with a probable rebased value of 95. It is to be noted that HSMR and other high level measures of mortality are subject to in year variation. **The 2010/11 end of year aggregate position was 102, this was rebased to 113 which will be the figure reported in the Good Hospital Guide**

Top Diagnostic Groups Contributing to Patient Deaths by Volume

April- July 2011

Diagnosis Group	Spells	Deaths	Observed Death Rate
Pneumonia	**75**	**16**	**21.30%**
Acute Cerebrovascular disease	**63**	**16**	**26.20%**
Acute and Unspecified Renal Failure	**23**	**8**	**34.80%**
Acute Myocardial Infarction	**77**	**5**	**6.50%**

Alert Status

Analysis: CQC Alert received in August 2011 for Complex Elderly Adults with: Nervous System Primary Diagnosis, Cardiac Primary Diagnosis, Urinary Tract or Male Reproductive System Primary Diagnosis.

Actions: A panel of consultants led by a specialist geriatrician are conducting a detailed case note review. This is being complemented by enhanced level data interrogation of the specified HRGs.The response was signed off by the Trust's Mortality Assurance Review Group (MoRAG) on 21 September 2011. To be reviewed by the CQC outlier panel on 12 October 2011.

Associated Indicators of Mortality

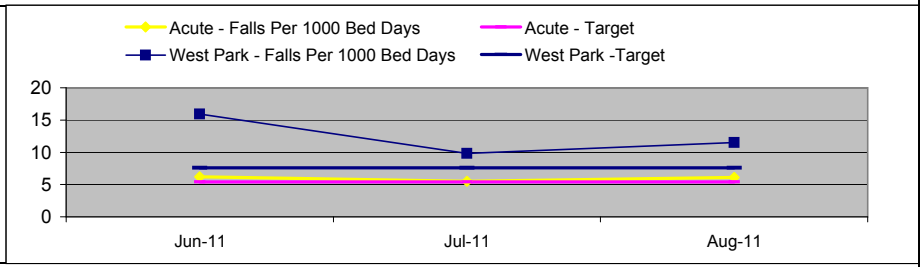
Indicator	Period	Target	Actual	RAG	TREND
Charlson Codes Per Spell (HED)	Apr-June 11	Peer Group Average **5.42**	**5.78**		↑
Palliative Care Deaths Per 1000 Spells	Apr-June 11	Peer Group Average **23**	**36**		↑
Expected Death Rate (Dr F)	Apr-June 11	Peer Group Average [4.25%]	**4.00%**		→

Analysis: The Trust's Specialist Palliative Care team has received a 67% increase in Referrals since 2009. On average 100 referrals to the Specialist Palliative Care Team are received monthly. At these levels our palliative care coding rate is 58% above peer group levels.

3.2 Inpatient Falls

The proportion of reported patient falls in hospital represents avoidable episodes of harm to patients. Measurements are at a rate of falls per 1000 Occupied Bed Days.

	Jun-11	Jul-11	**Aug-11**
Acute - Target per occupied bed days	<5.4	<5.4	<5.4
Acute - Number of falls per occupied bed	6.2	5.5	6.1
West Park- Target per occupied bed days	7.6	7.6	7.6
West Park - Number of falls per occupied bed	15.9	9.8	11.5
Number of falls resulting in serious injury	0	3	0



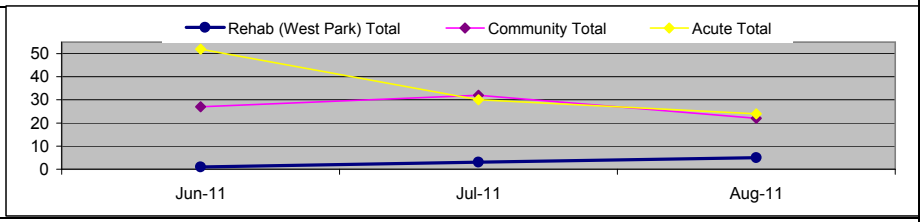
Analysis: There is currently good performance against the 50% reduction target set for falls with serious injury with 4 falls with serious injury to date against the annual target of 14

Actions: Rapid improvement programme continues across 11 inpatient wards across acute and rehabilitation. For the first wave the focus is now to continue and sustain improvements and to evaluate the methodology. For the second wave the programme requires further embedding in practice and regular monitoring.

