Surrey and Sussex NHS
Healthcare NHS Trust

Integrated Quality and Performance Report M11– February 2011

Presented by: **Bernie Bluhm (Chief Operating Officer) and Vikki Carruth (Deputy Chief Nurse)**
Authors: **Sharon Gardner Blatch (Head of Integrated Governance and Quality) Char Fletcher (Senior Performance Manager)**

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Performance Report M11 – February

Summary:

- The Q4 performance framework forecast is 'underperforming' (please see page 4 of this report for explanation).
- The 18 week position contained within the report is a preliminary position.
- There have been some technical issues with the migration of data to the new Cerner system. Therefore some numbers contained within the Intergraded Performance and Quality dashboard will appear in grey until the information can be validated. It is expected this situation will be resolved shortly.
- The Department of health has instituted a monthly mixed sex accommodation (MSA) return. It collects monthly data on the total occurrences of patients receiving care that are in breach of the sleeping accommodation guidelines. In line with that return, the trust will now report mixed sex breaches according to that definition.

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

Trust Board
24th March 2011
Agenda Item:

Trust objective:
Please list number and statement. this paper relates to.

Notes: (please cut & paste to a new page if not enough room)

Legal: What are the legal considerations & implications linked to this item? Please name relevant Act	
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)	

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1. Performance Framework Forecast

The Q4 performance framework forecast is 'underperforming'.

- The Department of Health (DH) has found a problem was it's calculation of the delayed transfers of care indicator (DTOC) for Q2. The Q2 report used the mean of weekly and monthly DTOC data, rather than taking the mean at the end of the month.
- This has lead to a change in the trusts rating in Q2 from performing, to performance under review
- In line with the DH escalation rules if a trust is rated as 'performance under review' for three or more contiguous quarters, that Trusts rating is automatically escalated to underperforming.

Acute Trusts

Service Performance (standards and targets) - Indicators, weighting and scoring

	Thresholds					Q4 Forecast as at 17 03 11				
Performance Indicator	Performing	Under-performing	Weighting for PF	Data frequency	Quarterly/YTD	Actual	FOT for Q4	Achieve / Fail Score	Weighted Score	Achieve / Fail
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	>95%	<94%	1	Quarterly data aggregated to YTD	YTD	82.40%	92.27%	0	0.0	under performing
Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops	5.0%	15.0%	1	Quarterly	YTD	1.40%	2.00%	3	3.0	Performing
MRSA	0	>1SD*	1	Monthly	YTD	4	On trajectory	3	3.0	Performing
C Diff	0	>1SD	1	Monthly	YTD	62	On trajectory	3	3.0	Performing
18 weeks RTT - admitted - Median@	<=11.1		0.50	Monthly data aggregated to quarterly	Quarter	14.0	13	0	0.0	under performing
18 weeks RTT admitted - 95th Percentile @	<=27.7		0.50		Quarter	32.0	29	3	1.5	under performing
18 weeks RTT - non-admitted including audiology (DAA)-median @	<=6.6		0.50		Quarter	4.0	5	3	1.5	Performing
18 weeks RTT - non-admitted including audiology (DAA)-95th percentile @	<=18.3		0.50		Quarter	20.0	18.5	3	1.5	performance under review
RTT incomplete - Median	<=7.2		0.50		Quarter	7.0	8	0	0.0	under performing
RTT - incomplete - 95th percentile	<=36		0.50		Quarter	25.0	23.0	3	1.5	Performing

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Q4 Performance Framework Forecast Cont…

