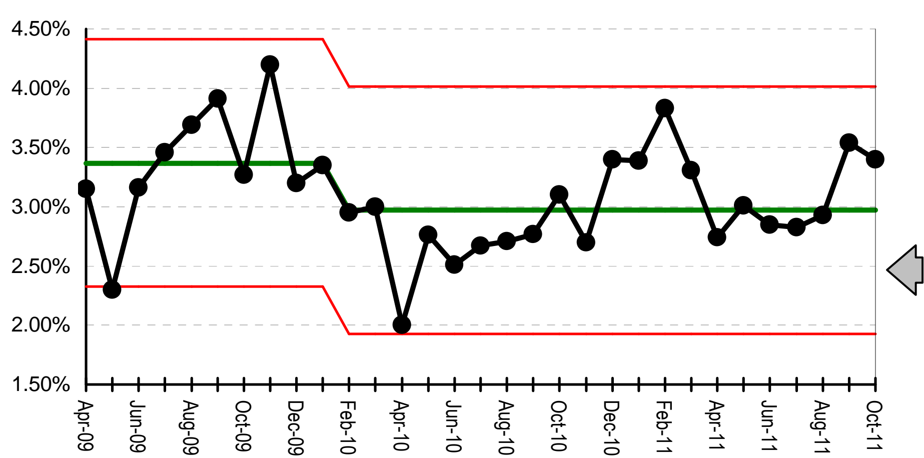
Appendix 3b

QUALITY & SAFETY DASHBOARD
Period: November 2011

Divisional Narrative: Surgery, Cancer & Diagnostics

Indicator: Sick Absence Rates	This period	
	Last period	

Analysis of the issues



Trust target is 2.5%

The division has a current average sickness rate of 3% against the 2.5% target. There was a slight upward spike during October, which has reduced slightly in November. As illustrated in the previous quality committee update there are still some concerns regarding the accuracy of sickness reporting and these have been flagged to the HR department and finance as the current ESR system is still not correctly mapped to the new divisional structure. As a result some of the self-service functionality on ESR continues to be linked to the old organisational structure and this is impacting on self service to some extent.

In terms of sickness trends in the division three particular areas emerged when analysing the figures for the month- surgical wards, histopathology and junior/middle grade doctors.

There has been an increase in recorded sickness levels amongst nursing staff on two of the surgical wards as indicated on the ward dashboards from Q3 onwards- Thorogood and Victoria. Thorogood ward increased due to 1WTE going on long term sickness leave whilst commencing chemotherapy which had a large percentage impact on Thorogood figures due to it being a ward with a small bed base (10 beds) and lower establishment. Victoria had two members of staff go off on long term sickness in addition to other staff sickness in the month- both undergoing cancer treatment.

During January 2012, one of the long term Victoria absentees has now returned on a part time phased return programme. The long-term Thorogood absence is now progressing down a retirement on ill health route supported by the Acting Matron for Surgery.

Coyle Ward is amber rated on the ward level dashboard for staff sickness. In addition to some ad-hoc staff sickness there is a particular impact on sickness % as a result of two HCA staff long term sickness . One individual is currently being managed through potential redeployment and has now successfully found alternative suitable employment outside of the organisation and the second

case is pursuing ill health retirement.

As reported last month there are three MLA staff members within pathology with high levels of sickness absence and high levels of Bradford scoring- they are all undergoing performance management of their sickness through the capability policy supported by Human Resources.

As reported previously there continues to be one long term sickness case amongst medical staffing- middle grade doctor. The individual is currently involved in a performance management process being led by the Divisional Medical Director as Case Manager.

Action plan:

Clinical managers and operational managers have already put in place the following key steps within their service areas:

- Use of Bradford scoring data collection for service areas
- Exit interviews for staff returning from sickness
- All junior and middle grade sickness is reported to the operational management team and captured on the leave database to enable performance monitoring
- Action plans agreed with HR for all long-term sickness and high Bradford scoring
- Monthly review of sickness rates at divisional board and divisional management team
- Regular review of department sickness rates with senior operational managers at one to one meetings with Director of Operations
- Head of Nursing and matrons review staff sickness at ward manager review meetings and performance meetings.

