Surrey and Sussex NHS
Healthcare NHS Trust

Integrated Quality and Performance Report M1– April 2011

Presented by: **Bernie Bluhm (Chief Operating Officer) and Jo Thomas (Chief Nurse)**
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Performance Report M1 – April

Summary:

- The report updates the Board on the key national, contractual KPIs across the Trust for the Month 1 of 2011-12 (April).
- The Performance Framework will no longer be reported as a separate item. Each of the indicators in the Performance Framework are included in the Main body of the report. Quarterly figures have been given for those metrics measured in the framework . The Q1 forecast for the trust is 'underperforming'
- The dashboard contained within this report is the revised Integrated and Quality dashboard. The KPI's have been split into two domains; Indicators used for external assessment and Indicators used for internal assessment
- The indicators used for external assessment headline measures contained within the Quality and Resource domain of the operating framework. The indicators included within the outcomes framework section of the report have been mapped to the five domains for delivery; Preventing people from dying prematurely, Enhancing the quality if life for people with long term conditions, helping people to recover from episodes of ill health or following injury, ensure that people have a positive experience of care, treating and caring for people in a safe environment. These represent the national measures the Trust will be responsible for delivering in the upcoming year.
- The indicators used for internal assessment have been mapped to those areas that are key to providing safe, high quality coordinated care.
- The report will allow the user to quickly and easily review year to date performance against target, monthly performance and quarterly trends.
- Underperformance will continue to be reported by exception. The direction of travel column on the performance report will also allow the user to identify the direction of travel verses plan for each indicator'
- There remain some Issues with validating the 18 week position. The data was not available at the time of this report.
- A Data Quality metric has been added to the board report, it will measure validity and data completeness. This metric will be populated from month 2.
- Data was not available in time for a workforce exception report to be included in this report.

Trust Board Agenda Item: 4.1	**Trust objective**: Please list number and statement. this paper relates to.	**Deliver safe, high quality co-ordinated care; Develop an effective organisation**

Action: The Trust Board is asked to note and accept this report.

Notes:

Legal: What are the legal considerations & implications linked to this item? Please name relevant Act	Not applicable.
Regulation: What aspect of regulation applies and what are the outcome implications? This applies to any regulatory body – key regulators include: Care Quality Commission, MHRA, NPSA & Audit Commission)	Department of Health.

Contents

1. Integrated Quality and Performance Dashboard

- Page 4 Operating framework metrics
- Page 5 Outcomes framework metrics
- Page 6 Internal metrics

2. Exception Reports

3. Glossary of Terms

Operating framework metrics

Surrey and Sussex NHS Healthcare NHS Trust

Operating Framework	Data Quality	Performance: Target	Performance: YTD Actual	Direction of Travel vs. Plan (▲=above plan ▶=on plan ▼=below plan)	Monthly Trend: Dec	Jan	Feb	March	April	Quarterly Trend: Q1 forcast	Q2 2010/11	Q3 2010/11	Q4 2010/11
Quality	Under Construction												
A&E time to initial assessment(95th percentile)		<15	116	▼				new metric for 2011/12	116				
Time to Treatment (median)		<60	78	▼				new metric for 2011/12	78				
Total time in A&E admitted (95th percentlie)		240	1013	▼				new metric for 2011/12	1013				
Total time in A&E non-admitted(95th percentlie)		240	446	▼					446				
% of patients in A&E under 4 hours		95%	87.2%	▼	85.6%	82.4%	82.0%	81.9%	87.2%		95.0%	93.0%	90.7%
number of of patients in A&E over 12 hours (trolley waits)		0	0	▶	11	0	0	3	0		0	11	3
A&E Unplanned Re-attendance rate (within 7 days)		<5%	9.4%	▼				new metric for 2011/12	9.4%				
Left without being seen (LWBS) Rate		<5%	3.6%	▲				new metric for 2011/12	3.6				
A&E Attaendances		N/A	4250		4572	4379	3833	4469	4250				
Emergency Readmissions within 30 days of discharge		TBD	3		3.3%	2.9%	3.4%	2.9%	3.0%				
MRSA (trust acquired)		0.33	0	▶	0	0	1	0	0		1	1	1
C Diff		4.2	3	▶	4	5	5	8	3		14	19	18
MSSA		N/A	5	▶				new metric for 2011/12	5				
18 weeks RTT admitted - 95th Percentile @		<=23		▼	26.0	29.0	32.0	32.0	Data not availabe			25	32
18 weeks RTT - non-admitted including audiology (DAA)-95th percentile @		<=18.3		▼	16.0	17.0	20.0	20.0	Data not availabe			16.7	20
RTT - incomplete - 95th percentile		<=28		▶	23.0	25.0	26.0	26.0	Data not availabe			23	26
Median wait times -non-admitted		N/A			5.0	6.0	4.0	4.0	Data not availabe				
Median wait times - admitted		11.1		▼	11.0	13.0	14.0	14.0	Data not availabe			12	13
RTT - incomplete -median		7.2		▶	8.0	7.0	7.0	7.0	Data not availabe			8	7
RTT - admitted 90% in 18 weeks		90%		▼	85.1	81.0	74.9	74.9	Data not availabe		90%		
RTT - non- admitted 95% in 18 wks		95%		▼	96.3	95.4	92.1	92.1	Data not availabe		97%		
2 week GP referral to 1st outpatient		93%	96.2%	▼	87.1%	93.9%	96.9%	95.2%	96.2%		91.1%	91.7%	92.4%
2 week GP referral to 1st outpatient - breast symptoms		93.0%	93.4%	▼	95.7%	93.8%	93.8%	93.9%	93.4%				
62 days urgent referral to treatment of all cancers		85%	86.60%	▲	87.2%	89.5%	89.6%	84.5%	86.6%		88.4%	88.7%	88.2%
62 wait first treatment from Consulatnt screening		90%	0.0%		0.0%	0.0%	100.0%	75.0%	0.0%				
Mixed Sex Accommodation		0	10	▼	6	6	0	10	10				
Patients that have spent more than 90% of their stay in hospital on a stroke unit		80%	60.0%	▼	59.0%	56.0%	48.0%	54.0%	60.0%				
Fractured Neck of Femur <36		85%	59.1%	▼	60.3%	59.0%	70.0%	73.3%	59.1%				
Resources													
FOT Performance against plan		N/A											
YTD performance		N/A	320		£185	-£66	£246	£215	£320				
Non-Elective FFCE's		N/A	1905		1919	2091	2059	2170	1905				

