Kingston Hospital NHS Foundation Trust

Clinical Quality Report
August 2014 (Month 5)

Executive Summary

The Trust Clinical Quality Report provides the Board with an overview of clinical quality. The metrics should be considered in the context of the overall performance of the Trust and in particular to determine if there are any changes in quality that might be due to the productivity programme.

There are areas of improvement in safety KPIs but there remain some concerns regarding quality of care in the Trust in August 2014. Mortality rates are maintained at a low level. The most recent in-hospital SHMI (June 2014) being 49 and the unadjusted mortality for June 2014, 1.0%. The Safety Thermometer harm free care has been improving for the last 5 months and in August stands at 94.62%.

Improvement in falls reduction was not sustained in August 2014, and there was 1 fall associated with moderate harm, a patient fractured their wrist. An internal investigation is taking place. All actions relating to prevention of harm events are continually reinforced. Falls alarms for all bathrooms are in the process of being installed and the new post falls approach (SWARM) continues to be piloted.

There were no grade 3 or 4 pressure ulcers in August, although the number of grade 2 pressure ulcers has increased slightly in month, in part due to two cases associated with endotracheal tube positioning, within the ITU. The rapid review process for grade 2 pressure ulcers is in place to enable the Pressure Ulcer Management Panel (PUMP) to review root causes and put learning into action. Recording and accurate reporting of VTE risk assessment fell below the required 95% performance at 93.9%. The Trust has decided to make this a mandatory field on CRS, at the request of clinicians, which prevents progression onto other steps until this is completed. The Director of IT is working with providers on a time frame for implementation of this request.

The Trust had two cases of C.difficile in August, for which Post Infection Reviews are taking place. This brings the total to 4 year to date which continues to be an improved position from 13/14. Actions to maintain this position continue. There were two E.coli bacteraemias in August 2014, no MRSA or MSSA bacteraemias. Hand hygiene compliance is improving, but remains below the 95% threshold . Actions are in place in areas with lower performance and a 'hand hygenius' campaign is currently being run by the infection control nurses to provide a greater degree of focus on hand hygiene compliance.

Response rates to complaints in a timely manner has reduced slightly in August 2014, and remains below the threshold set. Actions continue to take place at service line level to meet the requirement. The trial of telephone contact by specific service lines, has been approved by the Complaints Committee to be rolled out to all areas of the Trust. The number of complaints to the Trust fell in August 2014 was similar to that for previous months and there were no complaints referred to the Ombudsman.

The exception report provides a breakdown of FFT score by ward for August 2014. The Inpatient FFT has improved to 62 in August, and is the highest score this year. A&E FFT scores have held an improved position following a reduction from March - June 2014. Maternity scores have also improved following a reduction in July 2014. The ‘you said, we did’ campaign is now in place accross the Trust. The exception report shows that the performance does vary significantly between wards. We are continuing to provide the option to complete the FFT on a tablet computer or paper survey, in inpatient areas.

The percentatge of women with a primary postpartum haemorrhage of 2000ml or more has been higher than threshold for the last two months, although has reduced in August. The cases are all being reviewed and no specific trends identified to date. A joint study day is being run in October 2014 for maternity, with transfusion services to ensure shared learning.

The safe nursing & midwifery staffing information in August shows a slight reduction in daytime and night time qualified nurse fill rate which is indicative of the vacancy position and availability of temporary staffing during the peak holiday month of August. Corresponding increases in nursing/maternity assistant provision off set this reduction. This figure is expected to improve during September & October as the large number of new registered nurses & midwives commence work within the Trust.

Clinical Quality Dashboard - August 14

	Strategic objective	KPI description	Exec Owner	Reported in	Target	Actual 2013-14	Jun-14	Jul-14	Aug-14	2014-15 Q1	2014-15 Q2	YTD	Qtr Trend	Month Trend	Forecast	Comments
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	DB	Board - CPR, CQIC	<=1	13	1	0	0	3	0	3	↓	→		Target set as 10% reduction on 2013/14 outturn. Target is to have =<14.4 cases in 2014/15
	1	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	DB	CQIC	<=0.06	0.1	0.10	0.00	0.00	0.09	0.00	0.06	↓	→		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2)	DB	Board - CPR, CQIC	<=3	53	7	3	4	18	7	25	↓	↑		Corporate objectives set target as reduction of 10% on 2013/14 Outturn but this would be higher than the 2013/14 target so keeping 2013/14 target.
	1	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	DB	CQIC	<=0.5	0.4	0.68	0.29	0.4	0.56	0.33	0.47	↓	↑		
	1*	Number of Patient Safety Incident (PSI) Falls	JW	CQIC	<=51	770	65	64	69	173	133	306	↓	↑		Benchmark against Trust performance - 20% reduction on year end rate
	1*	Number of Patient Safety Incident Falls where moderate or severe harm occurred	JW	CQIC	<=14	7	1	1	1	5	2	7	↓	→		Target is a reduction of 15% on last year's outturn
	1*	Number of Patient Safety Incident Falls per 1000 G&A beddays	JW	Board - CPR, CQIC	<=4.7	5.9	6.4	6.1	6.6	5.4	6.3	5.8	↑	↑		Benchmark against Trust performance - 20% reduction on year end rate
	1*	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	Board - CPR, CQIC	<1	4	0	0	0	0	0	0	→	→		Target is zero tolerance as per national guidance and contract
	1*	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	DB	Board - CPR, CQIC	<=2	22	0	0	2	2	2	4	→	↑		Target set by NHS England. Full year target is <= 24 cases. This has been profiled evenly over the year.
	1*	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	CQIC	<=1	14	1	0	0	1	0	1	↓	→		
	1*	E.coli Bloodstream Infections (Hospital Acquired)	DB	CQIC	<=2	24	2	3	2	7	5	12	↓	↓		
	1	Nutrition - compliance with MUST assessment	DB	CQIC	>=85%	91.7%				86.0%		86.0%				Data is collected bi-annually as part of nutrition audit.
	1	Completed Patient Observations	DB	CQIC	>=97%	94.9%	93.9%	96.9%	96.1%		96.4%	95.8%	↑	↓		Collection method of this data is changing to NEWS .
	1	Medication Incidents	JW	CQIC		633	65	59	68	185	127	312	↓	↑		No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
	1	% of Medication Incidents Where Moderate or Severe Harm Occurred	JW	CQIC	<=4%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%	→	→		
	1	Number of Serious Untoward Incidents	JW	CQIC		45	5	5	3	12	8	20	↓	↓		No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
	1	Number of Never Events	JW	CQIC	0	2	0	1	0	0	1	1	↑	↓		
	1	Patient Safety Thermometer - % Harm Free Care	DB	CQIC		91.7%	92.42%	92.56%	94.62%	91.5%	93.6%	92.3%	↑	↑		
Effectiveness	1	SHMI	JW	Board - CPR, CQIC	<=95	92.8				94.3	93.2		↓			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. The score for the previous year is for the period Jul 12 to Jun 13 as published by the Information Centre in Jan 2014. Q2 score is for Jan 2013 to Dec 2013 as published by the Information Centre in April 2014 (latest available data)
	1	SHMI (In hospital Mortality)	JW	CQIC	<=73	55	49			50		50				Data from CHKS and reported in arrears.
	1	Unadjusted Mortality Rate	JW			1.2%	1.0%			1.1%		1.1%				
		% Emergency Readmissions following elective admission - 30 days	ST	CQIC		2.0%	1.5%	1.6%	2.5%	1.7%	4.2%	1.9%	↑	↑		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following emergency admission - 30 days	ST	CQIC		11.4%	12.7%	12.5%	14.2%	13.6%	13.3%	13.5%	↓	↑		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following all admissions - 30 days	ST	Board - CPR	<= 5.7%	5.5%	4.8%			5.0%		5.0%		↑		Data reported from CHKS and therefore in arrears. Target based on national peer upper quartile from CHKS.
	1	Prevention of hospital acquired VTE - % patients risk assessed	JW	CQIC	>=95%	86.6%	90.2%	95.0%	93.9%	90.6%	94.4%	92.1%	↑	↓		Target is national CQUIN.
	1	Hand Hygiene	DB	CQIC	>=95%	94.2%	94.9%	90.6%	93.9%	94.6%	92.4%	93.8%	↓	↑		Target is locally set.
	1	% of patients with a fractured neck of femur that went to theatre within 24 hours for repair of the fractured femur	JW	CQIC	>=70.0%	84.0%	83.9%			90.5%		90.5%		↓		Data from CHKS and will be reported 3 months in arrears.
	1	Open Incidents - % of Managers Reports Completed within 10 days	ST	CQIC		Not Available	52.5%	53.0%						↑		