Acute Trusts

Service Performance (standards and targets) - Indicators, weighting and scoring

	Thresholds					Q4 Forecast as at 17 03 11				
Performance Indicator	Performing	Under-performing	Weighting for PF	Data frequency	Quarterly/YTD	Actual	FOT for Q4	Achieve / Fail Score	Weighted Score	Achieve / Fail
2 week GP referral to 1st outpatient	93%	88%	0.50	Monthly	YTD	96.90%	92.50%	2	1.0	performance under review
2 week GP referral to 1st outpatient - breast symptoms	93%	88%	0.50	Monthly	YTD	93.80%	90.00%	2	1.0	performance under review
31 day second or subsequent treatment - surgery	94%	89%	0.33	Monthly	YTD	95.00%	97.40%	3	1.0	Performing
31 day second or subsequent treatment - drug	98%	93%	0.33	Monthly	YTD	100.00%	99.60%	3	1.0	Performing
31 day second or subsequent treatment - all cancers	96%	91%	0.33	Monthly	YTD	98.80%	98.70%	3	1.0	Performing
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments) compared to plan.	94% (only applies for Q4)	89% (only applies for Q4)		Monthly	Q4	Not Applicable				
62 day referral to treatment from screening	90%	85%	0.33	Monthly	YTD	0.0%	82%	0	0.0	under performing
62 day referral to treatment from hospital specialist	85%	80%		Monthly	YTD	Low Numbers				
62 days urgent referral to treatment of all cancers	85%	80%	0.33	Monthly	YTD	89.60%	88.00%	3	1.0	Performing
Reperfusion : Primary Angioplasty (PPCI)^	75.0%	60.0%	0.50	Annual but moving to quarterly during 2010/11	YTD	90.70%	90.70%	3	1.5	Performing
Reperfusion : Thrombolysis^	68.0%	48.0%	0.50	Annual but moving to quarterly during 2010/11	YTD	93.30%	93.30%	3	1.5	Performing
2 week RACP	98%	95%	1	Quarterly	YTD	100%	100%	3	3.0	Performing
Patients that have spent more than 90% of their stay in hospital on a stroke unit	60%	30%	1	Bi-Annual	08/09	28.20%	28.20%	2	2.0	Under performing
48 hours GUM access	98%	95%		Monthly	YTD	Not Applicable				
Delayed transfers of care	3.5%	5.0%	1	Quarterly	Total in period	2.80%	1.70%	3	3.0	Performing
Sum of weights			13.66667					Unweighted score	32.0	

Scoring values	
Underperforming:	0
Performance under review:	2
Performing:	3

Overall performance score threshold		
Underperforming if less than	2.1	Weighted score 2.3
Performance under review if between	2.1 and 2.4	underperforming

