Kingston Hospital NHS Foundation Trust

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Clinical Quality Report
February 2014 (Month 11)

Trust Board: 27th March 2014

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 some areas of concern regarding quality of care in the Trust in February 2014. However mortality rates are maintained at a low level. The most recent in-hospital SHMI (January 2014) being 60 and the unadjusted mortality for February 2014, 1.4%.

Performance in safety KPIs, hospital acquired infection, pressure ulcers and falls remain areas of specific attention and robust action plans are being implemented.

There were no instances of C.difficile in February 2014, the number of cases year to date remains 22. Although this has breached the ceiling target set for the Trust, Monitor have not reflected this adverse performance in our rating, which remains green, as it has been recognised that the Trust's action plan is robust. There have been no E.coli bacteraemias in February 2014.

The VTE risk assessment scores have still not recovered to the target rates reported earlier in the year. All clinical areas are focussing on improving this. Technical issues in the reporting process have been rectified and further actions have been taken to ensure that the recording process is followed and the workflow made easier.

There were 6 pressure ulcers in February 2014, 2 of which were grade 3/4. The Trust is still likely to achieve the performance set for the year with the more serious pressure ulcers and will set a target to anticipate a further reduction next year. The number of less serious pressure ulcers is already greater than last year but the rate per thousand bed days has remained static (0.4/1000 bed days year to date).

The new falls bundle is being piloted this month with the aim to roll out quickly across the Trust under the supervision of the clinical lead who has been full time since the beginning of this month. There were no falls associated with harm in February 2014. There rate of falls was lower this month compared to recent months (lowest rate since October 2013).

The number of complaints to the Trust in February 2014 was similar to that for most months of the year falling from the high number in January 2014. There were no complaints referred to the Ombudsman. The rate of response to complaints has improved but further work is required in the Service Lines to improve this.

The report details the ninth month of the Friends and Family test. The exception reports provide a breakdown of FFT score by ward for February 2014. The scores for inpatients are stable. The wards are now receiving their information with a comparison to other ward areas in preparation for the data to be presented on screens at the ward entrances by April 2014.

The quarter 3 perinatal mortality per 1000 births shows a rise to 5.6 per 1000 births, and relates to 7 still births during this period. The maternity team are reviewing these results, the rate includes 4 expected deaths.

Clinical Quality Dashboard - January 14

	Strategic objective	KPI description	Exec Owner	Indicator also reported in	Target	Actual performance (latest 3 months): Previous Year	December	January	February	Q1	Q2	Q3	Q4 (to date)	YTD	Future performance, trends and commentary: Qtr Trend	Mnth trend	Forecast	Comments
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 3-4)	DB	Board - CPR, CQIC	<=0.5	16	0	1	2	3	2	2	3	10	↑	↑		Target set as reduction of 10% on 2012/13 target.
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays	DB	CQIC	<=0.06	0.12	0.00	0.09	0.18	0.09	0.06	0.06	0.13	0.08	↑	↑		
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 2)	DB	Board - CPR, CQIC	<=3	39	6	7	4	12	14	16	11	53	↑	↓		Target set as reduction of 10% on 2012/13 Outturn. See Exception report 1
Safety	1	Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	DB	CQIC	<=0.3	0.3	0.6	0.6	0.4	0.4	0.4	0.5	0.5	0.4	→	↓		
Safety	1*	Number of Patient Safety Incident Falls where moderate or severe harm occurred	JW	CQIC			4	3	0	1	6	4	3	14	↑	↓		
Safety	1	Number of Patient Safety Incident Falls per 1000 G&A beddays	JW	Board - CPR, CQIC	<=4.8	5.6	6.8	7.4	5.0	5.5	5.6	6.2	6.2	5.9	↑	↓		Target is National Patient Safety Agency (NPSA) benchmark See Exception Report 2
Safety	1	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	Board - CPR, CQIC	<1	1	0	0	0	0	1	0	0	1	→	→		Target set by Department of Health Public Health England data shows for 2012/13, KHT's rate of hospital acquired bacteramias was 0.7 per 100,000 bed days, National rate was 1.2. Benchmark data is published annually.
Safety	1*	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	DB	Board - CPR, CQIC	<=1	23	0	1	0	8	7	6	1	22	↓	↓		Target set by Department of Health Public Health England data shows for 2012/13, KHT's rate of hospital acquired infections was 15.8 per 100,000 bed days, National rate was 17.3. Benchmark data is published annually.
Safety	1	MSSA Bacteraemias - Post 48hour (Hospital Acquired)	DB	CQIC	<=1	10	2	1	1	4	3	4	2	13	↓	→		MSSA is new to the CQR. Exception reports will be produced quarterly if required.
Safety	1	E.coli Bloodstream Infections (Hospital Acquired)	DB	CQIC	<=1.5	18	4	0	0	4	10	9	0	23	↓	→		Target based on a reduction on last year's outturn
Safety	1	Nutrition - compliance with MUST assessment	DB	CQIC	>=85%	92.1%				91.2%	93.1%			91.7%	↑			Data is collected tri-annually as part of nutrition audit.
Safety	1	Completed Patient Observations	DB	CQIC	>=97%	94.9%												Collection method of this data is changing to NEWS .
Safety	1	Medication Incidents	JW	CQIC		551	62	62	50	158	135	163	112	568	↑	↓		No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
Safety	1	% of Medication Incidents Where Moderate or Severe Harm Occurred	JW	CQIC	<=4%	1.3%	3.2%	0.0%	0.0%	0.6%	0.7%	1.8%	0.0%	0.7%	↓	→		
Safety	1	Number of Serious Untoward Incidents	JW	CQIC		45	4	5	4	5	19	9	9	42				No target set. Reporting of incidents is important and should not be discouraged by setting a ceiling target
Safety	1	Number of Never Events	JW	CQIC	0	2	0	1	0	1	0	0	1	2	↑	↓		
Safety	1	Patient Safety Thermometer - % Harm Free Care	DB	CQIC		90.5%	91.8%	90.8%	90.8%	92.7%	92.2%	90.3%	90.8%	91.7%	↓	→		Previous year figure is July 12 to March 13