Clinical Quality Dashboard - August 14

	Strategic objective	KPI description	Exec Owner	Reported in	Target	Actual 2013-14	Jun-14	Jul-14	Aug-14	2014-15 Q1	2014-15 Q2	YTD	Qtr Trend	Month Trend	Forecast	Comments
Patient Experience	1	Number of Complaints received this month	DB	CQIC		403	39	47	25	129	72	201	↓	↓		
	1	Number of Complaints reopened this month	ST	CQIC		59	8	6	7	18	13	31	↓	↑		
	1	Number of Complaints referred to ombudsman this month	ST	CQIC		6	0	0	0	0	0	0	→	→		
	1	% Complaints responded to within 25 working days	ST	CQIC	>=90%	67.6%	71.8%	68.1%		65.1%	68.1%	65.9%	↑	↓		Data reported 1 month in arrears
	1	Friends and Family Score - Trust	DB	CQIC		63	58	60	62	56	60	57	↑	↑		
	1	Friends and Family Score - Adult Inpatient	DB	CQIC	78	60	54	59	62	57	59	59	↑	↑		The Inpatient Response Rate was 48.7% for August 2014. Please note that Patients with a 0 LOS are currently being included in the Inpatient data. Once this data can be collected separately they will be included in the A&E data. The target for FFT has been based on achieving the current top 25th Percentile score for acute trusts.
	1*	Friends and Family Score - Outpatient	DB	CQIC		71	72	70	72	72	70	72	↓	↑		
	1	Friends and Family Score - A&E	DB	CQIC	68	52	54	59	58	50	59	52	↑	↓		The A&E Response Rate was 17.8% for August 2014. The target for FFT has been based on achieving the current top 25th Percentile score for acute trusts.
	1	Friends and Family Score - Maternity	DB	CQIC		63	64	48	68	66	48	66	↓	↑		The overall score has been collated from responses to the 4 maternity touchpoints. This covers the patients experience of antenatal, delivery and postnatal wards/community care.
	1	Friends and Family Score - Paediatric Inpatient	DB	CQIC		79	70	76	69	67	76	65	↑	↓		Includes scores from Sunshine Ward, Dolphin Ward and Neonates
	1	Number of Mixed Sex accommodation breaches	ST	CQIC	0	0	0	0	0	0	0	0	→	→		This is based on a national directive.
Safer Staffing	1	Day - Registered Midwives/Nurses Fill Rate	DB	CQIC			98.7%	96.1%	94.1%	97.5%	95.1%	96.3%	↓	↓		This is a new dataset.
	1	Day - Assistant Fill Rate	DB	CQIC			103.4%	109.5%	110.7%	104.9%	110.1%	107.6%	↑	↑		
	1	Night - Registered Midwives/Nurses Fill Rate	DB	CQIC			97.8%	97.6%	97.4%	98.3%	97.5%	97.9%	↓	↓		
	1	Night - Assistant Fill Rate	DB	CQIC			110.5%	116.8%	124.2%	108.4%	120.5%	114.4%	↑	↑		
	1	Overall Trust Fill Rate	DB	CQIC			100.4%	101.0%	101.0%	100.1%	101.0%	100.6%	↑	↑		
Maternity	1	Caesarean section rate	JW	CQIC	<=26%	27.5%	26.8%	26.9%	26.7%	29.5%	26.8%	29.5%	↓	↓		
	1	% women with a primary postpartum haemorrhage of 2000ml or more	JW	CQIC	<=1.0%	1.5%	0.8%	1.5%	1.1%	0.9%	1.3%	1.0%	↑	↓		
	1	Significant Perineal Trauma	JW	CQIC		3.3%	3.0%	2.9%	3.4%	3.1%	2.7%	3.1%	↓	↑		Data reported 1 month in arrears as requires coding to be completed
	1	Perinatal Mortality Rate per 1000 births	JW	CQIC	<=3.7	2.1				6.8		6.8				Data from CHKS. Target is National Peer rate from CHKS Data will be reported quarterly.
	1	Number of Red Maternity Escalations	JW	CQIC	0	0.0%	0	0	0	0	0	0	→	→		

Key: 1* Quality Account Objective

Qualitative Summary - August 2014

Clinical Audit

Prescribing of medicines is a task usually undertaken by doctors, although this was widened to include specific nursing and pharmacy staff around 20 years ago. At Kingston Hospital, a limited number of nurses and pharmacists are able to prescribe medicines and they should do this in accordance with the Kingston Hospital Non-Medical Prescribing Policy.

An audit has been carried out to ensure compliance with this policy. The audit reviewed the competency of the nurse/pharmacist to prescribe and reviewed in detail 179 prescriptions. The standards set for the audit – evidence of continuing professional development with regard to non-medical prescribing, prescribing within the scope of practice statement and signing the prescription – were all met. A small number of actions were nonetheless agreed to ensure future compliance, including updating the policy and ensuring that the non-medical prescribers 'list' is held by the Pharmacy Department. A re-audit will take place in 2015.

Complaints

The Trust received 25 formal complaints in August 2014 compared to 33 in August 2013. Emergency Services received the highest amount of complaints accounting for 60% of the total, followed by Specialist Services (28%), Clinical Support Services (8%) and Trust (4%). The most frequent complaint subject within the complaints that were received, related to appointments which accounted for 28%, followed by communication (24%) and care and treatment (16%) of the total.

Reopened Complaints

7 complaints were reopened in August 2014, arising from complaints first received in January 2014 (1), May 2014 (1), June 2014 (2), and July 2014 (3).

The reasons for these complaints reopening were:
Facts Challenged – 4
Further Questions – 2
Issues not responded to adequately - 1

Ombudsman Referrals

There were 2 complaints referred to the Ombudsman in August 2014.

Staff Award Winners

July - Dhilson Davis for the value of Responsible.

Dhilson was given the award for shouldering the burden of producing two sets of accounts: one for April 2013 as an NHS Trust, and one for May 2013-March 2014 as a Foundation Trust. He worked tirelessly, into the evenings and at weekends, to ensure the Hospital met the requirements of the Auditors and the deadlines for submission of the Accounts to Monitor and the Department of Health, safeguarding the Hospital's reputation.

August - Angela Buckell for the value of Responsible

Angela was nominated by two colleagues for her invaluable support and behind the scenes work on the CRS e-prescribing and clinical documentation project. Angela has a positive can-do attitude, doing her best to meet the many demands placed on her by the changing needs of the CRS project and the need to provide new staff induction training often at short notice. She worked additional hours, including weekends, whilst continuing with all the other aspects of her role always with a smile and cheerful attitude.

August - Diane Taboada for the value of Responsible

Diane was given the award for successfully launching CRS clinical records and e-prescribing on Bronte Ward in the same week that they had a pre CQC peer review and two national peer reviews for Chemotherapy and Haematology. During this time, Diane also managed to continue to meet the daily demands of a ward sister and remained positive throughout. She is an excellent role model for her staff, who have embraced the changes as a result of her positivity.

Clinical Quality Report **Author: Lisa Cheek**

Exception Report 1: Pressure Ulcer Stage 2

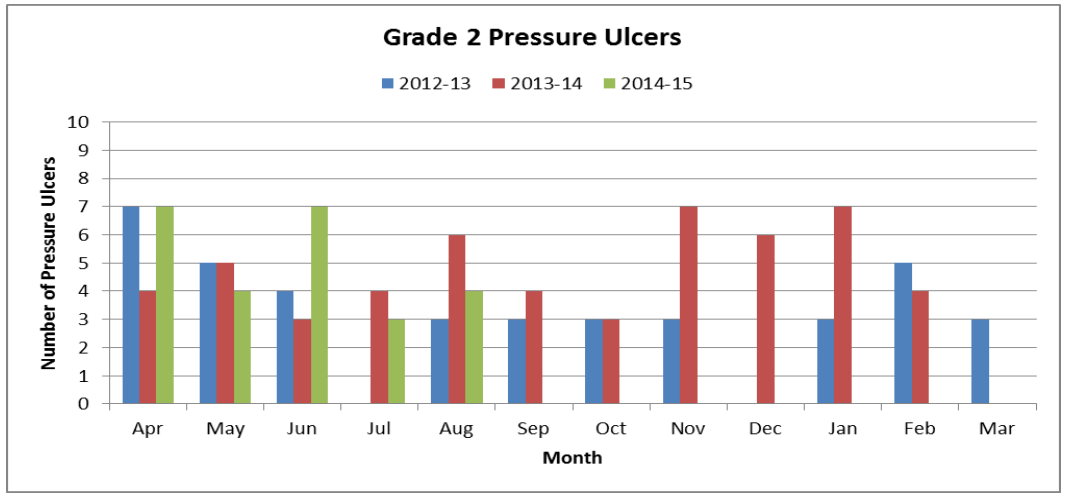
In August 2014, a total of 4 patients were reported as having developed Trust acquired stage 2 pressure ulcers (1 x Hamble Ward, 1 x Keats Ward and 2 x ITU). Senior Sister from Keats Ward and Matron from ITU presented their stage 2 checklist investigations at the Pressure Ulcer Management Panel meeting. Investigation from Keats Ward identified that this patient appeared to develop the pressure ulcer on the day before her discharge. Patient had been an inpatient for several weeks. All repositioning charts and care plans had been completed however there had been delays in the Waterlow and MUST assessments on admission.The panel found the decision around whether this was an avoidable or unavoidable pressure ulcer a difficult one as it appeared that significant measures had been put in place. However in light of the delay in Waterlow and MUST assesments, the panel deemed this pressure ulcer avoidable.

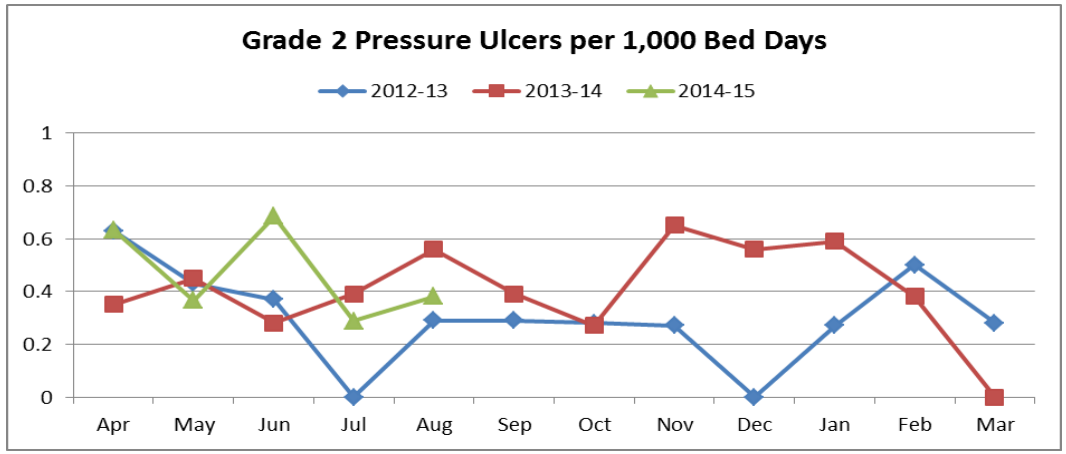
Investigations from ITU identified that both patients sustained device related pressure ulcers from endotracheal (ET) tapes. Investigation showed a failure to recognise that the tapes were too tight and/or the tubes were not being appropriately repositioned. Both patients were shown to be extremely high risk with significant numbers of underlying comorbidities. An action plan has been developed by the ITU Matron to aim to eliminate the development of avoidable pressure ulcers from the mouth as a result of ET tapes. This will be presented at the next PUMP meeting.

