Kingston Hospital NHS Foundation Trust

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Clinical Quality Report
Apr-16 (Month 1)

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.

The Trust has continued to have episodes of norovirus confined to the medical wards although the number of cases has reduced. There were no safety issues identified related to the periods of industrial action in April 2016 although as elective activity was cancelled there will have been an effect on patient experience. Fill rates of trained staff and assistants are meeting the national requirements and the overall fill rate for the Trust is 100%.
The unadjusted mortality rate in April 2016 is 1.2% and the Quarter 4 2015/6 Standardised Hospital Mortality Index (SHMI) 0.93, both indicative of good performance in the Trust. The safety KPIs are good in April 2016 with a total of only 4 pressure ulcers reported this month, none of which was grade 3. There were 4.8 falls per 1,000 bed days in April 2016, with 3 falls associated with moderate/severe harm.

The infection control safety KPIs are good this month. The percentage of completed observations for the Saving Lives (Hand Hygiene) Audit has reduced this month. Compliance with the monthly NEWS audit has also declined There are 7 observations that form the NEWS score, and where any of these are not undertaken a NEWS score is not recorded. In order to facilitate observations, wireless linked monitors are now in use in the surgical centre which save nursing time and allow quicker responses through a central alert of abnormal results to the outreach Team. This facility is being rolled out to the Emergency Department in June 2016.

Performance with responses to complaints within 25 days has not been maintained in March 2016, with 76.3% of the responses carried out within the agreed timescale.

The Trust-wide FFT score has remained high with 94.7% of patients responding that they would recommend the Trust to friends of family for care or treatment. The Emergency Department scores have also remained high but the Board should not that it remains difficult to get responses to the survey in A and E (response rate 3.7%)

The Board should note the addition of KPIs relating to Sepsis, which relate to screening and administration of timely antibiotics. These will be reported quarterly. Scores for percentages of patients being screened and assessed for Dementia are approaching target rates.

The Board should review progress with delivery of the Quality Goals appended to this report. The Board are asked to note and discuss the contents of the report.