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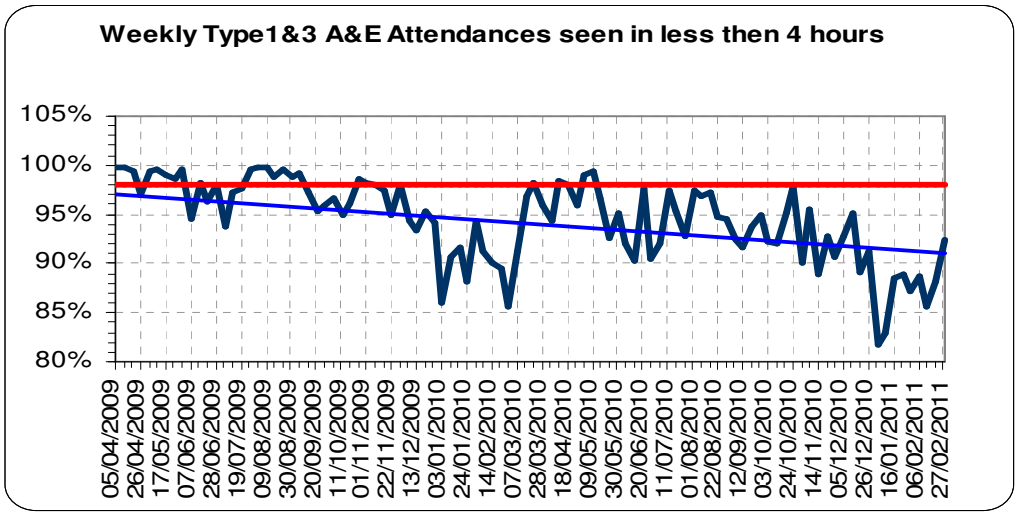
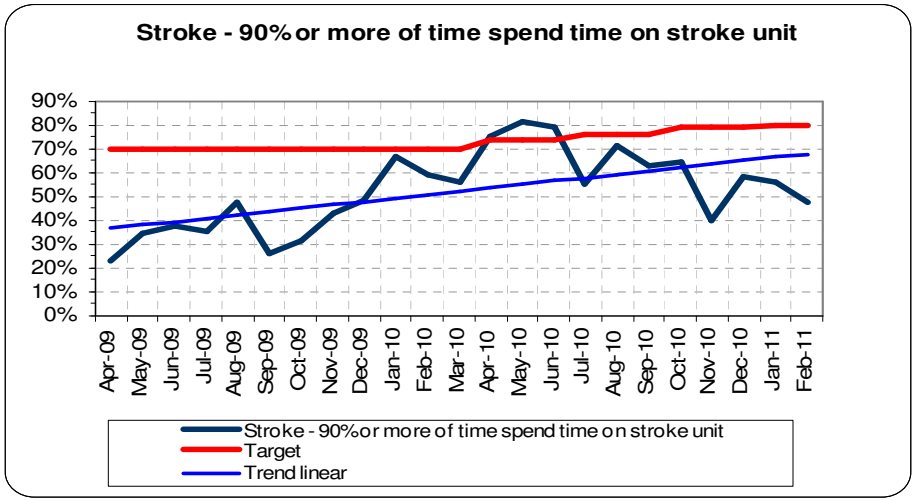
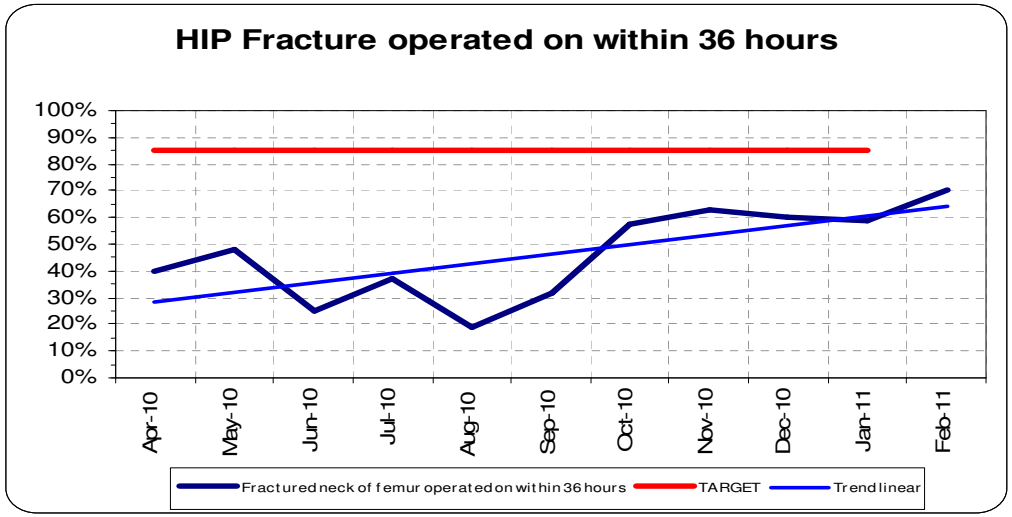
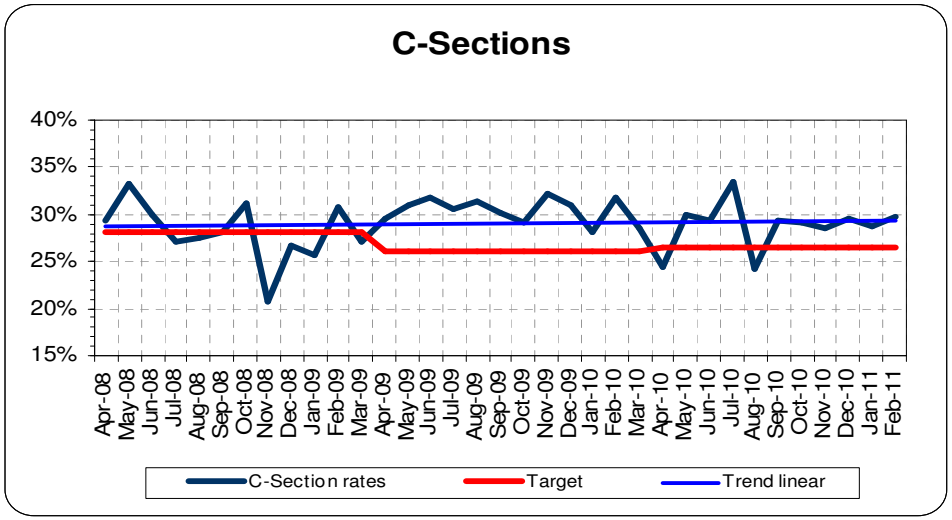
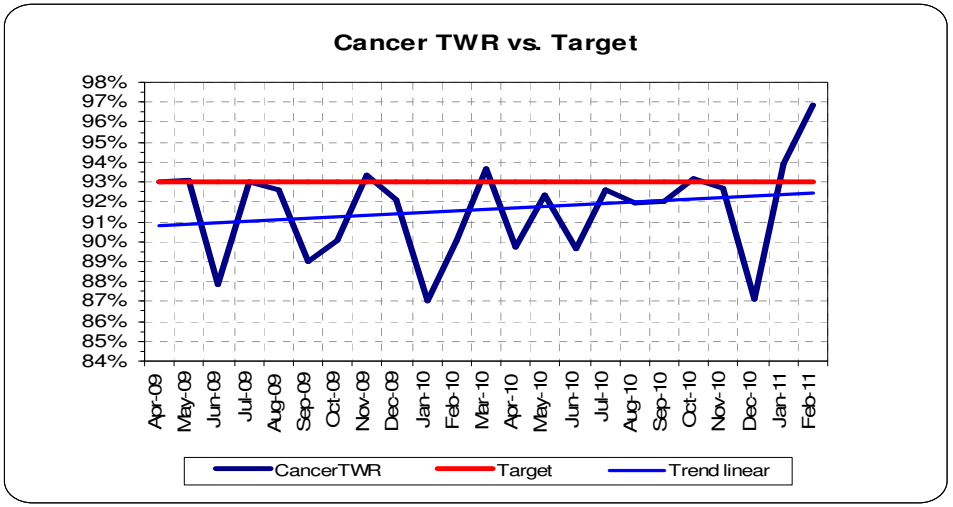