Clinical Quality Dashboard - January 14

Section	Strategic objective	KPI description	Exec Owner	Indicator also reported in	Target	Previous Year	December	January	February	Q1	Q2	Q3	Q4 (to date)	YTD	Qtr Trend	Mnth trend	Forecast	Comments
						Actual performance (latest 3 months)									Future performance, trends and commentary			
Effectiveness	1	SHMI	JW	Board - CPR, CQIC	<=95	88.7				89.8	93.1	92.8			↓			SHMI score < 100 is lower than expected mortality, taking into account age, gender, comorbidity and diagnosis grouping of patients. Q3 data is for the period Jul 12 to Jun 13 as published by the Information Centre in Jan 2014 Data for prior year is for period Oct 11 to Sep 12.
Effectiveness	1	SHMI (In hospital Mortality)	JW	CQIC	<=73	66	59	60		59	50	54	60	54	↑	↓		Data from CHKS and reported 2 months in arrears. Previous year and target based on April 2012 to January 2013
Effectiveness	1	Unadjusted Mortality Rate	JW			1.4%	1.3%	1.5%	1.4%	1.3%	1.1%	1.2%	1.4%	1.2%	↑	↓		CHKS data shows for Apr to Dec 2012, KHT's rate was 1.35% compared to a national rate of 1.30%.
Effectiveness	1	Excess Deaths	JW		<0	-263				-97	-103	-114		-314	↓			Data from CHKS and reported quarterly in arrears. A negative score means that there are less deaths than expected.
Effectiveness		% Emergency Readmissions following elective admission - 30 days	ST	CQIC		1.4%	1.6%	2.5%	2.9%	1.5%	1.9%	1.7%	2.7%	1.9%	↑	↑		Local data has been used to give an indication of performance.
Effectiveness	1,4	% Emergency Readmissions following emergency admission - 30 days	ST	CQIC		10.4%	10.7%	15.9%	14.3%	10.3%	9.8%	10.9%	15.1%	11.2%	↑	↓		Local data has been used to give an indication of performance.
Effectiveness	1,4	% Emergency Readmissions following all admissions - 30 days	ST	Board - CPR	<= 5.8%	5.6%				5.5%	5.3%	5.6%		5.5%		→		Data reported from CHKS and therefore in arrears. Target based on national peer upper quartile from CHKS.
Effectiveness	1	Prevention of hospital acquired VTE - % patients risk assessed	JW	CQIC	>=95%	91.9%	76.4%			93.5%	92.2%	78.9%		87.3%	↓	→		Target is national CQUIN.
Effectiveness	1	Hand Hygiene	DB	CQIC	>=95%	96.5%	94.7%	93.4%	95.1%	94.0%	93.1%	94.3%	93.4%	94.0%	↓	↑		Target is locally set.
Effectiveness	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%	81.8%	66.7%	88.6%		85.7%	89.7%	71.2%	88.6%	82.0%	↓	↑		Data from CHKS and will be reported 3 months in arrears. Data benchmarked against national peer performance for 2012/13
Effectiveness	1	Open Incidents - % of Managers Reports Completed within 10 days	ST	CQIC		Not Available	59%	55%	56%							↑		
Patient Experience	1	Number of Complaints received this month	DB	CQIC		391	28	41	24	94	104	104	65	367	↑	↓		
Patient Experience	1	Number of Complaints reopened this month	ST	CQIC		38	5	2	7	12	14	20	9	55	↑	↑		
Patient Experience	1	Number of Complaints referred to ombudsman this month	ST	CQIC		5	0	2	0	2	0	2	2	6	→	↓		
Patient Experience	1	% Complaints responded to within 25 working days	ST	CQIC	>=90%	79.3%	50.0%	48.8%		85.1%	67.3%	64.4%	48.8%	69.1%	↓	↓		Data reported 1 month in arrears
Patient Experience	1	Friends and Family Score - Trust	DB	CQIC			64	60	62	64	62	64	64	64	→	↑		The overall Trust Response rate was 7.3% in February. The target is to have a response rate over 15%
Patient Experience	1	Friends and Family Score - Adult Inpatient	DB	CQIC	78		61	55	58	61	61	60	56	60	↓	↑		The Inpatient response rate was 30.9% in February. 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. This has been based on June's published FFT data and will be reviewed quarterly.
Patient Experience	1*	Friends and Family Score - Outpatient	DB	CQIC			72	65	72	75	70	68	65	70	↓	↑		The outpatient response rate was 2.7% in February.
Patient Experience	1	Friends and Family Score - A&E	DB	CQIC	68		58	59	57	42	58	59	58	56	↓	↓		The A&E response rate was 26.1% in February. The target for FFT has been based on achieving the current top 25th Percentile score for acute trusts. This has been based on June's published FFT data and will be reviewed quarterly.
Patient Experience	1	Friends and Family Score - Maternity	DB	CQIC			64	64	61		62	65	64	64	↓	↓		The overall score has been collated from responses to the 3 maternity touchpoints. This covers the patients experience of antenatal, delivery and postnatal wards/community care.
Patient Experience	1	Friends and Family Score - Paediatric Inpatient	DB	CQIC			83	67	64	82	86	83	67	79	↓	↓		Includes scores from Sunshine Ward, Dolphin Ward and Neonates
Patient Experience	1	Number of Mixed Sex accommodation breaches	ST	CQIC	0	0	0	0	0	0	0	0	0	0	→	→		This is based on a national directive.
Maternity	1	Caesarean section rate	JW	CQIC	<=26%	27.5%	25.4%	28.7%	28.1%	25.1%	27.4%	27.3%	28.6%	27.0%	↓	↓		
Maternity	1	% women with a primary postpartum haemorrhage of 2000ml or more	JW	CQIC	<=1.0%	0.5%	0.4%	0.6%	0.5%	0.6%	0.7%	0.6%	0.5%	0.6%	↓	↓		
Maternity	1	Significant Perineal Trauma	JW	CQIC		2.5%				3.1%	3.0%	2.4%		2.9%	↓			Data reported 1 month in arrears as requires coding to be completed
Maternity	1	Perinatal Mortality Rate per 1000 births	JW	CQIC	<=3.7					2.1	2.7	4.8	0.0	2.6	↓			Data from CHKS. Target is National Peer rate from CHKS Data will be reported quarterly.
Maternity	1	Number of Red Maternity Escalations	JW	CQIC	0		0	0	0	0	0	0	0	0	→	→		

