Trust Board Meeting: Thursday 12 January 2012

TB2012.03

Title	**Quality Report**

Status	A paper for information
History	A regular monthly report

Board Lead(s)	Mrs Elaine Strachan-Hall, Chief Nurse Professor Edward Baker, Medical Director			
Key purpose	Strategy	**Assurance**	Policy	**Performance**

Summary

This report updates the Trust Board on the quality of care drawn from indicators and information collated for the month of October and activity during November 2011.

The report is divided into three sections: Safety, Effectiveness and Patient Experience.

The report also includes updates on activity in the across the OUH aimed at delivering quality improvements and in tackling some areas for specific improvements. The safety and quality scorecard and nursing quality scorecards and the 'three by three' matrix are brought together as appendices.

The following items are highlighted as key changes compared to the previous Quality Report:

1	A total of four SIRIs were investigated during November; three were related to deaths and one to an acquired pressure ulcer.
2	A summary of the Clinical Risk Management Annual Report 2010/11 is contained within this report and this provides an overview of key activities within the Trust.
3	There has been an increase in the amount of feedback received about the patient experience, compared to October 2011. Notable improvements have been reported about delays in answering telephones and responding to telephone messages.
4	The total number of complaints received in November has increased by 7%. The Ombudsman has upheld two complaints connected to their original handling by the Trust.
5	In relation to NICE Guidance, new guidance was issued titled Diagnostics Technology Guideline

At A Glance .....

	November 2011	Year to date	Target (where applicable)	
Safety				
C Diff infections	8	70	93	Performance on track
MRSA bacteraemia	0	4	4	Performance on track
SIRIS	4	26	-	
Effectiveness				
	September	**October**	**November**	
Safe wards	100%	100%	100%	→
Supportive measures	0	0	0	
Wards receiving intensive support	0	0	0	
Patient experience				
	September	**October**	**November**	
Positive feedback	61.7%	54.7%	68.1%	Improved position
Neutral comment	26.2%	31.2%	23.6%	No significant change
Negative comment	12.1%	14.1%	8.4%	Improved position
Totals rec'd	1145	920	1736	Increased numbers
Complaints	60	59	67	Increased numbers
% complaints responded to in 25 w'g days	97%	94%	96%	

Introduction

1. This report updates the Trust Board on the quality, safety and effectiveness of care drawn from indicators and information collated for the month of October and November (where available).

Safety, quality and risk

2. This section covers a number of areas that are included in the attached scorecard which has variety of indicators relating to safety, quality and risk, including SIRIs, complaints, HSMR, safety walk rounds, medication incidents and staff safety.

3. A total of four SIRIs were investigated in November across three separate divisions and included three deaths and one pressure ulcer.

SIRI reference	Nature/Cause
078	Patient admitted with overdose, found unresponsive and died despite resuscitation
079	Patient died from Clostridium difficle and recorded on part 1a of death certificate
080	Full leg dynacast removed to find cat 3/4 ulcer to left heel and cat 2 to knee. Patient had been inpatient with cast
081	Patient admitted with overdose of 20+ diet pills after intake of alcohol. Attended ED was discharged and re-attended and subsequently died

Quality Walk Rounds

4. During November 2011, seven programmed walk round visits were completed in the following areas:

Trust Site	**Ward/ Department**
Churchill Hospital	Wytham Wing
Churchill Hospital	Pharmacy Department
Wycombe Satellite Unit	Renal Unit
Horton General Hospital	Theatres, Day Case Unit
John Radcliffe	Cellular Pathology
John Radcliffe	Neuropsychology

5. Key headings are used to summarise the issues discussed and identified from the walk rounds. Specific issues are highlighted and fed back to the service and the Division. The following issues were raised:

Topic	Theme
Staffing	Staffing levels in two departments and VCF process
Environment	Limitations to functional space to support operational activity Fire sprinkler system needing review by Fire Safety Officer Flooring and ventilation needing assessment and repair
Equipment	Manual processes which are not cost effective
Communication	Closer liaison required between departments
EPR prescription	Prescription format to be re-assessed
Areas of good practice	The use of technology to automate key operational function and to support clinical practice with memory rehabilitation in young people

Clinical Risk Management Annual Report 2010/11

6. The annual report produced in December 2011 provides factual information relating to Clinical Risk Management within the Trust for the year 2010/11. The report details recent advances, current activities and continuing plans to take forward and improve the management of Clinical Risk within the Trust. It also contains incident trends analysis and performance against agreed reduction targets.

7. There has been an average increase in training for incident reporting and incident investigation by around 3% and incident reporting has increased by 2.75%. This is attributable to the increased focus on delivering bespoke training within Divisions.

8. There has been a 68% increase in NPSA electronic reporting via the anaesthetic department. The main reporters are consultants who find the electronic system user friendly.

9. The Trust falls within the 50th percentile of NPSA incident reporters per 1000 bed days within the Strategic Health Authority. In 2009/2010 the Trust was in the 25th percentile of all reporters. Notwithstanding this improvement the Trust is still a low reporter of incidents that do not cause harm and near misses. The reason for this is thought to be the current paper reporting system which will be replaced in 2012 by an electronic incident reporting system.

10. The number of Serious Incidents Requiring Investigation (SIRIs) has increased by 43% on 2009/2010 figures. This is mainly attributable to the increase in category 3 and 4 pressure ulcer investigations.

11. The SIRI process has been re-designed to reflect the process advocated by the National Patient Safety Agency and to accommodate the increase in SIRI workload.

12. A successful bid was made by the Professional Advisory Forum for Wound Healing (PAGWoH) to Charitable Funds for the provision of more Repose mattresses, trolley

overlays for emergency admission areas and the provision of heel wedges and boots to protect patients from the breakdown of tissue on heels.

13. Following the Never Event in the gynaecology theatres, the Trust has invested in Never Event training in conjunction with OxSTar – Oxford University simulation centre. A training film is being produced to ensure wider learning from the incident.

14. Following the receipt of incident forms related to the transport of specimens and blood a trial has been undertaken of a courier service between the Churchill and John Radcliffe hospital out of hours. Following its success, the service continues whilst finance is secured from participating Divisions and whilst the service is put out to tender.

Dr Foster and Summary Hospital Mortality Index (SHMI) update

15. Dr Foster Intelligence continues to measure mortality by the HSMR (Hospital Standardised Mortality Ratio) and HMR (Hospital Mortality Ratio). In October 2011 the SHMI (Summary Hospital Mortality Indicator) was launched as the sole new hospital-level indicator by the NHS Information Centre (NHS IC). The SHMI has now been introduced into the Dr Foster Intelligence 'Mortality Comparator tools'.