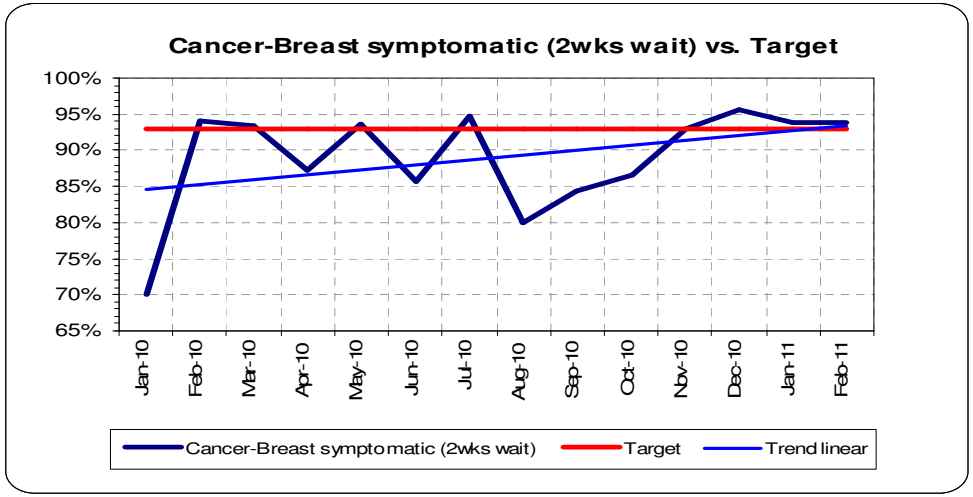


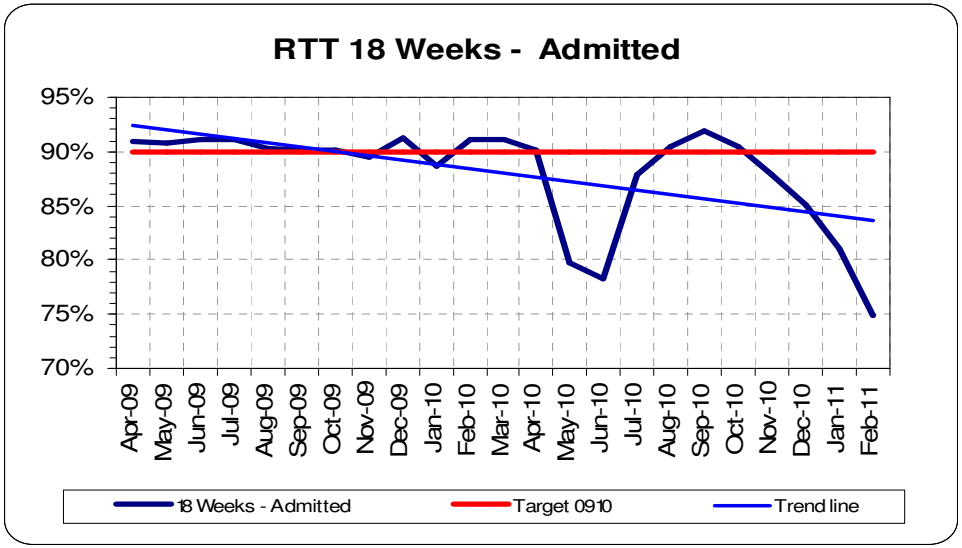


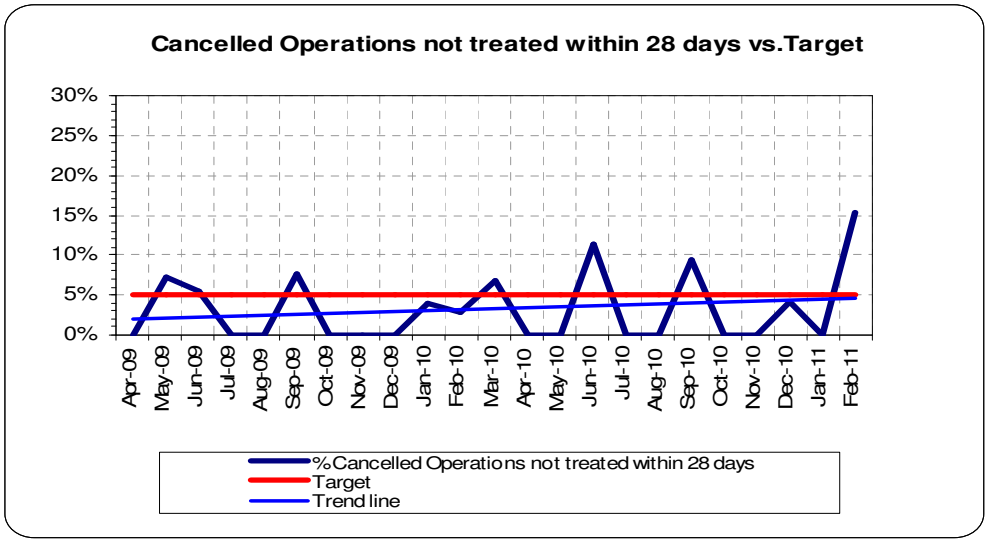


Charts for Performance Exception Areas









Exception Report – HR FEBRUARY 2011 (EO3- EO13)

Indicator Rationale	The Key Performance Indicators for HR include tracked measures for total staff in post, vacancies, agency and bank usage. Thresholds have been reduced in wte agency, wte bank and sickness absence in order to focus on planned reductions Total Agency amended to exclude medical staff with separate line for locum medical agency usage. RAG rating amended for locum medical staff to reflect % of total medical establishment consistent with % of total establishment for agency non medical. National target for sickness absence 3% by end of 2013 with current national average of 4.6%. Trust working to target of 3% by end of 2010.
Context	▪Bank and Overtime : ▪Agency: Wte agency excluding extra capacity decreased from 63 to 49. Wte bank and agency, extra capacity decreased from 53 to 49 ▪Medical Absence : Sickness absence shows a slight increase in absence of 0.2% Firstcare report indicates that this is due to normal seasonal fluctuations.
Actions to Date	▪General Recruitment and Senior Appointments: Seasonal increase in new starters and impact of nurse recruitment in Ireland has impacted on our vacancy rate which at 9.9% is the lowest this year. ▪Workforce scorecard introduced for Divisional meetings.

Operational Lead and Author	Janet Miller
Executive Lead	Yvonne Parker

Exception Report – HR FEBRUARY 2011 (cont'd)

Actions for Next Month	▪Continued work on Temporary Staffing Recovery Plan projects ▪Increased nursing establishments agreed to be input into e rostering system ▪Involvement of HRBPs in job planning and other areas of priority with medical staff within their specific directorates to be part of HRBP objectives ▪HRBPs to work in liaison with ETD to raise the % of appraisals within their specific Directorates ▪Monthly reports on ER issues to be produced for Directorates indicating trends for analysis and priority areas ▪Non Medical data from FirstCare to be reviewed and areas of concern targeted by HRBPs ▪Recruitment: : ▪12 nurses from Ireland interviewed January 2011 with planned start date of March 2011 ▪6 nurses from Ireland delayed start date – due to commence March 2011. ▪Further recruitment in Ireland arranged for 29th and 30th March