Key: 1* Quality Account Objective

Qualitative Report for February 2014

Clinical Audit
The Audiology Service at Kingston Hospital strives to comply with an accreditation programme called ‘Improving Quality in Physiological diagnostic Services’ (IQPS). Patient experience makes up one of the four parts of the IQPS framework and Audiology services are encouraged to receive patient feedback and action this where applicable.

Kingston’s Audiology Service has recently carried out a survey of its patients, both adult and children. Five of the six criteria set at the beginning of the survey were met (all scoring over 95%):

Patients are given enough information prior to the appointment about where to go and how to prepare
Patients are given enough privacy when discussing their procedure or treatment
Patients’ main reason for attending the clinic is dealt with to their satisfaction
Patients are treated with respect and dignity
Patients rate the care they receive as ‘excellent’, ‘very good’ or ‘good’

The remaining criteria “Patients are aware of who is performing their examination or procedure” scored 92%, under the 95% target set. This score was influenced by the fact that 7% patients were not able to remember whether or not the Audiologist had introduced themselves. The results have been discussed within the Audiology Department. Due to the good results, no specific actions for improvement are proposed at the moment, although this will be kept under review.

Complaints
The Trust received 24 formal complaints in February 2014 compared to 34 in February 2013. Emergency Services received the highest amount of complaints accounting for 54% of the total, followed by Specialist Services (46%). There were no complaints received in Clinical Support Services or Trust for this month. The most frequent complaint subject within the complaints that were received, related to care and treatment which accounted for 29%, followed by admission/discharge (21%) and communication (17%) of the total.

Reopened complaints

7 complaints were reopened in February 2014, arising from complaints first received in January 2013 (1), September 2013 (1), October 2013 (1), November 2013 (1) and December 2013 (3).

The reasons for these complaints reopening were:

Facts Challenged – 4
Further Questions – 3

Ombudsman Referrals

There were no complaints referred to the Ombudsman in February 2014.

Serious Incidents

In February the Trust declared four Grade 1 serious incidents; two related to Trust acquired stage 3 pressure ulcers, one was a fracture following a fall and the fourth was a Transfusion incident. The investigations into these incidents have commenced and the final reports will be signed doff by the Serious Incident (SIG) Group. In February 2014 the SIG signed off three reports, these related to; a fracture following a fall, suboptimal care of a deteriorating patient and an unexpected admission in to the NeoNatal Unit. No reports due in February 2014 were given an extension to their submission deadlines.
Due to the nature of one incident the Trust has requested that it be downgraded from a SI, by Kingston CCG, as it does not meet the permanent harm criteria. The Trust is waiting to hear from the CCG. Themes identified from recently closed investigation reports include; issues pertaining to accurate documentation and in particular in this period the completion and communication of skin assessments. Robust actions are being taken with staff when they have not followed Trust policy or procedure.