Hamble Ward have yet to present. Presentation due at next PUMP meeting.

A meeting has taken place between the Trust and Your Healthcare Kingston. Agreement was made to work towards a joint working approach to reduce the development of avoidable pressure ulcers across the health economy. The group will meet again in November to discuss strategies to reduce risk.

Work is taking place to develop a Tissue Viability web page providing information regarding the tissue viability service as well as how to access specialist advice. As part of this, the pressure ulcer patient information leaflet will be updated to give information specifically regarding pressure area management.





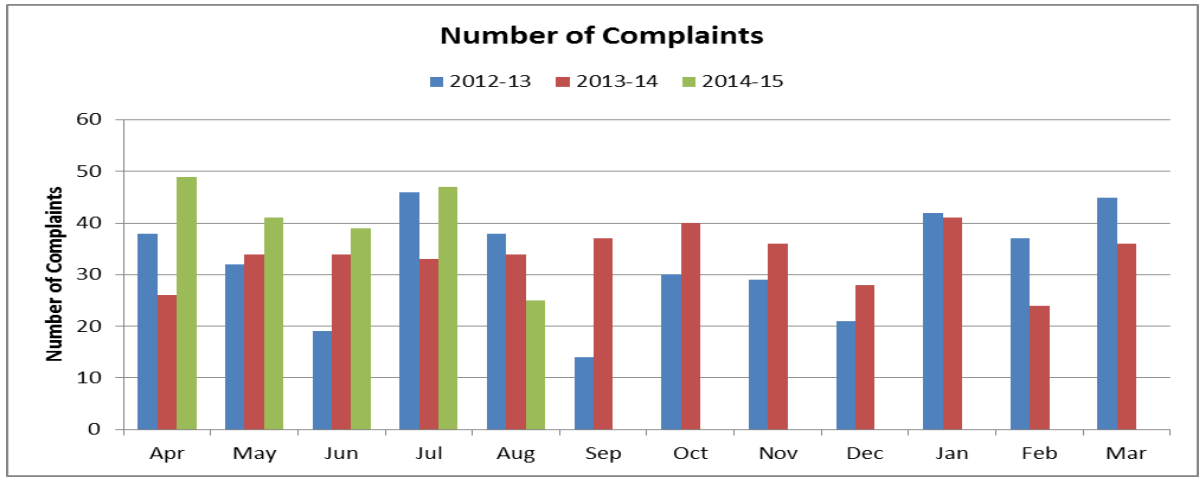
	Person Responsible	Date	Committee monitoring delivery
1. Retraining and checking staff awareness of the management of skin around ET tubes	Matron ITU	End Sept 2014	Service line governance meeting
2. Develop a criteria for the use of Anchorfast and soft tapes for ET tubes	Matron ITU	End Sept 2014	Service line governance meeting
3. • Review and revise mouth care competency	Matron ITU	End Sept 2014	Service line governance meeting
4. Trial soft ET tie	Matron ITU	Mid Oct 2014	Service line governance meeting

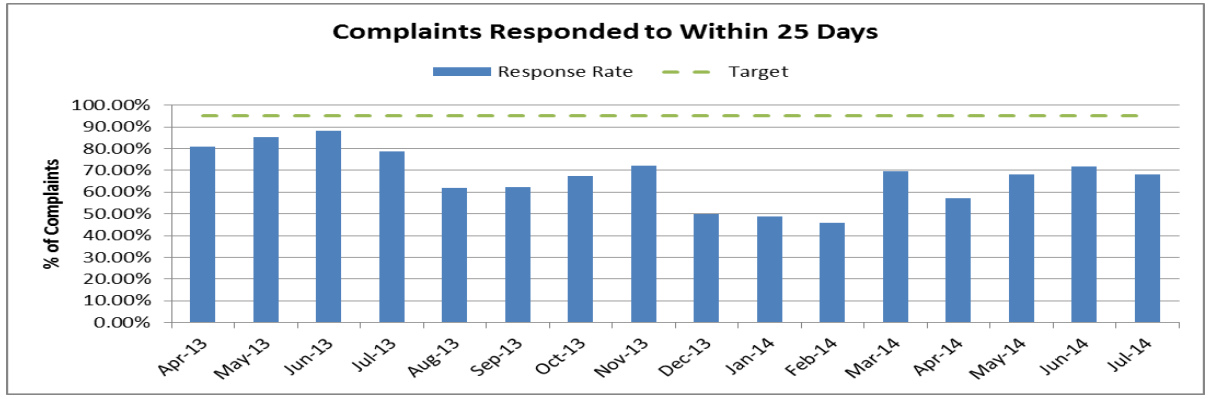
Clinical Quality Report **Author: Clare Parker**

Exception Report 2: Complaints responded to within 25 working days

The response rate in July 2014 was 68.1%, which remains below the 80% target. Service Lines receive weekly reminders of all open complaints and the Deputy Chief Executive discusses overdue complaints at weekly meetings with the Associate Directors.

Following the pilot of early telephone contact by senior members of the service line over the past 3 months, it was agreed by the Complaints Committee in September 2014 that this would now be rolled out to all complainants. This means all complainants would be telephoned by the service line to acknowledge receipt of the complaint within 3 days of receiving the complaint in the service line. This is to ensure all issues are included in the complaint response letter, agree a response date for complex complaints, and to resolve complaints immediately if possible. This will be rolled out during September & October and the complaints policy amended to reflect this. The Complaints team will speak to each SLM to advise of this new process and to provide the support necessary.





	Person Responsible	Date	Committee monitoring delivery
1. Twice weekly review of complaints list in Emergency Care	Associate Directors	On-going	Executive Management Committee
2. Escalation of delays in receiving statements to relevant manager.	Associate Directors	On-going	Executive Management Committee
3. Roll out of new complaints process to all service lines	Head of Complaints, Claims & Litigation	01/11/2014	Executive Management Committee
4. Implement changes to the complaints policy	Head of Complaints, Claims & Litigation	30/11/2014	Executive Management Committee

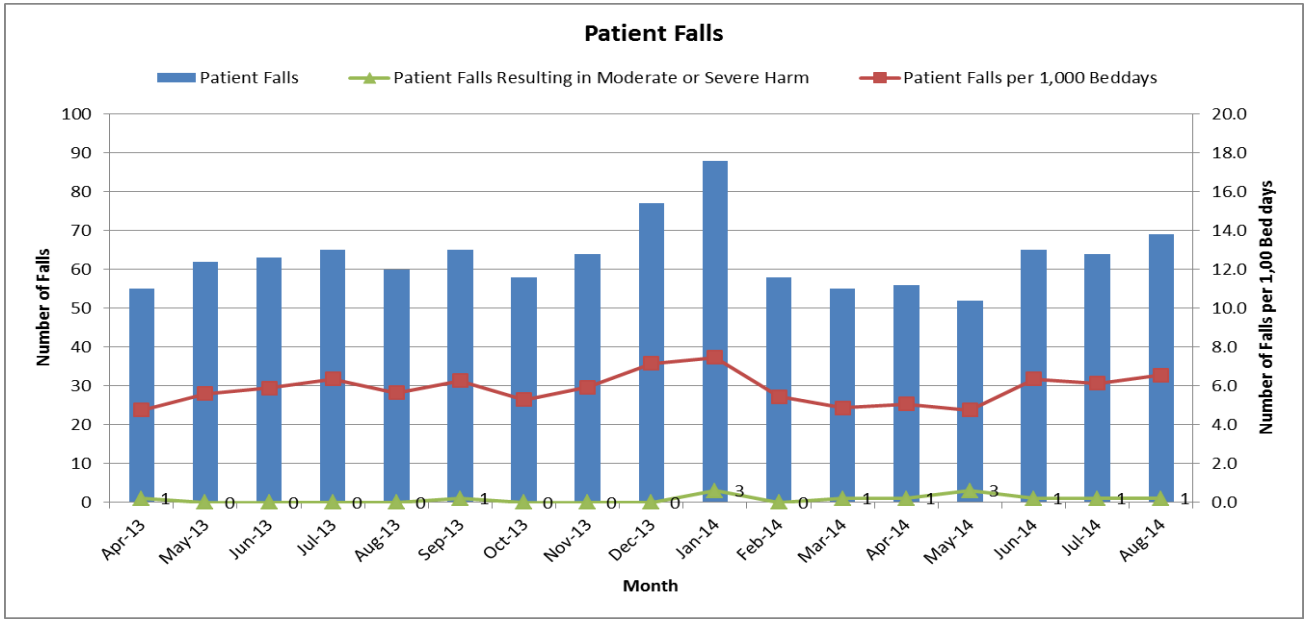
Clinical Quality Report **Author: Fergus Keegan**

Exception Report 3: Patient Safety Incident Falls

The falls rate for August is 6.6 falls per 1,000 bed days. This is a higher figure than in the previous month. The highest number of falls for July were on AAU (13 falls). Eight falls in August are from patients who have fallen more than once. There was one fall with harm resulting in a fractured wrist, which is subject to an internal investigation.

The installation of falls alarms in bathrooms will be completed by end of September as the brackets are all now in place ready to be populated with the alarms that have been purchased. The installation of replacement toilet seats and signage has been delayed whilst an affordable solution and source of funding is identified (initial costs prohibitively high).