Risks	Unplanned and urgent operational requirements including extra capacity will have negative impact on reducing agency and bank usage. Measures in place across South East Coast to protect posts for staff at risk across the patch to minimise redundancies.

Operational Lead and Author	Janet Miller Deputy Director of HR
Executive Lead	Yvonne Parker, Acting Director of HR

Exception Report – A&E

Indicator Rationale	98% of all A&E attendances should spend 4 hours or less from arrival in A&E to discharge, admission or transfer. This indicator includes a % of patients that attend local walk in centres. This indicator is calculated monthly for this report using the CQC / DH Framework methodology. The final CQC and the DH Performance Framework ratings are calculated using quarterly mandatory returns – these may differ slightly from the monthly figures as at the point of the quarterly return the walk in centre figures have been finalised.
Context	Performance in month was 81.92% and year to date stands at 90.47%. This is against a revised target of 95%. Patient flow through the hospital remains the key factor in the ability to achieve under 4 hour waits for A&E patients. There remains an outstanding performance notice from the PCTs for A&E performance. 3 consecutive months of performance at 98% or above will remove the performance notice. The expectation is that this will be revised to 3 consecutive months at 95%.
Actions to Date	▪ Circulation and increased monitoring of team roles and professional standards ▪Refocus role of Head of Capacity and the site team and revised management and timings of site meetings ▪ Commencement of joint matron and clinical site team ward rounds ▪ Delayed discharge taskforce has been established. ▪ Completed bed modelling and capacity review by sub specialty. ▪ Completion of review and implementation of changes to consultant job plans to ensure appropriate timing and delivery of inpatient ward rounds and implementation.
Actions for Next Month	▪ Commencement of the ED Transformation Workstream to redefine the clinical pathway through ED. ▪ Development of ED Remodelling of Clinical Pathways action plan ▪ Commence ED Consultant job planning ▪ Commencement of ECIST project support manager ▪ Develop specialty capacity proposal for consideration following completion of bed modelling.
Risks	▪ Increased attendances and admissions in winter months ▪ Increased age and acuity of patients leading to an increase in delayed discharges and subsequent length of stay ▪ Outbreaks of norovirus
Operational Lead and Author	Angela Stevenson, General Manager for Medicine
Executive Lead	Bernie Edwards, Director of Clinical Services