Outcomes framework metrics

		Data Quality	Performance		Direction of Travel vs. Plan	Monthly Trend					Quarterly Trend			
			Target	YTD Actual	▲=above plan ►=on plan ▼=below plan	Dec	Jan	Feb	March	April	Q1 forcast	Q2 2010/11	Q3 2010/11	Q4 2010/11
	Outcomes framework													
Effectiveness	HSMR	Under construction	100	98.2	▲	93	108	84.6	Data reported in arrears	Data reported in arrears				
Effectiveness	2 wks rapid access chest pain		100%	100%	►	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Effectiveness	Thromplysis 30 min door to needle time		75%	74.0%	▼	75.0%	83.3%	0.0%	0.0%	Data reported in arrears				
Effectiveness	PPCI 150 min call to ballon time		95%	90.0%	▼	100.0%	67.0%	100.0%	100.0%	Data reported in arrears				
Effectiveness	PPCI 120 min call to ballon time		60%	69%	▲	0.0%	67.0%	100.0%	33.0%	Data reported in arrears				
Effectiveness	Stroke/TIA treated within 24 hours		60%	93.0%	▲	62.5%	77.8%	40.0%	75.0%	93.0%				
Patient Experience	% of patients surveyed who would choose to be treated at SASH in Future		80%	N/A	▲	63.5%	92.0%	77.0%	94.0%	Not availabe				
Patient Experience	% of patients surveyed that staff treated them with kindness and respect		80%	N/A	▼	72.2%	78.0%	72.0%	78.0%	Not availabe				
Patient Experience	% of patients surveyed who felt their dignity was maintained the whole time they were a patient		80%	N/A	▲	81.0%	83.0%	80.0%	89.0%	Not availabe				
Safety	Newly acquired Pressure Ulcers (grade 2 and above)		TBD	15	►	13	15	12	21	15				
Safety	Number of falls reported as clinical incidents		73	18	►	46.0	32	42	20	18				
Safety	Number of medication errors resulting in an adverse event		0	0	▼	0	3	1	4	0				

Notes:

62 day wait percentage represents 0.5 breaches in month

The Thrombolysis target was achived in terms of the operation framework

Internal metrics

Area	Metric	Data Quality	Performance: Target	Performance: YTD Actual	Direction of Travel vs. Plan (▲=above plan ►=on plan ▼=below plan)	Monthly Trend: Dec	Jan	Feb	March	April	Quarterly Trend: Q1 Forecast	Q2 2010/11	Q3 2011/12	Q4 2011/12
	Safe, High Quality Coordinated Care													
Clinical Quality	VTE Risk Assessments		90%	*44.1	▼	38.6%	40.2%	38.5%	41.0%	43.6%				
Clinical Quality	HSMR Non-elective		<=100	99.2		95	110.4	85.5	Data reported in arrears	Data reported in arrears				
Clinical Quality	Number of falls resulting in a fracture/head injury		0	1	▼	1	1	0	2	1				
Clinical Quality	% of Stroke patients Scanned within 1 hour of hospital arrival		50%	43%	▼	28.0%	44.0%	27.0%	29.0%	43.0%				
Clinical Quality	% of SUI's due to be closed in month that were closed		100%	N/A		new metric for 2011/12				***N/A				
Clinical Quality	Number of Never events reported		0	0	►	0	0	0	0	0				
Clinical Quality	% Complaints responded to within agreed timeline with complainant/ 25 working days		80-90%	90%	►	93.1%	65.5%	78.3%	89.8%	90.0%				
Maternity	C-section rate			31.9	▼	29.6	28.8	29.7	32.7	31.9				
Maternity	% of women seen by a midwife or healthcare professional at 12 wks 6dys		90%	91.1%	►	87.4%	85.9%	89.5%	93.8%	91.1%				
Maternity	Breastfeeding initiation		90%			78.0%	81.0%	79.0%	Data reported in arrears	Data reported in arrears				
Infection Control	Hand Hygiene compliance		99%	97.6	▼	98.5%	99.1%	99.2%	99.6%	97.6%				
Infection Control	MRSA screening compliance (nonelective)		100%	102%	►		102.0%			Data Reported Quarterly				
Infection Control	MRSA screening compliance (elective)		100%	118%	▲	106.5	118.0%			Data Reported Quarterly				
Productivity and effectiveness	**% of cancelled operations not treated within 28 days		<=5%	13.00%	▼	4.1%	0.0%	8.3%	8.3%	13.0%				
Productivity and effectiveness	cancelled operations as a percentage of elective admissions		<=0.80	2.4	▼	3.9%	2.3%	2.2%	2.1%	2.4%				
Productivity and effectiveness	Daycase Rate					Under Construction								
Productivity and effectiveness	Average LOS non-Elective													
Productivity and effectiveness	Average LOS Elective													
Productivity and effectiveness	Delayed Transfers of Care		3.5%			1.58%	1.72%	2.65%	2.10%	1.84%				
Productivity and effectiveness	Excess follow ups		N/A			887	1175	1294	1386	1468				
Workforce	Vacancy Rate		<=10%			11.2%	10.8%	9.8%	9.8%	9.9%				
Workforce	Total Establishment		N/A	3056		3140	3136	3137	3136.3	3156				
Workforce	Total in post		2766			2787	2799	2825	2829	2845				
Workforce	Sickness absence rate		<=3.0%			4.9%	4.2%	4.4%	4.4%	3.8%				
Workforce	Total WTE Bank Staff (excluding extra capacity nursing)		<=210			198	246	232	240	228				
Workforce	Total WTE Agency Staff (excluding extra capacity nursin		<=40			58	63	60	59	50				
Workforce	% of staff who have completed stat and mandatory trainii		****6.6%	5%		new construction				5.0%				

* data as of 13/05/2011
** exception reports provided on a quarterly basis
***No SUI's were due to be closed in month
****Target is cumalative

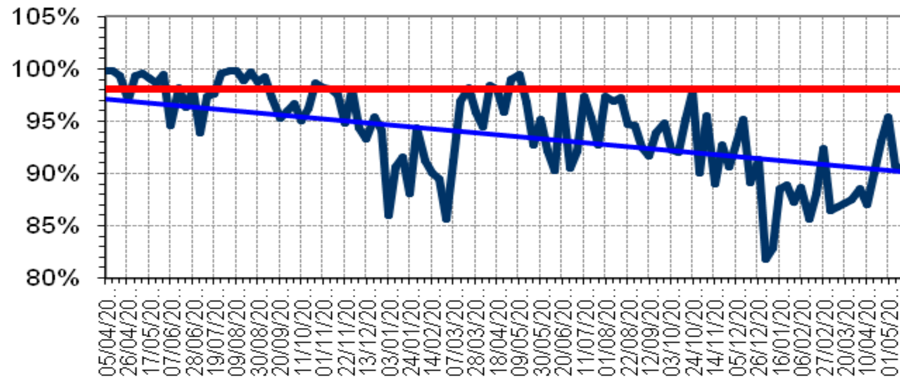
Contents

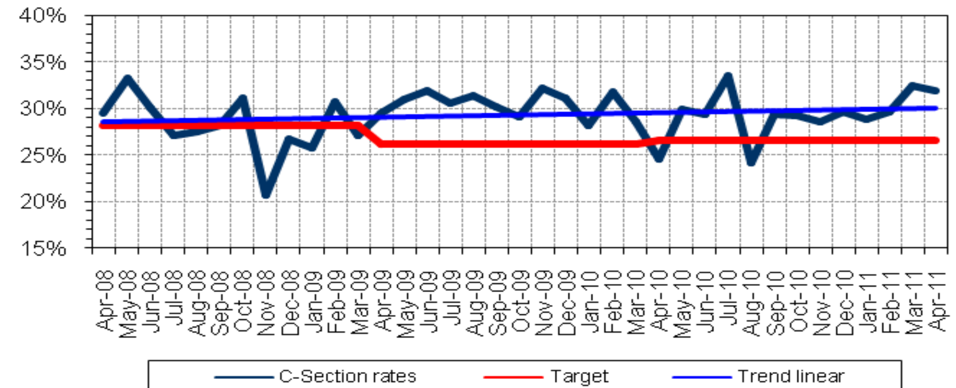
1. Integrated Quality and Performance Dashboard