A further NHS Quest day bringing together the falls clinical communities has taken place, which was attended by Kingston Hospital. Following a review at this the SWARM pilot is to continue on the two pilot wards until further embedded. A proposal for a PRE SWARM model to review interventions in place for at risk patients is being worked up by Kingston Hospital as part of the NHS Quest work stream.



Actions	Person Responsible	Date	Committee monitoring delivery
1. Continue implementation of actions arising through Trust Falls Group	Medical Director	Ongoing	Trust Falls Group
2. Extend falls alarm provision for bathrooms to other wards	Chris Simms/Paul Kirkby	30/09/2014	Trust Falls Group
3. Replace signage and toilet seats in bathrooms on medical wards	Medical matrons and ward sisters on medical wards Chris Simms, Estates manager	30/05/2014	Trust Falls Group
4. Extend length of SWARM pilot on Orthopaedic and Kennet Wards for post falls assessment.	Sarah Joseph, Matron	31/10/2014	Trust Falls Group
5. Work up Pre SWARM plans for NHS Quest review	Sarah Joseph, Matron	31/10/2014	Trust Falls Group

Clinical Quality Report **Author: Reinette Nell**

Exception Report 4: Friends and Family Test Inpatient

The inpatient FFT response rate for August 2014 was 50.7%. Our overall inpatient FFT score for August was 62, which is 3 points higher than our score was in July. This is the first time that the Trust has had a response rate of over 50% on the inpatient wards.

It is known that the top scoring Trusts for inpatient wards all use exclusively paper cards for collecting FFT data. We commenced a trial of paper cards in inpatient areas in July 2014 and initially assessed the impact of this on FFT scores in July. We have now undertaken another analysis with the August data. The analysis shows that the paper responses have not had a positive impact in terms of improving our scores. However, the paper responses arguably have made the test more accessible, most notably on elderly care wards. This in turn is helpful in terms of improving our response rate to gain a better understanding of our performance and in terms of how well we are meeting the needs of our patients. A review of our overall survey provision is taking place with an options appraisal going to the Executive Management Committee for review in October 2014.

Individual wards' scores and response rates continue to vary. The response rate target for wards will remain at 40% in line with the National CQUIN. However the target score will be reviewed in the light of the recent advice from NHS England that it is not possible to compare scores between different Trusts.

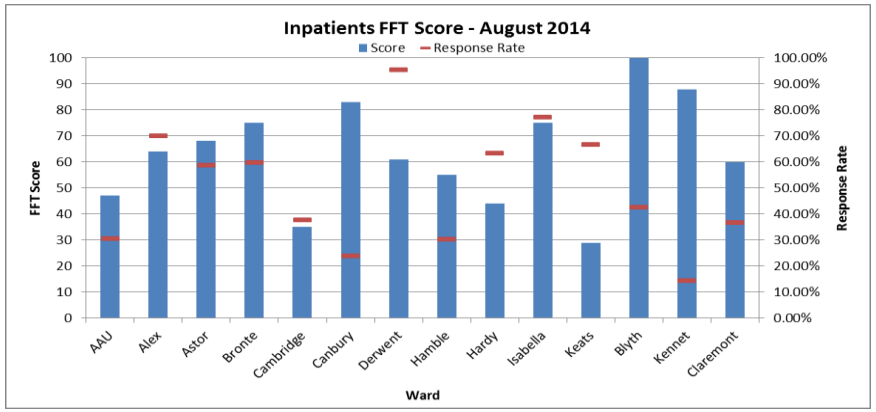
Blyth Ward's score improved by 35 points since July to 100 in August, which means that all 20 respondents said they were extremely likely to recommend the ward. Patients' comments were mostly about cleanliness and kind, cheerful and helpful staff. It would be useful to look into changes on the ward further to understand what has made this difference in terms of patients' experiences.

Derwent Ward's FFT score has improved by 49 points from where it was in July, however there are still comments about some staff being good and others less so. The Deputy Director of Nursing has developed an action plan with Derwent Ward to address areas for improvement and this will continue to be implemented over the course of the next few months.

Keats Ward's score dropped by 14 points since July and the main improvement comments were to do with perceptions of staff numbers, particularly at weekends. However patients generally commented that the existing staff are very good. Those who said they were not likely to recommend Keats said they did not have any particular reason for their answer.

Sisters and charge nurses are continuing to implement local action plans based on the analysis of the FFT each quarter, and this is being reported and monitored via the Patient Experience Committee.

The Trust has approved changes to patient menus in September 2014, so as to improve the food offering to patients following feedback from our Friends and Family Test. The Director of Estates & Facilities is currently negotiating final specifics and implementation timeline.



Actions	Person Responsible	Date	Committee monitoring delivery
1. Consider options appraisal for FFT system provision	Director of Nursing & Patient Experience	30/09/2014	Executive Management Committee
2. Implement Food improvement plan	Director of Estates and Facilities	31/12/2014	Patient Experience Committee
3. Fully implement action plan for improving inpatient experience	Director of Nursing & Patient Experience	31/03/2015	Patient Experience Committee
4. Evaluate the impact of paper surveys on FFT and consider roll out to other areas	Patient Experience Improvement Manager	Complete	Patient Experience Committee
5. Fully implement improvement plan for Derwent Ward	Deputy Director of Nursing	30/10/2014	Patient Experience Committee
6. Set new target FFT score and communicate this to wards	Deputy Director of Nursing for Patient Experience/ Patient Experience Improvement	30/09/2014	Patient Experience Committee
7. Further explore factors improving patient experience on Blyth Ward	Deputy Director of Nursing for Patient Experience/ Patient Experience Improvement	30/09/2014	Patient Experience Committee

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	Feb-13	C diff	2. Complete implementation of t the C. diff action plan in response to the peer review visit.	DB	31/03/2014	
2	Nov-12	C Section	1. Weekly CS meeting & CTG meeting for reflection of practice and learning.	JW	Ongoing	
3	Jan-14	Complaints	1. Weekly monitoring of all service line returns by Associate Directors.	ST	Ongoing	
4	Jan-14	Complaints	3. Escalation of delays in reporting to Divisional directors to performance manage SLMs	ST	Ongoing	
5	Jan-14	Complaints	3. Review pilot for telephoning at the point that the complaint starts	DB	30/09/2014	
6	Oct-13	Falls	1. Continue implementation of actions arising through Trust Falls Group	DB	Ongoing	
7	May-14	Falls	2. Extend falls alarm provision to other wards	DB	30/05/2014	
8	May-14	Falls	4. Replace signage and toilet seats in bathrooms on medical wards	DB	30/05/2014	
9	Jul-14	Falls	5. SWARM pilot on Orthopaedic and Kennet Wards for post falls assessment.	JW	31/08/2014	
10	May-14	A&E FFT	1. Monthly review of A&E FFT comments by relevant senior nursing staff	DB	Ongoing	
11	Jun-14	A&E FFT	5. REU to present at Patient Experience Committee	DB	22/09/2014	
12	Dec-13	Inpatient FFT	3. Complete review of inpatient meals	DB	30/06/2014	
13	Jun-14	Inpatient FFT	2. Implement Food improvement plan	DB	31/12/2014	
14	Jun-14	Inpatient FFT	3. Campaign materials in place accorss the hospital - 'you said, we did'	DB	31/07/2014	
15	Jun-14	Inpatient FFT	4. Fully implement action plan for improving inpatient experience	DB	31/03/2015	
16	Jun-14	Inpatient FFT	5. Implement the trial the use of paper surveys for gathering FFT feedback in inpatient areas	DB	31/07/2014	
17	Jun-14	Inpatient FFT	6. Evaluate the impact of paper surveys on FFT and consider roll out to other areas	DB	01/09/2014	
18	Dec-13	MSSA	3. Complete intravenous catheter Quality Improvement Project	JW	30/10/2014	
19	Jun-14	VTE	2. Daily checks of complaince by clinical areas and escalate non-completion to medical staff	DB	Ongoing	
20	Jun-14	VTE	3. Performance review of recovery plans at service line performance meetings	DB	Ongoing	

Clinical Quality Report - Glossary

Strategic Objectives	
1	To Deliver Quality Patient Centred Healthcare Services with an Excellent Reputation
2	To Deliver Care by Competent and Caring Staff Working in Effective and Supportive Teams who Feel Valued by the Trust
3	To Work with Partners to Consolidate and Strengthen the Healthcare we Deliver Together to our Local Community
4	To Work with GPs and Other Providers to Support the Delivery of More Care in Primary and Community Settings
5	To Deliver Well Managed, Quality Services Which are Value for Money for the Tax Payer