Clinical Quality Dashboard - April-16						Actual										
	Strategic objective	KPI description	Exec Owner	Reported in	Target/ Benchmark	2015-16	Feb-16	Mar-16	Apr-16	2015-16 Q4	2016-17 Q1	YTD	Qtr Trend	Month Trend	Forecast	Comments
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	DB	Board - CPR, CQIC, CRC	<=1	20	2	1	0	4	0	0	↓	↓		
	1	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	DB	CQIC, CRC	<=0.06	0.14	0.17	0.08	0.00	0.11	0.00	0.00	↓	↓		
	1	Number of patients with hospital acquired pressure ulcers (Grade 2)	DB	Board - CPR, CQIC, CRC	<=3	36	5	2	4	8	4	4	↑	↑		**See Exception Report 1**
	1	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	DB	CQIC, CRC	<=0.51	0.26	0.42	0.16	0.35	0.22	0.35	0.35	↑	↑		
	1	Number of Patient Safety Incident (PSI) Falls	JW	CQIC, CRC	<=58	774	78	70	55	225	55	55	↓	↓		
	1	Number of Patient Safety Incident Falls where moderate or severe harm occurred	JW	CQIC, CRC	<=6	18	3	2	3	8	3	3	↑	↑		
	1	Number of Patient Safety Incident Falls per 1000 G&A beddays	JW	Board - CPR, CQIC, CRC	<=5.3	5.5	6.5	5.1	4.8	6.2	4.8	4.8	↓	↓		
	1	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	Board - CPR, CQIC, CRC	<1	2	0	1	0	1	0	0	↓	↓		Target is zero tolerance as per national guidance and contract.
	1	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	DB	Board - CPR, CQIC, CRC		19	3	1	0	5	0	0	↓	↓		
	1	Clostridium difficile Infections - Post 72hours (Hospital Acquired) due to Lapse in Care **CONFIRMED**	DB	Board - CPR, CQIC	<1	3	0	0	0	0	0	0	→	→		Target set by NHS England. Full year target is <= 9 cases. This has been profiled evenly over the year. Cases of CDIFF resulting from a lapse in care are provisional. Once allocation has been confirmed by the Commissioning Support Unit and following a Post-Infection Review, cases will be confirmed and amended on the report as necessary.
	1	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	CQIC, CRC	<=1	9	0	2	0	2	0	0	↓	↓		Exception Report 1
	1	Completed Patient Observations	DB	CQIC, CRC	>=97%	92.6%	95.4%	95.8%	91.9%	95.3%	91.9%	91.9%	↓	↓		NEWS data
	1	Medication Incidents	JW	CQIC, CRC		718	56	42	45	163	45	45	↓	↑		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, CRC	<=4%	0.1%	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%	→	→		
	1	Number of Serious Untoward Incidents	JW	CQIC, CRC		46	3	2	4	10	4	4	↑	↑		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, CRC	0	0	0	0	0	0	0	0	→	→		
	1	Patient Safety Thermometer - % Harm Free Care	DB	CQIC, CRC		94.4%	95.21%	93.13%	92.14%	92.0%	94.5%	94.4%	↑	↓		
Effectiveness	1	SHMI	JW	Board - CPR, CQIC, CRC	<=95	89.6				87.6	93.18		↑			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. The Q4 score is for Jul-14 - Jun-15, published in Jan-16. The Q1 score is for Oct-14 - Sep-15, published in Mar-16.
	1	Unadjusted Mortality Rate	JW	CRC		1.2%	1.3%	1.2%	1.2%	1.3%	1.2%	1.1%	↓	↑		
	1	Sepsis - Percentage of eligible patients screened for sepsis	JW	CQIC, CRC			66.7%	66.7%		67.3%				→		Sepsis data is provided on a quarterly basis by Clinical Audit and is reported in arrears.
	1	Sepsis - Percentage of eligible patients who received antibiotics within 1 hour of arrival	JW	CQIC, CRC			76.9%	76.9%		57.5%				→		
	1	% of eligible patients screened for dementia	DB	CQIC, CRC	90%		79.8%	80.3%		82.0%				↑		Dementia reporting is carried out by Clinical Audit and is reported in arrears
	1	% of Patients with dementia who were appropriately assessed	DB	CQIC, CRC	90%		74.5%	87.1%		82.1%				↑		
	1,4	% Emergency Readmissions following elective admission - 30 days	DB	CQIC, CRC		2.1%	1.7%	2.0%	1.6%	1.9%	1.6%	1.6%	↓	↓		Local data has been used to give an indication of performance.
	1,4	% Emergency Readmissions following emergency admission - 30 days	DB	CQIC, CRC		14.0%	14.8%	13.1%	11.9%	13.8%	11.9%	11.9%	↓	↓		Local data has been used to give an indication of performance.
	1	Prevention of hospital acquired VTE - % patients risk assessed	JW	CQIC, CRC	>=95%	98.6%	98.1%	98.3%	98.7%	98.1%	98.7%	98.7%	↑	↑		
	1	Hand Hygiene	DB	CQIC, CRC	>=95%	89.3%	95.4%	93.6%	84.5%	94.1%	84.5%	84.5%	↓	↓		Target is locally set. **See Exception Report 2**
	1	Open Incidents - % of Managers Reports Completed within policy guidelines	DB	CQIC		53.68%	41%	36%	41%			41.0%		↑		