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	**Non- Admitted Pathway:** In Month 10 the Trust over all compliance was 94.9% (unvalidated), 9 specialities were below the 95% threshold: •General Surgery – 94.6% •Cardiology – 94.2% •Urology – 92.6% •Dermatology – 91.8% •Rheumatology – 91.7% •Geriatric Medicine – 91.2% •Gastroenterology – 90.5% •ENT – 90.3% •Neurology – 86.5%	**Admitted Pathway:** In Month 10 the Trust over all compliance was 79.9% (unvalidated), eight specialities were below 90% threshold, which were: •Gynaecology – 87.8% •General Surgery – 86.7% •Other – 85.3% •Ophthalmology – 82% •Trauma and Orthopaedics – 67.6% •Oral Surgery – 64.3% •ENT – 60.0% During the month of January 182 patients were cancelled due to bed pressures •The backlog at the end of the month was 1029
Actions to Date	▪ Outsourcing stopped in March ▪ Currently negotiating with organisations to increase capacity from 1st April. ▪ Elective lists are reviewed 24 hours prior to operating day in conjunction with operational bed pressures with view prevent cancellations on the day ▪ Maximising the use of Crawley DSU	
Actions for Next Month	▪ Surgical Division is waiting for Board decision on Backlog Reduction plan. ▪ Development of project for non-admitted pathway redesign	
Risks	▪ Operational bed pressures – resulting in cancellation of Elective Surgery ▪ 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).	

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

Exception Report Month 11 - Stroke:

1. 90% or more time spent of stroke unit
2. TIA treatment within 24 hours

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. 1. 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. 2. People who have had TIA are at a greater risk of stroke.
Context	•There were 29 stroke discharges with approximately* 48% spending 90% of their stay on the stroke unit. * Data cannot be fully validated until the Cerner upgrade issues affecting the ward based data are fully resolved. •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. Poor performance this month is due to extreme bed pressure made more challenging by ward closures 7-24 February due to outbreaks of D&V. •TIA performance dropped because 5 of the 6 high risk referrals that failed the 24 hr target were referred on a Saturday and we currently don't run the service at weekends. YTD performance remains on track and the recent audit demonstrates our performance is in line with best practice.
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 the substantive replacement is made. ▪ Pathway and booking process has been reviewed and communicated to GPs to improve communication and reduce time. ▪ An interim clinical pathway is in place to ensure we meet best practice.
Actions for Next Month	Develop an action plan to commence early supported discharge in the community– meeting with both commissioners is being scheduled. West Sussex pilot starts this month. Revised consultant job description to be agreed within the division and submitted to the College for approval. Timeline will be developed to deliver a a phased 6 - 7 day TIA service, which may involve a network solution.
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

Exception Report – 62 day Screening / Cancer two week rule

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 11**	**62 Day Screening** (Target 85%): Overall in M11 the Trust **was compliant** 88% patients were treated in time (42 referrals 5 breaches). The breaches occurred in: Breast (79% –14 referrals - 3 breaches). 1 due to bilateral breast disease that needed further staging over Christmas period. 2 due to lack of capacity – both seen as low risk after ambiguous FNA and excision Gynaecology (78% 4.5 referrals - 1 breach) patient needed a hip replacement first Head & Neck (0% 0.5 referrals -0.5 breach) Shared with Guildford. Consultant requested chemotherapy start earlier. UGI (83% 3 referrals - 0.5 breach) also shared with Guildford. Complex diagnostic pathway needed before treatment could commence.	**Cancer 2 Week Rule** (Target 93%)**:** In M11 the Trust **was compliant** with both the Cancer two week wait (96.9%) and the Breast Symptomic two week wait (93.7%).
Actions to Date	▪ Waiting list for Breast referrals is now below 1 week ▪GP practises continue to be called where a patient is deferring their appointment beyond two weeks.	
Actions for Next Month	▪ Job Planning currently underway to ensure correct capacity ▪ Out patient capacity being reviewed as part of business planning	
Risks	▪ Lack of capacity in Endoscopy due to winter bed pressures and equipment failure	