Additional actions:

Initial data cleansing has been done to ensure that the staff highlighted with high Bradford scores are correctly allocated to the right location and to ensure data is accurate due to issues with ESR hierarchy. The Head of Nursing and Assistant Director of Human Resources are due to meet to review the full list of high Bradford scoring nursing staff week commencing 12th January 2012 to determine whether the management plans and capability cases are appropriate and being managed as quickly and efficiently as possible by the ward teams.

Victoria ward has been targeted by the Head of Nursing for additional intervention given its percentage sickness rates and relatively large establishment level. The Head of Nursing and Acting Matron for Surgical Wards are working with the ward manager and have agreed local action plans.

The operations department PA organisational change is now complete and new post holders have taken up their roles. The PA for the surgical divisional will support the data capture of ESR data on staff sickness and Bradford scoring across the operational teams which will help to improve overall data accuracy.

Indicator: Mandatory Training	This period	
	Last period	

Percentage of staff having attended mandatory training in the last two years
Target = 95%. Actual : 59% (October data)

The main two reasons for poor performance within the division relate to 1. underreporting of data for staff that have undertaken mandatory training this year and 2. issues regarding compliancy within some of the divisional areas- specifically with regards to mandatory training levels amongst

clinical staff. Performance was 59% in October and provisionally stands at 65% for this period- final confirmed report not yet received from HR.

Proposed Actions:

The Division is currently significantly below its required mandatory training target of 95% compliance- with a reported figure of some 59% for the division in September. The division is focusing on two key strands in order to address the issues of poor mandatory training compliancy.

Reporting and data validation
Access to training and compliancy

1. Reporting and Validation

There is still significant under reporting of mandatory training compliancy trust wide because a number of staff cannot update on ESR appraisal or training attendances, some ESR hierarchies are unchanged since the organisational change and the allocations of services to divisions is still incomplete on ESR. There are also a number of staff that have provided evidence (hard copy) of attendance at mandatory training that are showing as non-compliant on the current report- largely because a lot of the manual records are not captured. In order to resolve the issue of reporting the following divisional actions have been agreed and these are being supported trust wide by the work finance and HR are leading on regarding ESR, data reporting and ESR organisational structure.

All service managers have been asked to submit hard copies of training documentation and appraisal information to their General Manager lead and the training team so that these can be included into future reporting. Inaccuracies in reporting will be escalated to the learning and development team who collate information on mandatory training. IM&T have provided operational teams with a full breakdown of mandatory training reports and allocated service areas which will be manually checked and amended if training data is missing

The main outstanding item in terms of reporting will be the amendment of the ESR system and ledger by HR and payroll respectively, which are still based on the old organisational structures at this point in time.

2. Access to Training & Compliance

One of the more significant issues with training rates is ensuring compliancy with the requirements to attend mandatory training and it is evident that even allowing for the issues described above that overall compliancy rates are not acceptable.

As illustrating when reviewing the detailed divisional figures this has proven more challenging for clinical teams, consultants and ward staff. In order to address this within the division we have to date agreed the following principles:

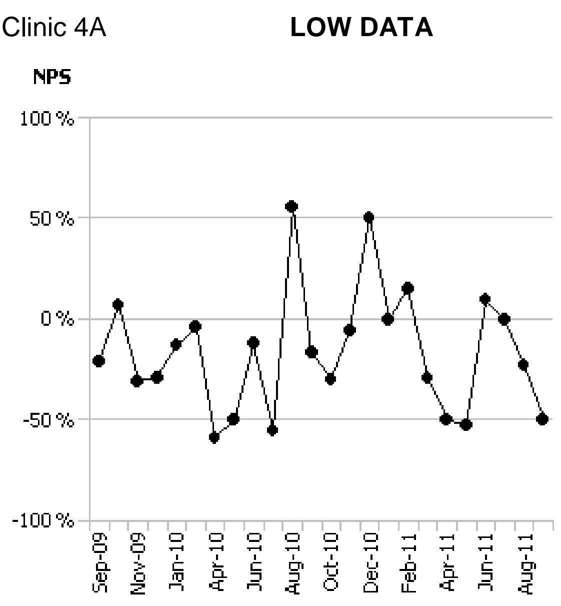
All service managers are required to complete a monthly update of performance against training rates within their areas, including plans for achieving 95% compliance to be reported through to the Divisional Management Team (DMT)
Ward managers will be expected to report on compliancy and progress as part of their ward performance review meeting to the head of nursing and Acting Matron
e-training modules are going on line in December and at a divisional level there will be a large campaign focussed on completing e-training (particular for clinical staff) from January 2012 onwards

Group sessions have been arranged for large clinical teams (theatres, anaesthetics) and these are planned on audit sessions and departmental sessions were possible
Staff appraisals will not be signed off without evidence of completed mandatory training and/or detailed plans of how they will achieve compliance

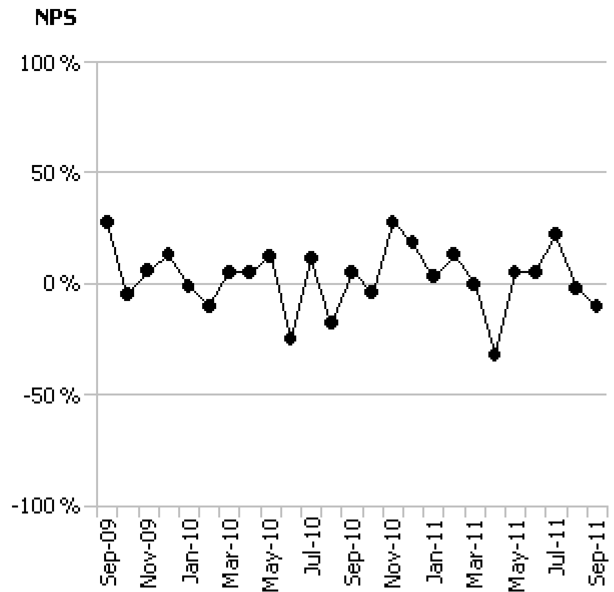
Indicator: Patient Experience	This period	
	Last period	

Analysis of the issues:

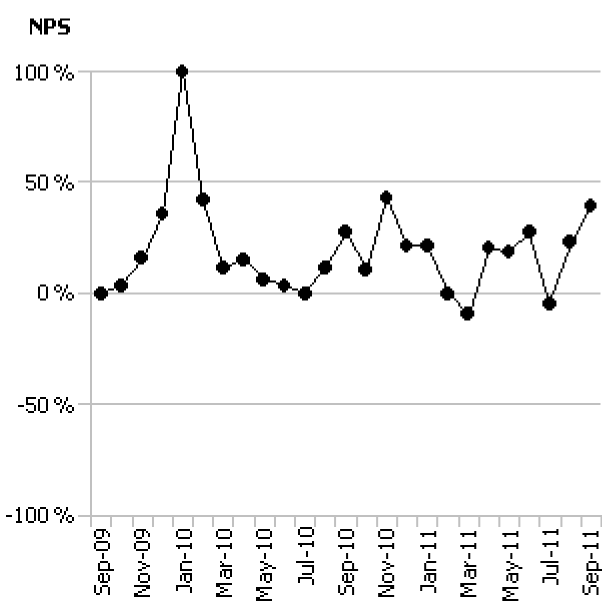
Clinic 4A **LOW DATA**



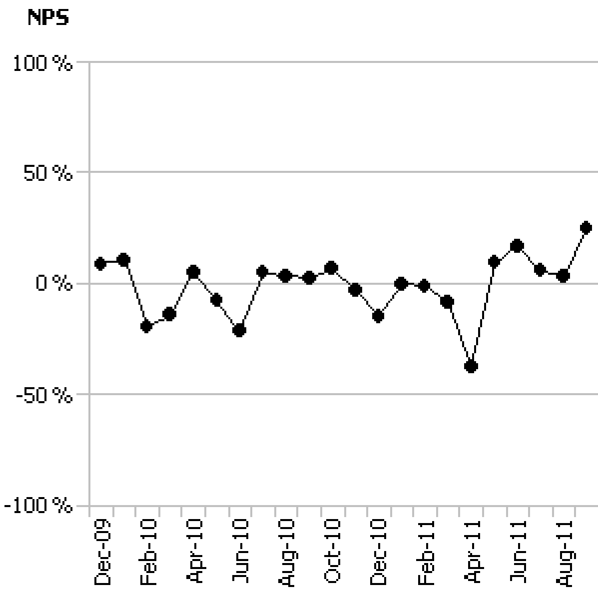
Clinic 4B



Clinic 1B



Clinic 3C



Surgery Outpatient Clinics 4A and 4B have negative net promoter scores. Clinic 4A has low return volumes given the high throughput of patients. Clinic 1B has consistently one of the highest net promoter scores in the Trust. Clinic 3C is showing improvement in scores. The data reported above is the same as presented at the last quality committee as new net promoter scores have not yet been published by the Information Team but will be reported in the next few weeks.

Outpatient Patient Experience & Satisfaction

Some of the particular concerns within the division relate to the outpatient net promoter scores and patient feedback received. This is primarily related to level 4 and in particular is being driven by patient experience within the breast clinics running in clinic 4A and some of the 4B clinics. This is replicated when the national cancer patient experience results are taking into consideration- Whittington Health scores badly in terms of cancer patient experience and this is particularly

relevant to patients on the breast cancer pathway. Some of the key issues raised through the patient feedback, cancer patient survey and peer review include:

- Overcrowded clinic waiting area
- Lack of waiting space
- Poor choice of dates for clinics
- Lengthy delays and waiting times in clinics
- Overbooked clinics and insufficient capacity
- Poor coordination by the clinical nurse specialists (urology and breast tumour sites)
- Poor quality of patient information/lack of written information
- Inadequate breast CNS capacity (cancer survey)
- Lack of time with consultant surgeon (cancer survey and local survey)

On the back of the national cancer survey, local net promoter scores and peer review assessment a number of actions have been implemented/are being implemented as detailed below.

Action plan:

Environment & Patient Information

- Pager system was introduced for clinic 4A patients (November 2012)
- Head of Nursing is producing information booklets (e-version and hard copy) for the top 20 procedures initially with the clinical nurse specialist leads (completion January 2012)
- All clinical nurse specialists now have dedicated Trust mobile phones rather than bleeps
- All CNS staff have dedicated business cards with their contact details and are acting as patient coordinators by specialty
- Head of Nursing has continued to carry out local audits and "mystery shopper" spot checks of all CNS contact details and ease of access
- Outpatient refurbishment works are underway with new flooring being laid within Clinics 4A and 4B.

Workforce

- Business case for additional urology and breast CNS posts were approved and post holders appointed (started January 9th 2012)
- Lead cancer nurse has been appointed and due to start 20th February 2012 and will be the named lead for cancer services, including cancer patient experience which encompasses a large amount of level 4 activity.
- Business case for additional surgical and imaging capacity (breast tumour site) approved at EC on 13.12.2011 and posts going out to advert This will mean there are 2 additional breast clinics per week and will be held on Tuesday and Thursday. Additional capacity and spreading clinic load across the week will reduce waiting time in clinic; crowded waiting room; improve choice of dates. Breast is the only speciality in which all referrals need to be seen within 2 weeks and this is a challenging area.
- A senior clinical nurse specialist forum has been established and will meet quarterly starting on January 12 2012 and will support improving patient experience within outpatients.