16. The next SHMI rate is due to be published by the NHS IC in January 2012. The current SHMI for 2010-11 is 1.02, within the expected range.

17. The SHMI/HSMR Reduction plan for 2011/12 includes a case note audits to identify missing Charlson Index co-morbidities and will include the pilot of an amended audit tool and process.

18. The top 10 diagnosis groups with the highest mortality rates and zero Charlson Index co-morbidities have been selected. This has been further broken down into age bands and a decision has been made to focus on patients over 75 years starting with the oldest first this.

19. Unlike the 2010-11 HSMR project, these audits will also examine patients who have not died since high risk patients with good outcomes have positive effect on the HSMR and SHMI. Thus the volume of notes requiring review will be significantly larger than the 2010-11 HSMR reduction project. An initial group of 425 notes from April to Sept 2011 will be examined.

20. To increase the flexibility within the process the pilot will involve lone Clinicians carrying out an initial review of notes (using guidance on Charlson Index co-morbidities). Audit forms annotated with Charlson Index co-morbidities will then be passed to a Senior Clinical Coder for the ICD10 codes to be inserted. It is hoped that this process will remove the constraints of matching diaries and will increase the ability of Clinicians to support the project.

Control of Infection matters

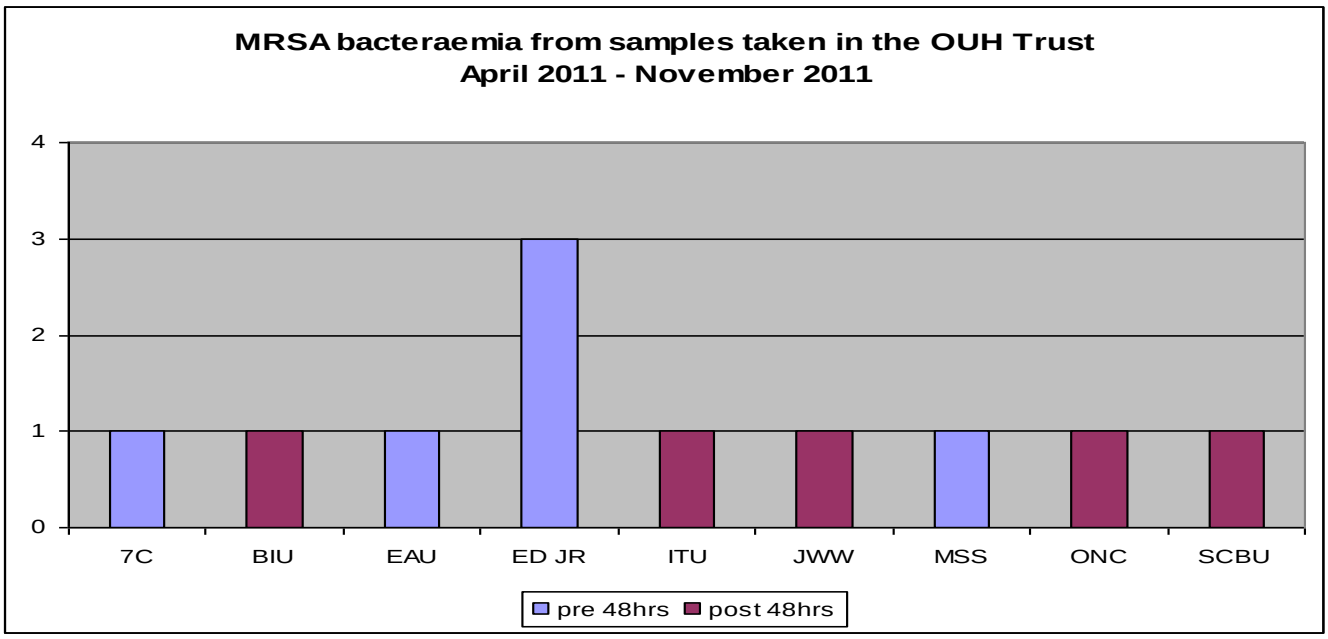
MRSA Bacteraemia 2011/2012

21. The annual ORH objective for MRSA bacteraemia for 2011/2012 is 6 MRSA positive blood cultures taken 48hrs after admission. The NOC is monitored separately until March 2012. The NOC have an annual limit of 1 and have had one MRSA bacteraemia since April 2011.

22. There were no cases of MRSA bacteraemia in November:

	Apr 11	May 11	Jun 11	July 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
Total per month	0	1	0	0	0	1	2	0				
Monthly limit	0	1	0	1	0	1	0	1	0	1	0	1
Cum total	0	1	1	1	2	2	4	4				
Cum DH allocated limit	0	1	0	2	0	3	0	4	0	5	0	6

23. Figure 1 below illustrates MRSA positive blood cultures taken from all sites of the OUH trust.



Clostridium difficile

24. The table below includes the number of patients who **tested positive after 72hrs** of admission. It does not inform the Trust of the overall burden of *Clostridium difficile*, as it excludes positive cases from samples taken within 72hrs of admission.

25. The MaRS Division (formerly the NOC) has an annual limit of 4 cases of C. diff; there have been four cases to date from April 2011.

	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
Total	5	5	8	7	14	9	14	8				
Monthly limit	12	12	12	12	12	11	11	11	11	11	11	11
Cum total	5	10	18	25	39	48	62	70				
Cum DH allocated limit	12	24	36	48	60	71	82	93	104	115	126	137

Nursing and Midwifery Quality Dashboard and Safer Care Matrix

26. The Safer Care 'three by three' risk matrices are now included in the Appendix showing data for each of the six Divisions and some key points covering all Divisional activities are highlighted on the accompanying sheets.

27. The summary safer care box is included below:

All Wards	Available permanent staffing[1] > 85%	Available permanent staffing 70 - 85%	Available permanent staffing Staffing below 70%
Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (fewer than 3 Red)	41	38	12

Patient Experience

28. The following table provides a summary of the top five feedback issues;

Top 3 patient feedback issues	October	November
Care & service positive feedback	395	792
Concerns about aspects of care offered	103	327
Appointment, treatment and discharge delays	85	110
Source of patient experience reports		November

[1] This figure is made up of permanent staff on the establishment, less staff on sick leave and maternity leave.