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 – 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 11 Performance	In February 30 patients were admitted with fractured neck of femur. ***36 Hours Compliance:*** 70% (21 patients) ***48 Hours Compliance:*** 87% (26 patients) ***Day 1 post op Physiotherapy:*** 87% (26 patients) ***NOF Bed:*** 3 patients transferred to a NOF bed within 4 hours ***Iliaca Femoral Block:*** 17% (5 patients) **DVT Prophyaxis**: 83% **Other Trauma:** there were 89 trauma admissions other than #NOF
Actions to Date	• Whilst Elective orthopaedic lists are being cancelled (due to bed pressures) excess trauma is being moved to the empty sessions • Orthogeriatric Ward commenced (junior rota change will take place at rotation in April) • External review of T&O Service undertaken full written report received and action plan developed. • Improved monitoring of #NOF as they are admitted through A&E in order to access # NOF bed on Newdigate ward. •Role of # NOF Coordinator and Trauma Coordinator completed and changes made.
Actions for Next Month	• Iliac block: Meeting to improve block placement w/e 18th March. • Develop protocol regarding the cancellation of #NOF patients for medical reasons. • Junior rota to change when junior medical staff rotate in April – move 2-3 juniors to the management of the Geriatricans.
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 – report author Philip Kemp, Divisional Chief Nurse for Surgery
Executive Lead	Bernie Bluhm, Director of Clinical Operations

Exception Report – Pressure Ulcers

Indicator Rationale	A key indicator and one of the High Impact Actions Data is monitored by Commissioners and SHA with expectations for significant reductions The Trust monitors monthly data in relation to any SaSH acquired ulcer grade 2 and above – this is our incidence The Trust also collects data on all pressure ulcers including patients admitted with them – this is our prevalence
Context	Quality of reporting has improved in the last few months with far more accurate information being reported. There are some reported incidents of difficulty in accessing specialist equipment quickly and there is little provision for Barriatric patients in the existing contract. This is currently under review. Some patients may have more than one ulcer and this is monitored internally by the Nursing & Midwifery Professional Committee.
Actions to Date	▪Core Quality Standard with auditing of documentation and actions ▪Now have identified Link Nurses to ensure accurate reporting ▪Reports reviewed in monthly Nursing & Midwifery meeting, actions taken are evaluated and discussed ▪TVN has sourced heel ulcer prevention devices (heel cups) which are now in use in Orthopaedics with plans to roll out Trustwide. ▪Incidence of 6% is below the national average of 8%
Actions for Next Month	▪Initial results for heel cups very positive with no new ulcers developed in patients with heel cups in place in the last month. Plans to roll out Trustwide. ▪To be included in the Management Board for Performance as part of the Divisions' Integrated Quality Performance Dashboard ▪Planned review of anti-embolism (TED) stockings by TVN as ongoing work re heel ulcer prevention
Risks	▪Concerns that there is still some under reporting in certain areas, although improving ▪There is a need for more ownership and rigorous interrogation of data by the clinical areas with a clear approach to action planning and prevention with an agreed reduction figure. This includes more robust investigation and Root Cause Analysis of ulcers above grade 2. ▪Pressure Ulcers now becoming part of Safeguarding Vulnerable adults agenda and incidences may be raised through alerts with formal investigations

Operational Leads	Divisional Chief Nurses
Executive Lead	Chief Nurse

Exception Report – NICE - Full Compliance with all applicable clinical guidelines

Surrey and Sussex NHS Healthcare NHS Trust

Indicator Rationale	When the Trust registered with the CQC, it stated there was a lack of data on our levels of compliance with historical NICE guidance.
Context	The Trust should have a robust process in place to ensure that it is fully informed over its level of compliance with all published NICE guidance.
Actions to Date	▪There has been no response from la small number of ead clinicians which resulted in a drop in compliance ▪All Lead clinicians have been written to asking for statement of compliance where there was no such assurance. ▪Non responders had a follow up letter sent from the Medical Director ▪As guidance is published, Leads are identified at the Lead Clinicians meeting to respond on behalf of the Trust on compliance. ▪The Trust now has a database which records all compliance data on compliance
Actions for Next Month	▪Further communication with the leads of guidance to ensure a response is received on compliance with Clinical Guidelines. ▪To be raised at Divisional meetings for further action.
Risks	▪ NICE is best practice and not knowing whether we are compliant has significant quality concerns

Operational Lead and Author	Jonathan Parr, Quality & Standards Lead
Executive Lead	Medical Director

Exception Report – Enhancing Quality Programme - percentage of eligible patients data entered

Surrey and Sussex NHS Healthcare NHS Trust

Indicator Rationale	The Enhancing Quality Programme was introduced across the region in April 2010 to improve the quality of care for 4 clinical pathways. The Trust is required to enter data on these pathways on a series of measures of quality.
Context	The Trust must enter data for 95% of eligible patients to ensure the data is reliable. It is also a requirement under the CQUIN scheme for 2010/11. The Trust has not achieved this for Pneumonia.
Actions to Date	▪Pathways have put in place systems in order to collect data. ▪Data completeness is monitored on a weekly basis ▪Support from the Clinical Audit team in collating medical records ▪Pneumonia and Hip & Knee Pathways have recently put in place a system of capturing data prospectively.
Actions for Next Month	▪ The audit team will prioritise the collation of notes to ensure 100% are available until the prospective collection is fully up and running.
Risks	▪ non-compliance with this metric will result in a loss of CQUIN funding