Staff Award Winners - March 2014

Clare Parker – Responsible
Maria Burns - Caring
Shelley Heard - Caring

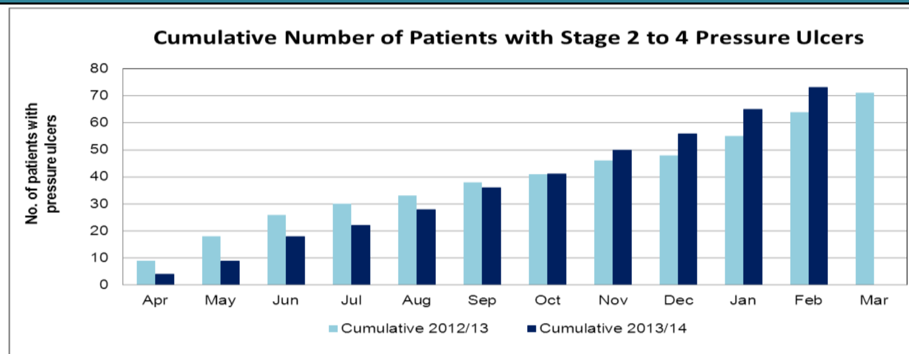
Clinical Quality Report

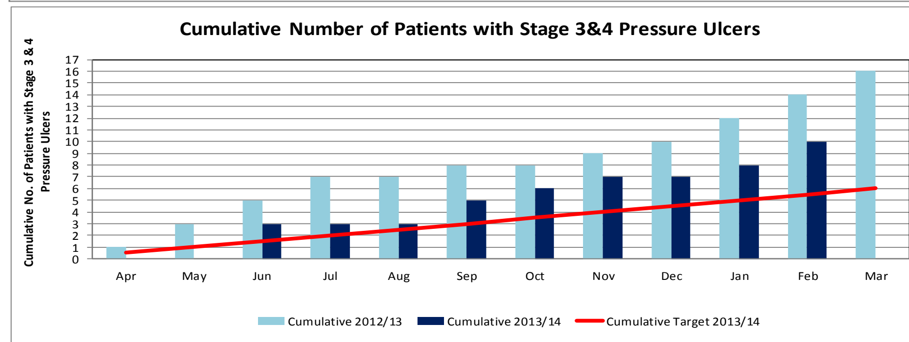
Author: Alison Williams

Exception Report 1: Pressure Ulcer Stage 2

In February 2014, a total of 4 patients were reported as having developed Trust acquired stage 2 pressure ulcers (2 x Derwent Ward, 1 x Hamble Ward, 1 x Blyth Ward). Also, 2 patients were reported as having developed Trust acquired stage 3 pressure ulcers (2 x Blyth Ward). Serious Incident Investigation has commenced for the patients with stage 3 pressure ulceration. Blyth Ward stage 2 pressure ulcer checklist was presented at the March Skin HIA group meeting. The pressure ulcer presented from Blyth Ward was deemed avoidable. Investigation indicated that despite the patient being at high risk with multiple underlying risk factors and comorbidities there was an inconsistency in the documentation, with not all of the repositioning schedules completed. Action plans have been developed for Blyth Ward with dedicated timeframes. Actions include the development of Nursing Support staff as skin champions for Blyth and Derwent Wards, clear identification of patients with pressure ulcers on the RAG boards and improved communication of skin integrity of all patients at shift handovers. To encourage an MDT approach to pressure area management, medical staff have received information regarding the CQC action plans and will be accountable for documenting patients skin condition in the medical notes. A presentation regarding pressure area management will be given to the Care of the Elderly grand round meeting in May 2014.

Temporary additional resource has been given for the Tissue Viability role to support pressure area management throughout the Trust but with specific focus on Derwent and Blyth Ward. Weekly audits of patients at risk on Blyth and Derwent Wards are being conducted by the Practice Development Team and fedback to the Ward Sister/Charge Nurses, Matrons and Tissue Viability Nurse Specialist. Checklists for the patients on Derwent and Hamble Ward will be reviewed at the next meeting on 31st March 2014. The Skin HIA group has now been renamed the Pressure Ulcer Management Panel meeting. The group will now be meeting as a full group on a monthly basis however fortnightly meetings will be held in between for any areas where stage 2 pressure ulcers have occurrred. Stage 2 checklists will be presented at the fornightly meetings to the Deputy Director of Nursing and the Tissue Viability Nurse Specialist by both senior ward staff and members of staff that were involved in the patients care to facilitate a quicker response time for the development and implementation of appropriate action plans.





	Person Responsible	Date	Committee monitoring delivery
1. Serious Incident investigations - Derwent Ward -1	Charge Nurse and Matron	31/03/2014	SI Group
2. Serious Incident investigation - Blyth Ward - 2	Charge Nurse and Matron	30/04/2014	SI Group
3. Complete the Blyth Ward pressure ulcer Action Plan	Charge Nurse and Matron	31/07/2014	Pressure Ulcer Management Panel
4. Complete Review of Derwent and Hamble ward stage 2 checklists	Ward Sister/Charge Nurse	31/03/2014	Pressure Ulcer Management Panel

Clinical Quality Report **Author: Duncan Burton**

Exception Report 2: Patient Safety Incident Falls

The falls rate in February is 5.0 falls per 1000 bed days and represents a reduction from prior months. There were no falls associated with moderate or severe with harm in February 2014.

The falls per 1000 bed days benchmarking is currently against the 2010 NPSA level. It is becoming increasingly apparent that this benchmark is out of date and not suitable for comparison of the Trusts falls levels. The NHS Quest Falls group will be used to identify benchmarking data & approach. A review of the thresholds for benchmarking has taken place with business intelligence in order that progress is tracked in 2014/15 against previous trust performance and reductions set within the corporate objectives 2014/15 . This will be reflected in reporting from April 2014 onwards.

The increase in falls in Hardy ward in month relates to a patient suffering repeated falls - which is being looked at by the falls project lead to ascertain learning. Kennett have not seen any common issues other than the demographic profile of the patients and have previously reported actions to the falls group in a deep dive. Bronte is undertaking a deep dive into fall at the falls group at the end of March 2014.

The senior physiotherapist (Olivia Frimpong) continues to be seconded to work specifically on additional falls prevention actions across the Trust. Olivia has been connected to the NHS Quest falls work stream. NHS Quest are treating falls as a 'wicked problem' and have commissioned external support to bringing organisations for 2 days in May in Exeter to work on falls with a workshop on solutions to this in June 2014. The Trust will send 2 representatives to this.

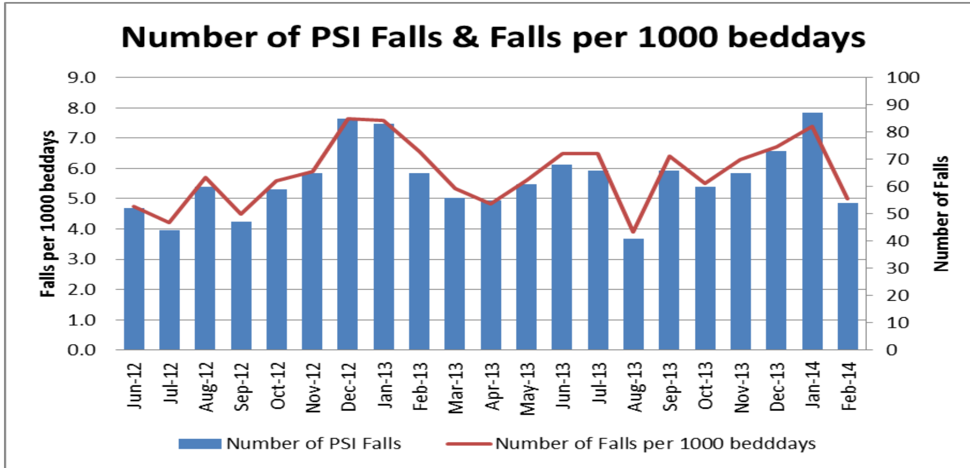
In February 2014 31%falls are associated with toileting and 15% happened within bathrooms. The trial of falls alarms in bathrooms has continues on Keats Ward with positive early signs. An evaluation of this is taking place in April 2014 to determine further roll out priorities.