3.3 Pressure Ulcers

Pressure Ulcers are commonly encountered and represent largely avoidable episodes of harm to patients. All healthcare acquired pressure ulcers are reported and the number of pressure ulcers by grades 2,3 & 4 are represented below.

Healthcare acquired pressure ulcers (Grades 2, 3 & 4)	Jun-11	Jul-11	**Aug-11**
Total Community Services	27	32	22
Total rehab (West Park)	1	3	5
Total New Cross Hospital	52	30	24
%Acute Inpatient Episodes	0.41	0.24	0.19



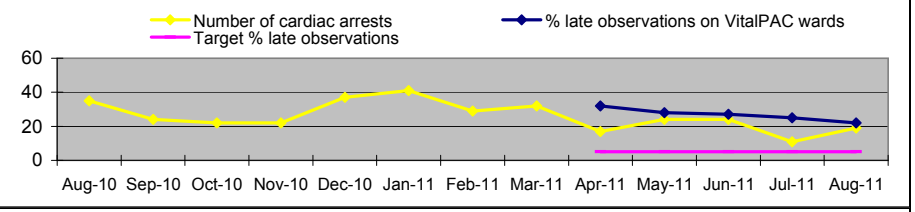
Analysis: There were 3 Grade 3 and no Grade 4 pressure ulcers in the month of August for New Cross Hospital. Six RCA investigations were completed for community awaiting confirmed outcomes.

Actions: Training continues to be cascaded to wards. Grading prompt cards being produced to aid grading of pressure ulcers. Pressure ulcer care package are being launched on medical wards, in one community locality and then to be cascaded across health economy. Mattress selection guides have been sent to teams. RCA trends to be analysed at Tissue Viability steering group and action plan agreed.

3.4 Recognition of the Deteriorating Patient

The aim is to reduce in-hospital cardiac arrest and mortality rate through earlier recognition and treatment of the deteriorating patient. This involves a review of how physiological observations are recorded and acted upon by staff, ensuring that staff are trained to undertake these procedures and understand their clinical relevance. In conjunction with this is the review of the use of the Early Warning Score system and communication of the deteriorating acutely ill adult patient. Measures include: Percentage of late patient observation and number of cardiac arrest or crash calls.

	Jun-11	Jul-11	**Aug-11**
Number cardiac arrests	24	11	19
% observations late	27%	25%	22%
Target (late observations)	5%	5%	5%



Analysis: The percentage of late observations has decreased slightly.

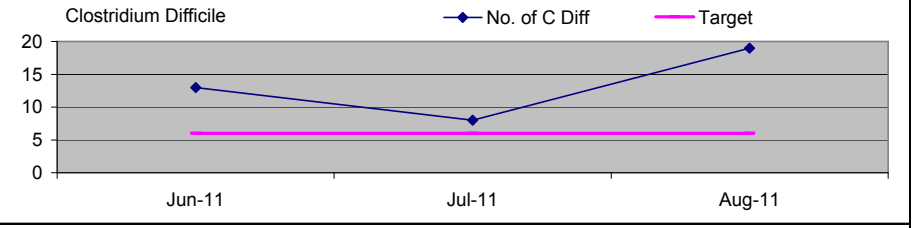
Actions: The wards have been identified where there are greater than 20% late observations and these areas are being monitored on a weekly basis.