Clinical Quality Dashboard - April-16

	Strategic objective	KPI description	Exec Owner	Reported in	Target/ Benchmark	Actual 2015-16	Feb-16	Mar-16	Apr-16	2015-16 Q4	2016-17 Q1	YTD	Qtr Trend	Month Trend	Forecast	Comments
Patient Experience	1	Number of Complaints received this month	DB	CQIC		465	42	38	40	120	40	40	→	↑		
	1	Number of Complaints reopened this month	DB	CQIC		65	8	5	9	17	9	9	↑	↑		
	1	Number of Complaints referred to ombudsman this month	DB	CQIC		7	1	0	0	2	0	0	↓	→		
	1	% Complaints responded to within 25 working days	DB	CQIC	>=90%	81.9%	83.3%	76.3%		82.5%				↓		Data reported 1 month in arrears. **See Exception Report 3**
	1	Friends and Family Score - Trust	DB	CQIC		95.09%	94.98%	95.64%	94.73%	94.95%	94.73%	94.73%	↓	↓		The FFT score is calculated by determining the number of people who are "extremely likely" or "likely" to recommend the Trust, as a proportion of the number of people who responded to the question.
	1	Friends and Family Score - Inpatient	DB	CQIC		93.15%	94.34%	94.56%	94.24%	94.64%	94.24%	94.24%	↓	↓		The Inpatients response rate was 50.5% for Apr-16 NHS England has reported that FFT Scores should not be used to compare performance of individual Trusts, however the benchmark is still used for internal reporting. NHS England has also specified that FFT should be inclusive of all patients regardless of age, therefore paediatric FFT responses are now included in the overall inpatient figures.
	1	Friends and Family Score - Paediatric Inpatient				93.59%	92.45%	90.32%	87.69%	92.06%	87.69%	87.69%	↓	↓		Paediatric inpatient FFT data is included in the main Inpatient FFT score, though the score is also reported and reviewed separately.
	1	Friends and Family Score - Outpatient	DB	CQIC		94.42%	91.95%	94.05%	93.38%	92.51%	93.38%	93.38%	↑	↓		
	1	Friends and Family Score - A&E	DB	CQIC		94.34%	94.31%	95.86%	95.86%	95.40%	95.86%	95.86%	↑	↑		The A&E response rate was 3.7% for Apr-16
	1	Friends and Family Score - Maternity	DB	CQIC		95.37%	97.95%	97.60%	96.68%	94.94%	96.68%	96.68%	↑	↓		The overall score has been collated from responses to the 4 maternity touch points. This covers the patients experience of antenatal, delivery and postnatal wards/community care.
	1	Friends and Family Score - Daycases	DB	CQIC		98.17%	97.85%	98.01%	97.95%	98.36%	97.95%	97.95%	↓	↓		
	1	Friends and Family Score - Support for Carers of Patients With Dementia	DB	CQIC						83.78%						
	1	Number of Mixed Sex accommodation breaches	DB	CQIC	0	5	0	0	0	0	0	0	→	→		This is based on a national directive.
Safer Staffing	1	Day - Registered Midwives/Nurses Fill Rate	DB	CQIC		93.97%	99.0%	97.3%	98.2%	97.3%	98.2%	98.2%	↑	↑		
	1	Day - Assistant Fill Rate	DB	CQIC		119.39%	123.4%	123.6%	139.5%	118.6%	139.5%	139.5%	↑	↑		
	1	Night - Registered Midwives/Nurses Fill Rate	DB	CQIC		98.65%	100.2%	101.6%	98.2%	99.8%	98.2%	98.2%	↓	↓		
	1	Night - Assistant Fill Rate	DB	CQIC		114.94%	133.0%	140.3%	145.5%	126.2%	145.5%	145.5%	↑	↑		
	1	Overall Trust Fill Rate	DB	CQIC		102.52%	107.2%	108.0%	110.5%	105.1%	110.5%	110.5%	↑	↑		
	1	% of Registered Nurse and Midwife Expenditure on Agency Staff	DB	FIC		14.48%	15.7%	16.7%	11.4%	15.3%	11.4%	11.4%	↓	↓		
Maternity	1	Caesarean section rate	JW	CQIC	<=26%	29.3%	30.07%	30.52%	29.46%	28.29%	29.46%	29.46%	↑	↓		**See Exception Report 4**
	1	% women with a primary postpartum haemorrhage of 1500ml or more	JW	CQIC	<3.1%	3.3%	4.67%	3.71%	5.17%	3.80%	5.17%	5.17%	↑	↑		**See Exception Report 5**
	1	% women with a primary postpartum haemorrhage of 2000ml or more	JW	CQIC	<=1.0%	1.1%	1.87%	0.41%	2.02%	0.97%	2.02%	2.02%	↑	↑		
	1	Significant Perineal Trauma	JW	CQIC		2.69%	0.04%	0.07%	3.35%	2.76%	3.35%	3.35%	↑	↑		Data reported 1 month in arrears as requires coding to be completed

Qualitative Summary - April 2016

Clinical Audit

As part of the accreditation of the Trust's endoscopy service, the Endoscopy Team carries out patient surveys each year. Patients using the service are asked questions about general issues, such as being given adequate information, and also about their comfort during their procedure.

All patients surveyed (n=100) reported that they were given sufficient opportunity and time to ask questions about their procedure and the majority (98%) were given information on what needed to happen after their procedure. The majority of patients (85%) rated the pain they experienced during the procedure as either 'better than expected' or 'as expected'. Patient comments received through the survey are shared with members of the Endoscopy Team to ensure that care continues to improve and all patients' needs are met.

Complaints

The Trust received 40 formal complaints in April 2016 compared to 37 in April 2015. Emergency Services received the highest amount of complaints accounting for 50% of the total, followed by Specialist Services (28%), Corporate Services (10%), Clinical Support Services (8%) and Trust (5%).