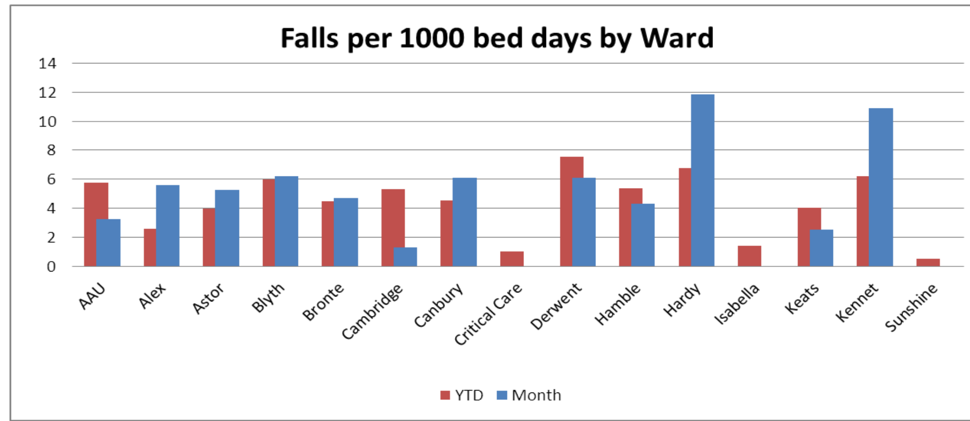
The simplification of the falls assessment and bundle (reduced to four pages) has been completed and trialled on AAU and Keats ward to illicit feedback from staff. Further amendments are taking place based on this and will be rolled out to other areas in April 2014.

Initial scoping for the retendering of the Trusts bed stock which is required this year is taking place and falls prevention is being included as a significant area of focus within this e.g. low beds.

The Trust has taken part in the national falls audit - the internal results of which were reviewed by the Falls group in February 2014 - areas for additional focus are around asking patients about their fear of falling, which is addressed in the new bundle, and medication, which is being addressed by pharmacy.

Jane Wilson, Medical Director will become the Chair of the Falls Group from March onwards, in lieu of realignment of roles within the Quality Directorate.



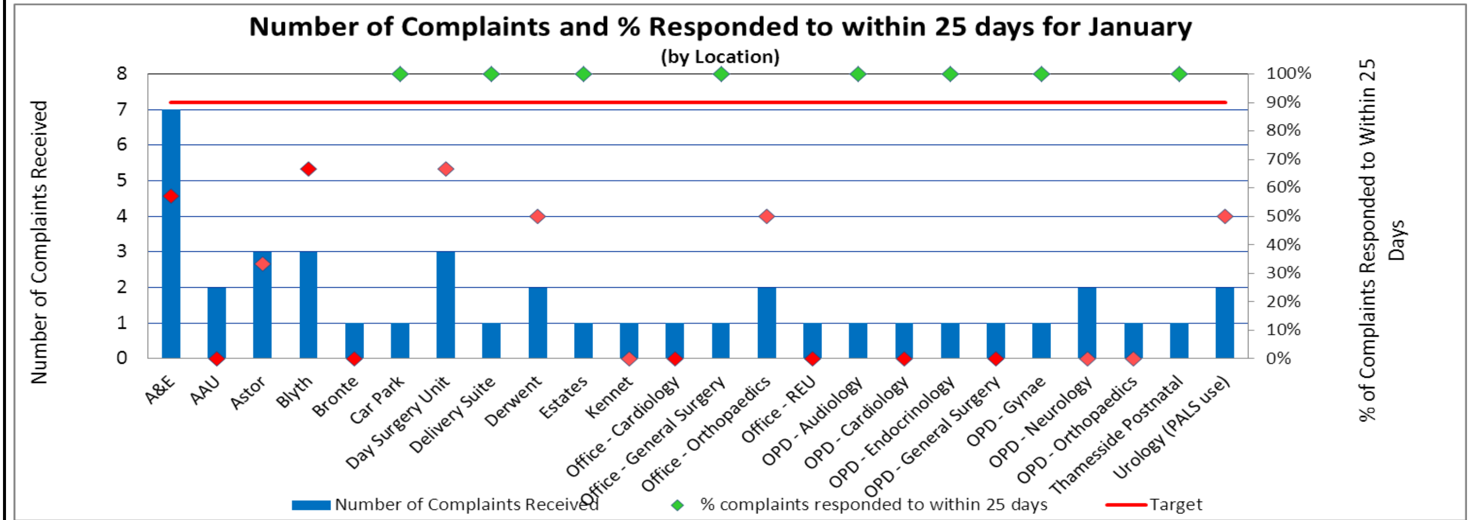


Actions	Person Responsible	Date	Committee monitoring delivery
1. Continue implementation of actions arising through Trust Falls Group	Medical Director	Ongoing	Trust Falls Group
2.Roll out revised falls bundle following trial changes	Olivia Frimpong, Physiotherapist	28/04/2014	Trust Falls Group
3. Undertake Bronte Ward deep dive	Ward Sister	31/03/2014	Trust Falls Group
4. Engage with NHS Quest falls wicked problem events in May & June 2014	Olivia Frimpong, Physiotherapist	30/06/2014	Trust Falls Group
5. Undertake falls alarm trial within bathrooms on Keats ward	Julie Drabwell, Ward Sister	28/03/2014	Trust Falls Group
6. Complete review of requirments for bed contract	Paul Kirkby, Clinical Engineering	28/06/2014	Trust Falls Group

Clinical Quality Report **Author: Tracey Moore**
Exception Report 3: Complaints responded to within 25 working days

Commentary

The management of complaints within 25 days continues to be challenging within the service lines. This is partly due to the development of CDs, matrons and service line managers in their new roles, to vacancies and to the complexity of some of the complaints which have required extensive and lengthy investigation. A number of actions have been taken in the divisions including the following: 1. Full devolution of responsibility for the complaints to the service lines in emergency care. 2. Review of the complaints list by the AD at the weekly 1:1 meetings with the service line managers in emergency care and specialist medicine. 3. Use of Ulysses in specialist medicine to more effectively manage complaint responses and all relevant paperwork.