3.5 Healthcare Acquired Infections (HCAIs)

Clostridium difficile (C diff) and Meticillin Sensitive *Staphylococcus aureus* (MSSA) are an important indicator of infection prevention and control. The target for 2011/12, using the RWHT internal definition of attribution of cases, is no more than 6 C diff cases per month (72 or fewer per year) (2010-11 target was <7.5 per month) and 2.5 MSSA bacteraemias per month (30 per year attributable to RWHT).

3.5.1 Clostridium Difficile - hospital acquired for ages >2 years

	Jun-11	Jul-11	**Aug-11**
Number of C Diff	13	8	19
Cum Plan	18	24	30
Cum Actual	38	46	65
Cum Variance	20	22	35

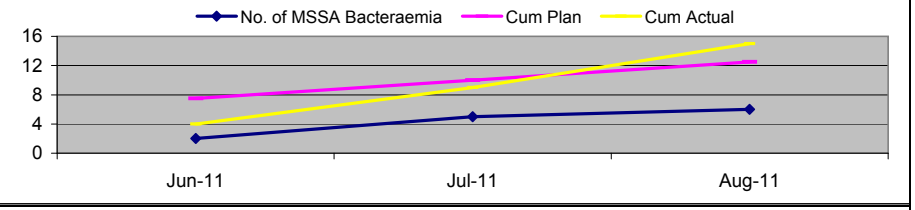


Analysis: The highest monthly total for several years. No immediately apparent explanation; one ward had three cases, but a review meeting did not identify any areas of concern or poor practice. The remaining 16 cases were distributed across 13 different wards.

Actions: The Trust Antimicrobial Prescribing Guidelines have been rewritten to take into account the latest evidence on high-risk antibiotics for causing *C. difficile* disease. A meeting has taken place between the DIPC and an SHA HCAI Programme Specialist, which identified several potential courses of action; a further meeting including other members of the Infection Prevention Team plus key clinical staff is planned to take place in the coming weeks. Since hydrogen peroxide environmental decontamination of the ward that had three cases in August it has had no further cases.

3.5.2 MSSA Bacteraemia

	Jun-11	Jul-11	**Aug-11**
No. of MSSA Bacteraemia	2	5	6
Cum Plan	7.5	10	12.5
Cum Actual	4	9	15
Cum Variance	-3.5	-0.5	2.5



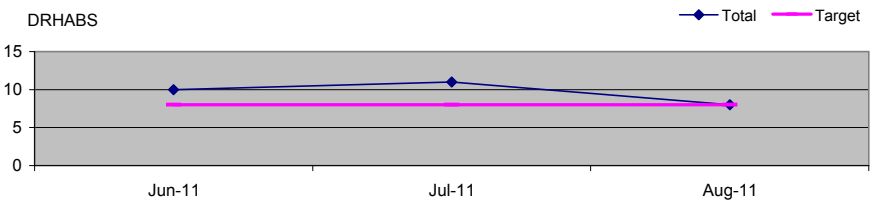
Analysis: Another month with a high total, putting us over the cumulative target for the first time this year. The six cases occurred in five different wards or clinical areas. The underlying causes were: an intravenous line, secondary to a ventilator associated pneumonia (VAP), cellulitis in a renal dialysis patient, an implantable cardiac device (which had been in place for more than a year), the source of one could not be found and one was a probable contaminant in a neonate.

Actions: Work is underway to scope the potential for a Trust IV Team. This would take responsibility for training around line insertion and care. The VAP care bundle is being used in appropriate areas. MSSA screening of renal dialysis patients is underway. The number of contaminated blood cultures in Paediatrics is reducing.

3.5.3 Device Related Hospital Acquired Bacteraemias

Following a reduction in Device Related Hospital Acquired Bacteraemias (DRHABS) by 25% in 2010/11 the aim of this initiative is to reduce device related hospital acquired bacteraemias by 10% by April 2012. The current internal target is 8 per month.