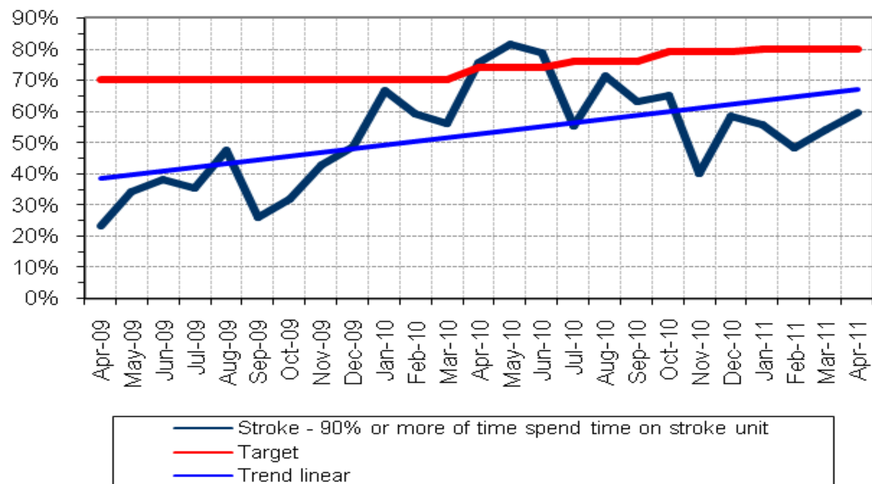
2. Exception Reports

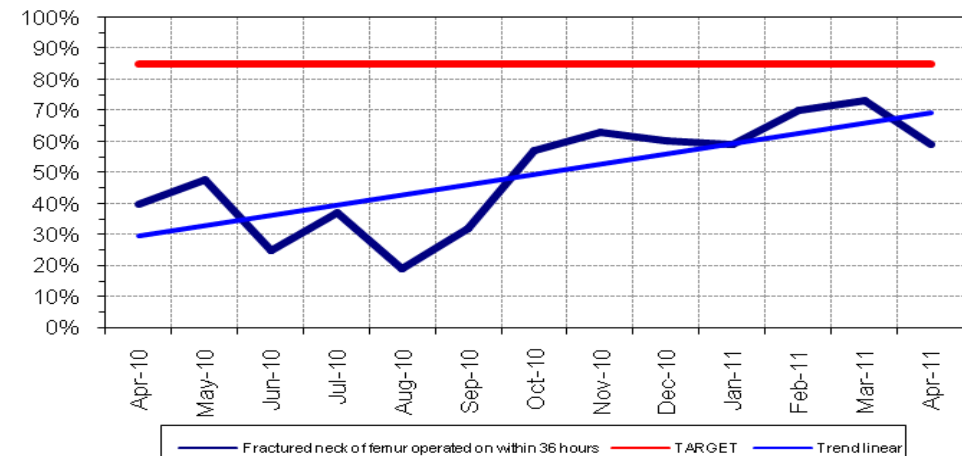
3. Glossary of Terms

2. Charts for Performance Exception Areas

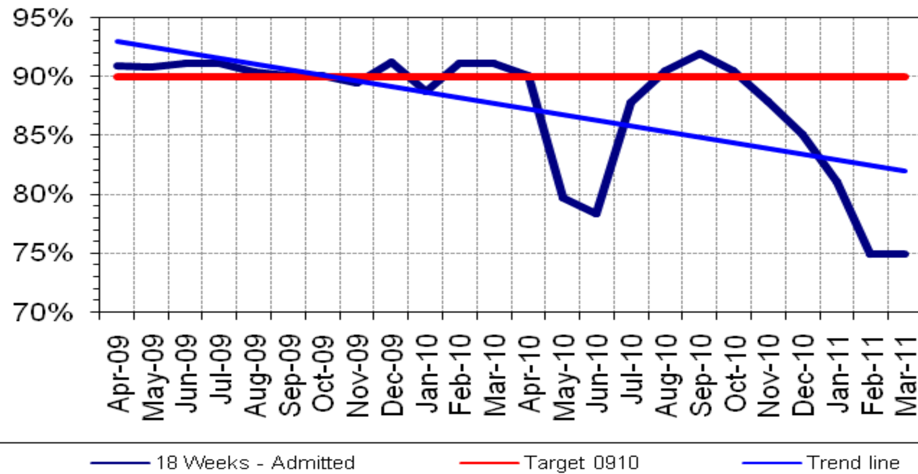


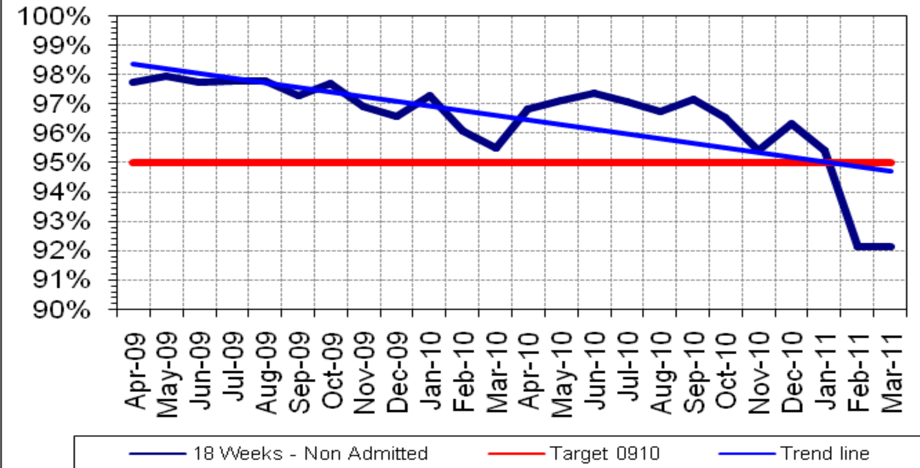






Charts for Performance Exception Areas





Surrey and Sussex Healthcare NHS Trust

Exception Report – 18 weeks admitted

Indicator Rationale	The CQC Periodic Review in 2009/10 outlines that Trusts are expected to maintain a maximum waiting time of 18 weeks from referral to start of treatment for 90% of admitted patients and 95% of non admitted patients. The DH is no longer performance managing Trusts centrally on 18 weeks but locally this target remains in force embedded through the acute contract and the NHS Constitution pledge
Context	• Following the Cerner upgrade in the 28th Feb, we have not been able to access the RTT report and therefore are currently unable report on 18 week performance. (Information department are now able to run 18 week reports – data now needs to be validated and it is hoped to have a report in time for Management Board Performance Meeting)
Actions to Date	▪ From the 1st April all patients being booked in 18 week date order (other than cancers and clinical urgent) ▪ Outsourcing of ENT, Orthopaedics continues ▪ Elective lists continue to be reviewed 24 hours prior to operating day in conjunction with operational bed pressures with view prevent cancellations on the day ▪ Meeting held with SHA, PCT's and Trust Exec Lead (Bernie Bluhm) to review Trusts 18 week position and agree way forward - PCTS to submit plan by 18th May ▪ Have meet with the PCT's (West Sussex and Surrey) to explain modelling - both back log clearance and sustainability. ▪ PCT's agreed to adopt the IST sustainable modelling that we have completed, but are validating the numbers
Actions for Next Month	▪Agree plan with PCT's and submit to SHA ▪Work with Information Dept to get access to 18 weeks RTT reporting
