TB2014.73 Board Quality Report – Appendix 1

BQR ID	Rating	Rating Last Period	Descriptor	Period	Threshold Source	Red	Amber
PS01	96.73% Amber	Green	Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]	Jun 14	Internal	95%	97%
PS02	93.21% Green	Amber	Safety Thermometer (% patients receiving care free of any harm - irrespective of acquisition) [one month in arrears]	Jun 14	Internal	91%	93%
PS03	91.54% Red	Red	VTE Risk Assessment (% admitted patients receiving risk assessment)	May 14	National	95%	95.25%
PS04	3 N/A		Serious Incidents Requiring Investigation (SIRI) reported via STEIS	Jun 14		N/A	N/A
PS05	7 Green	Green	Number of cases of Clostridium Difficile > 72 hours (cumulative year to date)	May 14	National	11	N/A
PS06	1 Red	Red	Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)	May 14	National	1	N/A
PS07	91.4% Green	Red	Antibiotic prescribing - % prescriptions where indication and duration specified [most recently available figure, undertaken quarterly]	Apr 14	Internal	85%	88%
PS08	95.8% Green	Amber	Antibiotic prescribing - % compliance with antimicrobial guidelines [most recently available figure, undertaken quarterly]	Apr 14	Internal	93%	95%
PS09	76.92% Amber	Amber	% patients receiving stage 2 medicines reconciliation within 24h of admission	Jun 14	Internal	75%	85%
PS10	95.57% Amber	Green	% patients receiving allergy reconciliation within 24h of admission	Jun 14	Internal	94%	96%
PS11	2168 N/A		Total number of incidents reported via Datix	Jun 14		N/A	N/A
PS12	4.94% Green	Amber	% of incidents associated with moderate harm or greater	Jun 14	Internal	6.5%	5%
PS13	2 N/A		Total number of newly acquired pressure ulcers (category 2,3 and 4) reported via Datix	Jun 14		N/A	N/A
PS14	3 Green	Red	Falls leading to moderate harm or greater	Jun 14	Internal	8	7
PS15	0 Green	Green	Number of hospital acquired thromboses identified and judged avoidable [two months in arrears]	May 14	Internal	1	0
PS16	57.75% N/A		Cleaning Score - % of inpatient areas with initial score > 92%	Jun 14		N/A	N/A
PS17	4.81% Green	Green	% 3rd and 4th degree tears in obstetrics [C&W Division]	May 14	Internal	5%	N/A
PS18	99.58% Green	Green	% radiological investigations achieving 5 day reporting standard [CSS Division]	May 14	Commissioner	95%	98%
PS19	13 N/A		Number of CAS alerts received	Jun 14		N/A	N/A
PS20	0 Green	Green	CAS alerts breaching deadlines at end of month and/or closed during month beyond deadline	Jun 14	Internal	1	N/A
CE01	0.96 N/A		Standardised Hospital Mortality Ratio (SHMI) [most recently published figure, quarterly reported as a rolling year ending in month]	Sep 13		N/A	N/A
CE02	189 N/A		Crude Mortality	Jun 14		N/A	N/A
CE03	63.36% Red	Red	Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]	May 14	National	80%	90%
CE04a	78% Red	Red	Statutory and Mandatory Training - % required modules completed	Jun 14	Internal	85%	95%
CE04b	29% Red	Red	Statutory and Mandatory Training amongst honorary contract holders (% relevant modules completed)	Jun 14	Internal	85%	95%

CE05	90.82% Amber	Amber	ED - % patients seen, assessed and discharged / admitted within 4h of arrival	May 14	National	85%	95%
CE06	85.07% Green	Green	Stroke - % patients spending > 90% of admission in specialist stroke environment	May 14	National	70%	80%
CE07	82.81% Amber	Amber	Stroke - % patients accessing specialist stroke environment within 4h of arrival	May 14	National	75%	85%
CE08	480 N/A		Transfer Lounge Usage	Jun 14		N/A	N/A
CE09	93.46% Green	Green	% of elective paediatric day cases managed as such (Did not result in an overnight stay) [C&W Division]	May 14	Internal	70%	75%
CE10	6.2 Amber	Green	Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]	May 14	Internal	8	5
CE11	0% Green	Green	Vascular - % mortality following elective AAA repair [NOTSS Division]	May 14	Internal	5%	3%
CE12	100% Green	Green	Cardiology - % patients receiving primary angioplasty within 60 minutes of arrival at hospital [MRC Division]	May 14	Internal	85%	90%
CE13	1.9 Green	Amber	Cardiology - Mean number of days from referral to admission to cardiology at tertiary centre [MRC Division]	May 14	Internal	3	2
CE14	0% Green	Red	Cardiac surgery-% rate of patients with organ space infections following cardiac surgery via the sternum [MRC Division]	May 14	Internal	1%	0.5%
CE15	0% Green	Green	Cardiac Surgery - % mortality following elective primary CABG [MRC Division]	May 14	Internal	6%	4%
CE16	2 Red	Amber	Number of unscheduled returns to theatre within 48 hours [NOTSS Division]	May 14	Internal	2	1
CE17	100% Green	Green	Rheumatology - % relevant patients who have their DAS28 score documented [NOTSS Division]	May 14	Internal	95%	98%
CE18	1 Amber	Green	Number of unscheduled returns to theatre in gynaecology [C&W Division]	May 14	Internal	2	1
CE19	602 N/A		Number of patients admitted to SEU wards from SEU triage [S&O Division]	May 14		N/A	N/A
CE20	75.82% Red	Red	% patients having their operation within the time specified according to their clinical categorisation [CSS Division]	Jun 14	Internal	90%	95%
CE21	2.61% Amber	Amber	Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	Jun 14	Internal	4%	2%
CE22	73.72% Green	Green	% fractured NOF patients who receive surgery within 36 hours of admission [NOTSS Division]	Mar 14	Commissioner	70%	72%
CE23	21.63% Green	Green	% deliveries by C-Section [C&W Division]	May 14	Commissioner	33%	23%
CE24	1.05% Green	Green	7 day admission rate following assessment on (and discharge from) paediatric CDU [C&W Division]	Jun 14	Internal	4%	2%
PE01	78 Green	Green	Friends & Family - Net Promoter Score [one month in arrears]	May 14	Internal	63	70
PE02	96.4% Green	Green	Friends & Family - proportion extremely likely or likely to recommend [one month in arrears] – Inpatient and Emergency Department Only.	May 14	Internal	90%	94%
PE03	83 Amber	Red	Complaints Received	May 14	Internal	90	80
PE04	2 Red	Green	Number of complaints received initially graded as RED	May 14	Internal	2	1
PE05	295 N/A		PALS contacts made	May 14		N/A	N/A
PE06	4	Red	Single sex breaches	May 14	National	3	2
PE07	70.97% Green	Amber	% patients EAU length of stay < 12h	Jun 14	Internal	65%	70%
PE08	3.75% N/A		% Complaints upheld or partially upheld [Quarterly in arrears]	Mar 14		N/A	N/A