	Person Responsible	Date	Committee monitoring delivery
1. Weekly monitoring of all service line returns by Associate Directors.	Associate Directors	On-going	Executive Management Committee
2. Review pilot of Ulysses in specialist medicine and consider role out.	Associate Directors	30/04/2014	EMC
3. Escalation of delays in receiving statements to relevant manager.	Associate Directors	On-going	Executive Management Committee

Clinical Quality Report **Author: Reinette Nell**

Exception Report 4: Friends and Family Test Inpatient

The inpatient FFT response rate for February 2014 was 30.9 %. From January 2014 onwards we are required to achieve a minimum of a 20% response rate. Our overall inpatient FFT score for February was 58. National benchmarking of the FFT score continues to put the KHT inpatient wards in the bottom quartile of Trusts nationally. Response rates and scores of different wards remain variable as shown within the table.

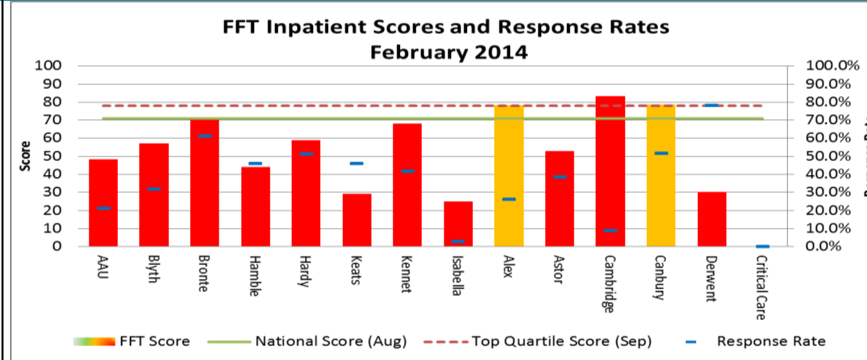
It is anticipated that the CQC inpatient survey report for 2013 will be published at the start of April and analysis of comanality between the results and FFT will be undertaken to inform ongoing areas of focus.

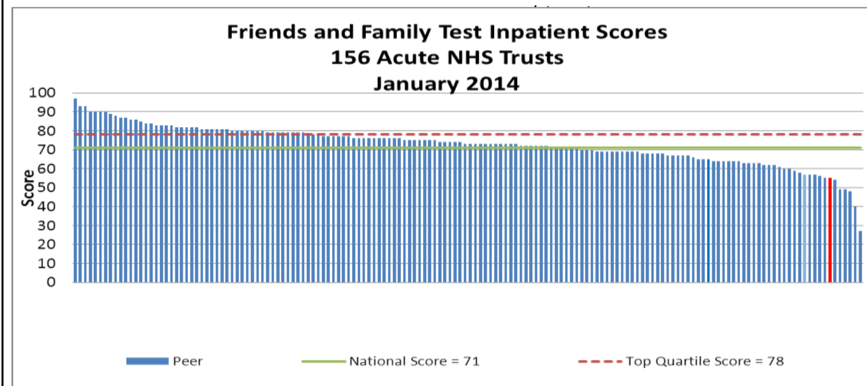
In February 2014 the results of qualitative ward level analysis was completed and a process is in place for this to be produced on a quaterly basis by the clinical audit team was established. These results have been provided to the Patient Experience Committee and the Ward Sister/Charge Nurses and service line teams.

Ward rankings continue to be included in the team brief for March and April 2014. Plans are on track to install ward level information screens within the ward areas in time for 1st April 2014. This will improve information for patients/visitors/staff on a range of areas which include assurance on staffing levels, the FFT score and FFT ranking position with other wards, and how to make a complaint or compliment.

Tasting sessions for a potential new food supplier took place in February and early March 2014 and the feedback is being assessed as part of the evaluation. Sourcing of bowl covers is currently taking place. 60 dining companions were trained in February 2014 and the availability of these companions is expected to have a positive impact on people's experience of meal times.

The review of the Trusts Quality Strategy in 2014 (Coporate Objective 14/15) will incorporate a review of the Trusts overall approach to improving the patient experience.





Actions	Person Responsible	Date	Committee monitoring delivery
1. Weekly review of FFT comments for wards	Matrons and Ward sisters	ongoing	Patient Experience Committee
2. Implement ward level electronic information screens with key patient & visitor information	Director of Nursing & Patient Experience	31/03/2014	Patient Experience Committee
3. Complete purchase and implement thermal bowl covers	Estates Director	31/03/2014	Nutrition Steering Group
4. Complete review of inpatient meals	Director of Nursing & Patient Experience / Estates Director	30/06/2014	Patient Experience Committee
5. Complete implementation of safe staffing national guidance publication action plan	Director of Nursing & Patient Experience	30/06/2014	Clinical Quality Improvement Group
6. Complete review of Trusts Quality Strategy	Director of Nursing & Patient Experience	31/10/2014	Clinical Quality Improvement Group /Trust Board