	Jun-11	Jul-11	**Aug-11**
Target (monthly)	8	8	8
DRHABS	10	11	8



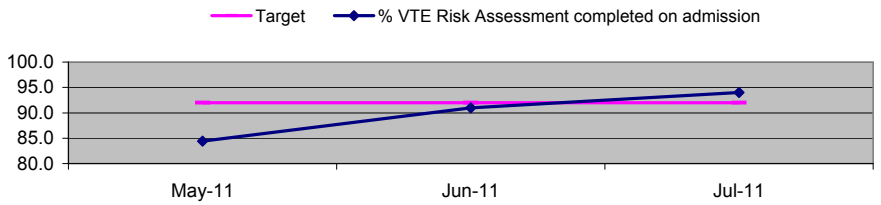
Analysis: Of the 8 DRHABS in August, 3 pertained to urinary catheters, 2 to central lines, 1 to the insertion of a tracheal stent, 1 to a venflon and 1 to a ureteric stent. (Please note that June's acquisition has been reduced to 10 due to inaccurate reporting of a DRHAB relating to a catheter.)

Actions: Monthly ward audits regarding the maintenance of catheters in the clinical areas are taking place and the results fed back to ward managers and Matrons. They are demonstrating improvements in care standards. Action to take regarding the reduction in the associated infection risk of re-catheterisation is to be considered at a Group Meeting this week. The Central Venous Access Course continues.

3.6 Venous Thrombo Embolism

Venous thromboembolism (VTE) is one of the commonest causes of avoidable death in hospitals. There is a national VTE risk assessment and prevention pathway, which has been developed by the Department of Health following NICE Guidance released in January 2010. Compliance with VTE risk assessment is a CQUIN requirement, set at 90%. This is one of 7 key NICE standards for VTE prevention that the Trust is aiming to reach.

	Jun-11	Jul-11	**Aug-11**
% adult patients with completed VTE risk assessment	91.0%	94.0%	90.9%
Number of patients with hospital acquired VTE	9	12	tbc
Number of patients with community acquired VTE	28	42	tbc



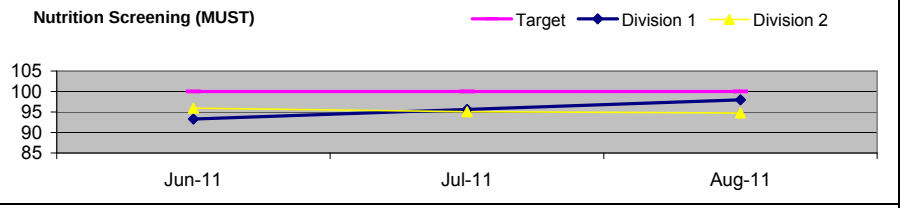
Analysis: The percentage of VTE risk assessments consists of three elements - low risk cohorts (as defined by the SHA), maternity (recorded on paper & entered in Euroking) and acute adult inpatients (recorded on VitalPAC). The total compliance for August dropped slightly, which may be due to a new intake of junior doctors.

Actions: Monthly compliance data is distributed by Specialty. The VTE nurses are working with clinical areas to improve compliance and to complete RCA investigations on patients with confirmed VTE. Not all the VTE cases have been investigated for the month of August therefore data is not yet available and will be reported next month.

3.7 Nutrition

MUST is a nutritional screening tool. All adult patients should undergo nutrition risk screening and those identified as high risk should have a full nutritional assessment.

% adult inpatients with completed MUST	Jun-11	Jul-11	**Aug-11**
Division 1	93.3%	95.6%	98%
Division 2	95.9%	95.1%	94.8%
Target	100%	100%	100%



Analysis: Overall compliance is reduced in Division 2 due to the inclusion of Adult Community Services. A recent essence of care benchmark audit demonstrated a 71% compliance rate with MUST. Action plans to achieve compliance have been put in place.