PE09	0 Green	Red	Number of legal claims received / inquests opened initially graded as RED	Mar 14	Internal	2	N/A
PE10	50.67% Amber	Green	% patients returning feedback forms in specialist surgery outpatients [NOTSS Division]	May 14	Internal	45%	60%
PE11	11 N/A		Number of reopened complaints	May 14		N/A	N/A

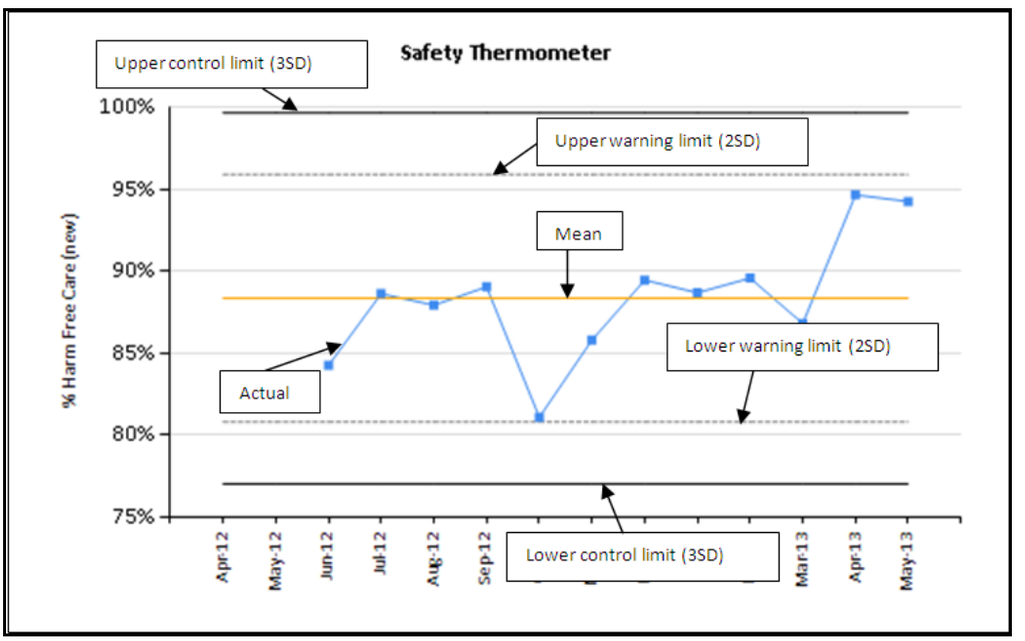
How to interpret charts

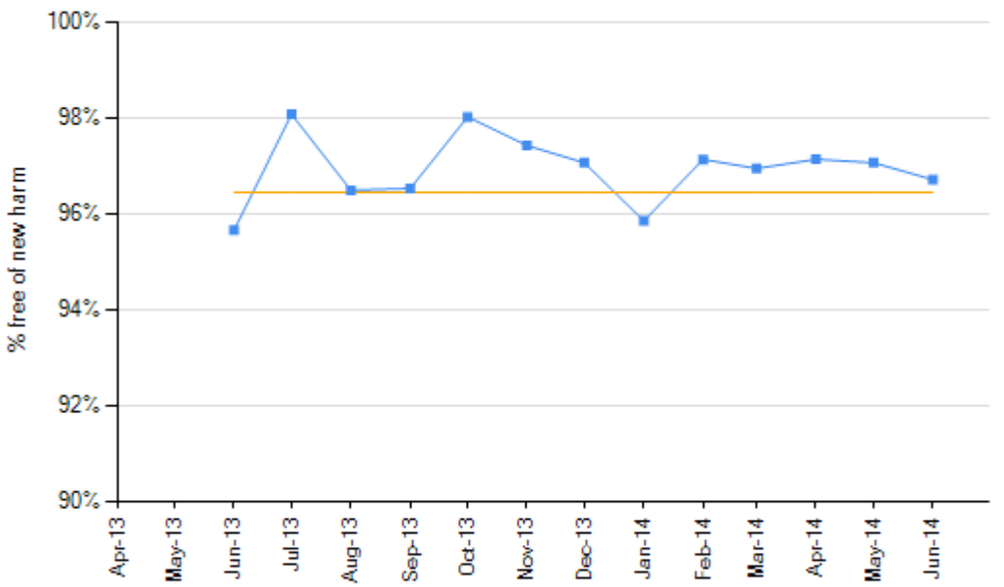
Data are presented in this report in a number of different ways – including statistical process control (SPC) charts, line charts (without confidence intervals / control limits), histograms and cumulative histograms. Graphics have been selected in order to encourage the analysis of trends and to identify when a change in relation to the historical position is likely to be 'real' or statistically significant.

SPC charts show a trend line and allow easy reference to the historical mean for that metric at a time at which it was stable and 'within control'. Where shown, the mean is displayed as a horizontal orange line. In addition, warning limits and control limits are shown where appropriate, above and below the mean. Warning limits are placed at two standard deviations (2SD – dashed black line) and control limits at three standard deviations (3SD – solid black line). If a data point is found beyond the control limit (3SD from the mean) in either direction, the change is statistically significant and is very unlikely to have occurred simply by chance.

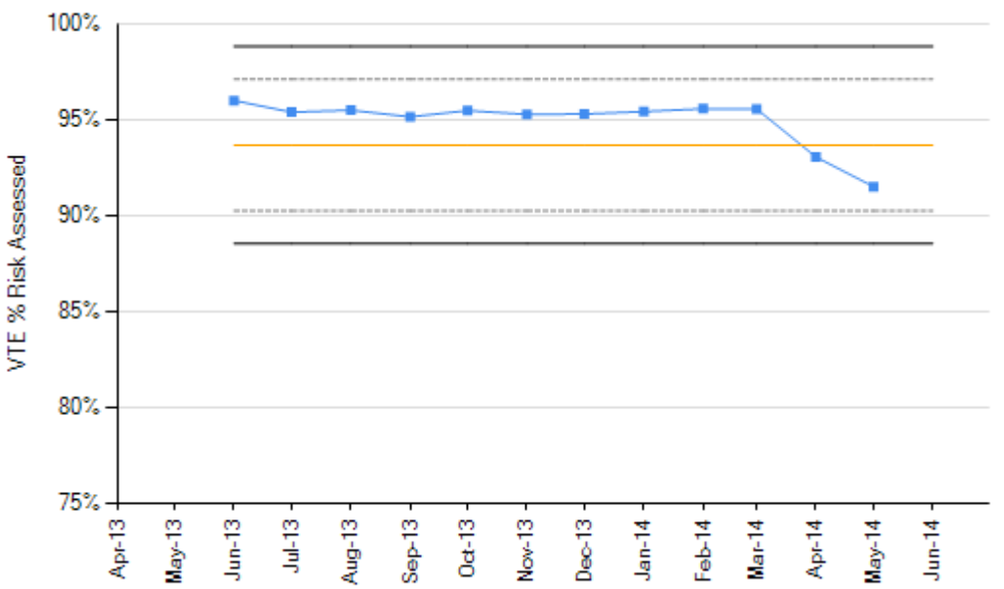
There are other patterns within the data that are likely to reflect real change as opposed to random fluctuation – these patterns are known as special cause variations. They include:

2 consecutive points lying beyond the warning limits (unlikely to occur by chance)
7 or more consecutive points lying on the same side of the mean (implies a change in the mean of the process)
5 or more consecutive points going in the same direction (implies a trend)



Patient Safety **PS01 Safety Thermometer (% patients receiving care free of any newly acquired harm) [one month in arrears]**	**Narrative**
	This deterioration is marginal however a continued lower than expected reporting. To be monitored by the Patient Safety and Clinical Risk Committee, and where necessary further action taken to improve results.