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
1	Oct-13	C diff	2. Develop a business case for an antibiotic APP.	DB	28/02/2014	
2	Nov-13	C diff	4. Implement Actimel for patients commencing antibiotics and audit the process.	DB	28/01/2014	
3	Feb-13	C diff	1. Complete review of PIR of case 22	DB	05/03/2014	
4	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	
5	Feb-13	C diff	3. Complete implementation of Actimel for patients commencing antibiotics and audit the process.	DB	15/03/2014	
6	Feb-13	C diff	4. Establish a mechanism to audit PPI use in the Trust.	DB	15/03/2014	
7	Feb-13	C diff	5. Revise the diarrhoea algorithm in order to provide clear guidance on taking stool specimens associated with laxative use.	DB	15/03/2014	
8	Nov-12	C Section	1. Weekly CS meeting & CTG meeting for reflection of practice and learning.	JW	Ongoing	
9	Oct-13	Complaints	2. Arrange complaints workshop, suppported by Claire Parker for investigating officers focusing on style and the addressing of each issue raised in the letter.	ST	30/12/2013	
10	Dec-13	Complaints	1. Clear back log of complaints - there are currently 10 in progress across the 2 service lines.	ST	12/02/2014	
11	Dec-13	Complaints	2. Implement robust administrative system for all areas in conjunction with the service line admin managers.	ST	31/01/2014	
12	Jan-14	Complaints	1. Develop complaint management process in SLMs	ST	31/03/2014	
13	Jan-14	Complaints	1. Weekly monitoring of all service line returns by associate directors	ST	Ongoing	
14	Jan-14	Complaints	3. Escalation of delays in reporting to Divisional directors to performance manage SLMs	ST	Ongoing	
15	Feb-14	Complaints	2. Review pilot of Ulysses in specialist medicine and consider role out.	ST	30/04/2014	
16	May-13	Ecoli	1. Reduce the use of indwelling urinary catheters & achieve CQUIN requirements	DB	15/12/2013	
17	Dec-13	Ecoli	1. Catheterisation policy is currently being re-written.	DB	31/01/2014	
18	Dec-13	Ecoli	2. Band 6 Nurse catheterisation skills training.	DB	30/04/2014	
19	Oct-13	Falls	1. Continue implementation of actions arising through Trust Falls Group	DB	Ongoing	
20	Jan-14	Falls	2.Implement revised falls bundle within wards		28/03/2014	
21	Dec-13	Falls	3.Approve and launch falls leaflet	DB	28/02/2014	
22	Dec-13	Falls	4. Review benchmarking methodology for falls	DB	30/03/2014	
23	Dec-13	Falls	5. Review learning from visit to QEH	DB	28/01/2014	
24	Dec-13	Falls	6. Undertake falls alarm trial within bathrooms on Keats ward	DB	28/03/2014	
25	Jan-14	Falls	3. Undertake case review for patient with repeated falls	DB	28/02/2014	
26	Jan-14	Falls	6. Complete review of requirments for bed contract	DB	28/06/2014	
27	Feb-14	Falls	2.Roll out revised falls bundle following trial changes	DB	30/04/2014	
28	Feb-14	Falls	3. Undertake Bronte Ward deep dive	DB	31/03/2013	
29	Feb-14	Falls	4. Engage with NHS Quest falls wicked problem events in May & June 2014	DB	30/06/2014	
30	Nov-13	Inpatient FFT	2. Implement FFT reports in Disco system to enable tracking of scores, response rates, feedback themes and rankings compared to other wards.	DB	31/01/2014	
31	Nov-13	Inpatient FFT	3. Complete review and refresh of Inpatient Experience Action Plan to include emerging themes	DB	31/01/2014	
32	Nov-13	Inpatient FFT	4. Implement ward level electronic information screens with key patient & visitor information	DB	31/03/2014	
33	Nov-13	Inpatient FFT	5. Complete purchase and implement thermal plate covers	DB	31/01/2014	
34	Nov-13	Inpatient FFT	6. Complete ward level theme analysis	DB	31/01/2014	
35	Dec-13	Inpatient FFT	1. Weekly review of FFT comments for wards	DB	ongoing	
36	Dec-13	Inpatient FFT	6. Complete review of inpatient meals	DB	30/06/2014	
37	Jan-14	Inpatient FFT	2. Complete review of PICKER Inpatient Survey results and	DB	31/03/2014	
38	Jan-14	Inpatient FFT	4. Complete purchase and implement thermal bowl covers	DB	31/03/2014	
39	Feb-14	Inpatient FFT	5. Complete implementation of safe staffing national guidance publication action plan	DB	30/06/2014	
40	Feb-14	Inpatient FFT	6. Complete review of Trusts Quality Strategy	DB	31/10/2014	
41	Oct-13	Maternity FFT	Increase response rate for TP1: Use of volunteers in the ante natal clinc to ensourage usage of the device. Set up a meeting with Laura Shalev-Green to identify volunteers to assist.	DB	31/12/2013	
42	Oct-13	Maternity FFT	Agree an action plan based on feedback from women from each TP with achievable measurable objectives with support from Patient Experience Manager.	DB	31/12/2013	
43	Nov-13	MSSA	2. Implement programme to introduce ANTT training and competency assessment for all clinical staff undertaking aseptic procedures.	DB	30/06/2014	
44	Nov-13	MSSA	3. Improve adherence to Trust policy on isolation, hand hygiene, peripheral line care and urinary catheter care on AAU.	DB	31/01/2014	
45	Nov-13	MSSA	4. Improve adherence to Trust policy on hand hygiene on Derwent Ward .	DB	31/01/2014	
46	Dec-13	MSSA	1. Medical staff to be reminded of the importance of documenting the date and time of inserting IV devices.	DB	31/01/2014	
47	Dec-13	MSSA	3. Complete intravenous catheter Quality Improvement Project	DB	30/10/2014	
48	Dec-13	MSSA	4. Training for A&E staff on the use of tunnelled lines in A+E	DB	31/03/2014	
49	Oct-13	Pressure Ulcers	4. Complete Pressure Area Awareness Training - Derwent Ward	DB	31/01/2014	
50	Dec-13	Pressure Ulcers	1. Complete review of Astor Ward and Derwent Ward cases at Skin HIA group.	DB	17/02/2014	
51	Jan-14	Pressure Ulcers	1. Serious Incident investigations - Derwent Ward -1	DB	31/03/2014	
52	Jan-14	Pressure Ulcers	2. Serious Incident Investigation - Hamble Ward	DB	17/03/2014	
53	Feb-14	Pressure Ulcers	2. Serious Incident Investigation - Blyth -2	DB	30/04/2014	
54	Feb-14	Pressure Ulcers	3. Complete the Blyth Ward pressure ulcer Action Plan	DB	31/07/2014	