KPI definitions

KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG Score
1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	Number of patients with a newly hospital acquired pressure ulcers (Grade 3-4)	Target set as 10% reduction on 2013/14 outturn. Target is to have =<14.4 cases in 2014/15	Year to date performance is red	Data Source: Ulysses	Green Red	Full year < = 14.4 Full year > 14.4
2	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	Number of patients with a newly hospital acquired pressure ulcers (Grade 3-4) divided by number of General and Acute occupied beddays	Target is calculated based on the reduction of actual numbers as set out in the Trust's Corporate Objectives	Year to date performance is red	Data Source: Ulysses and internal bedstate summary	Green Red	<= 0.06 >0.06
3	Number of patients with hospital acquired pressure ulcers (Grade 2)	Number of patients with hospital acquired pressure ulcers (Grade 2)	Corporate objectives set target as reduction of 10% on 2013/14 Outturn but this would be higher than the 2013/14 target so keeping 2013/14 target	Year to date performance is red	Data Source: Ulysses	Green Red	Full year <= 36 Full year > 36
4	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	Number of patients with a newly hospital acquired pressure ulcers (Grade 2) divided by number of General and Acute occupied beddays	Target is calculated based on the reduction of actual numbers as set out in the Trust's Corporate Objectives	Year to date performance is red	Data Source: Ulysses and internal bedstate summary	Green Red	<= 0.5 > 0.5
5	Number of Patient Safety Incident (PSI) Falls	Number of falls reported on Ulysses		An exception report will be generated each month there is an occurrence.	Data Source: Ulysses	Green Red	<=51 >51
6	Number of Patient Safety Incident Falls where moderate or severe harm occurred	Includes falls resulting in moderate harm to severe harm/death	Target is a reduction of 15% on last year's outturn	Exception reports to be produced when severe fall has been reported.	Data Source: Ulysses	Green Red	
7	Number of Patient Safety Incident Falls per 1000 G&A beddays		Benchmark against Trust performance - 20% reduction on year end rate		Data Source: Ulysses	Green Red	<=4.7 >4.7
8	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	Number of hospital acquired MRSA bacteraemia (admission to positive test >48 hours)	Target is based on Department of Health set objective (maximum of 1) and Monitor Compliance Framework (de minimis of 6 cases).	An exception report will be generated each month there is an occurrence.	Data Source: Infection Control team - as reported to HPA	Green Amber Red	Full year =< 1 Full year > 1 and =< 6 Full year > 6
9	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	Number of hospital acquired C diff bacteraemia (admission to positive test >72 hours)	Target set by NHS England. Full year target is <= 24 cases. This has been profiled evenly over the year.	Year to date performance is red	Data Source: Infection Control team - as reported to HPA	Green Red	Full year < =24 Full year > 24
10	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	Number of hospital acquired MSSA bacteraemia (admission to positive test >48 hours)	Target is based on Department of Health set objective (maximum of 1) and Monitor Compliance Framework (de minimis of 6 cases).	An exception report will be generated each month there is an occurrence.	Data Source: Infection Control team - as reported to HPA	Green Amber Red	Full year =< 1 Full year > 1 and =< 6 Full year > 6
11	E.coli Bloodstream Infections (Hospital Acquired)	E.coli Bloodstream Infections (Hospital Acquired). Note HPA have not defined 'Hospital Acquired' so using post 72 hrs as with C diff	Target based on last year's outturn and set at <24 for full year, profiled evenly across the year.	Quarterly when year to date performance is red	Data Source: Infection Control team - as reported to HPA	Green Red	<=2 >2
12	Nutrition - compliance with MUST assessment	Compliance with the Malnutrition Universal Screening Tool (MUST); a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese		Year to date performance is red	Data Source: Clinical Audit	Green Amber Red	>=85% >=70% and <85% <70%
13	Completed Patient Observations		Target is Locally set	Year to date performance is red	Data Source: Clinical Audit	Green Amber Red	> =97% < 97% and > 94% < 94%
14	Medication Incidents	The number of incidents which actually caused harm or had the potential to cause harm involving an error in administrating, prescribing, preparing, dispensing or monitoring medication.	No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target		Data Source: Ulysses		
15	% Medication Incidents Where Moderate or Severe Harm Occurred	Numerator: Medication Incidents Where Moderate or Severe Harm Occurred Denominator: Total Number of Medication Incidents	Set following Deep Dive into medication Incidents	Exception report required whenever red in month	Data Source: Ulysses		
16	Number of Serious Untoward Incidents	Total number of serious untoward incidents reported to the Risk Management Team	No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target		Data Source: Ulysses		
17	Number of Never Events	"Never events" are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.		Exception reports will not be produced for never events but instead the comment should reference the SI report.		Green Red	=0 >0
18	% Harm Free Care	% of patients audited on Patient Safety Thermometer where no harm recorded.	tbc based on CQUIN	Year to date performance is red	Data Source: Patient Safety Thermometer		
19	In-Hospital Summary Hospital-level Mortality Indicator 2013	SHMI calculated where observed deaths only include deaths in hospital.	National Peer Apr 12 to Mar 13	Exception Report if above target for month	Data Source: CHKS		
20	Unadjusted Mortality Rate	Number of Deaths / Number of discharges (excludes Well Babies)			SSRS Discharge Report		
21	% Emergency Readmissions following elective admission - 30 days						
22	% Emergency Readmissions following emergency admission - 30 days	The percentage of emergency admissions that were subsequently re-admitted to the Trust (via A&E) within 30 days of discharge					
23	% Emergency Readmissions following all admissions - 30 days		Thresholds are based on national upper quartile performance, CHKS analysis for Apr 2013 - Feb 2014.	An exception report will be generated on red performance at YTD.		Green Red	<= 5.7 > 5.7
24	Prevention of hospital acquired VTE - % patients risk assessed	Percentage of admitted patients receiving a VTE risk assessment.	Threshold from NHS Performance Framework 2013/14			Green Amber Red	>= 95% < 95% and > 90% < 90%
25	Hand Hygiene	Number of times hands were washed / number of observed opportunities hand should have been washed. Shown as a percentage.	Target is locally set.	Year to date performance is red	Data Source: Infection Control team - Monthly Audit	Green Amber Red	>= 95% >= 90% and < 95% < 90%
26	% of patients with a fractured neck of femur that went to theatre within 24 hours for repair of the fractured femur		Data benchmarked against CHKS national peer top 25th percentile performance for 2012/13 - to be reviewed. Uses National Hip Database Audit data for targer		Data Source: CHKS		
27	Open Incidents - % of Managers Reports Completed within 10 days				Data Source: KHT Datix/Ulysses		
28	Number of Complaints received this month	The number of complaints received during the reporting month	No target set		Data Source: Ulysses		

KPI definitions

KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
29	Number of Complaints reopened this month	The number of complaints that were re-opened during the reporting month	No Target set		Data Source: Ulysses		
30	Number of Complaints referred to ombudsman this month	Total number of complaints received that were referred to the Ombudsman	No Target set		Data Source: Ulysses		
31	% Complaints responded to within 25 working days	Percentage of the received complaints which were responded to within the 25 day deadline. Data are reported 1 month in arrears to allow 25 day deadline.	Target Locally Set	An exception report will be generated when monthly performance red.	Data Source: Ulysses	Green Amber Red	>=90% <90% and >80% <80%
32	Friends and Family Score - Trust	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.			Data Source: FFT - RaTE		
33	Friends and Family Score - Inpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	>=78 <78 and >72 <72
34	Friends and Family Score - Outpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE		
35	Friends and Family Score - A&E	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	>=68 <68 and >54 <54
36	Friends and Family Score - Maternity	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	TBC
37	Friends and Family Score - Paediatric Inpatient	The Friends and Family Test is a simple, comparable test. The Friends and Family Test (FFT) score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.	National data - top 20%		Data Source: FFT - RaTE	Green Amber Red	TBC
38	Number of Mixed Sex Accommodation breaches	Number of breaches of mixed sex accommodation	NHS 2011/12 Operating Framework	An exception report will be generated for any mixed sex breach		Green Red	=0 >0
39	Day - Registered Midwives/Nurses Fill Rate	Day Staffing Rate - Percentage of actual hours worked by Registered Midwives/Nurses compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
40	Day - Assisstant Fill Rate	Day Staffing Rate - Percentage of actual hours worked by Assistants compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
41	Night - Registered Midwives/Nurses Fill Rate	Night Staffing Rate - Percentage of actual hours worked by Registered Midwives/Nurses compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
42	Night - Assisstant Fill Rate	Night Staffing Rate - Percentage of actual hours worked by Assistants compared to the planned hours.	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
43	Overall Trust Fill Rate	Overall Staffing Rate - Total hours worked as a percentage of the planned hours	TBC	TBC	Data Source: Local staff survey collection	Green Red	TBC
44	Caesarean section rate	The percentage of deliveries performed as a C section Numerator: Number of C-section deliveries Denominator: Total number of deliveries	CHKS - SHA London Peer 75th Percentile	Exception report if latest 3 months are red	CRS	Green Amber Red	<= 26% 26% - 29% >= 29%
45	% women with a primary postpartum haemorrhage of 2500ml or more	Numerator: The number of women with a primary post partum haemorrhage of 2000ml or more Denominator: The total number of deliveries	HCC Review of Maternity Services 2008 median of 1.9 per 1,000 births ranging from 0.1 per 1,000 to 8 per 1,000.	Exception report if latest 3 months are red	CRS	Green Red	< =1% > 1.5%
46	Significant Perineal Trauma	The percentage of women with 3rd or 4th degree tears					
47	Perinatal Mortality Rate per 1000 births	The rate per 1000 births Numerator: The number of stillbirths + neonatal deaths Denominator: Total number of births	Last Year's Performance = 3.7 2011 National Data = 7.5	When Quarterly performance is red	CRS		
48	Number of Red Maternity Escalations						