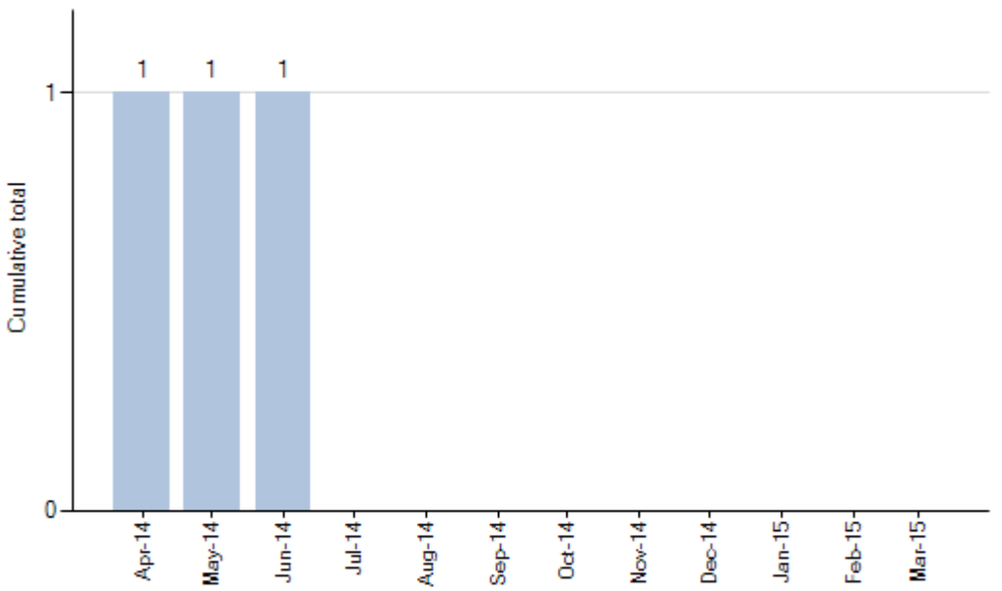
The proportion of patients without any documented evidence of a new pressure ulcer (developed at least 72 hours after admission to this care setting, category II-IV), harm from a fall in care in the last 72 hours, a new urinary infection in patients with urinary catheter (which has developed since admission to this care setting) or new VTE (developed since admission to this organisation). [Owner: A Northover].

Patient Safety **PS03 VTE Risk Assessment (% admitted patients receiving risk assessment)**	**Narrative**
	Deterioration coincides with switching off of assessment functionality within Casenotes system on 09 April. EPR is now the only route for assessment (apart from NOC site where paper is still used).

The chart shows the proportion of inpatients within the Trust risk assessed for VTE (either individually or as part of a cohort). The data point for the most recent calendar month may improve up until submission to NHS England as further cohorted patients are identified following clinical coding. Earlier figures are those submitted to NHS England. [Owner: A Still / I Reckless].

Patient Safety

PS06 Number of cases of MRSA bacteraemia > 48 hours (cumulative year to date)



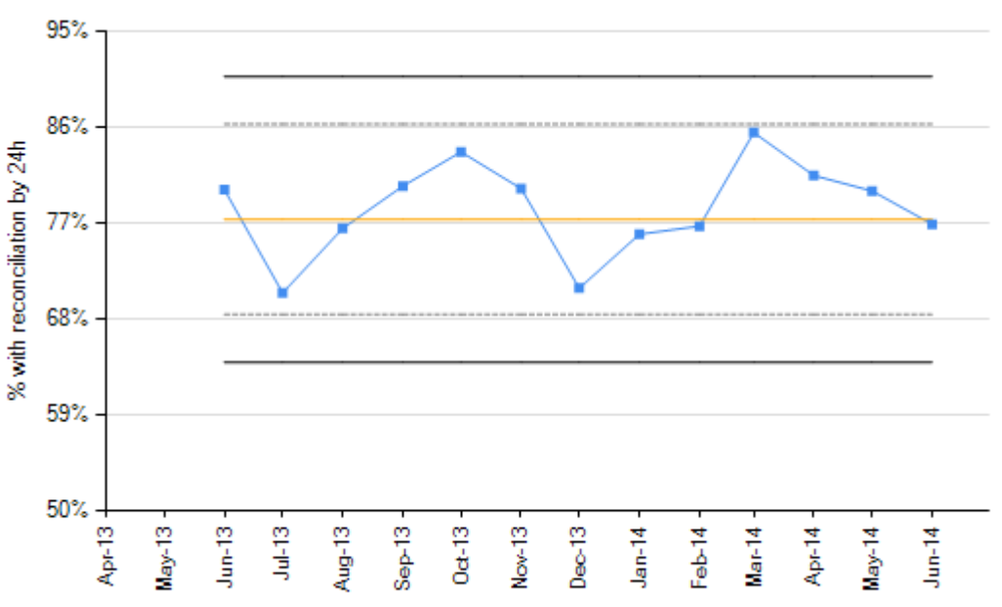
Narrative

One case of MRSA bacteremia was reported during June 2014 and was determined to have been unavoidable.

The chart shows the number of cases of MRSA bacteraemia reported via UNIFY (external IT system). If a case is subsequently removed in following consultation with CCG (for example, attributed to a referring hospital), the figure will be modified in future graphs. [Owner: L O'Connor].

Patient Safety

PS09 % patients receiving stage 2 medicines reconciliation within 24h of admission



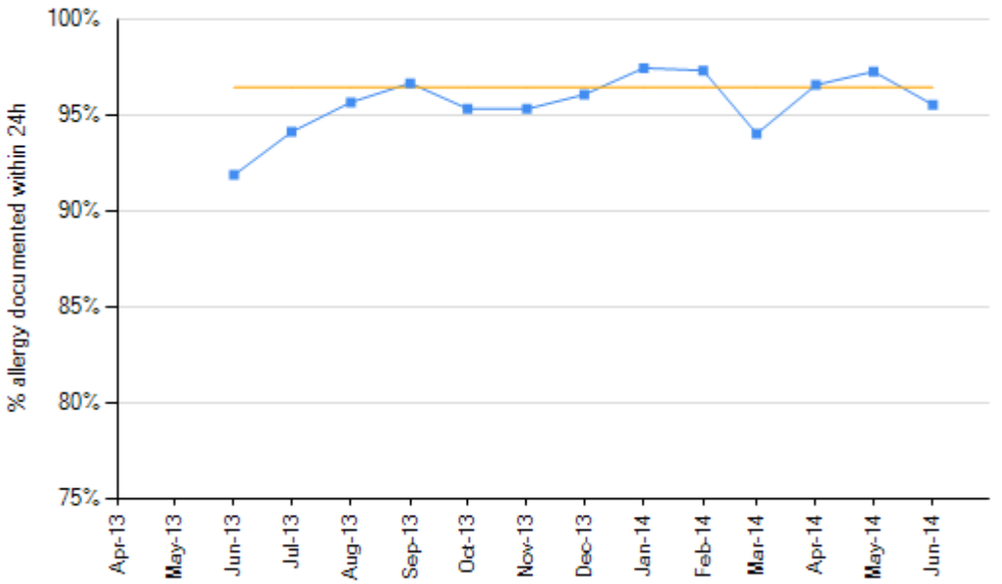
Narrative

Closely monitored through relevant Clinical Governance forums and reported as part of Divisional quality reporting to the Clinical Governance Committee

The chart shows the proportion of inpatients for whom second stage pharmacy-led medicines reconciliation is completed within 24 hours of admission. Spot check audit by pharmacy staff once per month. Approximately 600 patients are included in the audit Trust-wide. Please note that this audit was not performed in May 2013 due to capacity issues in pharmacy. [Owner: P Devenish].