Pathway Redesign

- UNIPART have been working with the clinical and operational teams to support a piece of work reviewing and redesigning the patient pathway for clinic 4A, with the aim of streamlining the service and reducing the total time patients spend in clinic in order to improve the patient experience.

- The Head of Nursing is working with the urology CNS team to redesign the patient pathway to enable dedicated CNS support by individual tumour site (February 2012 start date)

- Outpatient improvement action plan is underway with key aims of reducing waiting times in clinics; DNA rates and cancellation rates. Partial booking has been rolled out in highest

DNA speciality (ophthalmology) and will be rolled out across ENT and urology by the end of January 2012.

Indicator: Cleanliness	This period	
	Last period	

November audit results

Coyle & Thorogood failed to meet hand hygiene standards (both Red rated). Both Coyle and Thorogood received a RAG rating of red for Hand Hygiene during November 2011. In both cases the non-compliancy related to non-medical staff (portering and pharmacy)- the Head of Nursing for Surgery has escalated this with Steven Packer, Assistant Director of Facilities and Helen Taylor, Head of Pharmacy as part of the performance management process.

Victoria was amber rated for Ward Cleanliness in November 2011 scoring 90%.

Hand hygiene

What has already been done

- All wards have dedicated infection control link workers who lead on monthly study training which includes infection control for ward staff. Hand hygiene compliance and expected standards amongst temporary staff and student nurses is included as part of induction and local induction.
- The Matron for Infection Control (Patricia Folan) undertook a targeted piece of work with critical care during December to review hand hygiene practice and assessment methodology due to the change in assessment criteria and associated practice. Critical Care was green rated during November 2011 having previously RAG rated as red for hand hygiene in October 2011.

Further Action:

- Wards that have scored below 95% are having daily audits of hand hygiene until they are compliant and this is reported daily through to the Head of Nursing and Matron for Infection Control. As per policy, all areas that were non compliant were re-audited daily until results were above 95%

Ward Cleanliness

Victoria was amber rated for Ward Cleanliness in November 2011 scoring 90%. This was the first audit undertaken by the domestic team leaders and ward managers and further training is to be provided in the methodology to ensure consistent approach. This is particularly relevant when looking at the scores for Victoria and the recorded compliance rate.

When the environmental audit is undertaken there are a range of checks that can be undertaken and assessed. The facilities team carried out an average of 105 checks per ward during November- with an average of 5 checks per ward failing compliance. However, the team only carried out a 59 point check on Victoria ward with each failure having a higher percentage contribution to overall compliance. This has been escalated to Mr Steven Packer, Assistant Director of Facilities, by the Head of Nursing to ensure that there is a higher range of checks undertaken and to ensure greater consistency of reporting across the wards.

What has already been done

- Thorogood ward failed against the “ward cleanliness” audit in October due to environmental failures- associated with damaged ward walls (trolley damage) that needed repairing and some flooring that needs upgrading that resulted in a non-compliance. Thorogood Ward is due to have its ward upgrade (as part of the PFI upgrade cycle) commence in February 2012 and this will include upgrading tiling, flooring and walls in order to meet the required clinical standard.

Further Action:

- This was the first audit undertaken by the domestic team leaders and ward managers and further training is to be provided in the methodology to ensure consistent approach led by Steven Packer, Assistant Director of Facilities.
- The frequency of cleanliness audits will be increased on Victoria until they achieve the required compliancy standards.

Indicator: VTE Screening	This period	
	Last period	

Analysis of the issues – November data

VTE Assessment by Admitting Specialty - November 2011

*Updated 28/12/2011

Division	Admitting Specialty	Coded Results*				Uncoded	Grand Total
		Valid Assessments		No Valid Assessment			
Surgery	Dermatology	87	100%	0	0%	0	87
	Ear, Nose & Throat	5	100%	0	0%	0	5
	Urology	239	91%	24	9%	0	263
	General Surgery	254	82%	57	18%	0	311
	Trauma & Orthopaedic	199	82%	45	18%	0	244
Surgery Total		784	86%	126	14%	0	910

As indicated above VTE screening rates are below the target performance within two specialty areas – trauma and orthopaedics and general surgery.