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	20/06/2012	Pressure Ulcers G3&4	1. Meeting with all Cambridge Ward registered nurses to ensure all staff are aware of their accountability to patients, NMC and to the Trust.	JP	Completed	
2	20/06/2012	Pressure Ulcers G3&4	2. Implement process of identifying patients at risk of developing a pressure ulcer on the Cambridge Ward RAG board (black dot)	JP	Completed	
3	20/06/2012	Pressure Ulcers G3&4	3. Cambridge Ward Sister to conduct daily patient/relatives ward round	JP	Completed	
4	20/06/2012	Pressure Ulcers G3&4	4. Reintroduce and embed two hourly rounding on Cambridge Ward	JP	Completed	
6	20/06/2012	Pressure Ulcers G3&4	5. Develop and embed a process to escalate skin integrity deterioration to the nurse in charge	JP	Completed	
7	20/06/2012	Pressure Ulcers G3&4	6. UndertAle training on waterlow assessment and Pressure ulcer management for all registered nurses on Cambridge and Astor.	JP	Completed	
8	20/06/2012	Pressure Ulcers G3&4	7. Presentation of Cambridge/ Astor Ward action plan outcomes	JP	Completed	
9	25/07/2012	Pressure Ulcers G3&4	8. Complete Serious Incident investigations, identifying actions.	JP	Completed	
10	25/07/2012	Pressure Ulcers G3&4	9. Present results to Director of Nursing and Divisional Risk Boards	JP	Completed	
11	06/09/2012	Pressure Ulcers G3&4	10. Hamble Ward to complete Serious Incident investigations, identifying actions.	JP	Completed	
13	06/09/2012	Pressure Ulcers G3&4	12. Claremont Ward to complete Serious Incident investigations, identifying actions.	JP	Completed	
14	06/09/2012	Pressure Ulcers G3&4	13. Present results from Claremont Ward to EMC	JP	Completed	
15	26/09/2012	Pressure Ulcers G3&4	14. Implementation of the Pressure Ulcer Care Bundle	JP	Completed	
17	26/09/2012	Pressure Ulcers G3&4	16. Quality Assurance Committee to conduct a “deep dive” review of pressure area care	JP	Completed	
18	06/09/2012	C diff	1. Progress Clostridium difficile action plan and monitor implementation via Nursing Quality Assurance Framework; Frontline Focus Friday, Infection Control Group and Divisional Risk Board Meetings	JP	Completed	
19	06/09/2012	C diff	2. Establish an antibiotic stewardship task and finish group	JP	Completed	
21	26/09/2012	C diff	4. Ribotyping [identifies the strain(s) of Clostridium difficile causing the infection] for all Hardy ward CDT patients (to ascertain if cross-infection has occurred)	JP	Completed	
22	26/09/2012	C diff	5. C. difficile RCA template revised to capture information on patient placement and other colonised/ infected patients on same ward	JP	Completed	
29	20/06/2012	Patient Observations	1. Communication of performance to senior nurses	JP	Completed	
ıation scree	20/06/2012	Patient Observations	2. Ward Sister to conduct daily patient/ relatives ward round	JP	Completed	
31	20/06/2012	Patient Observations	3. UndertAle monthly documentation audit on ward to identify where any actions to improve standards are required	JP	Completed	
32	20/06/2012	Patient Observations	4. Attendance at Acute Response Group	JP	Completed	
33	20/06/2012	Patient Observations	5. Monitoring of training plan and remedial action where needed	JP	Completed	
35	25/07/2012	Patient Observations	7. Head of Nursing to meet with ward manager to agree improvement plan for Hamble/ Kennet and AAU	JP	Completed	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
42	20/06/2012	Percentage of Normal Deliveries	3. A water birth study day was undertAlen in July to encourage uptAle of waterbirth and use of Malden suite and home birth	JW	Completed	
48	25/07/2012	NPS	2. Develop team and Divisional patient experience action plans to include improvement actions based on patient feedback in the NPS survey.	JP	Completed	
49	25/07/2012	NPS	3. Review the target response rates to ensure they are appropriate.	JP	Completed	
1	06/09/2012	Pressure Ulcers G3&4	1. Present results from Hamble Ward to EMC	JP	19/09/2012	
2	26/09/2012	Pressure Ulcers G3&4	2. Executive Team Department/ Ward visits to include a focus on pressure area care	JP	01/10/2012	
6	26/09/2012	C diff	1. Hardy ward Clostridium difficile action plan devised and implemented (hand hygiene awareness; weekly hand hygiene audits; deep clean throughout ward; equipment cleaning & think clean afternoon.)	JP	24/10/2012	
7	18/10/2012	C diff	2. A task and finish group chaired by the DON/DIPC has been set up to monitor progress with the C. difficile action plan, RCA summary, exception report and isolation / hand hygiene audit results	JP	Completed	
8	18/10/2012	C diff	3. Carry out a deep clean on Hardy ward	JP	Completed	
10	18/10/2012	C diff	5. Carry out an point prevalence isolation audit	JP	Completed	
11	18/10/2012	C diff	6. Information sheet on C. diff given out to the wards - to be read and signed by all nursing staff.	JP	Completed	
12	18/10/2012	C diff	7.When patients are GDH positive but toxin negative (colonised but not infected with C diff) medical staff will be notified by a Microbiology Consultant, in order to ensure optimal management.	JP	Completed	
15	20/06/2012	Medication Incidents	1. Assessments for all F1 doctors to be completed before end of September each year and arrangements for prescribing assessments to be confirmed	JW	Completed	
16	20/06/2012	Medication Incidents	3. Include responsibility for reporting medication errors in Junior doctor induction	JW	Completed	
17	20/06/2012	Medication Incidents	4. Further work to be undertAlen on drug administration through Frontline Focus Friday	JW	Completed	
19	20/06/2012	Medication Incidents	6. Produce comprehensive reports with greater granularity and analysis drug incident data to Medicine Safety Group, Patient Safety Committee and Divisional Risk Boards	JW	Completed	
20	25/07/2012	Never Event	1. Grade 2 Investigation	JW	Completed	
25	26/09/2012	Complaints	Consolidate the timings in the response process to reduce the initial response time available and increase the available review time	ST	Completed	
26	18/10/2012	Complaints	1. Head of Nursing (Surgery) has responsibility for coordinating responding to complaints in a timely fashion	ST	Completed	
28	20/06/2012	Percentage of Normal Deliveries	1. A Consultant midwife led clinic was established in Jan 2012 to encourage woman who have had a previous traumatic experience, requesting an elective C section, to have a normal delivery.	JW	Completed	
29	20/06/2012	Percentage of Normal Deliveries	2. An action plan has been developed to support increase in deliveries on the Midwife Led Unit.	JW	Completed	
30	20/06/2012	Percentage of Normal Deliveries	3. A water birth study day was undertAlen in July to encourage uptAle of waterbirth and use of Malden suite and home birth	JW	Completed	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
34	18/10/2012	Percentage of Normal Deliveries	4. A weekly normal birth forum has been introduced by the consultant midwife as part of the action plan,to review and disseminate learning for midwives. It is antispated that this will help to increase the number of women who go on to have a normal birth.	JW	Completed	
35	20/06/2012	PPH	1. Audit all PPHs over 2litres between april 2012- June 2012.	JW	Completed	
36	20/06/2012	PPH	2. UndertAle an audit of small volume PPH	JW	Completed	
37	27/06/2012	PPH	3. Agree recommendations and actions	JW	Completed	
38	28/06/2012	Still Birth	1. Review each still birth to identify any contributing factors.	JW	Completed	
1	18/10/2012	Pressure Ulcers G3&4	3. Weekly audit on Blyth Ward of the Pressure Ulcer Care Bundle	JP	Completed	
2	18/10/2012	Pressure Ulcers G3&4	4. Ward Sister supervision of care using new handover checklist	JP	Completed	
3	18/10/2012	Pressure Ulcers G3&4	5. Serious incident investigation	JP	Completed	
4	18/10/2012	C diff	1. Hardy ward action plan to be tAlen to Divisional Risk Board meeting	JP	Completed	
5	18/10/2012	C diff	2. Executive Team walkabouts to focus on isolation	JP	Completed	
6	18/10/2012	C diff	3. Weekly hand hygiene audits will occur in all areas where scores are low until improvement is demonstrated (Bronte, A&E, Hamble, Hardy, Keats, Cambridge, Isabella, Delivery Suite, Radiology)	JP	Completed	
9	30/11/2012	C diff	6. Additional audits to be undertAlen - pilot Hardy ward (isolation audits)	JP	Completed	
10	01/12/2012	C diff	7. HCAI Peer review	JP	Completed	
13	25/07/2012	Patient Observations	6. Revised ward handover procedures (to include SBAR) in Medical Wards to aid (Hamble outstanding)	JP	Completed	
14	20/06/2012	Complaints	Complaints team will continue to chase the outstanding information.	ST	Completed	
15	20/06/2012	Complaints	Weekly Chief Operating Officer (COO) meeting with DMs tracks complaints performance	ST	Completed	
16	20/06/2012	Complaints	Include a standing item regarding complaints on Divisional Risk Board	ST	Completed	
22	25/07/2012	Open Incidents	1. Divisions to focus on timely return of the Managers Report in accordance with the policy and to monitor this monthly within the Divisional Risk Boards	ST	Completed	
23	25/07/2012	Open Incidents	2. The Divisional Risk Managers are to ensure prompt inputting of incidents and sending weekly summaries of all incidents reported by Area to the relevant Manager	ST	Completed	
27	18/10/2012	Falls	2. Review training for new staff to the department to ensure a standardised approach.	JW	Completed	
3	28/11/2012	C diff	3. Audit of stool charts, laxative use, PPI prescriptions, antibiotic use on Hardy ward.	JP	28/11/2012	
4	19/12/2012	C diff	4. Chlorclean to be used for routine daily cleaning in medicine, ITU & Sunshine	JP	30/11/2012	
5	19/12/2012	C diff	3. Use of stool charts, laxative use, rapid isolation of patients with diarrhoea and collection of stool samples discussed at ICLP meeting and FFF	JP	07/12/2012	
6	19/12/2012	C diff	4. Monthly isolation audits in medicine	JP	Ongoing	
7	19/12/2012	C diff	5. Appropriate collection of stool samples to be raised with nursing & medical staff	JP	10/12/2012	
1	28/11/2012	C diff	1. Antibiotic stewardship group to be set up, twice weekly ward rounds, antibiotic awareness day (19.11.12)	JP	01/12/2012	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
2	28/11/2012	C diff	2. Augmentin audit and audit of 48 hour antibiotic review	JP	01/01/2013	
3	30/01/2013	C diff	3. Time to isolate audit (process in place, tAIen through EMC and FFF)	JP	31/01/2013	
7	30/01/2013	C diff	7. Equipment cleaning audit implemented	JP	10/12/2012	
10	19/12/2012	Pressure Ulcers	2.Matron to be based on ward to support development of ward sister and team	JP	Commenced Nov 2013	
11	19/12/2012	Pressure Ulcers	3. Serious incident investigation	JP	01/02/2013	