Risks	▪ Operational bed pressures – resulting in cancellation of Elective Surgery (in order to implement plan Elective beds need to protected) ▪ Due to high number of cancellations there is a on going high risk of breaching the 26week and 28 day target due to capacity issues. Also cancelling patients multiple times (=>3). ▪ Plan not agreed between Trust and PCT's or PCT's and SHA

Operational Lead and Author	Hamish Wallis, Assistant Director of Clinical Services for Surgery
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report – Cancer Waits

Indicator Rationale	Cancer is a major health issue in the UK; one in three people will be diagnosed with cancer in their lifetime, and one in four will die of cancer. Late diagnosis has been a major factor contributing to poor cancer survival rates in the UK.	
Context **Month 01**	**31 Day Wait for second or Subsequent Treatment Surgery** (Target 94%) Trust achieved 88.8% compliance due to 2 breaches Breach report: (Breast) Elective capacity issue due to study leave and annual leave. Breach report: (Urology) Urgency was not indicated on TCI card (CWT sticker not used) and MDT Coordinator was unaware of recurrence in this patient and therefore unable to escalate.	**62 Day Screening** (target 90%) Trust achieved 0% compliance due to 0.5 breaches of 0.5 patients treated Breach report: this is a shared breach for colorectal screening with the Surrey Breast Screening Centre who referred the patient to us on day 42 of the pathway.
Actions to Date	▪ GP practises continue to be called where a patient is deferring their appointment beyond two weeks ▪ Annual leave management centralised and minimum staffing protocols agreed	
Actions for Next Month	▪ Out patient capacity continues to be monitored on weekly basis. ▪ Monitor leave requests to ensure capacity is sufficient to meet demand ▪ Protocol for identifing cancer patients to be re enforced to all medical staff	
Risks	▪ Capacity issues – especially within Endoscopy	