Patient Safety

PS10 % patients receiving allergy reconciliation within 24h of admission



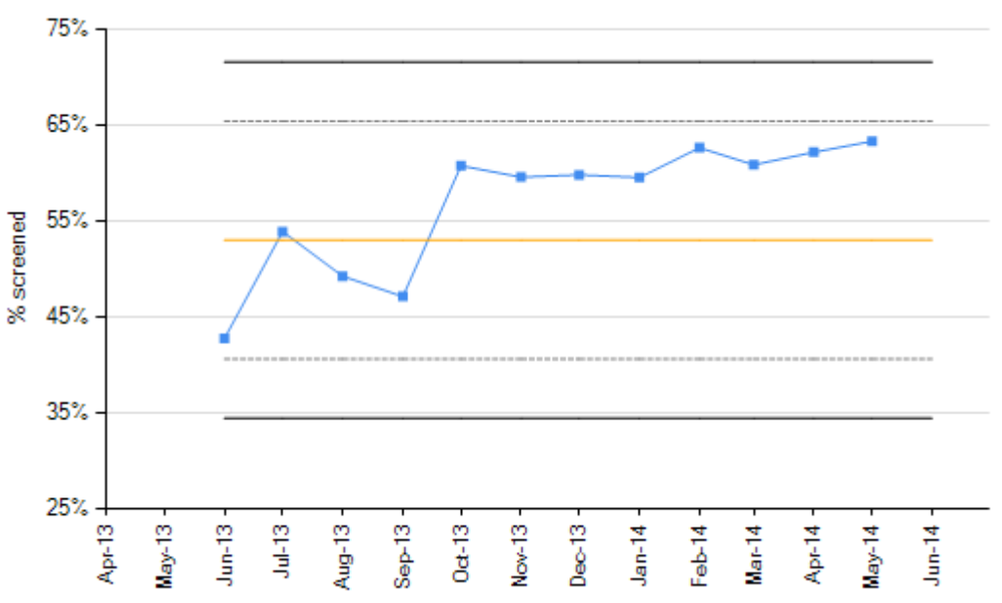
Narrative

Closely monitored through relevant Clinical Governance forums and reported as part of Divisional quality reporting to the Clinical Governance Committee

The chart shows the proportion of inpatients within the Division for whom allergy status has been documented at the time of a spot check audit by pharmacy staff once per month. In August 2012, the criteria changed to allergy status documented prior to pharmacy intervention. Please note that this audit was not performed in May 2013 due to capacity issues in pharmacy. [Owner: P Devenish].

Clinical Effectiveness

CE03 Dementia - % patients aged > 75 admitted as an emergency who are screened [one month in arrears]



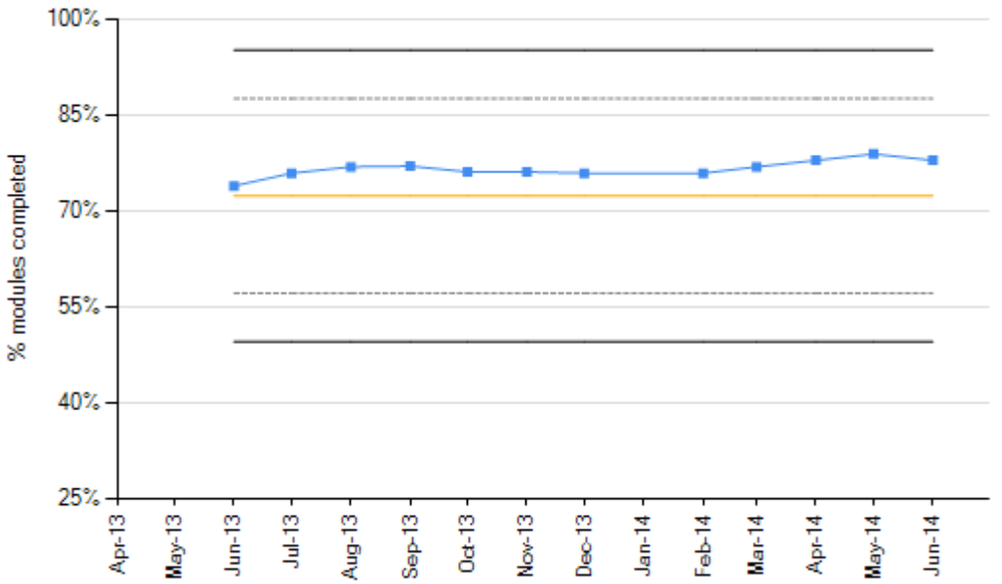
Narrative

Continues as a CQUIN goal into 2014/15. Ongoing changes to IT systems within the Trust have resulted in improved results, an upward trajectory is noted, however further improvements continue in Q1 and Q2 2014/15. Data for end of Q1 not available at time of writing.

Elderly patients admitted on a non-elective basis should be screened for dementia using a screening question and / or a simple cognitive test. Performance shown in this graph reflects figures submitted monthly to NHS England. These figures are derived from both EPR and local paper-based systems.

Clinical Effectiveness

CE04a Statutory and Mandatory Training - % required modules completed

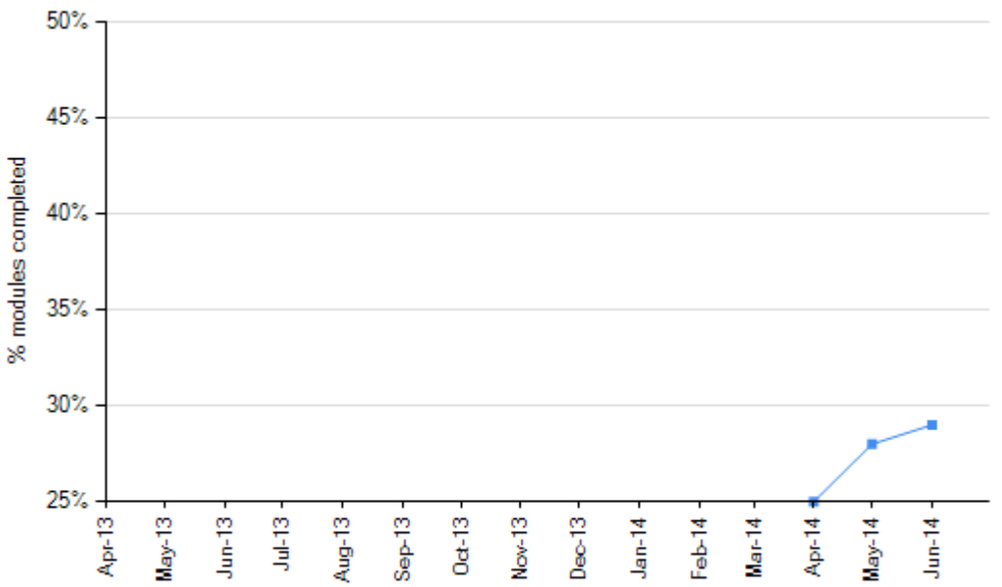


Narrative

This is a relatively new metric reported in this report. The recent external report on the MQF recommended action to improve results