What has already been done:

A large amount of work within the division has focused on increasing screening rates for elective (surgical and day case) procedures as this was a particular problem area for the division. As a result of this the Pre-operative assessment process was strengthened in conjunction with the admissions and listing of patients for surgery. This has resulted in significant improvements in VTE screening with patients being assesses for VTE risk by the pre-assessment nursing team. This includes a VTE assessment for patients that had previously not undergone a full POA assessment by the nursing team. As a result VTE screening rates for October and November were 97% compliant for elective day case VTE screening and 99% compliant for inpatient elective screening.

The remaining area of focus within the division relates to VTE screening rates for emergency admissions - 61% based on current figures. The non-compliance relates mainly to general surgery patients and specifically to those admitted to Victoria Ward. Only 42% of patients admitted as an emergency onto Victoria Ward had a full VTE assessment undertaken.

Weekly VTE screening reports have now been produced by ward area and patient type and are being provided for ward teams, clinical directors and specialty clinical leads to track progress against VTE screening on a weekly basis.

Future Actions:

General Surgery

The General Manager for Surgery and Clinical Director for Surgery (Hasan Mukhtar) were asked at the November Divisional Board to develop a detailed action plan outlining how they will improve VTE screening rates for patients admitting non-electively onto Victoria ward and this is to be reported back and approved at the Division of Surgery, Cancer and Diagnostics Divisional Board during January 2012.

Following on from the intensive care NHS support team visit it was agreed by the Clinical Director for Surgery and Divisional Director to pilot admitting surgical emergency admissions direct to Mary Seacole- this has now commenced. Patients admitted through Mary Seacole have a higher level of compliancy (VTE screening) and can be easily managed through a single pathway. This will help to support some of the VTE assessment for general surgery patients and is tracked by the Clinical Site Practitioners that are co-located on Mary Seacole Ward.

Orthopaedic Emergency Admissions

There is a smaller proportion of emergency patients admitted via Coyle Ward that did not undergo VTE screening in October. These relate to emergency trauma admissions and fractured neck of femur patients. For the fractured neck of femur patients VTE Screening is included as a component part within the fractured NOF pathway and integrated care policy that is being developed as part of the divisional QIPP programme for this year as outlined in this report under the readmissions section.

Indicator: Falls	This period	
	Last period	

The division was rated RED for falls in November 2011. There were a total of 10 falls recorded on the Trust dashboard this month. No falls were graded as high risk in terms of patient harm.

Coyle 5 (last month 1)
ICU 0 (last month 0)
Thorogood 3 (last month 1)
Victoria 2 (last month 2)

Two of the falls were reported twice on the system so the actual number of falls for November is 9.

One fall was caused by the failure of a domestic to place a warning sign on a wet floor, which the patient subsequently slipped and fell on. This is being formally investigated by Steven Packer, Assistant Director of facilities.

5 patients found by the side of bed having undergone a full risk assessment upon admission.

The three remaininhg falls related to patients that were assessed as low risk and not requiring any additional support or mobilisation that subsequently slipped or fainted whilst using the bathroom and toilets.

Action already in place:

- All patient falls are recorded as a DATIX incident report and this is immediately escalated through to the Divisional Head of Nursing so that immediate intervention can take place if required.
- All high risk falls or trends are assessed using full Root Cause Analysis in order to identify potential themes and issues associated with patient falls.
- Falls awareness and the use of the assessment tool is included in the ward study day

curriculum
- During the summer of this year the SAFE ward rounds project introduced across wards

Further Actions:

Starting January 2012 all wards are now assessed against the number of completed falls risk assessments within the division, led by the Head of Nursing, as part of each wards monthly dashboard report in order to ensure full assessment are undertaken for all patients admitted to the wards. A trust wide training programme was also introduced on January 4th 2012 and new documentation was launched. The risk assessments will be regularly assessed as part of this ongoing work.