Operational Lead and Author	Hamish Wallis – report author Philip Kemp, Divisional Chief Nurse for Surgery
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report Month 12 - Stroke

Surrey and Sussex NHS Healthcare NHS Trust

Indicator Rationale	110,000 people have a stroke each year, around a third of whom die. Stroke is the largest single cause of adult disability there are around 300,000 people in England living with moderate to severe disabilities as a result of a stroke. Good care on a dedicated stroke unit is the single most effective way to improve outcomes for people with stroke. This indicator is a good proxy for reducing disability and death due to stroke. Expected position by the end of 2010-11: 80% of people with stroke spend at least 90% of their time on a stroke unit. People who have had TIA are at a greater risk of stroke.
Context	• There were 37 stroke discharges in April with 60% spending 90% of their stay on the stroke unit; demonstrating a steady month by month improvement. • Achievement of the 90% indicator is strongly linked to the emergency patient flow pathway and associated actions relating to bed management and effective and timely discharge. The non-performing pathways were again linked to continued pressures on bed capacity.
Actions to Date	▪ We have undertaken an analysis on performance which demonstrates that optimum monthly discharges are 35 and that performance improves inversely with occupancy rate. ▪ We have increased our compliment of band 6 nurses so that bed placement can be improved over the 24/7 period. ▪ Outlying patients are reviewed daily and repatriated as soon as clinically appropriate. ▪ Locum consultant on Capel ward appointed until a substantive appointment is made. Job description for the substantive post is awaiting College approval. ▪ TIA pathway and booking process has been reviewed and communicated to GPs to improve communication and reduce time. ▪ Pathway breaches are analysed and discussed within the Stroke team to identify and act upon lessons learned. ▪ West Sussex Early Supported Discharge pilot underway (too early for results and under threat due to funding cuts).
Actions for Next Month	▪ Ring-fence beds on Abinger ward to be used for Stroke patients only and monitor impact on a weekly basis. ▪ Agree start date for Early Supported Discharge for east Surrey patients.
Risks	• Winter pressures. • D&V outbreaks and subsequent ward closures.

Operational Lead and Author	Natasha Hare, Service Manager
Executive Lead	Bernie Bluhm, Director of Clinical Operations

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Exception Report – VTE

Indicator Rationale	VTE is a measure of a patients susceptibility to developing thromboembolytic complications. This is a CQUIN target which aims to improve clinical outcomes for patients and additionally has a financial incentive.
Context	The failure to undertake adequate VTE thromboprophylaixs risk assessment is a national problem and is contributing to the avoidable death of many patients every year. There is National best practice guidance which is linked to CQUIN funding to further encourage focus on this area of patient safety.
Actions to Date (Medical Division)	Snapshot performance in October 2010 For Medical division was 18% which improved dramatically to 93% in November 2010 following action detailed below. Current performance is reported at 58% for May which is surprising due to the conclusive nature of the change that we have implemented. Include VTE scoring as a mandatory filed in the electronic clerking system completed by the admitting doctor.
Actions to Date (Surgical)	Of 1346 eligible patients for VTE, 287 were recorded electronically as having received an assessment with the Surgical Division in Month 01. This equates to 21.32% of eligible patients against a target of 90% •All junior staff have been trained and given passwords and the last rotation induction day to enable them to record VTE assessments electronically •Have undertaken review of what is being included and what should be excluded from the list of patients eligible for VTE Assessment – there are a large portion of patients being included that should not be (i.e. Ophthalmology, Endoscopy).
Actions for Next Month (Medical Division)	Investigate and verify the data- early indication is that the number of VTE forms is being collected from the patient tracking system and the number of patients from Cerner. This suggests that the way the data is being interpreted is flawed. We are investigating and will take corrective action where necessary.
Actions for Next Month (Surgical Division)	. Ensure that the list of eligible patients is correct . ▪ Issue to be raised at Specialty meetings with Consultants to ensure that they re-enforce to junior staff the requirement to complete assessments electronically. ▪ Performance to be monitored on weekly basis and non compliant areas addressed immediately ▪ to split monitoring in to emergency and elective.
Risks	

Operational Lead and Author	Angela Stevenson, AD Medicine , Hamish Wallis (AD Surgery)
Executive Lead	Bernie Edwards, Chief Operating Officer