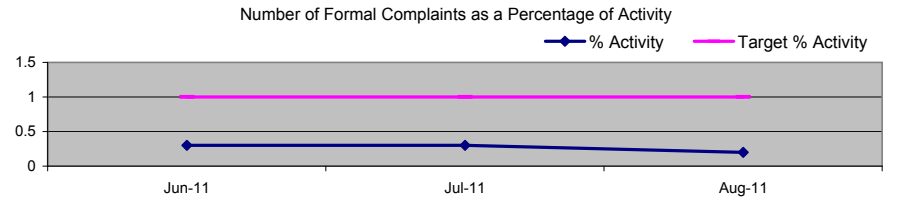
Actions: Protected mealtimes are being re-enforced on 5 pilot wards, with ongoing work through the nutrition action team meetings. Nutrition training for nurses now being delivered at 2 levels on induction: Level 1 (Importance of nutrition, ordering meals and special diets, optimizing nutritional intake, protected mealtimes, feeding patients and monitoring intake) for HCAs and RNs, and Level 2 for RNs (nutrition screening, care planning and safe delivery of artificial nutrition). Mandatory requirement to update every 3 years, either via taught session, or e-learning (currently being developed).

4) PATIENT EXPERIENCE

4.1 Formal complaints

The following numbers are based on the number of formal complaints received during the quarter. There is no national target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. However there is an expectation that the number of complaints received is less than 1% of the activity for the Trust. The percentage of complaints based on the number of inpatient spells is shown in the graph below.

Target	Jun-11	Jul-11	**Aug-11**
1.00%	0.3%	0.3%	0.2%



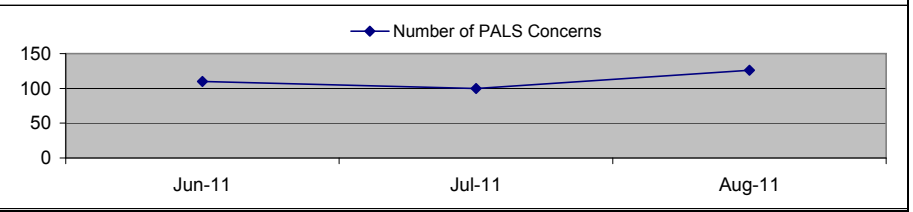
Analysis: 21 complaints were received in August 2011 which equates to 0.2% of Trust activity

Actions: No action required

4.2 PALS Concerns

The following numbers are based on the number of informal complaints received during the quarter. There is no national target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. The number of informal complaints is shown in the graph below.

Jun-11	Jul-11	**Aug-11**
110	100	126



Analysis: The number of PALS contacts continues to rise, as awareness of the service is raised through a Trust wide poster campaign. The 3 most common themes for PALS are information (regarding diagnostic results, diagnosis, conflicting information, health records not available at appointment), delays (including cancellation or change of appointments) and general care of patients (including poor communication with patient/relatives).

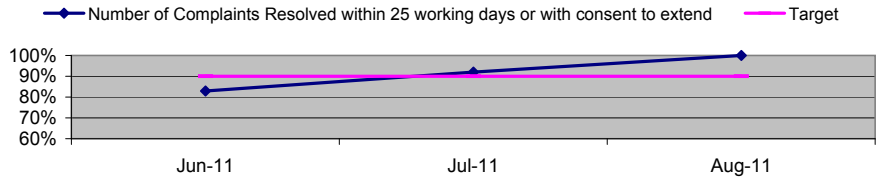
Actions: Themes of PALS enquiries will continue to be monitored

4.3 Formal Complaints resolved within 25 days

The Trust aims to provide first class responses to greater than 90% of all complaints within 25 working days and an action plan in place.