Telephone calls (to PALS)	159
Comments & Suggestion Forms	39
Letters and Web feedback	20
E-mails (via PALS)	46
In person (to PALS)	32
Let Us Know Your Views (Questionnaires)	113

29. Total feedback score for September, October and November are shown below.

	September		October		November	
Positive	**707**	**63.6%**	**503**	**54.7%**	**1182**	**68.1%**
Neutral	**299**	**25.7%**	**287**	**31.2%**	**409**	**23.6%**
Negative	**139**	**10.7%**	**130**	**14.1%**	**145**	**8.4%**

30. November was the first month during which delays answering the telephone or responding to telephone messages have not been reported as a significant communication concern.

31. High profile signposting for patient experience reporting and access to patient services have been prepared by Oxford Medical Illustration and been tested in different hospital locations. There is an early indication that questionnaire utilisation is increasing in these areas.

32. Despite concerns raised via the Trust questionnaire, greater than 80% of respondents indicate their recommendation of the trust hospitals.

Complaints and Organisational Learning

2011/2012	Apr 11	May 11	Jun 11	July 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
Complaints	56	61	51	47	71	60	59	67				
Cumul.	56	117	168	215	286	346	405	472				
2010/2011	67	63	88	61	50	75	62	62	72	68	68	56
Cumul.	67	130	218	279	329	391	453	515	587	655	723	779

33. Sixty seven new complaints were received in November which represents a 7% increase over the previous month.

34. The key themes identified in the complaints received in the Trust in November were patient care/experience, behaviour, communication, and delays/waiting times.

35. The main theme in the clinical Divisions continueto be patient care / experience.

36. The Divisions are using the feedback from complaints to respond to individual issues which can be complex and multi-faceted and to introduce changes and these have begun to be reported in the monthly Divisional reports to the Clinical Governance Committee.

37. The response time for to acknowledge complaints within three working days for November was 99%.

Ombudsman Investigations and updates

38. In November the Ombudsman's Office wrote to the Trust enclosing a draft report setting out the provisional conclusions of their investigation and the recommendations that the Ombudsman is minded to make, specificially in relation to shortcomings in the administration of the complaint (this concerned an incident in June 2009 which was responded to in October 2009). However, the complainant wrote again in June 2010 and the matter was referred to the Ombusdman.

39. The Ombudsman considered another complaint about two issues arising in January 2011. The complaint was received in January 2011 (following the first incident) and responded to in February 2011 covering both issues. The Ombudsman agreed that local resolution had been incomplete and agreed with the Trust's local remedy of a financial offer to the patient in recognition of the pain that he endured following his admission to hospital.

40. In another complaint, concerning an issue occuring in November 2010, received in December 2010 and responded to in February 2011, following the unexpected death of a patient in neurosciences. The Ombudsman has agreed to leave the complaint open while the Trust considers a direct request for compensation by the mother, allowing more time for the parties to achieve resolution.

NICE Guidance

41. NICE guidelines covering clinical (CGs), interventional procedure (IPGs), technology appraisal (TA), public health (PHG) and medical device (MTGs) are issued each month. These are sent to the appropriate Clinical Director within the Division to review for relevance, applicability and compliance. The Clinical Director is responsible for returning the compliance statement and for delivering implementation of recommendations and for the audit of implementation. A Clinical Implementation Lead (CIL) may be assigned within the Directorate.

42. A new type of guidance was issued titled 'Diagnostics Technology Guideline' (DTG) and is reported for the first time in October 2011.

43. If partial compliance has been declared, the CIL is responsible for undertaking the gap analysis and preparing an action plan for full compliance. Delivery against the

actions will be monitored through Divisions' reports to the Clinical Audit Committee. Recommendations for any non-compliance must be reported via the Division's monthly quality reports to the Clinical Governance Committee and then to the Trust Board for ratification.

44. There were four new NICE guidelines issued in October 2011. The Trust has partial compliance for one of the guidelines, reported as non-applicable, as only being used for research purposes and not routine use.

45. A summary of compliance for the period of May – October is provided as follows;

Guideline	May	June	July	August	September	October
CGs	One issued and not applicable to the Trust	One issued and Trust is partially compliant and recommendations are being developed to achieve compliance	Two issued and Trust fully compliant	One issued and Trust declared fully compliant	Two issued. One not relevant. One declared partial compliance and recommendations are being developed to achieve compliance	One issued and declared compliant
IPGs	n/a	n/a	Four issued. One declared fully compliant and three not applicable.	Two issued one not applicable. One declared fully compliant	Two issued. Neither relevant as services not provided by the Trust.	n/a
TA	One issued and the Trust was fully compliant	Three issued and the Trust will be compliant subject to PCT funding from October 2011.	Four issued and Trust was fully compliant	Two issued not relevant as Services not provided by Trust	n/a	Two issued. One declared partially compliant and one compliant
PHG	n/a	None Issued	None issued	n/a	n/a	n/a
MTGs	None issued	n/a	Two issued. Devices not supported by NICE	n/a	n/a	n/a
DTG						One issued and not applicable

Conclusions and recommendation

46. The Board is asked to receive the report which highlights the wide range of activity across the organisation.

47. The Board is asked to note the actions being taken across the Trust.

Mrs Elaine Strachan–Hall, Chief Nurse
Professor Edward Baker, Medical Director

Appendices attached

Safety, Quality and Risk Score Card
Nursing metrics

KEY to Nursing metric CHARTS

Key
Poor
Fair
Good

National Cleaning Specification (%)				
V. High Risk	**	>95	90-95	<90
High Risk	*	>92	87-92	<87
Significant Risk		>85	80-85	<80

Antimicrobial Prescribing	
Green	80% or more
Amber	70 - 79%
Red	69% and below

Staffing Available to Care for Patients			
Excludes all vacancies and absences as a % of budgetted establishment			
	< 70%		70-85%
	>85%		

Key: **N/A** = Not Available **N** = National Target **P** = PCT Target **L** = Local Target

From November * includes data from

		Threshold	April	May	June	July	August	September	October	November *	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Completion of Walk Rounds	4> p.m. **(L)**	10	7	10	2	8	7	4	16	10	8	8	8	**8.p.m.**
2011-12	Completion of Walk Rounds	N/A	6	5	14	5	7	7	11	7	5				**7.p.m**