14	19/12/2013	Never Event	1. Grade 2 investigation	JW	17/12/2013	
15	18/10/2012	Complaints	1. Follow up with individuals who do not reply in a timely way	ST	30/11/2012	
16	19/12/2012	Complaints	2. Chief Operating Officer to investigate the causes of the poor performance	ST	Completed	
18	18/10/2012	Percentage of Normal Deliveries	1. The VBAC clinic is now established and uptAIe is increasing, outcomes are being monitored and will be presented at Clinical Governance.	JW	31/12/2012	
24	19/12/2012	Percentage of Normal Deliveries	7. A weekly normal birth forum has been introduced by the consultant midwife as part of the action plan, to review and disseminate learning for midwives. It is anticipated that this will help to increase the number of women who go on to have a normal birth.	JW	Forum Established	
25	25/07/2012	NPS	1. Completion of the Outpatient Redesign project, for main outpatient areas. This involves mapping and improving the patient flow through the system. 2 year programme on track	JP	Completed	
28	18/10/2012	Falls	1. Validation of PSI Falls incidents with Falls Lead for June and July data. Following this a validation of data from April to Present to ensure correct definition of NRLS is used. A look back exercise of PSI incidents for 2011 to review to validate falls data.	JW	Completed	
34	28/11/2012	Never Event	Grade 2 Investigation	JW	18/03/2013	
35	28/11/2012	C Section	1. Audit of Robson group 1 Caesarean section. Singleton Cephalic presentation >37 weeks spontaneous labour with presentation of findings at Clinical governance meeting.	JW	01/01/2013	
36	28/11/2012	C Section	2. CS rate Discussion at consultant O&G 'away day	JW	23/11/2012	
39	30/01/2013	VTE	1. Highlight poor performance to Divisional Directors.	JW	Completed	
12	20/02/2013	Pressure Ulcers	3. New band 7 Charge Nurse appointed to Blyth Ward	DB	01/01/2013	
16	18/10/2012	Percentage of Normal Deliveries	3. A Consultant midwife led clinic was established in Jan 2012 to encourage woman who have had a previous traumatic experience, requesting an elective C section, to have a normal delivery. Maternal request CS remains a challenge and alternative pathways/management are being explored with Obstetric team.	JW	31/12/2012	
20	19/12/2012	Percentage of Normal Deliveries	7. A weekly normal birth forum has been introduced by the consultant midwife as part of the action plan, to review and disseminate learning for midwives. It is anticipated that this will help to increase the number of women who go on to have a normal birth.	JW	Ongoing	
24	18/10/2012	Falls	2. QA process to be implemented for all incidents	JW	31/10/2012	
25	19/12/2012	Falls	3. Continue Falls audit and report to the Patient Safety Committee	JW	18/02/2013	
26	19/12/2012	Falls	4. Analyse the increased falls incidents on AAU and Claremont to establish if there is any new learning	JW	18/01/2013	
28	20/02/2013	Falls	6. Further deep dive into Octobers, Novembers and Decembers falls data required	JW	20/02/2013	
30	28/11/2012	C Section	2. Presentation of VBAC team audit and Consultant MW audit Jan/Feb. Normality MW study days commencing March 2013	JW	01/02/2013	
31	30/01/2013	VTE	1. Re-emphasise and remind medical teams to undertAIe assessment on ward rounds.	JW	31/01/2013	
5	30/01/2013	C diff	5. Diarrhoea Care Bundle implementation - IPCT to include in training and send global email	DB	16/01/2013	
6	27/02/2013	C diff	6. Implement a '5 key pieces of equipment' audit	DB	28/12/2012	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
7	27/02/2013	C diff	7. IPCT spot check on '5 key pieces of equipment'	DB	12/02/2013	
2	30/01/2013	C diff	2. KPI Report for EMC, Divisions and ward scorecard	DB	14/01/2013	
3	30/01/2013	C diff	3. Antibiotic Management Group to meet	DB	07/02/2012	
20	27/03/2013	Normal Birth (Non instrumental delivery)	6. The Big Push campaign. For five weeks in January and February the CM and LW lead are ran a campaign to improve second stage management. The aim was to enhance clinical decision mAling and promote normality using the five 'P's Powers, Passage, Passanger, Psyche and Partogram. A second stage management tool has been developed to support clinical decision mAling and will be launch in March.		29/03/2013	
26	41360	Falls	3. Merge Task and Finish and Falls group. Re-energised falls	JW	Completed	
28	41304	VTE	2. Check risk assessment completed when undertAling surgi	JW	31/01/2013	
31	41360	C Section - Primip	3. Feedback to staff at labour ward forum, department O&C	JW	Completed	
1	30/01/2013	C diff	4. Augmentin use audit and review of antibiotic use at 48 hours	DB	Completed	
2	27/02/2013	C diff	8. Commence a review of antibiotic use at 48 hours	DB	Completed	
3	27/02/2013	C diff	9. Raise awareness of and promote use of diarrhoea care bundle	DB	Ongoing	
4	27/03/2013	C diff	IPCT to clarify guidance on stool specimen tAling	DB	Completed	
5	28/03/2013	C diff	IPCT to report innappropriate transfer as clinical incident and to relevant people including HPA and SGH ICN's.	DB	Completed	
3	May-13	C diff	3. Stool charts changed, with specific messages regarding timely specimens and the fact that specimens mixed with	DB	Completed	
4	May-13	C diff	4. IPCT to clarify guidance on stool specimen tAling - posters put into all sluice areas, information given at team	DB	Completed	
8	Jan-13	Pressure Ulcers	1. Serious incident investigations	DB	Completed	
9	Apr-13	Pressure Ulcers	2. Serious incident investigation -ITU	DB	Completed	
11	Feb-13	Pressure Ulcers	4. Blyth Ward four week audit of pressure area management documentation	DB	01/04/2013	
17	Mar-13	Falls	2. Development and implementation of revised falls action plan as following amalgamations of groups & QAC deep dive	JW	Completed	
1	May-13	C diff	1. Antibiotic audits continue in medicine and surgery and include audit on compliance with antimicrobial policy.	DB	Ongoing	
2	May-13	C diff	2. IPCT ward rounds continue 3 times a week, to re-iterate messages around stool specimens, isolation and antibiotics.	DB	Ongoing	
5	Jun-13	C diff	5. Staff education on Bristol stool form scale - revised educational posters to be rolled out	DB	Completed	
6	Jun-13	C diff	6. New posters on diarrhoea and when to tAle a sample were installed in sluice rooms; key messages were sent via global email.	DB	Completed	
7	Jun-13	C diff	7. A 'deep clean' took place on Blyth ward on May 24th and chlorclean is used for all cleaning in all wards.	DB	Completed	
8	Jun-13	C diff	8. Weekly hand hygiene audits in Blyth ward.	DB	Completed	
9	Jun-13	C diff	9. Two new infection control link nurses to be recruited and trained in Blyth ward.	DB	Ongoing	
10	Jun-13	C diff	10. Nursing handover sheets to include more information on infection	DB	Completed	
12	Jun-13	C diff	12. Ensure correct stool sample pots are available	DB	Completed	
1	May-13	C diff	1. Antibiotic audits continue in medicine and surgery and include audit on compliance with antimicrobial policy.	DB	Ongoing	
2	May-13	C diff	2. IPCT ward rounds continue 3 times a week, to re-iterate messages around stool specimens, isolation and antibiotics.	DB	Ongoing	
6	Jul-13	C diff	6. Blyth ward action plan in place to address potential cross infection including 'fogging'of the ward.	DB	Completed	
8	Jul-13	C diff	8. infection Control column added to handover sheet in Blyth ward	DB	Completed	
12	Jul-13	C diff	12. New posters on diarrhoea and when to tAle a sample were installed in sluice rooms; key messages were sent via global email.	DB	Completed	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	May-13	C diff	1. Internal Audit of Compliance with the antimicrobial prescribing policy	DB	tbc	
3	Jun-13	C diff	3. Diarrhoea algorithm to be reviewed and re-issued	DB	01/07/2013	
4	Jul-13	C diff	4. Improve documentation on stool charts and laxative use	DB	31/07/2013	
8	Aug-13	C diff	8. IPCT review of transfers from other Trusts within 24 hours of admission	DB	Completed	
15	Apr-13	Pressure Ulcers	1. Serious incident investigation - Kennet Ward	DB	tbc	
16	May-13	Pressure Ulcers	2. Skin Awareness Training, AAU	DB	30/06/2013	
17	May-13	Pressure Ulcers	3. Development of strategies to reduce PU numbers in orthopaedics meeting	DB	31/05/2013	
18	Jun-13	Pressure Ulcers	4. BIPAP Awareness Training	DB	31/07/2013	
19	Jun-13	Pressure Ulcers	5. Highlighted pressure relieving strategies implemented in Orthopaedics	DB	30/06/2013	
20	Jun-13	Pressure Ulcers	6. Stage 2 pressure ulcer checklists to be presented at Skin HIA meeting	DB	15/07/2013	
27	Jun-13	Falls	2. Review June 2013 NICE guidance and undertAIe GAP analysis identifying any areas for focus within the Trust .	DB	28/06/2013	
29	Jul-13	Falls	4. Complete Falls Audit	DB	20/07/2013	
35	Aug-13	A&E FFT	1. The volume of respondents will be split over the 3 areas: Majors/ Minors/ Paeds. This can be subdivided over the day/ night. Team have a target of a minimum of 8 per shift per area to achieve. Allows identification of responsible individuals.	DB	22/07/2013	
36	Aug-13	A&E FFT	2. Daily reports of volume compliance to be sent to Mike Walker & Emma Duffy so that the progress can be tracked, and managers can intervene should there be a risk of not achieving the target.	DB	22/07/2013	
37	Aug-13	A&E FFT	3.Agenda item at the following; Senior nurse Meeting, Staff Meeting, ED Governance Meeting for monitoring.	DB	22/07/2013	
3	Jul-13	C diff	3. High fibre diet clarification for patients on menus to be commenced in Autumn 2013	DB	01/09/2013	
4	Jul-13	C diff	4. Exploration into the use of sporicidal wipes that are now available, for cleaning equipment.	DB	31/07/2013	
5	Aug-13	C diff	5. Staff training and assessment package developed to promote timely stool sample collection, improve awareness of diarrhoeal stool types, improve documentation of bowel activity using appropriate terminology, requirement for isolation within two hours of onset of suspected infective diarrhoea	DB	23/08/2013	
6	Aug-13	C diff	7. Monitoring of adherence to Hand Hygiene and PPE and standards of environmental cleanliness	DB	12/08/2013	
17	Jul-13	Pressure Ulcers	7. RCA Investigation - Cambridge Ward	DB	21/08/2013	
18	Jul-13	Pressure Ulcers	8. RCA Investigation - Keats Ward	DB	21/08/2013	
19	Jul-13	Pressure Ulcers	9. RCA Investigation - Bronte Ward	DB	21/08/2013	
31	Aug-13	Falls	8. Disseminate falls audit results	DB	Completed	
34	Aug-13	A&E FFT	2. Daily reports of volume compliance to be sent to Mike Walker & Emma Duffy to track progress & intervene as required.	DB	Ongoing	
36	Aug-13	Inpatient FFT	1. Weekly tracking of response rate compliance	DB	01/09/2013	
37	Aug-13	Inpatient FFT	2. FFT to be agenda item and NMAC,sisters' meeting	DB	20/08/2013	