Percentage of complaints responded to within 25 working days and with action plan in place

Jun-11	Jul-11	**Aug-11**
83%	92%	100%



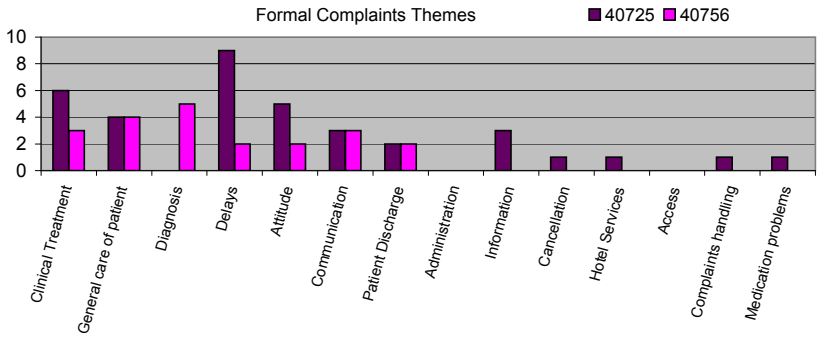
Analysis: All complaints received in August were dealt with either within the 25 working day timescale or within an extension period agreed with the complainant.

Action: A new centralised process for obtaining consent was implemented from 1 August and is working well, this will continued to be monitored

4.4 Formal Complaints trends

Analysis of complaint themes during the quarter is detailed in the graph below.

	Jun-11	Jul-11	**Aug-11**
Number of formal complaints	23	36	21



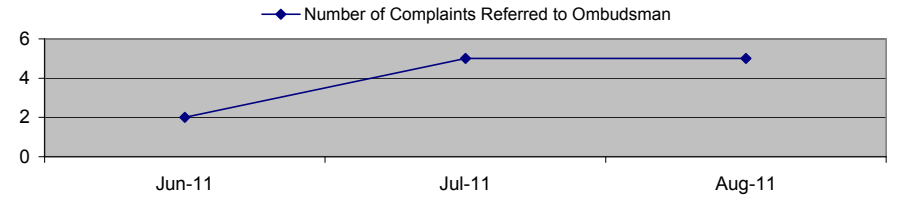
Analysis: The top three themes raised in formal complaints during August were diagnosis (incorrect or none given) general care of patients and clinical treatment

Action: Formal complaints issues will continue to be monitored where trends are found these will be investigated further

4.5 Ombudsman

The role of the Parliamentary & Health Service Ombudsman is to consider complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service. The Ombudsman will normally only take on a complaint after the complainant has first tried to resolve the complaint with the organisation involved and has received a response from them. The number of complaints referred to the PHSO by complainants is detailed below.

	Jun-11	Jul-11	**Aug-11**
Number of complaints referred to the PHSO	2	5	5

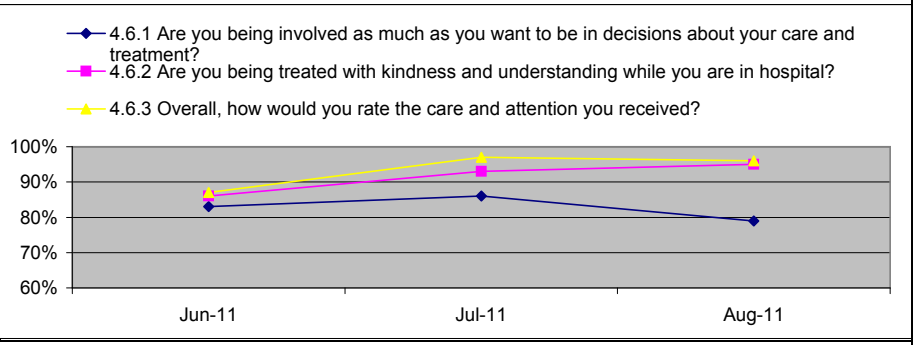


Analysis: Five complaints were referred to the PHSO during August. Of the five referred in July two were returned to the Trust for local resolution, two were closed without investigation and one continues to be assessed for suitability for formal PHSO investigation

Actions: A review of the process for monitoring complaints accepted for review by the PHSO is currently taking place to ensure all key directors/ divisional management teams are involved.