The most frequent complaint subjects that were received related to care and treatment (28%), followed by appointments and communication (18% each), estates (10%), admission/discharge (8%), diagnosis, medication and procedural issues (5% each), documentation and test/investigation (3% each).

Reopened complaints

Nine complaints were reopened in April 2016, arising from complaints first received in January 2016 (2), February 2016 (4) and March 2016 (3).

The reasons for these complaints reopening were:

Further Questions – 7
Facts Inaccurate – 1
Recurrent Issues – 1

Ombudsman Referrals

No complaints were referred to the Ombudsman in April 2016.

Clinical Quality Report **Author: Andrea Cain**

Exception Report 1: Pressure Ulcers

In April 2016 4 patients were identified as having developed Trust acquired pressure ulcers. These have been raised as incidents and discussed at the intermediate Pressure Ulcer Management Panel (PUMP).
- Hamble had a patient with unavoidable stage 2 pressure damage
- Keats had a patient with unavoidable stage 2 pressure damage.
- Derwent had oatient with unavoidable stage 2 pressure damage
- Hamble had a patient with avoidable stage 2 pressure damage

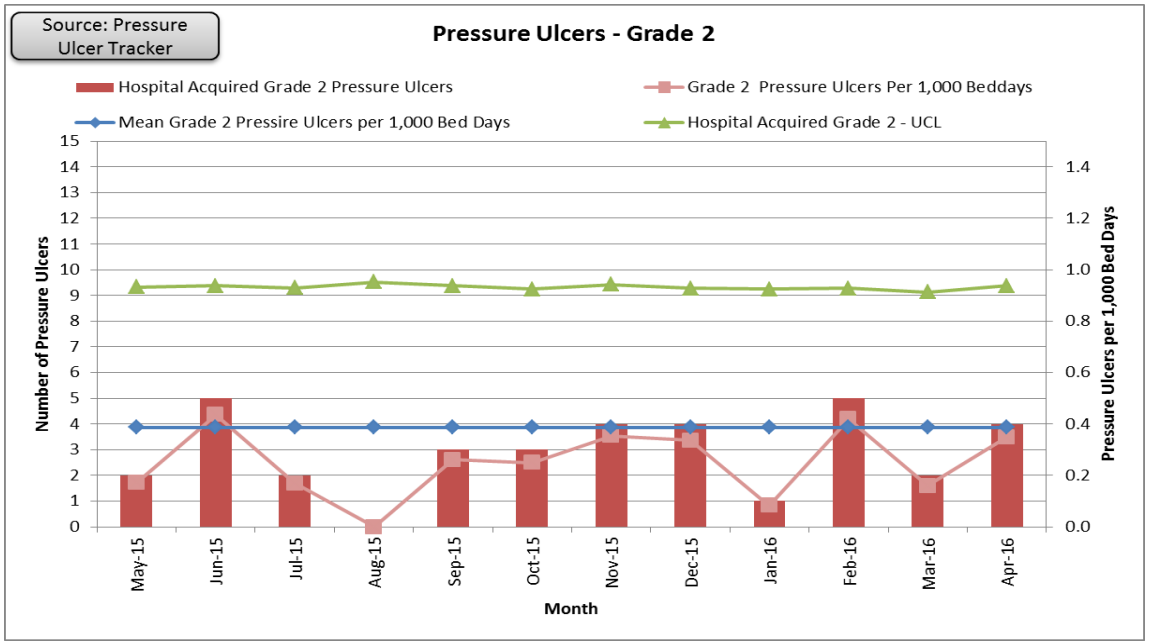
A patient developed a Deep Tissue Injury (DTI) on Kennet ward. This has been discussed with the community Tissue Viability Nurse (TVN) and is still a Deep Tissue Injury (DTI), awaiting staging in community.

Patients were raised as incidents and have been discussed at intermediate PUMP.

PRESSURE ULCER STRATEGY :
A meeting has taken place with Kingston community matron Re: the patient passport. - feedback to be discussed at monthly PUMP meeting.
Leaflets distributed to replenish stock. Wards should be able to re-order mid May 2016.

ACTIONS TAKEN TO PREVENT FURTHER PRESSURE DAMAGE
The Tissue Viability Nurse will continue ward training which includes education of reassessing pressure damage risk when condition deteriorates or patient has an existing grade 1 pressure ulcer.This training also covers the checking of patients skin and use of body maps on CRS on patient transfer so as high risk patients are handed over effectively.