Clinical Quality Report - Change Log

Change Number	Date	KPI	Change	Request Owner	Action by
1	Apr-13	Number of patients with Hospital acquired pressure ulcers (Grade 3 and 4)	10% reduction to 2012/13 target. Annual target for 2013/14 is now 6	DB	CO
2	Apr-13	Number of patients with Hospital acquired pressure ulcers (Grade 2)	10% reduction to 2012/13 outturn. Monthly target for 2013/14 is now <=3	DB	CO
3	Apr-13	E.coli Bloodstream Infections (Hospital Acquired)	Amend target to be reduction on 2012/13 outturn (18) Monthly target <=1.5	DB	CO
4	Apr-13	% of Medication Incidents Where Moderate or Severe Harm Occurred	Amend target to be % of all medication incidents rather than number and set target <4% following Deep Dive into medication Incidents.	JW	CO
5	Apr-13	Patient Safety Thermometer - % Harm Free Care	Indicator added. Need to calculate target based on CQUIN	DB	CO
6	Apr-13	% Emergency Readmissions following elective admission - 30 days	Add indicator and base on local data	ST	CO
7	Apr-13	% Emergency Readmissions following all admissions - 30 days	Amended target to be top 25th percentile for Apr to Feb 2013/12 from CHKS and use CHKS data to compare	ST	CO
8	Apr-13	SHMI (In hospital Mortality)	Amended target to be based on Apr to Feb 13	JW	CO
9	Apr-13	Prevention of hospital acquired VTE - % patients risk assessed	Amend target for 2013/14 CQUIN green>95% amber between 95% and 90%	JW	CO
10	Apr-13	Hand Hygiene	Amended Score required for amber to 90%	DB	CO
11	Apr-13	Net Promoter Score	All indicators removed as replaced by FFT in February	DB	CO
12	Apr-13	Caesarean section rate	Target amended based on CHKS - SHA London Peer 75th Percentile	JW	CO
13	Apr-13	Caesarean section rate - primip	Indicator removed	JW	CO
14	Apr-13	% women with a primary postpartum haemorrhage of 2500ml or more	target based on HCC Review of Maternity Services 2008 median of 1.9 per 1,000 births ranging from 0.1 per 1,000 to 8 per 1,000.	JW	CO
15	Apr-13	Significant Perineal Trauma	Previously % of 3rd and 4th degree tears. Target to be agreed.	JW	CO
16	Apr-13	Perinatal Mortality Rate per 1000 births	New Indicator to be reported quarterly. (previously reported still birth rate)	JW	CO
17	Apr-13	Number of Red Maternity Escalations	New Indicator	JW	CO
18	Apr-13	Spontaneous Vaginal Delivery Rate	Indicator removed	JW	CO
19	Apr-13	Breast Feeding Initiation Rate	Indicator removed	JW	CO
20	Apr-13	Number of post operative PE or DVT	Indicator removed	JW	CO
21	Apr-13	A&E - % of A&E Attendances for Cellulitis + DVT that end in Admission	Indicator removed	JW	CO
22	Apr-13	Number of Intensive Care Unit patients who are readmitted into ICU after fit for transfer	Indicator removed	JW	CO
23	Jun-13	% women with a primary postpartum haemorrhage of 2500ml or more	Amended to 2000ml in line with sector scorecard	JW	CO
24	Jul-13	Friends and Family Score - Inpatient	Amended to include only Adults as submitted to DH	DB	CO
25	Jul-13	Friends and Family Score - Paediatric Inpatient	Include a new indicator to show Paediatric data previously included in inpatient score	DB	CO
26	Aug-13	Friends and Family Score - Inpatient & A&E	Rag rating included following publication of national data	DB	CO
27	Sep-13	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	Amended 2012/13 Pressure Ulcer Figure from 14 to 16 following additional data from Alison Williams	DB	CO
28	May-14	E.coli Bloodstream Infections (Hospital Acquired)	Removed indicator as it is being monitored locally by the Infection Control team	DB	SO
29	May-14	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	Removed indicator as it is being monitored locally by the Infection Control team	DB	SO

	KPI description	Exec Owner	Indicator also reported in	Target	RAG Green	RAG Amber	RAG Red
	Number of patients with pressure ulcers (Grade 3-4)	JW	Board - CPR, CQR	1	1		
	Number of patients with pressure ulcers (Grade 2)	JW	Board - CPR, CQR	<=3	3		
	Number of patients with pressure ulcers (Grade 3&4) per 1000 beddays	JW	CQR	<=0.06	0.06		
	Number of patients with pressure ulcers (Grade 2) per 1000 beddays	JW	CQR	<=0.5	0.500		
	Number of Patient Safety Incident Falls	JW	CQR	<=51	51		
	PSI Patient Falls per 1000 G&A beddays	JW	Board - CPR, CQR	<=4.7	4.7		4.7
	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	JP	Board - CPR, CQR	<=0	0		1
	Clostridium difficile Infections - Post 36hours (Hospital Acquired)	JP	Board - CPR, CQR	<=2	2		2
	E.coli Bloodstream Infections (Hospital Acquired)	JP	CQR	<=2	2		2
	Nutrition - compliance with MUST assessment*	JP	CQR	>=85%	85%		70%
	Medication Incidents	JP	CQR	<=30	30		
	Number of Serious Untoward Incidents	JP	CQR				
	Number of Never Events	JP	CQR	0	0		
	Completed Patient Observations	JP	CQR	>=97%	97%		94%
	Number of Post Operative PE or DVT	JW	CQR				
	Improve percentage completion of early cognitive assessments of patients aged over 65 admitted to Kingston	JP	CQR				
	SHMI	JW	Board - CPR, CQR	<95	95		
					71		105
	% Emergency Readmissions following emergency admission - 30 days	ST	CQR				
	% Emergency Readmissions following all admissions - 30 days	ST	Board - CPR	< 5.7%	5.70%		5.70%
	Prevention of hospital acquired VTE - % patients risk assessed	JW	CQR	>95%	95%		90%
	Hand Hygiene	JP	CQR	>95%	95%		90%
	A&E - Percentage of A&E Attendances for Cellulitis + DVT that end in Admission	JW	CQR				
	A&E - Patients presenting in High Risk Groups	JW	CQR				
	Certification against compliance with requirements regarding patients with learning disabilities	JP	CQR	0	0		>0
	Number of Complaints	JP	CQR				
	Number of Complaints reopened	ST	CQR				
	Number of Complaints referred to ombudsman	ST	CQR		4		8
	% Complaints responded to within 25 working days	ST	CQR	>=90%	90%		80%
	FFT - Trust	DB	CQR				
	FFT Score - Inpatient	DB	CQR		78.00		72.00
	FFT Score - A&E	DB	CQR		68.00		54.00
	FFT Score - Maternity	DB	CQR		70.00		
	A&E - Service Experience	ST	CQR				
	Number of Mixed Sex accommodation breaches	ST	CQR	0	0		
	Average Number of Preoperative bed days for patients with fractured neck of femur	JW	CQR	<=1.5	74.10%		

	KPI description	Exec Owner	Indicator also reported in	Target	RAG Green	RAG Amber	RAG Red
	Reduce the number of Intensive Care Unit patients who are readmitted into ICU after fit for transfer	JW	CQR				
	Open Incidents	JP	CQR		60%		20%
	Caesarean section rate	JW	CQR	<=26%	26%		29%
	Caesarean section rate - Primip	JW	CQR	<=28%	28%		30%
	Normal delivery Rate	JW	CQR	>58%	58%		
	% women with a primary postpartum haemorrhage of 2500ml or more	JW	CQR	<1%	1%		1.5%
	% of 3rd and 4th degree tears	JW	CQR	<5%	5%		
	Number of stillbirths	JW	CQR	<=1	0.49%		
	Perinatal mortality rate	JW	CQR				
	Term admissions to Neonatal unit	JW	CQR				
	Maternal Admissions to ITU	JW	CQR				
	1:1 Care in established labour	JW	CQR				
	Breast Feeding Initiation Rate	JW	CQR	>=86.5%	86.50%		85.50%
	Nursing establishments	DG	CQR				