Indicator: 2/3/4 Pressure Ulcers	This period	
	Last period	

Analysis of the issues:

There was one reported grade 2/3/4 pressure on the Intensive Care Ward in November. The patient was transferred to ITU from Meyrick ward with a grade 2 pressure ulcer at that point in time. RCA is currently being investigated to identify causes and identify the root cause.

Actions in Place:

Safe rounds have been introduced across all wards (Summer 2011) and one of the components of the safe rounds includes changing the patients position, if required, during the two hourly review.

New pressure ulcer cushions and mattresses have recently been approved by capital monitoring committee and purchased and are have now been distributed (November 2011) across the wards to support patient management and reduce risks of pressure ulcers by improving the availability of pressure relieving equipment.

Future Work:

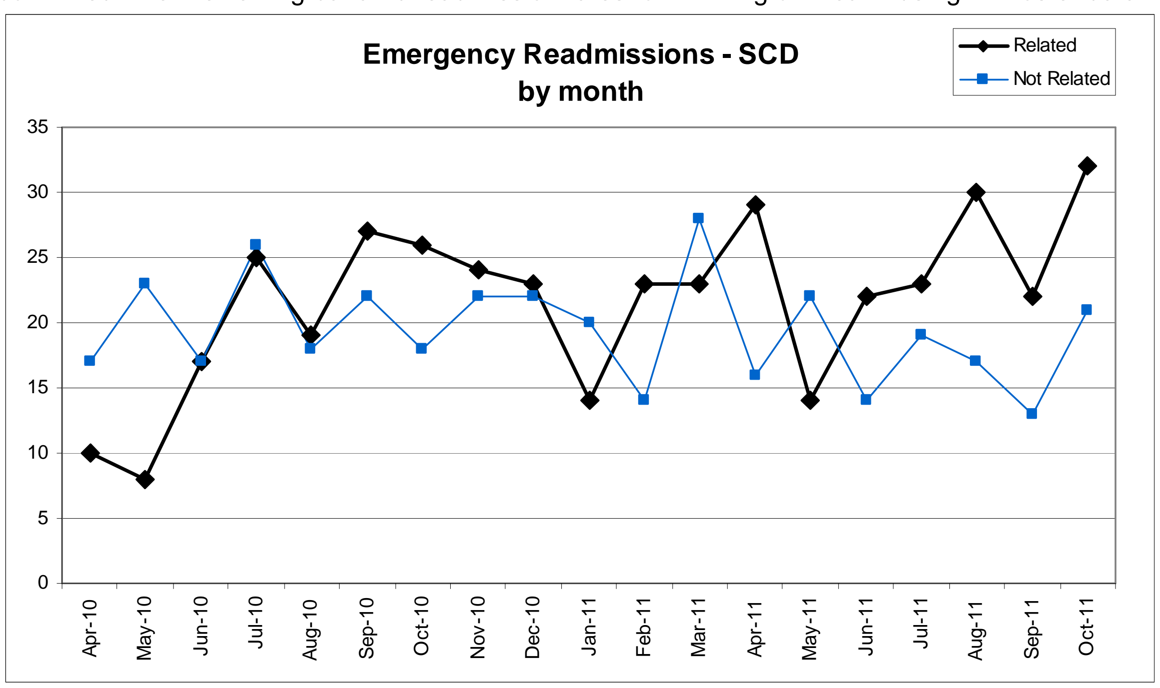
Whilst the number of grade 3/4 pressure ulcers has been minimal the NOF scorecard and incident reporting has alerted the Head of Nursing to a slight upward trend in low grade pressure ulcers on Coyle Ward during Q3 (low grade is not reported on current quality dashboard). Jane Preece (Tissue Viability Nurse) has been asked to do run a specific workshop on Coyle regarding pressure ulcer prevention- this will include running some additional group education sessions and enhanced training for ward staff during January and February 2012. It is worth noting that during December 2011 there has been some reduction in total reported pressure ulcers (all grades) across surgery compared to the previous month- 4 were reported in November and 2 in December (all grades). This correlates timing wise with the new pressure relieving mattresses and cushions being introduced.