The PAST (pressure ulcer support team) will begin from 1st May. The team will review all processes within the ward to see if anything further could be done to reduce the incidence of pressure damage. The Pressure Ulcer Management Team (PAST)will consist of nurses to begin withand then involve multidisclipinary team members as deemed necessary.



	Person Responsible	Date	Committee monitoring delivery
1. Rollout of MDT/SWARM approach to pressure ulcers	PUMP	08/03/2016	PUMP

Clinical Quality Report **Author: Fran Brooke-Pearce**

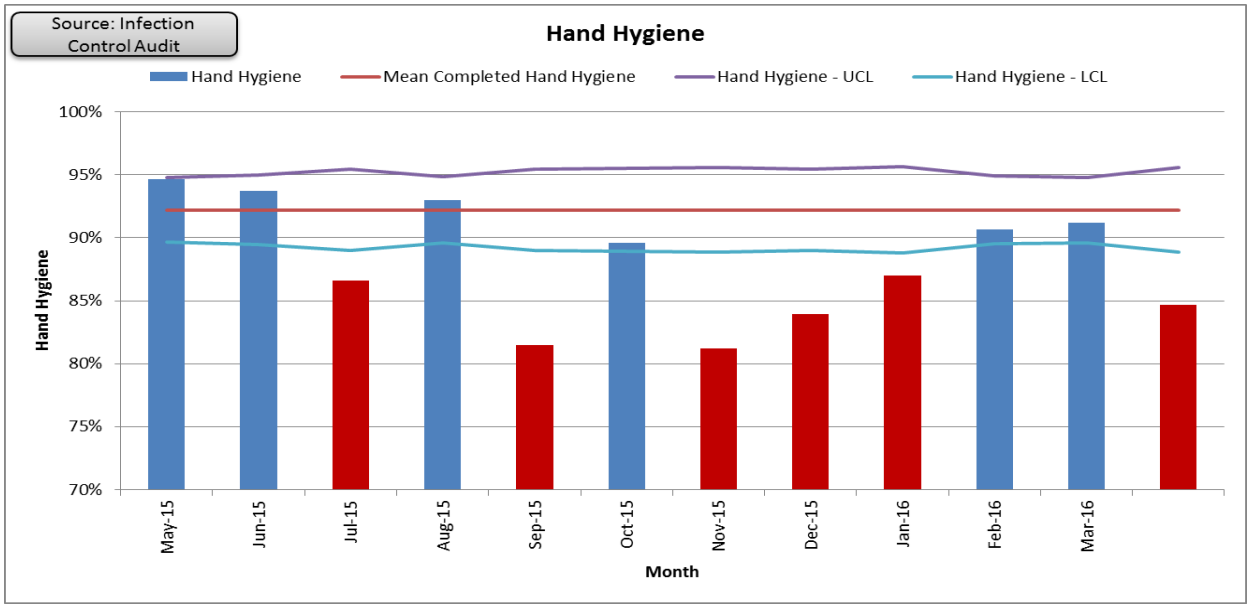
Exception Report 2: Hand Hygiene

February and March were not peer review audits as the wards had norovirus. April was peer review month.

The IPCT have created another Hand Hygiene Action Plan to increase scores. The action plan focuses on increasing Hand Hygiene awareness through production of new posters to be published throughout the Trust and clinical areas. Plans are being implemented to increase engagement of Consultants through appointment of Hand Hygiene "Champions", and to create a video clip demonstrating Hand Hygiene techniques to be displayed on the screens in ward areas.

Other aspects of the Action Plan relate to more advanced training of staff to ensure auditing is carried out in accordance with guidelines, and is uniform across all areas of the Trust. The Link Practitioners are being reminded again about the audits and the importance of getting above ten observations and feeding back immediately to the non-complier and the nurse in charge.

Plans to reintroduce Infection Control as an element of the Mandatory Training of staff are being investigated by the Infection Control Team.



Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
Production of new posters for the Trust and for clinical areas	Infection Prevention and Control Team/Communications	30/06/2016	Infection Prevention & Control Group
Request the return to face to face IC mandatory corporate induction and update training	Infection Prevention and Control Team	30/06/2016	Infection Prevention & Control Group
Link Practitioner training to promote and ensure audit compliance	Infection Prevention and Control Team	30/06/2016	Infection Prevention & Control Group

Clinical Quality Report **Author: Clare Parker**

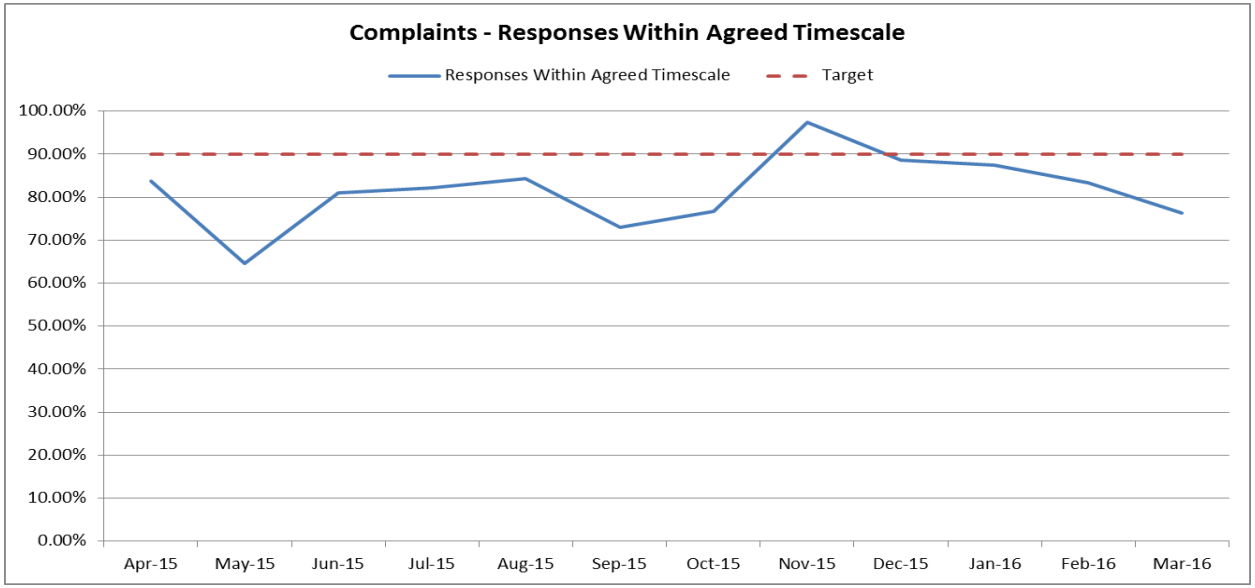
Exception Report 3: Complaints Response Rate

The Complaints Response Rate for Mar-16 was 76.9% which is below the 90% target.

The main delayed responses were in the Emergency Department. Other overdue responses related to one complaints in each of Paeds, Maternity and Neurology, and were the result of particularly complex complaints.

ED have cleared the majority of their backlog of complaints. The ED Service Manager has confirmed that they are setting up more robust processes around PALS/Complaints/SIs to ensure that each is logged on their own ED spreadsheet, triaged and then referred to the appropriate manager/clinician with deadlines set within the Service Line. They envisage that this will give them much better grip on managing complaints within the Service Line.

The Complaints team continue to anticipate, and regularly and robustly chase up any responses that are approaching the response deadline. The Complaints Manager dedicates the majority of her time to the accurate logging, notifying and chasing up of potentially overdue responses, and giving her support to ensure that Service Line Managers have the best opportunity to provide responses on time. Where necessary, and increasingly, the Complaints team draw together complaint responses where Service Lines cannot agree on a lead Service Line. The Complaints team will continue to regularly remind Service Line Managers of response deadlines and to offer support where needed.