Operational Lead and Author	Jonathan Parr, Quality & Standards Lead
Executive Lead	Chief Nurse

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Exception Report – Participation in applicable national clinical audit

Indicator Rationale	The Trust should participate in all national audits as identified on the National Clinical Audit and Patient Outcomes Programme (NCAPOP)
Context	Trust participation in these audits is now reported in the Annual Quality Account and is also monitored by the CQC. The Gynaecologists have made the clinical decision not to participate in the National Audit into Heavy Menstrual Bleeding for the following reasons: ● The audit aims to benchmark the Trust locally and nationally based only on a quality of life survey. The Gynae team feel that this audit method will not provide sufficient confidence in measuring this indicator. Some of the concerns are: –lack of clinical data to support patient survey – patient confidentiality –staffing commitment
Actions to Date	Clinical Audit Team have liaised with the Division about the importance of undertaking all National Audits
Actions for Next Month	The Trust needs to develop a process to raise concerns about National Audits and gain senior sign off for decisions affecting the whole Trust.
Risks	▪Reduced participation will be published in Quality Account

Operational Lead and Author	Jonathan Parr, Quality & Standards Lead
Executive Lead	Medical Director

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Exception Report – VTE Thromboprophylaixs

Indicator Rationale	Patient Safety and Clinical Effectiveness Trust Objective 1 – Safe, high quality co-ordinated care National quality improvement priority
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. Trust performance is the subject of concerted action.
Actions to Date	▪Thrombo prophylaxis Group launched an implementation plan. This included a clear communication strategy on expectations, identification of resources to allow live data collection on compliance and gaps to optimise patient safety. ▪Medical Division is currently utilising on line on call system to compile the VTE form. Completing the VTE assessment tool is a mandatory part of the patient registration process. The bespoke system created in house with the assistance of Dr. Ben Mearns assists the user in calculating the risk level of the patient. An electronic record is then generated and stored allowing clinicians and staff easy assess to assessment results. ▪Compliance in AMU currently at 100% with increasing compliance month on month across the medical division ▪This auditable process has encouraged the behavioural change required to successfully implement VTE Thrombo prophylaxis at the Trust
Actions for Next Month	▪Currently rolling out on call system trust wide. ▪ Project Group to meet and discuss lessons learned from first roll out
Risks	▪ Reputation risk with commissioners, stakeholders and patients

Author	Charminia Fletcher, Senior Performance Manager
Executive Lead	Rob Haigh, Medical Director (Clinical), Ian Mackenzie, Director of Business Intelligence (Data Collection)

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Exception Report – Patient Experience

Indicator Rationale	Patient experience provides a key measures of the quality of services provided by the Trust. Patient experience improvements are a National CQUIN. Patient experience and outcomes are Key criteria for CQC registration compliance.
Context	The Trust has invested in and implemented a real time monitoring system to survey patients every month to ensure we can respond to their needs in a timely fashion, identify their issues and use the feedback to improve services. Also, 5 questions are incorporated into the 2010/11 CQUIN "To enable responsiveness to the personal needs of patients." **NC2 - National Patient Experience Indicator** A composite indicator evaluating patient experience, based on the Care Quality Commission (CQC) National Inpatient survey. Average of age/sex adjusted scores of the following 5 questions from CQC adult inpatient survey. • *Were you as involved as you wanted to be?* • *Did you find someone to talk to about worries and fears?* • *Were you given enough privacy ?* • *Were you told about medication side effects to watch for ?* • *Were you told who to contact if you were worried ?* Calculation is provided within the "Patient Experience Benchmarking Tool FINAL"
Actions to Date	▪RTM implemented in Crawley and ESH – inpatients, outpatients and ED. ▪Some operational delivery of improvements process & local action in all clinical areas in response to their feedback ▪Public facing webpage with survey results and action plans
Actions for Next Month	▪Divisional Chief Nurses and senior managers to continue to update action plans and ensure robust processes in place in all areas within divisions to improve service in response to feedback. ▪Roll out of additional RTM devices to remaining areas
Risks	▪Being prepared for discharge and being informed are consistently scoring below threshold ▪Impact on CQC registration through perceived lack of action in response to patient experience feedback ▪Timely action planning at divisional level ▪Poor uptake/use of surveys

Operational Lead	Divisional Chief Nurses
Executive Lead	Chief Nurse

Contents

5. 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