Clinical Effectiveness

CE04b Statutory and Mandatory Training amongst honorary contract holders (% relevant modules completed)



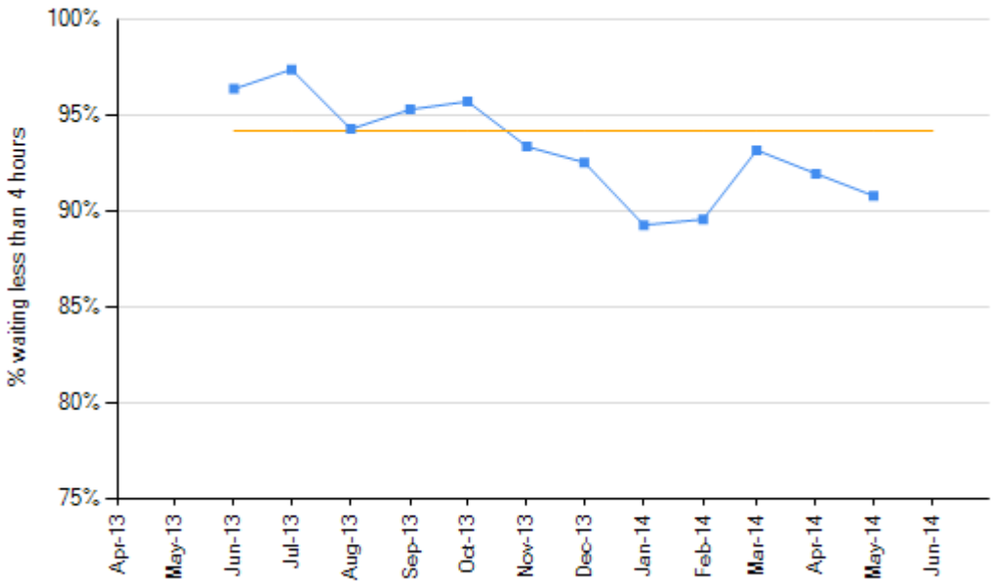
Narrative

This is new indicator, therefore there are no trend data available. The indicator has been developed to provide granularity. Honorary contract holders are not attributed to a Division.

A significant group of honorary contract holders are included within the overall S&M compliance figures for the Trust but not within the figures for any individual Division. Work is underway to review the way in which these data are reported and managed. [Owner: Ian Mackenzie]

Clinical Effectiveness

CE05 ED - % patients seen, assessed and discharged / admitted within 4h of arrival



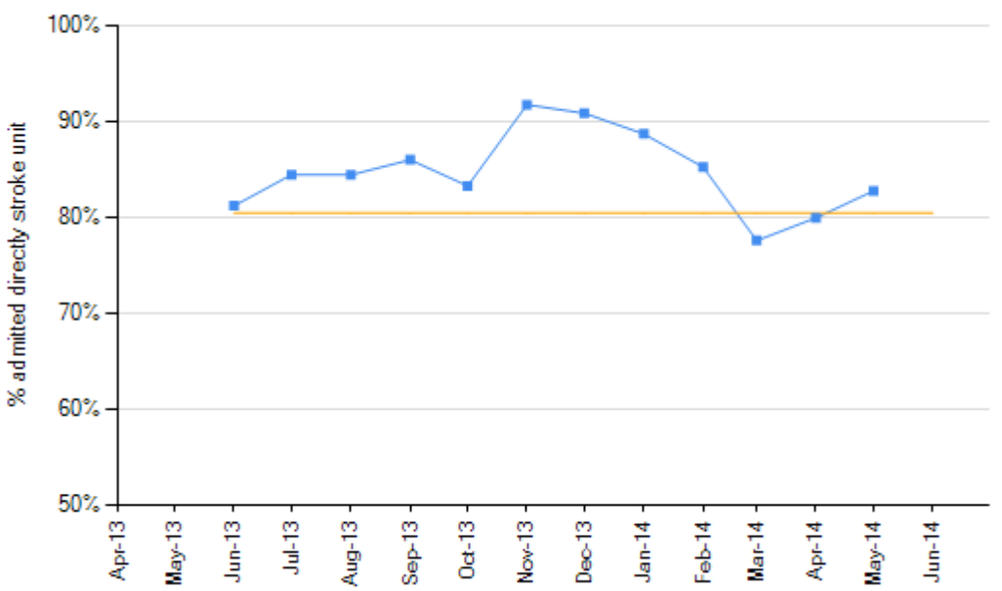
Narrative

Monthly and quarterly results are monitored through Divisional and Directorate performance and Clinical Governance meetings.

% Patients attending ED who are discharged or admitted within 4 hours of arrival. [Owner: EMT]

Clinical Effectiveness

CE07 Stroke - % patients accessing specialist stroke environment within 4h of arrival

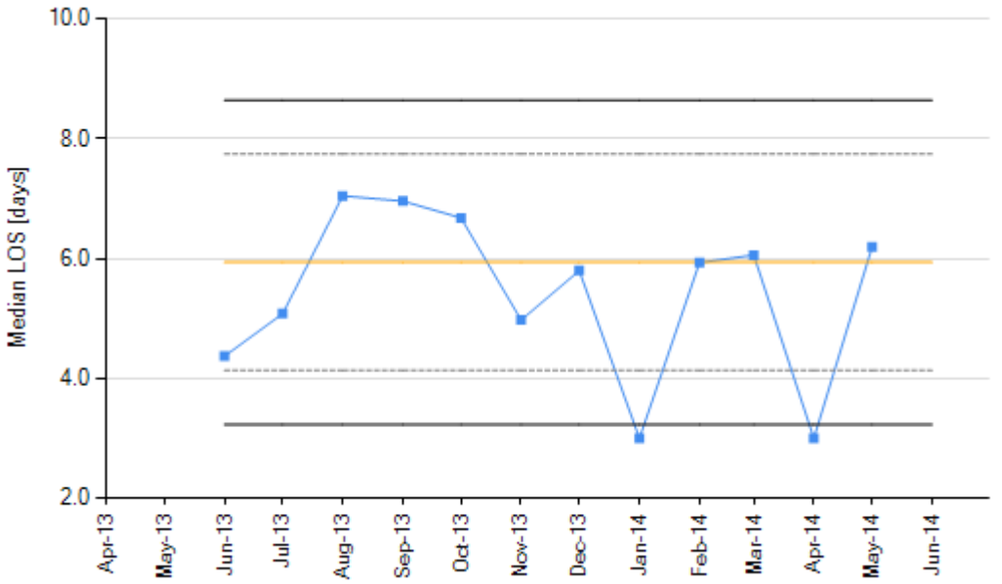


Narrative

No new data for June 2014, a verbal report may be available at the sitting of the Board