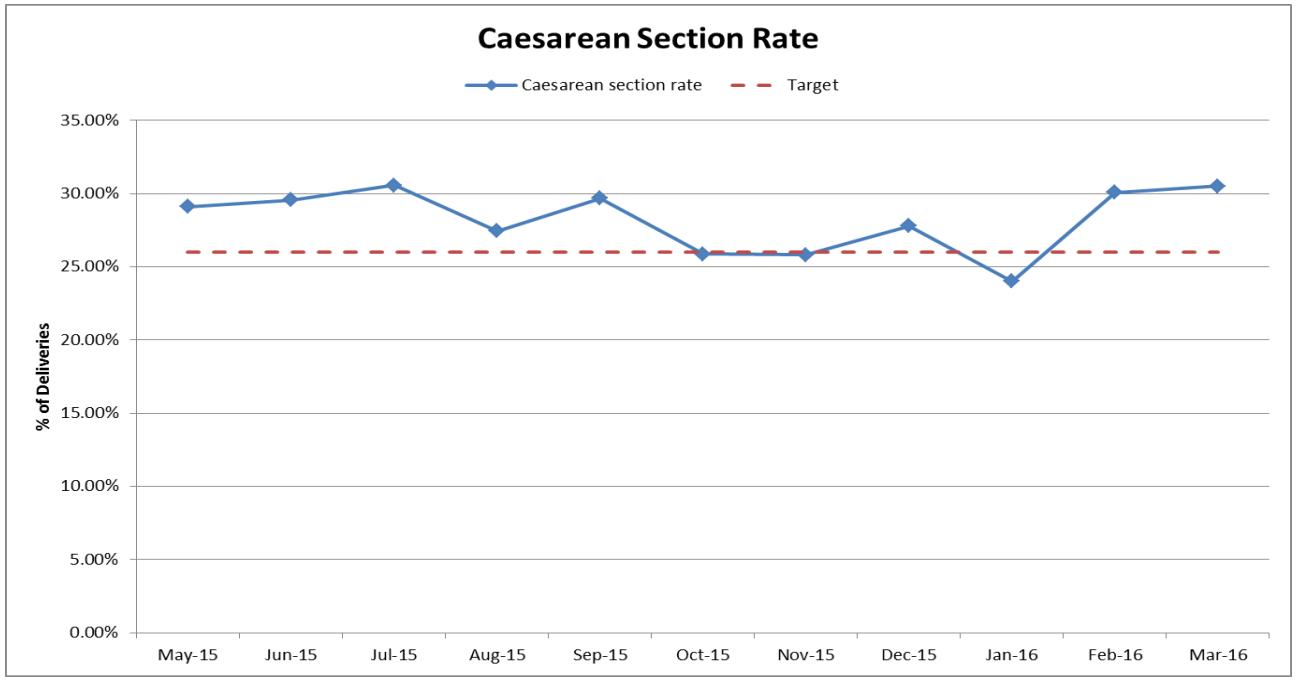
Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
Emergency Department - Complaints Procedure Review	ED Service Manager	31/05/2016	Governance Meeting

Clinical Quality Report **Author: Anna Dellaway**

Exception Report 4: Maternity - Caesarean Section

The maternity service, having improved the LSCS rates over the previous 4 months, is now experiencing a rise in the number of women who have a CS since February 2016. The rates were 30% for February, 30.5% for March but reduce to 29.5% in April 2016. All emergency births are reviewed by the SUTS team to determine whether the management was appropriate, and our emergency caesarean section numbers remain similar or lower to than others in the sector.

The number of elective CS, 13.5%, is higher than the national average of around 11% and we have a large number of maternal request caesarean sections. The consultant labour ward lead is reviewing 24 cases of maternal request LSCS to identify themes and ensure the correct pathway is being followed. The consultant midwife and consultant obstetrician for labour ward are planning to implement a pathway particularly for VBAC women. This approach has been successful elsewhere and it is anticipated that the % will gradually come down.