Clinical Quality Report - Action Log

Action Number	Date	KPI	Action	Owner	Action by	Status
55	Feb-14	Pressure Ulcers	4. Complete Review of Derwent and Hamble ward stage 2 checklists	DB	31/03/2014	
56	Dec-13	VTE	1. All Clinical Directors made aware of the poor performance and asked to develop local actions for their areas.	JW	01/01/2014	
57	Dec-13	VTE	2. Clinical Directors in AAU and Maternity to develop specific plans to improve assessment recording in their areas.	JW	01/03/2014	

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	Feb-14	A continence nurse is currently being recruited.	No longer an action.	DB	WC

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. Undertake 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	
30	20/06/2012	Patient Observations	2. Ward Sister to conduct daily patient/ relatives ward round	JP	Completed	
31	20/06/2012	Patient Observations	3. Undertake 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 undertaken in July to encourage uptake 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 undertaken 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 undertaken in July to encourage uptake 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. Undertake 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 taken 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 undertaken - 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, taken 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 uptake 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 undertake 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 making 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 making 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 undertaking 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 taking	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 taking - 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 take 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 take 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 undertake 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 - 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 further 10% reduction on 2012/13 Target. Target is to have =<6 cases in 2013/14	Year to date performance is red	Data Source: Ulysses	Green Red	Full year < = 6 Full year > 6
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 Integrated Business Plan	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)	Target set as further reduction of 10% on 2012/13 Outturn	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 Integrated Business Plan	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 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	
6	Number of Patient Safety Incident Falls per 1000 G&A beddays		National Patient Safety Agency - national average in 2010 was 4.8 falls per 1000 bed days.		Data Source: Ulysses	Green Red	<=4.8 >4.8
7	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
8	Clostridium difficile Infections - Post 72hours (Hospital Acquired)	Number of hospital acquired C diff bacteraemia (admission to positive test >72 hours)	Target set by Department of Health, Full year target is <= 15 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 < =15 Full year > 15
9	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 <18 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	<=1.5 >1.5
10	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%
11	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%
12	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		
13	% 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		
14	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		
15	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	FALSE
16	% 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		
17	SHMI	SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline (England). The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patients who died in hospital plus those who died within 30 days of discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model using patient age, gender, admission method, Charlson Comorbidity Index and diagnosis grouping.	Figure calculated is based on benchmark across hospitals	Exception report if above target	Data shown are from NHS Information Centre	Green Amber Red	< =95 >95 and < 105 >105
18	In-Hospital Summary Hospital-level Mortality Indicator 2013	SHMI calculated where observed deaths only include deaths in hospital.	National Peer Apr 12 to Jan 13	Exception Report if above target for month	Data Source: CHKS		
19	Unadjusted Mortality Rate	Number of Deaths / Number of discharges (excludes Well Babies)			SSRS Discharge Report		
20	Excess Deaths	The difference between expected Deaths and actual deaths at the Trust	Based on indictor itself		Data Source: CHKS		

KPI definitions

KPI	KPI Name	KPI Definition	Source of Benchmark/target	Exception Report Criteria	Data Source	RAG Colour	RAG_Score
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 2012 - Feb 2013.	An exception report will be generated on red performance at YTD.		Green Red	<= 5.8 > 5.8
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 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		
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 - run by external company	tbc	tbc
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.	Based on National Top Quartile score for Jun 13 data. Amber Is between average and Top Quartile Score		Data Source: FFT - run by external company	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.			Data Source: FFT - run by external company	tbc	tbc
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.	Based on National Top Quartile score for Jun 13 data. Amber Is between average and Top Quartile Score		Data Source: FFT - run by external company	Green Amber Red	>=68 <68 and >54 <54
36	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	FALSE
37	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%
38	% women with a primary postpartum haemorrhage of 2500ml or more	Numerator: The number of women with a primary post partum haemorrhage of 2500ml 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%
39	Significant Perineal Trauma	The percentage of women with 3rd or 4th degree tears				tbc	
40	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		
41	Number of Red Maternity Escalations						

	KPI description	Exec Owner	Indicator also reported in	Target	RAG Green	Amber	Red
	Number of patients with pressure ulcers (Grade 3-4)	JW	Board - CPR, CQR	0.5	0.5		
	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	0.300		
	Number of Patient Safety Incident Falls	JW	CQR	<=34	34		
	PSI Patient Falls per 1000 G&A beddays	JW	Board - CPR, CQR	<=4.8	4.845		4.845
	MRSA Bacteraemias - Post 48hour (Hospital Acquired)	JP	Board - CPR, CQR	<=1	1		
	Clostridium difficile Infections - Post 36hours (Hospital Acquired)	JP	Board - CPR, CQR	<=1	1		1
	E.coli Bloodstream Infections (Hospital Acquired)	JP	CQR	<=1.5	1.5		
	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	< 5.77%	5.77%		6.77%
	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
	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	Amber	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				