Clinical Effectiveness

CE10 Vascular - Mean length of stay for patients undergoing elective AAA repair (3 month rolling period) [NOTSS Division]



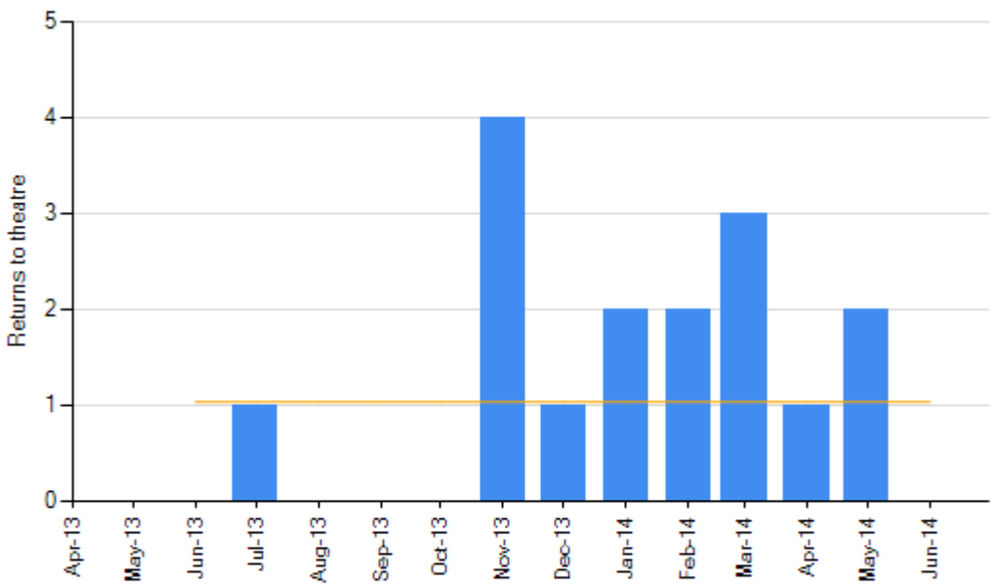
Narrative

No new data for June 2014, a verbal report may be available at the sitting of the Board

Information collected from ORBIT and based on the primary procedure coded and elective admission method.

Clinical Effectiveness

CE16 Number of unscheduled returns to theatre within 48 hours [NOTSS Division]



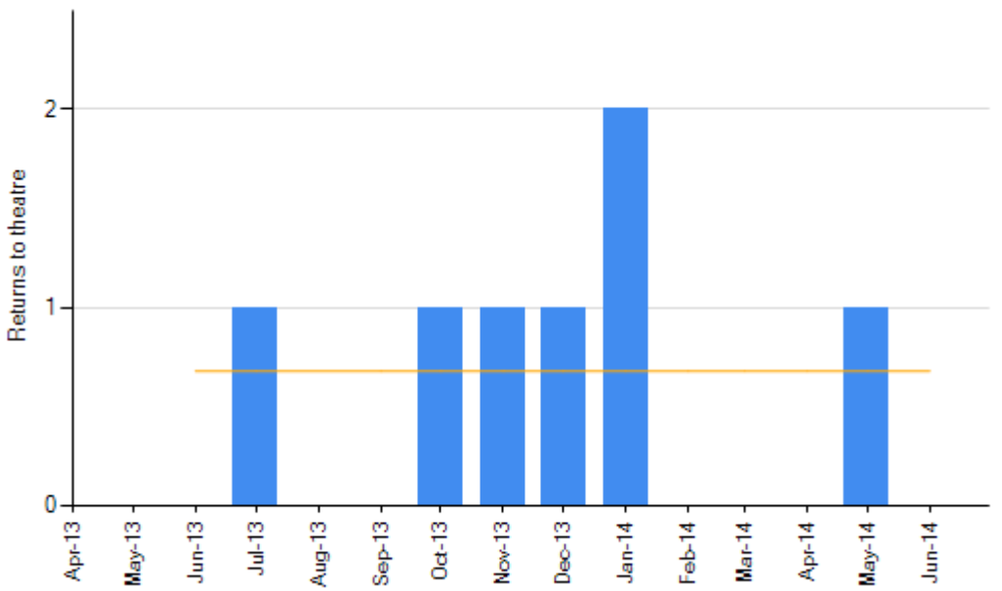
Narrative

No new data for June available at time of writing. A verbal report may be available, however referred to the Directorate Mortality and Morbidity meeting to investigate and report through Divisional reporting processes.

The chart shows the actual number of unplanned returns to theatres within 48 hours per month. All returns to theatres are reported on Datix for the division. The returns within 48 hours are extracted from the system and reviewed as an outcome indicator.

Clinical Effectiveness

CE18 Number of unscheduled returns to theatre in gynaecology [C&W Division]



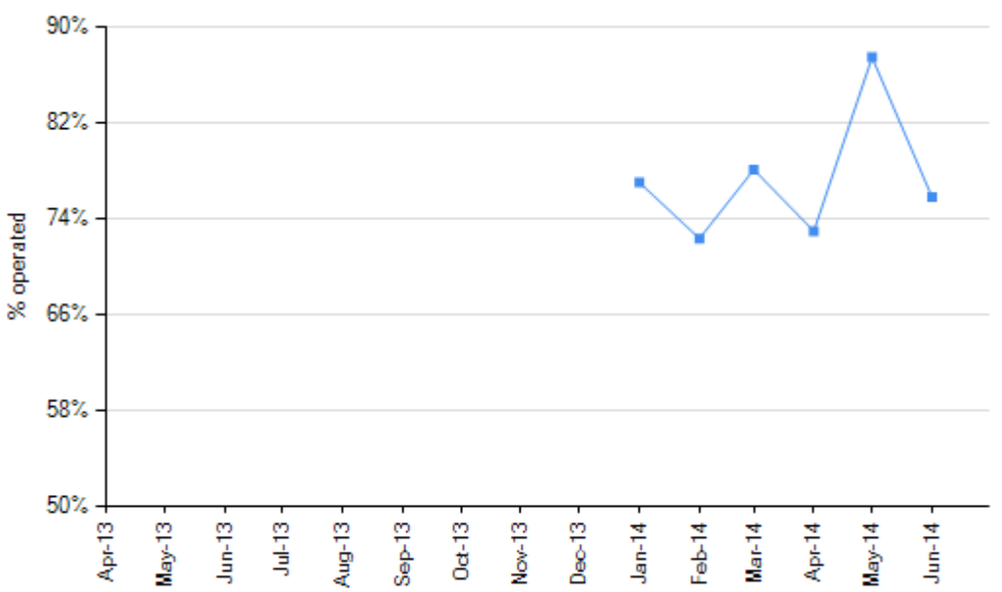
Narrative

No new data available at time of writing, however referred to the Directorate Mortality and Morbidity meeting to investigate and report through Divisional reporting processes.