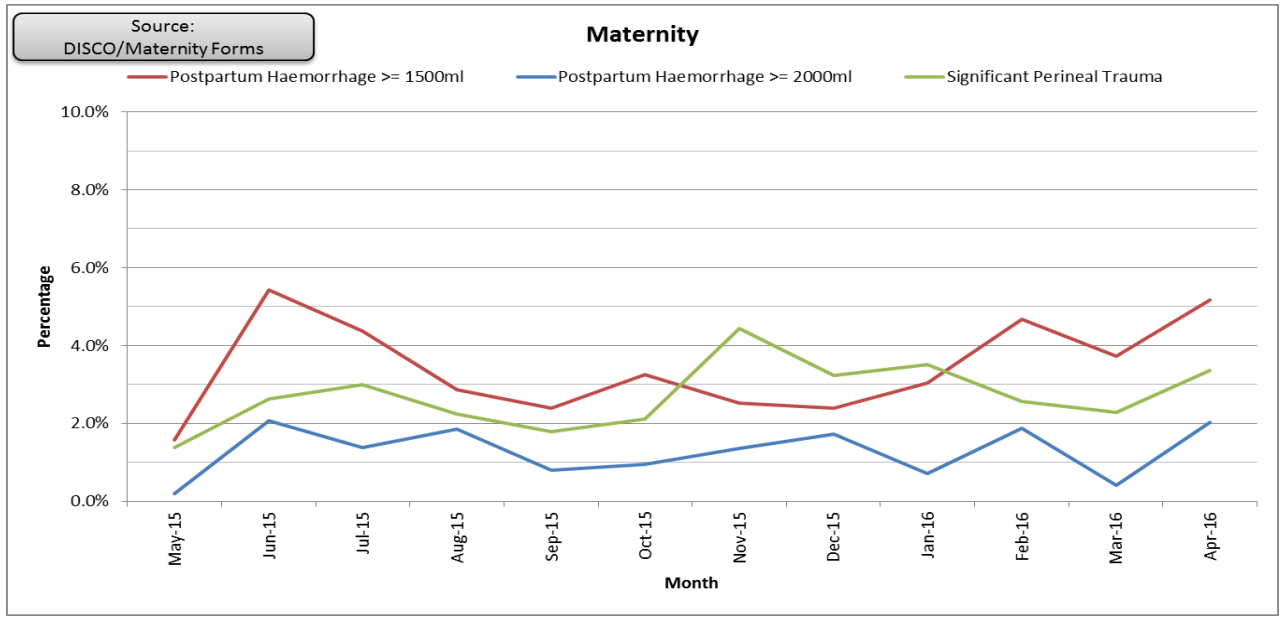
Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
Review all emergency birth April- June. Provide a summary report of themes and issues	SUTS team	31/07/2016	Maternity Risk Group/SLM
Complete review of case series maternal request LSCS	Gabby Bambridge	01/08/2016	Maternity Risk Group/SLM
Implement VBAC pathway	Elizabeth Hamilton and Gabby Bambridge	01/08/2016	Maternity Risk Group/SLM

Clinical Quality Report **Author: Anna Dellaway**

Exception Report 5: Maternity - Postpartum Haemorrhage

The maternity service has experienced a rise in the PPH rate of 1500mls or more from a target of <3.1% to between 3.71 - 5.17%. The overall PPH rate for 2015/16 was 3.2%. There is a rolling audit of PPH cases, and as a result of themes from the most recent audit, labour ward lead consultant is carrying out targeted teaching for junior doctors on the instrumental delivery to minimise trauma.

The risk team will now carry out a deep dive on PPH to identify any further themes and concerns. This should be in a position to report back in July. The SUTS team review all emergency births for further discussion and learning on whether a CS or instrumental delivery was necessary. The higher LSCS rate experienced over this time may well have contributed to the raised PPH rate. The unit is following the recommendations of the SWL PPH toolkit. We will continue to monitor the rates of PPH to ensure the upward trend does not continue.



Actions	Person Responsible	Date & RAG status	Committee monitoring delivery
Deep dive into PPH to identify themes and concerns	Anna Dellaway, Louise Wheeler and Diana Fleming	01/08/2016	Maternity Risk Group/SLM

Clinical Quality Report - Action Log						
Action Number	Date	KPI	Action	Owner	Action By	Status
1	Oct-14	Falls	1. Continue implementation of actions arising through Trust Falls Group	JW	Ongoing	
2	Jun-15	FFT	1. Complete Team Development Programme by all Inpatient Wards	DB	30/11/2015	
3	Feb-16	Pressure Ulcers	1. Rollout of MDT/SWARM approach to pressure ulcers	DB	08/03/2016	
4	Mar-16	Infection Control	VIP Scoring Guideline Changes	DB	19/04/2016	
5	Apr-16	Maternity - C-Section	Review all emergency birth April- June. Provide a summary report of themes and issues	JW	31/07/2016	
6	Apr-16	Maternity - C-Section	Complete review of case series maternal request LSCS	JW	01/08/2016	
7	Apr-16	Maternity - C-Section	Implement VBAC pathway	JW	01/08/2016	
8	Apr-16	Maternity - PPH	Deep dive into PPH to identify themes and concerns	JW	01/08/2016	
9	Apr-16	Hand Hygiene	Production of new posters for the Trust and for clinical areas	DB	30/06/2016	
10	Apr-16	Hand Hygiene	Request the return to face to face IC mandatory corporate induction and update training	DB	30/06/2016	
11	Dec-15	Hand Hygiene	Link Practitioner training to promote and ensure audit compliance	DB	30/06/2016	
12	Dec-15	Hand Hygiene	IPCT to monitor the Trust Hand Hygiene Action Plan and report through ICG.	DB	22/01/2016	