Mortality Rates

		Threshold	April	May	June	July	August	September	October	November	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Numbers of Deaths (excl. Sobell House)		218	216	202	185	219	201	216	220	268	260	206	220	
	Hospital Standarised Mortality Ratio (HSMR)	Less than 100	90.1	98.9	85.8	87	97.5	94.5	94.5	94.7	106.4	94.7	94.6	88.6	
	Hospital Mortaility Ratio (HMR)	Less than 100	92.9	96.4	83.2	88	94.9	94.4	94.4	90.8	100.0	100.4	90.2	87.9	
2011-12	Numbers of Deaths (excl. Sobell House)		231	203	200	154	213	204	202	222*					
	Hospital Standarised Mortality Ratio (HSMR)	Less than 100	95.8	86.2	94.1	80.6	95.5								
	Hospital Mortaility Ratio (HMR)	Less than 100	95.6	88.3	99.4	76.5	100.1								

Serious Incidents Requiring Investigation (SIRIs)

		Threshold	April	May	June	July	August	September	October	November	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Number of SIRIs completed in 45 working days	90% **(P)**	88%	25%	100%	88%	93%	90%	100%	100%	100%	100%	100%	100%	**90%**
	Number of SIRIs	<65 p.a. **(L)**	8	4	7	8	15	5	2	10	0	15	9	10	**93 p. a**
2011-12	Number of SIRs completed in 60 working days or agreed extension	90% **(P)**	100%	100%	86%	100%	100%	83%	100%	100*%					**96%**
	Number of SIRIs		6	3	6	7	5	7	1	2*					

Formal Complaints

		Threshold	April	May	June	July	August	September	October	November	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Number of formal complaints	56	67	63	88	61	50	75	62	62	72	68	68	56	**66 p.m.**
	Time taken to acknowledge formal complaints (3 working days)	95% **(P)**	100%	100%	100%	99%	100%	100%	98%	100%	99%	99%	96%	100%	**99%**
	Time taken to respond to formal complaints (25 working days)	95% **(P)**	87%	65%	80%	85.0%	91%	97%	98%	98%	92%	99%	93%	100%	**90%**
2011-12	Number of formal complaints		56	61	51	47	71	60	59	75*					**60 p.m**
	Time taken to acknowledge formal complaints (3 working days)	95% **(P)**	100%	98%	100%	98%	99%	99%	98%	99*%					**99%**
	25 working days to respond to formal complaints or agreed extension	95% **(P)**	100%	100%	98%	100%	100%	100%	94%	96%					**99%**

Medication Incidents

		Threshold	April	May	June	July	August	September	October	November	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Reporting of controlled drug adverse events to the Local Intelligence Network	100% quarterly **(N)**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
	Number of serious medication incidents	6 p.m. **(P)**	4	4	4	10	5	2	7	5	4	5	3	7	**5 p.m.**
2011-12	Reporting of controlled drug adverse events to the Local Intelligence Network	100% quarterly **(N)**	100%	100%	100%	100%	100%	100%	100%						**100%**
	Number of serious medication incidents (orange and red)	6 p.m. **(P)**	6	2	2	2	7	4	3						**4**

Patient Falls

		Threshold	April	May	June	July	August	September	October	November	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Number of serious patient falls (red and orange)	<41 p.a. **(P)**	4	4	4	5	3	5	1	0	2	4	3	2	**48 p.a.**
2011-12	Number of patient falls (red and orange)	<37 p.a. **(P)**	4	4	4	5	3	1	6						**46 p.a.**

Number of Reportable Injuries, Diseases & Dangerous Occurrence (RIDDOR) Incidents

		Threshold	April	May	June	July	August	September	October	November	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Over 3-day RIDDOR reports for staff	<48 p.a. **(N)**	11	5	4	6	5	6	7	5	1	5	4	7	**66 p.a**
	Major Injury RIDDOR reports for staff	<9 p.a. **(N)**	0	0	1	0	0	0	0	0	1	0	0	1	**3 p.a.**
2011-12	Over 3-day RIDDOR reports for staff	<44 p.a. **(N)**	5	3	9	6	6	5	2	3	0				**51 p.a**
	Major Injury RIDDOR reports for staff	<6 p.a. **(N)**	0	0	0	0	0	0	2	3	0				**5 p.a**

Staff Accidents

		Threshold	April	May	June	July	August	September	October	November	December	January	February	March	Forecast Out-turn (FOT)
2010-11	Number of accidents resulting in harm	<72 p.m. **(L)**	79	68	80	81	74	73	68	68	64	56	72	72	**68 p.m.**
	Staff Slips, Trips & falls (on same level) resulting in harm	<8 p.m. **(L)**	7	3	10	10	10	9	8	7	7	3	6	10	**8 p.m.**
	Manual & mechanical handling incidents causing musculoskelatal disorders	<16 p.m. **(L)**	18	15	18	18	11	15	13	12	16	11	16	17	**15 p.m.**
	Physical assaults that result in harm	<6 p.m. **(L)**	8	11	3	4	7	7	8	2	6	5	8	8	**6 p.m.**
	Diagnosed with occupationally acquired dermatitis under RIDDOR	<3 p.m. **(L)**	0	0	0	1	0	1	0	1	0	1	0	1	**0.4 p.m.**
2011-12	Number of accidents resulting in harm	<72 p.m. **(L)**	80	70	69	75	80	56	60						**70**
	Staff Slips, Trips & falls (on same level) resulting in harm	<8 p.m. **(L)**	9	12	8	10	7	0	5						**7**
	Manual & mechanical handling incidents causing musculoskelatal disorders	<16 p.m. **(L)**	14	11	17	16	19	9	8						**13**
	Physical assaults that result in harm	<6 p.m. **(L)**	6	7	5	6	8	6	11						**6**
	Diagnosed with occupationally acquired dermatitis under RIDDOR	<2 p.m. **(L)**	0	0	0	0	0	0	0	0	0				**0**

01-Nov-11

November Data

Gynae and Maternity Quality Scorecard Board

CQC Outcomes			8		8	8		8	8	8
Division	Directorate	Ward	Hand Hygiene		ANTT Injectables	Saving Lives Catheter Care		MRSA / MSSA post 48 hrs	C-Diff post 72 hrs	National Cleaning Overall Score
			Nursing	Non Nursing		Catheter Insertion	Catheter on going care			
Gynae and Maternity	Gynae	JR Gynae*	100%	100%						93%
		HGH Gynae*	100%	100%						95%
	Maternity	Delivery Suite / Obs	100%	50%						94%
		Spires Midwifery Led								97%
		Level 5								90%
		Level 6	100%	100%						96%
		Level 7								95%
		HGH Delivery Suite								91%
		HGH Post Natal Ward								98%

8		8
Antimicrobial		
% Correct prescription	% End date included	VTE
50%	70%	70%
NA	NA	
NA	NA	
NA	NA	
NA	NA	
NA	NA	86%
NA	NA	
NA	NA	
100%	70%	