4.6 Patient Experience Tracker

	Jun-11	Jul-11	**Aug-11**
4.6.1 People that said yes definitely to: Are you being involved as much as you want to be in decisions about your care and treatment?	83%	86%	79%
4.6.2 People that answered yes all of the time to :Are you being treated with kindness and understanding while you are in hospital?	86%	93%	95%
4.6.3 People that answered 'excellent or good to :Overall, how would you rate the care and attention you received?	87%	97%	96%



Analysis: The number of patients surveyed in August was 484, there has been a decrease in the number of people feeling they are definitely being involved as much as they want in decisions about their care. The number of people feeling they are being treated with kindness and understanding continues to increase.

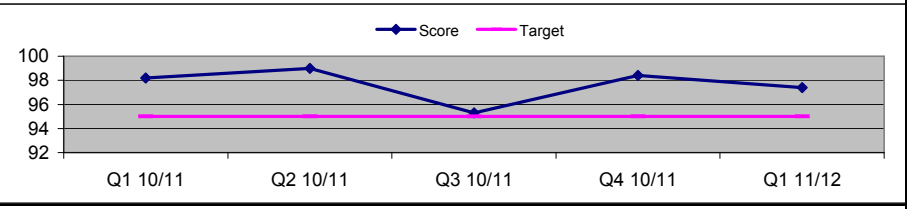
Actions: The patient experience Lead will be meeting with Matrons over the next two months to review the data gathered by the patient survey and how it is being used to improve practice at a ward level.

5) PATIENT SAFETY AND QUALITY

5.1 Hand Hygiene Practice

Consistent hand hygiene is key to high quality infection prevention practice. Quarterly audits measure compliance with hand hygiene standards. The Trust has set a target of 95%.

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
95%	99.0%	95.3%	98.4%	97.4%



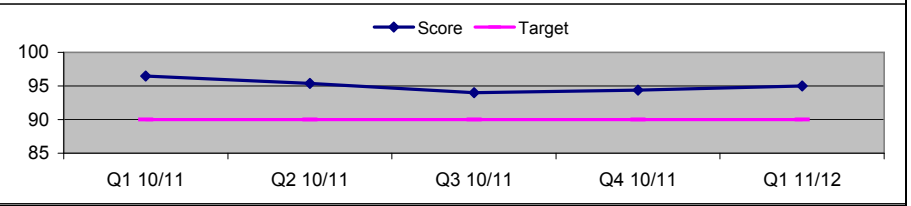
Analysis: Information reported quarterly

Actions:

5.2 Environmental standards

Cleanliness and tidiness of the environment is an important quality marker and valued highly by patients and the public. Quarterly audits measure compliance with stringent environmental standards. The Trust has set a target of 90%.

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
90%	95.4%	94.0%	94.4%	95.0%



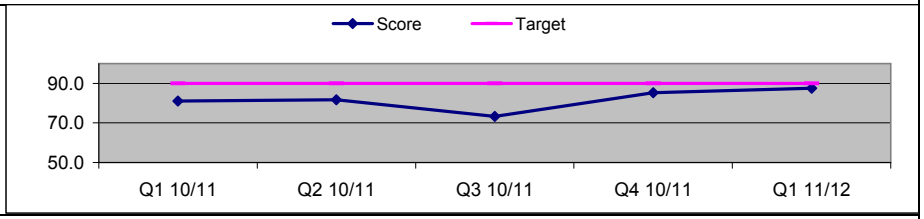
Analysis: Information reported quarterly

Actions:

5.3 Essence of Care standards

Essence of Care audits are conducted quarterly to measure compliance against a small number of key standards embracing privacy & dignity, communication, nutrition, personal hygiene, mental health and continence. The Trust has set a target of 90%.