Surrey and Sussex NHS
Healthcare NHS Trust

Exception Report – Thrombolysis

Indicator Rationale	MINAP data, Door to Needle time less than 30 mins for more than 75% of patients.
Context	Failure to achieve the door to needle times for 2010/11, result of 74% for year. 0% in March. Numbers of eligible patients very small, only one patient in March therefore one failure = 0%. Service has moved to PPCI only on march 21s, thrombolysis now not offered.
Actions to Date	▪Reviewed all failed patients to see if any pattern to events. ▪All patient delays identified as occurring in ED. ▪Updated ED Matron for cascading to all staff. ▪Early initial assessment and review by Dr part of ED work stream
Actions for Next Month	▪Thrombolysis not being offered as a treatment going forward, all patients for PPCI. ▪Continued work on meeting new quality indicators for ED
Risks	Review of MINAP data collection required with change from thrombolysis to PPCI as a treatment for STEMI.

Operational Lead and Author	Paula Tooms
Executive Lead	

Exception Report – Caesarean Sections

Indicator Rationale	SEC SHA committed to reducing caesarean sections across the health economy to achieve a reduction in maternal morbidity whilst maintaining good clinical outcomes for babies. The plan was to achieve 23% across Southeast Coast by the end of 2010 / 11, following a successful bid for innovation funding for a one year project to normalise birth in the region.
Context	SaSH, along with a number of other Trust's in SEC, have historically had a c section rate in excess of 30% and outturn for 2009/10 was 29.6% against a contractual target of 26.1%. The Trust were engaged in a Joint Clinical Investigation with the PCTs over this high rate and agreed that the target for 2010/11 should be 26.5%, recognising the step change that needed to occur. In the calendar year 2010 we realised a 1.8% reduction against the previous years figures, with a year end total of 28.6%. However, the financial year end total was disappointing, coming in at 28.9%, showing only a .8% reduction.
Actions to Date	▪ Creation of birthing unit ▪ Information to women in first pregnancy that elective LSCS not an option in the absence of clinical need ▪ Workshops / staff engagement sessions to educate all staff in line with NHSi recommendations ▪ Daily review of all potentially avoidable emergency LSCS's ▪ Part of SEC launch for project following SHA Innovations bid – complied with all recommendations as outcome to the project ▪ Reviewed VBAC pathway agreed (Matron Project) ▪Consultant debrief on ward post delivery to record discussions re next pregnancy recommendations ▪Action plan progresses constantly
Actions for Next Month	▪After 2 months of an in excess of 31% LSCS rate, more detailed analysis is being undertaken to identify which Consultants & Registrars are undertaking the Caesareans with a view to managing. Prospective audits also to be undertaken. Also going to recruit a VBAC midwife to lead on supporting education for VBAC women. ▪Continue to progress the actions as outcome to the SEC project – we still anticipate seeing positive outcomes to the work undertaken, as much was around VBAC (Vaginal Birth After Caesarean), and we would not see the benefits of this work until women return for subsequent babies. ▪Plans to staff birthing unit separately – currently recruiting to new post specifically for band 7 team leader for the Birthing Unit – 4 applicants. This will further enhance the normalising birth agenda. Interviews 10.5.11.
Risks	▪ Having met with the Public Health leads in early April, there is to be no negotiation this year on the 23% target – this poses a significant
Operational Lead and Author	Sue Chapman, Head of Midwifery / Nursing & Governance, Women & Child Health
Executive Lead	Mary Sexton, Director of Nursing, Quality & Governance

Exception Report – Falls Medical Division (April 2011)

Indicator Rationale	Within the Medical Division patient falls remains the highest reported incident. In April one fall was reported as major, resulting in a fracture neck of femur.
Context	Patient admitted to Nutfield ward on the 30/3/2011 with a history of shortness of breath and recurrent falls. Falls risk assessment and falls action plan completed and patient being nursed in a bed near the bathroom facilities. Patient was mobilising independently. Patient commenced onto twice daily diuretics. Patient suffered an un-witnessed fall whilst mobilising independently to the bathroom. Examined by medical staff, x-ray undertaken and orthopaedic review requested. Patient was commenced onto neurological observations. X-ray showed a fractured neck of femur and patient underwent surgery.
Actions to Date	▪Incident fed back to ward staff for local learning. ▪Amber investigation form completed. ▪Elderly care matron aware of fall and ensured all appropriate actions taken.
Actions for Next Month	▪To ensure that robust plans are put in place to support the recommendations made from the assessment process in this case toilet plans to raise awareness around the correlation between diuretics and frequency. ▪Development of post fall protocol around care of patient to include frequency of and type of observations that should take place.
Risks	▪ Reduced staffing due to vacancies or sickness resulting in reduced supervision. ▪Potential Increase in confused elderly patients more at risk of falls.