Currently recorded manually.

Clinical Effectiveness

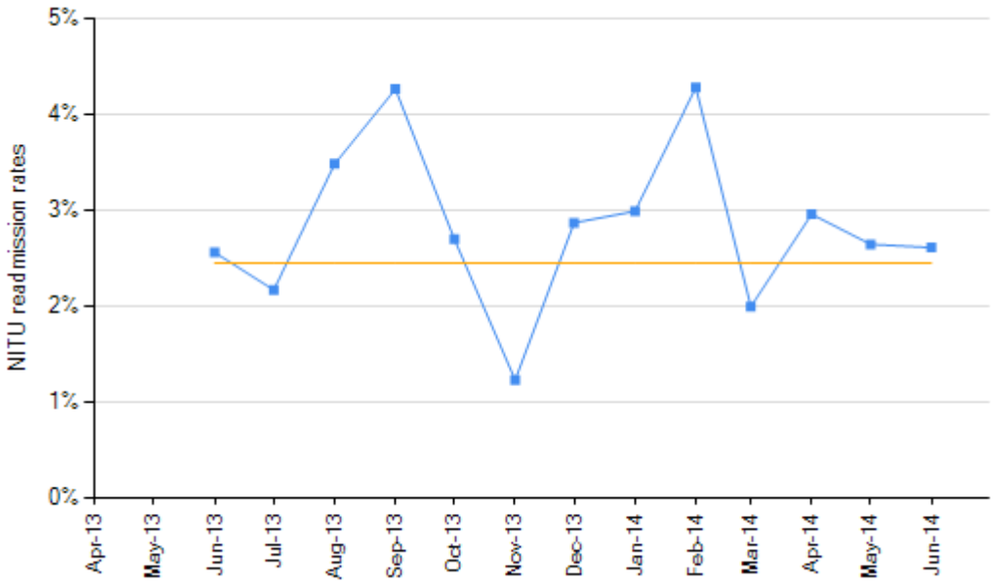
CE20 % patients having their operation within the time specified according to their clinical categorisation [CSS Division]



Narrative

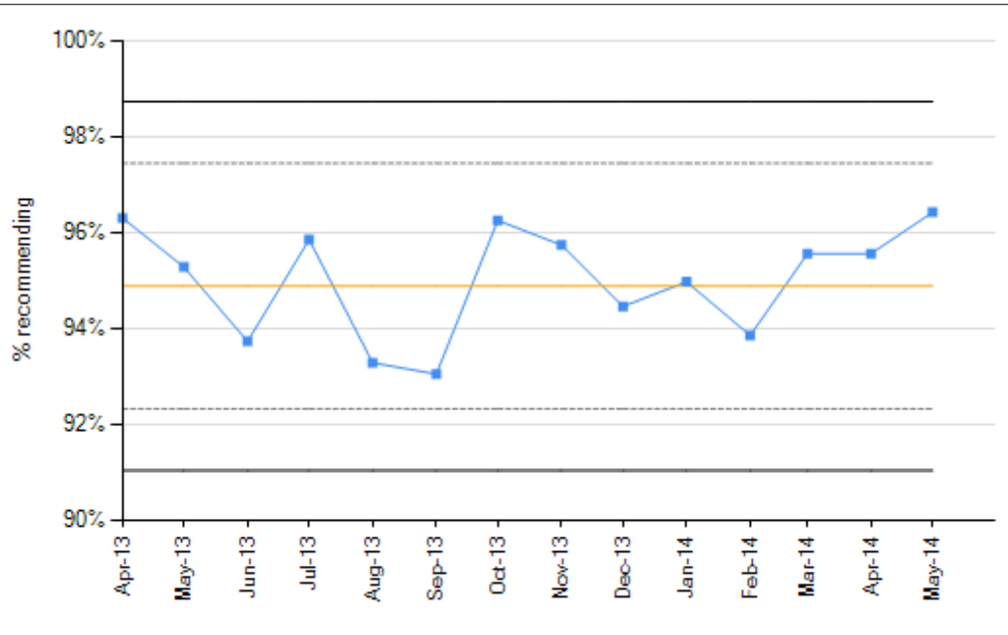
Relatively short collections period of data to date, further review of the base line metric is required.
Further discussions in progress regarding data collection methodology.
Monitored through Clinical Governance and performance reporting processes.

Clinical Effectiveness

CE21 Neuroscience Intensive Therapy Unit (NITU) readmission rate within 48 hours of discharge [NOTSS Division]	Narrative
	To be referred to the Directorate Mortality and Morbidity team to review the relevant cases and report back through Divisional reporting processes

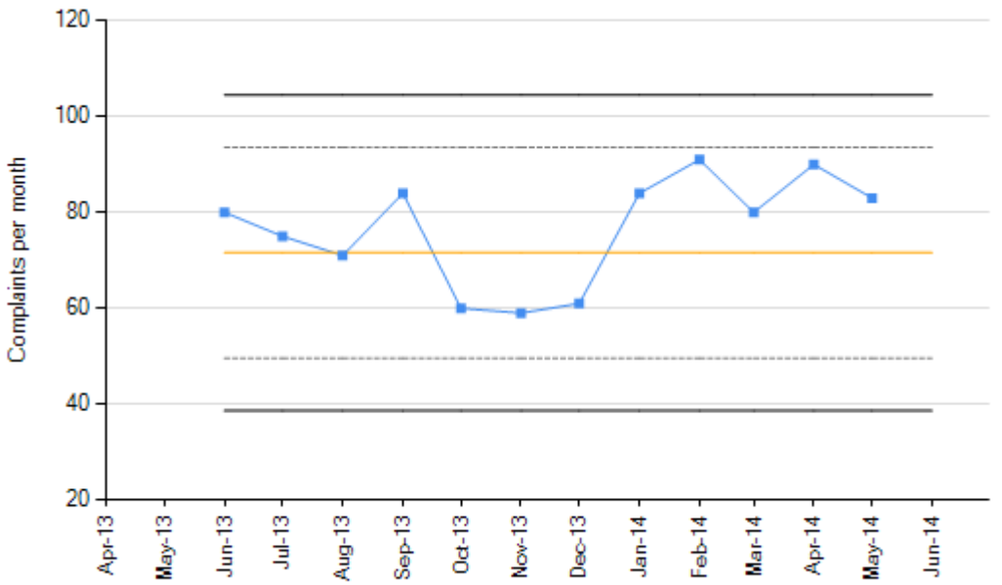
One would not expect patients to be readmitted to NITU following discharge. The measure aims to highlight whether patients are discharged too early. Data collected at local level and presented as number of readmissions against number of discharges.

Patient Experience

PE02 Friends & Family - proportion extremely likely or likely to recommend [one month in arrears]	Narrative
	Further detail of actions taken in response to this result are noted in section 8 of the Board Quality Report. The data present relates to the combined score for inpatient and emergency department only, and excludes maternity services.