4	4 & 9	4	4	5	1	4	17	4 & 20	13			13	13
Total No of Falls	Total No of medication errors	Compliance with Track and Trigger / EWS	Pressure Ulcers Grade 3/4 / Skin Integrity	Compliance with Nutritional Assessments	Single Sex Breaches	Compliments	Complaints	SIRIs Not Incl Pressure Ulcers	% shifts 'agreed staffing'	% shifts 'minimum staffing'	% shifts 'at risk staffing'	Agency Fill Rate	% Actual Staffing to Budget (minus absences and vacancies & Supernumary Staff)
0	1								100%	0%	0%		82.8%
0	0								100%	0%	0%		88.6%
1	1					0	3						
0	0					0	0						
0	1					0	0						
0	0					0	1						
0	0					0	0						
1	0					0	1						
0	0					0	0						

Falls
At HGH - Husband of a woman felt faint in AN clinic , went outside and fainted, banged head cut on head noted - sent to ED departement.

JR Incident - Invloved a student midwife fainting at a delivery and fell against door - No injury sustained.

Hand hygiene - Medical staff not compliant to hand hygiene on both DS and OA. DS manager to address.

VTE scores for Women's - updates on VTE are provided through Divisional Quality Reports to the Clinical Governance Committee

Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (Les than 3 Red)	Maternity JR and HGH sites Gynaecology JR & HGH sites		
	Safe Staffing > 85%	**Staffing 70 - 85%**	**Staffing below 70%**

01-Dec-11

November Data

C & W Quality Metrics Scorecard Board

CQC Outcomes			8		8	8		8	8	8	8		8	8	4	4 & 9	4	4	5	1	4	17	4 & 20	13			13	13
Division	Directorate	Ward	Hand Hygiene		ANTT Injectables	Saving Lives Catheter Care		MRSA / MSSA post 48 hrs	C-Diff post 72 hrs	National Cleaning Overall Score	Antimicrobial		VTE		Total No of Accidents	Total No of medication errors	Compliance with Track and Trigger / EWS	Pressure Ulcers Grade 3/4 / Skin Integrity	Compliance with Nutritional Assessments	Single Sex Breaches	Compliments	Complaints	SIRIs Not Incl Pressure Ulcers	% shifts 'agreed staffing'	% shifts 'minimum staffing'	% shifts 'at risk staffing'	Agency Fill Rate	% Actual Staffing to Budget (minus absences and vacancies & Supernumary Staff)
			Nursing	Non Nursing		Catheter Insertion	Catheter on going care				% Correct presciption	% End date included																	
Children's	Paediatrics	Toms *	94%	89%	97%					90%	73%	73%			0	0	100%		100%	0	0	0		63%	32%	5%	na	76.5%
		Robins *	100%	100%	96%					94%	90%	90%			0	0	100%		100%	0	1	1		90%	10%	0%	na	89.8%
		Childrens Ambula	95%	75%	93%					90%					0	0	100%		100%	0	2	0					na	
		HGH Children	95%	95%	90%					97%					0	0	100%		100%	0	0	0		100%	0%	0%	100%	77.0%
		Bel / Dray *	100%	100%	94%					95%	73%	40%			0	0	100%		100%	0	2	0		55%	39%	11%	33%	74.5%
		Kamrans **	100%	96%	92%					94%	100%	100%			0	0	100%		100%	0	0	0		94%	6%	0%	na	90.4%
		Melanies *	100%	100%	94%					97%	N/A	N/A			0	0	100%		100%	0	0	0		83%	17%	0%	na	82.5%
	Paediatric Critical Care	NNU**	100%	100%	94%					94%	100%	100%			0	12	na		na	0	0	0		98%	2%	0%	88%	74.0%
		SCBU**	90%	90%	90%					95%					0	1	na		na	0	1	0		100%	0%	0%	100%	85.4%
		PHDU**	85%	70%	90%					96%					0	0	100%		na	0	0	0		98%	0%	2%	na	78.6%
		PICU**	90%	90%	90%					93%	100%	100%			0	0	100%		na	0	0	0		99%	0%	1%	na	

Non nursing handwashing - Nurses challenging doctors who do not comply with hand washing

Anti-microbial - Juniors to check charts on ward round - monitored by Consultants & nurses

Medication errors NNU = 12 - all medication errors are reviewed and reviews include observations of practice

Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (Les than 3 Red)	ROBINS KAMRANS SCBU	TOMS HGHCW BELL-DRAY MELANIES NNU PICU/PHDU	
	Safe Staffing > 85%	**Staffing 70 - 85%**	**Staffing below 70%**

November Dat: NTSS Multidisciplinary Quality Scorecard

CQC Outcomes			8		8	8		8	8	8	8		8	4	4 & 9	4	4	5	1	4	17	4 & 20	13			13	13
			Hand Hygiene			Saving Lives Catheter Care					Antimicrobial																	
Division	Directorate	Ward	Nursing	Non Nursing	ANTT Injectables	Catheter Insertion	Catheter on going care	MRSA / MSSA post 48 hrs	C-Diff post 72 hrs	National Cleaning Overall Score	% Correct presciption	% End date included	VTE	Total No of Falls	Total No of medication errors	Compliance with Track and Trigger / EWS	Pressure Ulcers Grade 3/4 / Skin Integrity	Compliance with Nutritional Assessments	Single Sex Breaches	Compliments	Complaints	SIRIs Not Incl Pressure Ulcers	% shifts 'agreed staffing'	% shifts 'minimum staffing'	% shifts 'at risk staffing'	Agency Fill Rate	% Actual Staffing to Budget (minus absences and vacancies & Supernumary Staff)
Neuro, Trauma, Specialist Surgery (3)	Neuro	NICU **	91%	100%	100%	n/a	n/a			92%	100%	100%		0	3			100%	0	19	0					84%	88.8%
		Neurosciences IP *	90%	80%	100%						73%	73%		5	4	100%	2	100%	0	23	2		42%	43%	15%	83%	75.1%
		Neurosciences OPD								88%										0	0						76.9%
	Trauma	2A *	92%	91%	100%	100%	100%			90%	100%	90%		2	1	90%		100%	0	18	0		87%	13%		87%	87.0%
		3A *	100%	100%	100%	100%	100%			94%				2	1	100%	1	95%	0	18	0		83%	17%		86%	90.1%
		Trauma OPD	100%	80%						n/a										0	0						77.4%
		F Ward *	100%	90%	90%	90%	95%			94%	40%	40%		6	2	90%		91%	0	0	0		75%	25%		79%	77.0%
	Specialist Surgery	SSIP *	100%	n/a	90%					91%	93%	57%		2	2	100%		100%	0	10	1		96%	4%		100%	85.6%
		Lichfield *	80%	n/a	n/a					95%										4	0					69%	86.0%
		SSOPD	95%	80%						No audit										2	1						45.8%
		OPD Eye	100%	n/a						88%										2	2					100%	85.0%
		OMFS OPD	90%	40%						no audit										0	0						83.0%

Pressure Ulcers - Neurosciences, were picked up on admsission and assessment, not acquired in hospital. Pressure Ulcer 3A was found on assessment on admission from AICU.