Operational Lead and Author	Lisa Cheek – Divisional Chief Nurse
Executive Lead	

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Exception Report – Fractured Neck of Femur

Indicator Rationale	Fractured neck of femur is the most serious consequence of falls in older people with a mortality rate 10% at one month after a fall, 20% at four months and 30%at one year.
Context	As of 1st April 2010, best practice guidelines changed to 36 hours from admission to operation. Figures are now calculated using these guidelines although both this and the previous target of 48 hours are reported.
Month 01 Performance	44 patients admitted with fractured neck of femur in month 01. ***36 Hours Compliance:* 59.09**% (26 patients) ***48 Hours Compliance:* *79.55***% (35 patients) ***Day 1 post op Physiotherapy:*** *59.09%* (26 patients) ***NOF Bed:*** *5* patients transferred to a NOF bed within 4 hours ***Iliaca Femoral Block: 15.91***% (7 patients) **DVT Prophyaxis**: 87% **Other Trauma:** there was 97 trauma admissions other than #NOF in month 01 (of which 35 were paediatrics) Mid month there was a disproportionate increase in the number of non #NOF trauma cases which were clinically urgent and therefore took priority on the Trauma list displacing #NOF patients
Actions to Date	• Orthogeriatric Ward rounds taking place every day on Newdigate ward • Have bee unable to ring fence #NOF beds (due to bed pressures) however the ward has at all times got two patients identified that could be transferred when a #NOF patients is identified in ED. Lack of joined up work to then facilitate the transfer of the patients • All consultants agreed in Job Planning to review Trauma list night before and to agree order of list for next day. • Have agreed to use the Theatre Seminar room for the morning Trauma meeting.
Actions for Next Month	• Training of Iliaca Femoral Block taking place at Audit Day for Anesthetic Staff • Ensure there is joined up teaming working between the Ward, ED and Bed Managers in facilitating moving patients off ward and from ED when #NOF in ED • Capital bid submitted for renovation work to Theatre Seminar room to make it fit for Moring Trauma meetings • Review protocol on Trauma management when there is an increase in admissions
Risks	• Fluctuations of demand and our ability to adapt quickly to this (impact on Elective pathway) • Winter Bed Pressures – restricting ability to ensure patients in #NOF bed (Newdigate Ward) within 4 hours

Operational Lead and Author	Hamish Wallis, Assistant Director of Clinical Services for Surgery
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report – Mixed Sex Accommodation April 2011 (Medical)

Indicator Rationale	DH target to achieve same sex accommodation. Financial penalty will be incurred for each patient in mixed sex accommodation.
Context	22 Mixed sex accommodation breaches occurred in the Discharge Lounge. 6 mixed sex accommodation for non clinical reasons occurred in the CCU. The Trust continued to be very busy throughout March and all escalation areas were open impacting on the ability to keep same sex accommodation in all areas.
Actions to Date	▪Site meeting attended by operation staff and clinical staff and all opportunities explored to prevent any mixed sex accommodation. ▪All potential need to mix a bay are escalated through the matron of the area to ensure all alternatives are considered first. ▪At weekends there is now a clinical matron and issues are raised to the clinical matron on duty. ▪When mixed bays have occurred privacy and dignity is maintained through the use of screens and patients are informed about the reason for why the bay has been mixed.
Actions for Next Month	▪To continue to monitor mixed sex accommodation breaches and to enter breaches onto the database. ▪Matrons to monitor areas where mixed sex breaches have occurred and to ensure that all actions are put in place to ensure privacy and dignity is maintained. ▪Divisional Nurse to audit monthly a couple of patients to ensure all actions were appropriate.
Risks	▪Operational difficulties continue to result in mixed sex accommodation. ▪Potential to result in increased complaints and patient dissatisfaction.

Operational Lead and Author	Lisa Cheek – Divisional Nurse Medicine
Executive Lead	

Contents

1. Integrated Quality and Performance Dashboard

2. Exception Reports

3. Glossary of Terms

3. Glossary Of terms

- MRSA - Methicillin-resistant *Staphylococcus aureus*
- Cdiff - *Clostridium difficile*
- HSMR – Hospital Standardised Mortality Rates
- TIA - Transient Ischaemic Attack
- RIDDOR – Reporting of Injuries Dieses And Dangerous Occurrences
- ITU – Intensive Treatment Unit
- WTE – Whole Time Equivalent
- FFCE – First Finished Consultant episode
- AMI – Acute Myocardial Infraction
- RACP – Rapid Access Chest Pain
- CDS – Commissioning Data Set
- LOLER - Lifting Operations and Lifting Equipment Regulations 1998
- SUI – Serious Untoward Incident
- ITU – Intensive Treatment Unit
- H&S – Health and Safety