	2010/11			2011/12
Target	Q2	Q3	Q4	Q1
90%	81.7%	73.3%	85.2%	87.6%



Analysis: Information reported quarterly

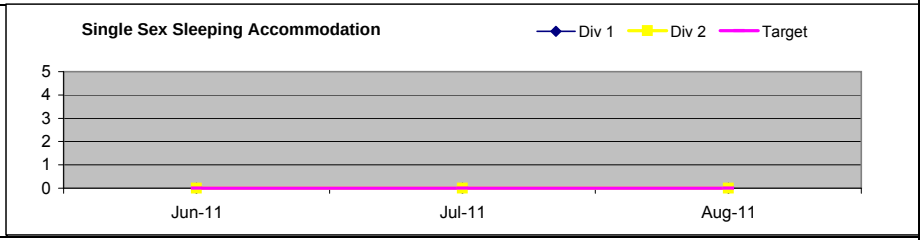
Actions:

5.4 Single sex accommodation

Patients want care delivered in single sex accommodation. The vast majority of our clinical areas have declared themselves compliant against Department of Health standards for single sex accommodation. A small number of areas are not currently compliant, these include: Deanesly Ward, EAU, Renal Unit and Endoscopy all of which are waiting for building work. Additionally, it is known that ICCU, while making every attempt to segregate men and women, will be unable to achieve this consistently for clinical reasons. The measure below includes the number of incidents in those areas that have declared themselves compliant. We will measure incidents of mixed sex sleeping accommodation.

Number of incidents	Jun-11	Jul-11	**Aug-11**
Division 1	0	0	0
Division 2	0	0	0
Target	0	0	0

Definition of Single sex incident: A patient located in a bay with patients of the opposite sex is defined as one incident (e.g in a six bedded bay, 1 incident not 6 incidents)



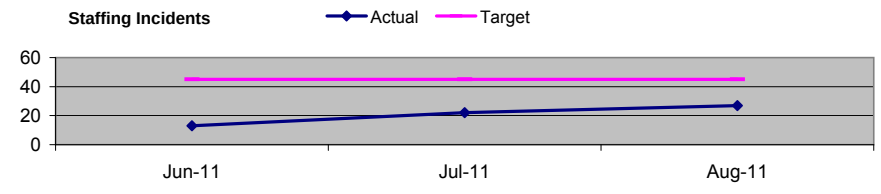
Analysis: No single sex incidents reported

Actions:

5.5 Nursing & Midwifery staffing levels

Nursing staffing levels impact on the safety and quality of patient care. The wards and departments within the Trust have agreed normal staffing levels. Deviations from normal staffing levels that impact on the safety or quality of patient care are reported as incidents. The target is 45 incidents per month based on an average number of 50 incidents per month in 08/09.

	Jun-11	Jul-11	**Aug-11**
Division 1	4	11	10
Division 2	9	11	17
Total	13	22	27
Target	45	45	45



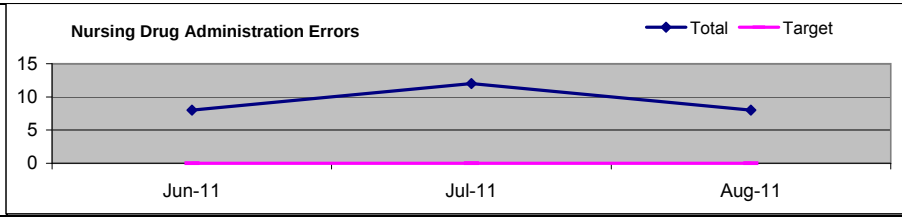
Analysis: No incidents resulting in patient harm

Actions: Matrons monitoring and reviewing the impact of staffing levels.

5.6 Medication administration incidents

Medication incidents cover a wide range of events involving the prescription, administration and provision of medicines to take home. These incidents have the potential to harm patients and therefore all reported incidents are investigated. The indicator set for medication incidents is concentrating on nursing administration errors resulting in low, moderate & high levels of harm or causing death.

	Jun-11	Jul-11	**Aug-11**
Division 1	5	8	2
Division 2	3	4	6
Total	8	12	8
Target	0	0	0



Analysis: No incidents resulted in patient harm.

Actions: Staff managed in accordance with drug error management policy. Pharmacy has introduced a new protocol for the management of patient's own controlled drugs in D6.