Hand Hygiene Audit OMFS - Infection control team are working with the departement and will conduct a re-audit in December.

Antimicrobial prescribing again highlighted at Divisional Meeting. Divisional Director has emailed lead cons (13/12/11) on F ward to make addressing this a priority. Divisional Nurse will do a walkabout on 20/12/11 and report back findings.

SSOPD staffing due to current vacancies, Matron Turner is supporting the department and recruitment is in process, for the specialist post associated with this department.

Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (Les than 3 Red)	OMFS, OPD Eye, SSIP, Lichfield, 2A, 3A, NICU	Neuro, F ward, Trauma OPD, Neuro OPD	SSOPD
	Safe Staffing > 85%	**Staffing 70 - 85%**	**Staffing below 70%**

November Data S & O Multidisciplinary Quality

CQC Outcomes			8		8	8		8	8	8	8		8		4	4 & 9	4	4	5	1	4	17	4 & 20	13			13
Division	Directorate	Ward	Hand Hygiene		ANTT Injectables	Saving Lives Catheter Care		MRSA / MSSA post 48 hrs	C-Diff post 72 hrs	National Cleaning Overall Score	Antimicrobial		VTE		Total No of Falls	Total No of medication errors	Compliance with Track and Trigger / EWS	Pressure Ulcers Grade 3/4 / Skin Integrity	Compliance with Nutritional Assessments	Single Sex Breaches	Compliments	Complaints	SIRIs Not Incl Pressure Ulcers	% shifts 'agreed staffing'	% shifts 'minimum staffing'	% shifts 'at risk staffing'	% Actual Staffing to Budget (minus absences and vacancies & Supernumary Staff)
			Nursing	Non Nursing		Catheter Insertion	Catheter on going care				% Correct prescription	% End date included															
Surgery & Oncology (6)	Oncology	Oncology Ward **	93%	100%	83%	na	na			83%	67%	67%	N/A		7	6	90%		70%	0	8	0	1	40%	49%	11%	80.9%
		Oncology Treatment	64%	100%						100%			N/A		0	0	na		na	0	15	3					
		Haematology **	100%	95%	80%	na	na			95%	84%	84%	N/A		2	1	70%		100%	0	22	0		77%	19%	4%	74.8%
		Sobell *	100%	98%	90%	100%	100%			94%	100%	100%	N/A		5	0	na		100%	0	17	0		31%	36%	33%	89.8%
	Surgery - JR, HGH, Churchill & Endoscopy	SEU D & Triage*	95%	90%	90%	0%	100%			93%	100%	100%	N/A		0	0	100%		100%	0	5	0		76%	13%	11%	90.7%
		SEU E	92%	92%	92%	0%	0%			94%	100%	100%	N/A		1	1	99%		100%	0	2	0		76%	13%	11%	90.5%
		SEU F *	95%	92%	89%	0%	100%			93%	100%	100%	N/A		3	1	100%		100%	0	2	1		76%	13%	11%	72.8%
		5F *	100%	100%	92%	100%	100%			94%	N/A	N/A	N/A		2	4	100%		87%	0	3	1		46%	38%	16%	78.1%
		JR Endoscopy **	82%	80%	90%					93%			N/A		0	1				0	5	2					94.2%
		HGH Endoscopy **	100%	100%	100%					97%			N/A		0	0				0	3	0					67.7%
		HGH E Ward *	95%	95%	99%	100%	100%			96%	100%	91%	N/A		0	1	95%		100%	0	13	1		87%	13%	0%	86.0%
		UGI *	88%	86%	84%	n/a	100%		1	92%	n/a	n/a	N/A		5	1	100%		100%	0	15	0		62%	36%	2%	83.2%
		Colorectal *	100%	100%	40%	n/a	80%			88%	n/a	n/a	N/A		3	0	100%		100%	0	17	0		67%	27%	6%	79.4%
		Jane Ashley *	100%	100%	71%	n/a	n/a			97%	n/a	n/a	N/A		0	1	80%		100%		24	0		84%	16%	0%	58.2%
	Renal, Transplant & Urology	Urology *	100%	100%	100%	0%	56%			92%	80%	80%	N/A		0	0	70%		100%	0	4	2		59%	36%	5%	56.7%
		Transplant **	100%	94%	92%	na	na			93%	100%	95%	N/A		3	1	98%		100%	0	12	0		47%	53%	0%	81.6%
		Renal Ward **	100%	88%	90%	n/a	n/a			94%	100%	100%	N/A		2	2	100%		100%	0	5	0		64%	36%	0%	81.6%
		ORH Dialysis *	90%	n/a	100%					87%			N/A		0	0				0	0	0					89.1%
		Stoke Mandeville *	90%	n/a									N/A		0	0				0	0	0					72.5%
		Milton Keynes *	100%	n/a	100%								N/A		0	0				0	1	0					88.1%
		Swindon *		n/a									N/A		0	0				0	1	0					100.0%
		Wycombe *	100%	100%	100%								N/A		0	0				0	0	0					79.5%
									1						33	20		0		0	174	10	1				

Action/Intervention Plans

1. ANTT Results not consistently high:
Audit fedback to clinical teams and now working with infection control team and Professional Development Nurses to re-fresh training with clinical staff this month

2. Anti-microbial results poor on oncology ward.
This has been discussed with the Clinical Lead and Clinical Director who will instigate audits of documentation of prescriptions in drug charts for the next 2 weeks and identify and re-train any prescribers failing to prescribe correctly.

3. Clinical Area cleaning scores remain variable.
Despite focused re-audits of clinical areas, wards continue to fail cleaning scores predominantly as a result of poor nurse and cleaning services scores.
These are being addressed by a series of repeat audits and results are beginning to improve.

Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (Les than 3 Red)	Sobell House, 6D, 6E, JR Endoscopy, E ward, ORH Dialysis, MK Renal Unit, Swindon Renal Unit	Oncology, Haematology, 6F, 5F, Colorectal, Upper GI, Wytham, Renal, Stoke Mandeville renal Unit, Wycombe Renal Unit.	HGH Endoscopy, Jane Ashley Centre Ward, Urology
	Safe Staffing > 85%	Staffing 70 - 85%	Staffing below 70%

01-Nov-11

November **C, V & T Quality Scorecard Board**

CQC Outcomes			8	8	8	8		8	8	8	8		8	8	4	4 & 9	4	4	5	1	4	17	4 & 20	13			13	13
Division	Directorate	Ward	Hand Hygiene		ANTT Injectables	Saving Lives Catheter Care		MRSA / MSSA post 48 hrs	Post 72 hrs C-Diff	National Cleaning Overall Score	Antimicrobial		VTE		Total No of Falls	Total No of medication errors	Compliance with Track and Trigger / EWS	Pressure Ulcers Grade 3/4 / Skin Integrity	Compliance with Nutritional Assessments	Single Sex Breaches	Compliments	Complaints	SIRIs Not Incl Pressure Ulcers	% shifts 'agreed staffing'	% shifts 'minimum staffing'	% shifts 'at risk staffing'	Agency Fill Rate	% Actual Staffing to Budget (minus absences and vacancies & Supernumary Staff)
			Nursing	Non Nursing		Catheter Insertion	Catheter on going care				% Correct presciption	% End date included																
Cardiac, Vascular and Thoracic (3)	Medicine	CCU *	100%	100%		100%	100%			96%	N/A	N/A			1	0			100%	0	11	0					100%	
		CAS **	80%	80%	N/A					94%					0	0	100%			0	6	0					88%	72.8%
		Cardiology *	100%	100%	96%	100%	100%		1	97%	N/A	N/A			6	1	100%		100%	0	35	0					100%	69.5%
	Surg & Vasc	CTCC **	100%	100%	45%		100%			96%	100%	100%			1	1			100%	0	11	0					70%	89.1%
		CTW *	100%	100%	100%		100%			97%	80%	90%			4	4	100%		100%	0	20	2		52%	45%	3%	64%	87.0%
		6A *	100%	100%	100%		100%		3	96%	90%	90%			3	3	100%		93%	0	18	0	1	26%	69%	5%	60%	86.5%
	P P	5D*	97%	86%	100%	100%	100%			92%	N/A	N/A			0	0	100%		100%	0	10	2					N/A	88.8%

Low ANTT and some hand hygiene scores, PDN and infection control link nurses involved in raising profile, education and increased auditing.

Recruitment plan in place to improve staffing levels

C-Difficile - root cause analysis undertaken, actions highlighted to all team. SIRI relates to C-diff.

Falls - all pts identified at hand over, falls leaflets in all rooms, 6A planning intentional rounds, no themeds identified.

6A reporting of low percentage of shifts at agreed staffing refelcts predominantly in CSW vacancies which are now filled

Intensive Support (More than 3 Red)			
Safe Care (Les than 3 Red)	5D	CCU CAS Cardiology CTCC CTW 6A	
	Safe Staffing > 85%	**Staffing 70 - 85%**	**Staffing below 70%**

01-Nov-11

November Data

EMTA Multidisciplinary Quality Scorecard Board

CQC Outcomes			8		8	8		8	8	8	8		4	4 & 9	4	4	5	1	4	17	4 & 20	13			13	13
			Hand Hygiene			Saving Lives Catheter Care					Antimicrobial															
Division	Directorate	Ward	Nursing	Non Nursing	ANTT Injectables	Catheter Insertion	Catheter on going care	MRSA / MSSA Post 48 hrs	C Diff post 72 hrs	National Cleaning Overall Score	Antimicrobial	VTE	Total No of Falls	Total No of medication errors	Compliance with Track and Trigger / EWS	Pressure Ulcers Grade 3/4 / Skin Integrity	Compliance with Nutritional Assessments	Single Sex Breaches	Compliments	Complaints	SIRIs Not Incl Pressure Ulcers	% shifts 'agreed staffing'	% shifts 'minimum staffing'	% shifts 'at risk staffing'	Agency Fill Rate	% Actual Staffing to Budget (minus absences and vacancies & Supernumary Staff)
Emergency Medicine, Therapies & Ambulatory (7)	Emergency Medicine	JR ED **	89%	89%	100%					93%			0	0	100%			0	0	4		73	27	0	35%	77.9%
		JR EAU *	98%	78%	100%	0%	0%			89%	36%	45%	3	4	95%	1	100%	0	2	2	1	72	20	8	26%	58%
		HGH ED **	100%	100%	100%					94%			0	0	100%	1		0	2	4					90%	88.8%
		HGH MAU *	100%	100%	100%	0%	0%			94%			0	0	100%		100%	0	1	0					80%	86.9%
		7A *	100%	90%	0%		0%			97%	75%	58%	8	1	100%		100%	0	9	0		60	38	2	20%	54.4%
		7B *	100%	88%	100%		100%			93%	90%	70%	5	1	100%		100%	0	0	0		87	12	1	9%	69.9%
		7C *	100%	100%	0%		0%			95%	80%	70%	5	0	98%	1	96%	0	8	0		55	36	9	28%	100.0%
		7D *	85%	60%	0%		0%			93%	82%	64%	8	0	80%		100%	0	0	0		72	23	5	28%	72.9%
		7F	100%	100%	0%		0%			91%	80%	70%	2	0	100%		73%	0	0	0		72	26	2	22%	48.0%
		5A *	86%	88%	n/a					94%	n/a	n/a	9	1				0	3	0		86	8	6	24%	100.0%
		PAU *	100%	100%	n/a		100%		1	90%	n/a	n/a	24	1				0	0	0		71	22	7	25%	96.4%
		Oak *	100%	100%	100%	100%	100%			95%	93%	86%	9	1	95%		100%	0	6	0		68	32	0	0%	81.6%
		Laburnam *	95%	95%	100%	95%	95%	1		94%	91%	91%	4	0	95%		100%	0	5	0		66	34	0	0%	83.2%
		Juniper *	95%	95%	100%		95%			94%	92%	92%	2	1	100%	1	100%	0	7	1		66	34	0	0%	89.1%
		Level 4 *	100%	100%	0%	0%	0%			91%	90%	80%	25	0	100%		100%	0	4	0		47	44	9	60%	88.0%
		ASU *	100%	92%	100%	100%	100%			91%	82%	91%	2	0	96%		100%	0	2	1		73	23	4	20%	100.0%
	Ambulatory, Chest, ID	John Warin **	93%	100%	0%					94%	100%	83%	2	0	100%		96%	0	0	1		81	16	3	2%	72.0%
		Geoffrey Harris *	100%	100%	0%	0%	0%				100%	100%	0	0	100%		100%	0	18	1		59	32	9	0%	87.0%
		Treatment Centre	100%	95%	0%					84%			0	0				0	2	0						58.9%
		Dermatology	100%	100%	0%					92%			0	0					0	0						87.5%
		Immunology	100%		0%					na			0	0					2	0						84.6%
		OCDEM Endocrine	100%	100%	0%					na			0	0					3	0						92.2%
		OCDEM Diabetes	100%	100%	0%					na			0	0					3	1						100.0%
		Sleep Physiology	N/A	N/A	0%					na			0	0					4	0						98.7%
		GUM	100%	100%	0%					na			0	0					5	1						90.0%
		Genetics			0%					na			0	0					2	0						88.5%