Indicator: Emergency Readmissions	This period	
	Last period	

Analysis of the issues:

Readmissions following an elective or day case discharge within 30 days are set at a target level of zero and there is a requirement to reduce the number of readmissions following an emergency discharge by 25%.

There has been no reduction in the rate of readmissions following an elective discharge or those following an emergency discharge. It is however worth noting that the overall readmission rate for surgical patients as a proportion of total activity is relatively low, does not always relate directly to the procedure and the dataset includes readmission rates for bariatric surgery patients, which have a slightly higher complication and therefore higher readmission rate (within 30 days). This is confirmed when reviewing bariatric readmission rates for Whittington Health using Dr Foster data.



General Surgery

Within General Surgery the department has now submitted its proposals to the Executive Committee (20th December) outlining plans for expanding consultant general surgeon cover in line with emergency care standards in order to provide 12/7 consultant presence for Whittington Health. The business case was approved and job descriptions are with the Royal College of Surgeons awaiting approval to advertise with the aim of implementing the new rot at the end of Q4. The Trust already has daily consultant input for the specialty but this will increase the coverage throughout the working week. This will enable 12/7 coverage to be provided when the 2 further posts are filled and will completely separate out elective and on-call commitment ensuring there is increased consultant presence throughout the week to manage emergency cases (highest readmitting group) and also to ensure that consultant that are on-call do not have clashes with elective commitments.

In terms of supporting readmissions this will ensure that there is increased consultant presence throughout the week and increased proportion of consultant led procedures (as opposed to consultant supervised) will be increased. It will also enable more rapid access to theatre for complex cases admitted non-electively that require consultant input. The increased presence will also enable a more complete ward round of patients to be taken throughout the week and enable emergency admissions to be reviewed by a consultant throughout the working day over a 12 hour period. It is envisaged that this increased level of consultant input will facilitate improved decision making, support discharge and help to potentially reduce complications.

Enhanced Recovery

The roll out of enhance recovery for elective procedure is being used to support improved efficiency (length of stay), patient experience and the quality of the pre-assessment, procedure and discharge process. This has already been introduced over the last year across elective knee surgery and some hip surgery and is well established for colorectal patients. The advantage of

the pathway is that is standardises care and reduces variation in terms of both potential length of stay and outcome/readmission risks. As part of this years divisional QIPP programme the full roll out of enhanced recovery for all hip surgery and gynaecology surgery is currently being implemented, with the aim of all elective patients going through an ER pathway by the end of quarter.

Orthopaedics

In addition to the enhanced recovery work described above the other area of potential readmission relates to emergency trauma patients who arrive with fractured neck of femur. Readmissions can be due to a range of potential issues including post surgical complications through to inadequate discharge planning and support

The main divisional QIPP programmes this year covers the fractured neck of femur pathway. The aim of this particular programme of work is to improve the outcome, experience and quality of patients presenting with fractured neck of femur at Whittington Health and this should help to also support readmission work. The project is being led by Mary Jamal, Deputy Director of Operations and aims to deliver the following objectives.

- The pathway is co-ordinated and designed to reduce actual length of stay and to limit variation, reduce mortality and re-admissions
- Appropriate, medically fit patients receive surgery within 24 hours
- Patients are mobilised within 12-18 hours post op and receive therapy input over weekends Patients are discharged back to their usual address using a criteria based discharge process Health and social care multi agency teams are co-ordinated and integrated across the patient pathway
- LOS is reduced from average of 21days (current) to 6 days (national best practice)