Patient Experience

PE03 Complaints Received



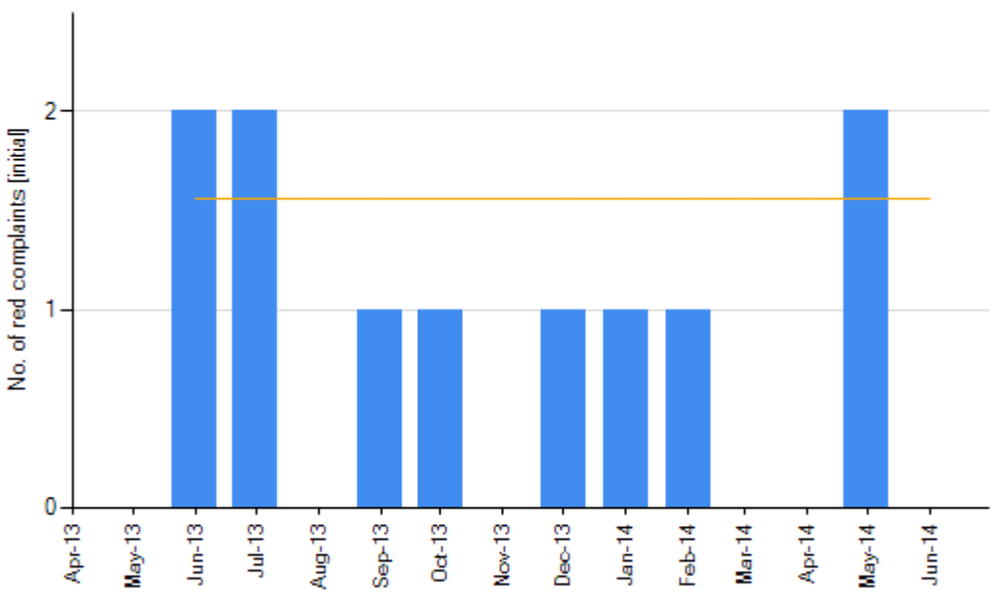
Narrative

No new data available at time of writing. A verbal report may be provided directly to the Board.

The chart shows the number of new complaints received and logged by the corporate complaints department [Owner: K Harris].

Patient Experience

PE04 Number of complaints received initially graded as RED



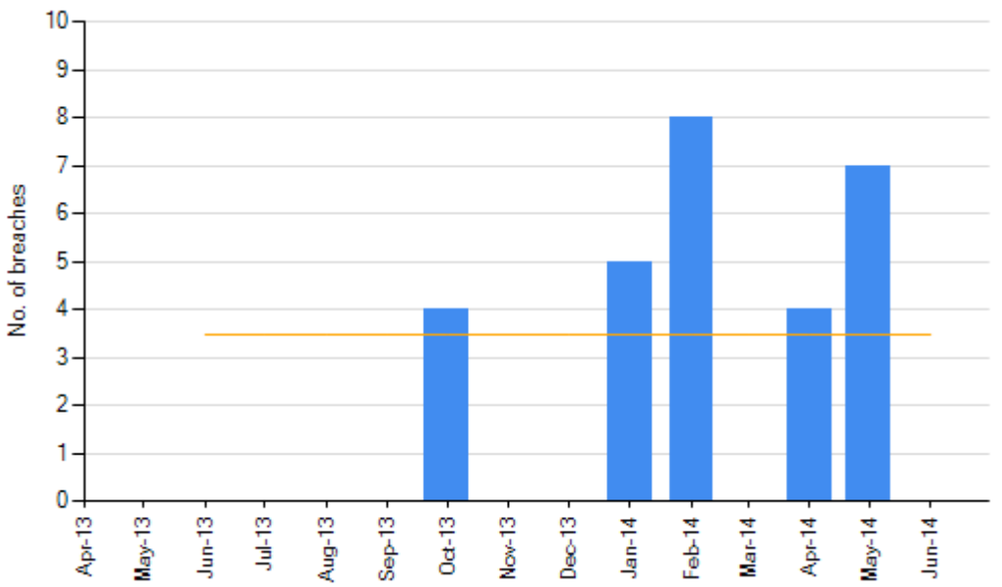
Narrative

No new data available at time of writing, however a verbal report may be provided to the Board.

The chart shows the number of new complaints received and initially rated as 'RED' by the corporate complaints department [Owner: K Harris].

Patient Experience

PE06 Single sex breaches



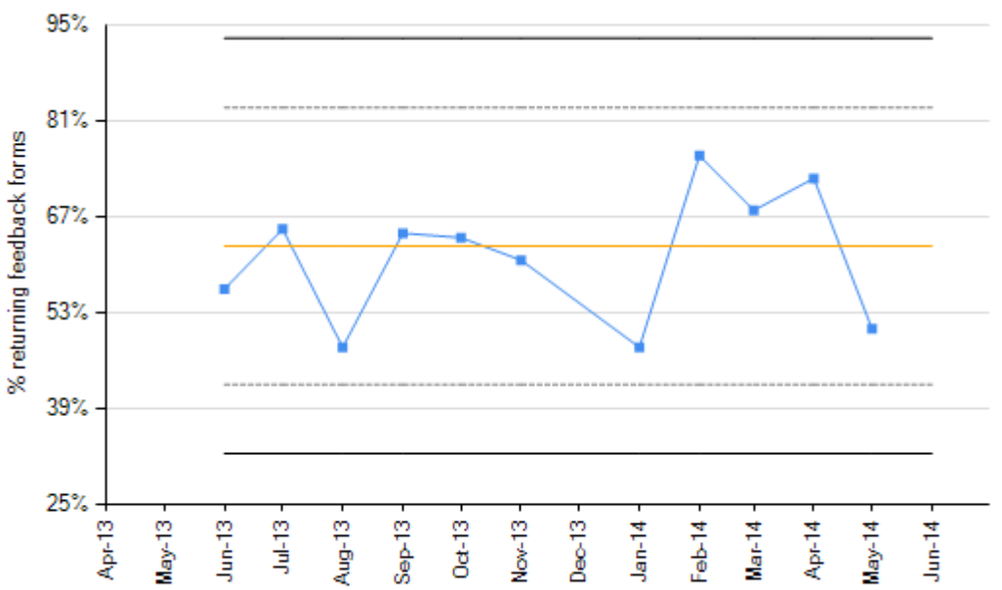
Narrative

Data for June not available at time of reporting. A RCA is in performed on all non-justifiable single sex breaches.
Further efforts are being made to share and clearly articulate the definitions of a clinically justifiable breach more widely in the organization.

The chart shows the number of single sex breaches reported via UNIFY. Those cases judged to be clinically justifiable are not reported here. [Owner: C Heason].

Patient Experience

PE10 % patients returning feedback forms in specialist surgery outpatients [NOTSS Division]



Narrative

No new data available at time of writing, a verbal report may be available to the Board.
Referred for investigation and reporting to the Clinical Governance Committee.

Feedback forms are available to all patients in specialist surgery outpatient departments and patients are encouraged to complete. Data, both positive and negative, are reviewed to identify area of good practice and areas for improvement. Data are collected locally on number of forms completed and returned against total number of outpatients per month.