Problem	Action
Low cleaning scores (ASU)	Raised at ward meeting, cleaning schedule established and weeking meetings with supervisor.
VIP specifically audited this month (7D)	Issue highlighted to staff, re auditing.
80 % HH for CSWs (7D)	All staff have tottles, housekeeper ensuring end of bed dispensers are replaced when empty.
Low staffing and high agency use (5A)	Deputy ward matron now ward based and reviewing daily staffing levels.
High number of falls (5A)	One particular patient had multiple falls, wrist bands in place to alert staff to those at risk.
Low cleaning scores (PAU)	Daily cleaning schedules in place, discussed at ward handover and in ward meetings.
JR EAU	
Fall from repose mattress	Escalated to company, design being modified, attachments now more secure (was elastic) now clip.
Medication errors	Drug room now created on EAU
Low cleaning scores	Reviewed with assessment team, sisters closely monitoring areas where failed.
Previous non-compliance with MUST (EAUs) -	SNAP tool implemented with both EAU depts. Red tray protocol in place both EAUs.
Commenced EPR (EDs)	A significant change for ED staff - agency use increased to support this implementation.
Low hand hygiene (EAU)	Perform regular audits - real time education to those who fail -take individual names and feed back to clinical units

Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (Les than 3 Red)	**Genetics, GUM, Sleep Physiology, OCDEM Diabetes, OCDEM Endocrine, Dermatology, Geoffrey Harris, ASU, Level 4, Juniper, Laburnum, PAU, 5A, 7C, HGH MAU, HGH ED**	**Immunology, John Warin, Oak, 7D, JR ED**	**Treatment Centre, 7F, 7B, 7A, JR EAU**
	Safe Staffing > 85%	**Staffing 70 - 85%**	**Staffing below 70%**

November Data CCTDP Quality Metrics Scorecard Board

CQC Outcomes			8		8	8		8		8		8		8	4	4 & 9	4	4	5	1	4	17	4 & 20	13			13	13
			Hand Hygiene			Saving Lives Catheter Care						Antimicrobial																	
Division	Directorate	Ward	Nursing	Non Nursing	ANTT Injectables	Catheter Insertion	Catheter on going care	MRSA / MSSA post 48 hrs	C-Diff post 72 hrs	National Cleaning Overall Score		% Correct presciption	% End date included	VTE	Total No of Falls	Total No of medication errors	Compliance with Track and Trigger / EWS	Pressure Ulcers Grade 3/4 / Skin Integrity	Compliance with Nutritional Assessments	Single Sex Breaches	Compliments	Complaints	**SIRIs** Not Incl Pressure Ulcers	**% shifts 'agreed staffing'**	**% shifts 'minimum staffing'**	**% shifts 'at risk staffing'**	Agency Fill Rate	% Actual Staffing to Budget (minus absences and vacancies & Supernumary Staff)
Critical Care, Theatres, Diagnostics & Pharmacy (6)	Anaes / CC / Th	AICU **	90%	75%	100%	100%	97%	1		97%		100%	100%	86%	0	1		1		11	8	0		100%	0%	0%	100%	87.4%
		CICU **	90%	85%	100%		95%			95%					0	1				1	6	0						
		HGH CICU **	100%	60%	100%		100%			97%					0	1				0	8	0		100%	0%	0%	100%	84.7%
		HGH DCU *								87%					0	0				0	0	0		100%	0%	0%	100%	74.5%
		Th West Wing **	100%	71%	100%	100%				92%					0	0				0	0	0		100%	0%	0%	100%	60.2%
		Th JR **	82%	50%	70%	60%				91%					0	0				0	0	0		100%	0%	0%	100%	64.4%
		Th HGH **		80%	80%	100%				93%					0	0				0	0	0		100%	0%	0%	100%	81.0%
		Th Churchill **	90%	42%	60%	100%				95%					0	0				0	0	0		100%	0%	0%	100%	73.4%
		Th TDA / DCU *								95%					0	0				0	1	0		100%	0%	0%	100%	36.0%

AICU/ CICU/CCU

The action plan submitted last month continues with regard to the saving lives audits. All Band 7 and 8 are undertaking audits in addition to band 5 and 6 nurses to ensure a top down - bottom up approach to improve these results. This approach is working. Nurse handwashing has improved during November. Medical handwashing has not despite raising this issue at the most recent consultant meeting in critical care. The Matron now plans to meet with the Clincial Director and create an action plan to ensure success and improvement in the January 2012 numbers. There has been a reduction in medication errors, due to the introduction of a compulsory teaching & competency package for all staff.

During the month of November 2011 an individual patient developed a occipital pressure sore due to being too unstable to rotate. The patient received all the appropriate pressure relieving devices .

Theatres West Wing and JR

Saving lives champions continue to promote hand hygiene, ANTT and saving lives audits. Matron working with Carillion to improve cleaning scores which will be further helped by new cleaning schedules and each theatre on level 1 & 0 being deep cleaned once a week by the orderlies.

Theatres Churchill and Horton

Matron reports poor compliance from medical staff re Hand Decontamination at point of care. Matron to discuss with new Clinical Director and action plan will be formulated jointly by end Jan 2012. 90% relevant nursing staff have had ANTT training during the month of November. Divisional Nurse raising with Medical Director.

Intensive Support (More than 3 Red)			
Supportive measures (3 Red)			
Safe Care (Les than 3 Red)		AICU, CICU, CCU Preop Assessment Pain Team Horton Theatres	JR Theatres Churchill Day Case Unit Resusitation
	Safe Staffing > 85%	**Staffing 70 - 85%**	**Staffing below 70%**