Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD
25th October 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for September 2012.
ASSURANCE (Risk) / IMPLICATIONS	The Quality Report provides assurance that Quality indicators are being monitored and assessed and that mitigating actions are being put in place as required.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience are occurring. Stakeholder views have been sought as part of the Quality Account development process.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non-compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health Act (2009) and failure to do so could affect the Trust's registration and Monitor licence.
The Trust Executive Committee is asked to:	Review the paper; discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr David Fluck, Medical Director & Suzanne Rankin, Chief Nurse
Date:	17th October 2012
Decision:	For Noting

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indicator Definitions

Table 1 is made up of 6 main columns:

1. Description of Measure

1-01 The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charleston Comorbidity Index and diagnosis grouping.

A 3 year dataset is used to create the risk adjusted models. A 1 year dataset is used to score the indicator. The 1 year dataset used for scoring is a full 12 months up to, and including, the most recently available data. The 3 years used for creating the dataset is a full 36 months up to, and including, the most recently available data.

1-02 The HSMR is a method of comparing mortality levels in different years, or for different subpopulations in the same year, while taking account of differences in casemix. The ratio is of observed to expected deaths (multiplied conventionally by 100). Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100.

For all of the 56 diagnosis groups, the observed deaths are the number that have occurred following admission in each NHS Trust during the specified time period. The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient.

1-03 Crude mortality is the total number of deaths against the total number of patients discharged in the month. (A patient will only be counted once even if they have been admitted more than once in the month). The actual number is in brackets.

1-04 Mortality where the primary diagnosis was UTI (SHMI).

1-05 Number of Hospital acquired MRSA.

1-06 Number of Hospital acquired C-Diff.

1-07 The number of patients with a VTE (Venous Thromboembolism) assessment who then had a Pulmonary Embolism or Deep Vein Thrombosis (during their stay).

1-08 The total number of Serious Incidents requiring Investigation.

1-09 The proportion of Grade 2 incidents against the total number of Serious Incidents Requiring Investigation (SIRI).

1-10 The total number of Falls.

1-11 The number of Falls that were Grade 3 and above of the total number of falls.

1-12 The percentage stroke patients who spent 90% of their stay on a stroke ward of their total admission.

1-13 Average number of beds available (including escalation beds) in the month against the average number of beds occupied taken at midnight from PAS.

1-14 The percentage of patients who were transferred between wards, 3 or more times during their admission.

1-15 Patent Satisfaction - Net Promoter.

1-16 The total number of formal complaints received.

1-17 Proportion of formal complaints received (for inpatients only) against the number of discharges.

2. Target (T*) - where possible a national (N) or local (L) strategic health authority target has been used, but where this is not available, we have used a percentage improvement on the 2011/12 year end total.

3. Forecast - the calculation is as follows:
The forecast is calculated for individual targets using the performance to date, any foreseen changes and then extrapolated over the year.

4. Actual - this is the actual achievement for the month.

5. Performance - Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, deterioration on the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an 'up' arrow as higher numbers may be worse and thus will be represented by a 'down' arrow.

6. Year-to-Date (YTD) - The sum of the activity from the beginning of the financial year (April).

1.2 Quality and Safety Balanced Scorecard and Commentary

Table 1: Quality Performance Dashboard

1. To achieve the highest possible quality of care and treatment for our patients

	Patient Safety & Quality		Annual Target 12/13	Annual Forecast 12/13	Sep Actual	Performance			YTD 12/13
						July	Aug	Sep	
1-01	Summary Hospital-level Mortality Indicator (SHMI)*	N	<100	<100	46	▼	▲	▲	60
1-02	HSMR*	N	<100	<100	-	▲	▲	-	82
1-03	Crude mortality (Excluding readmissions)	L	1.6	<1.6	1.61%	▲	▲	▼	1.5%
1-04	Mortality UTI as Primary Diagnosis (HSMR)*	N	<100	>100	-	◄►	▲	-	126.1%
1-05	MRSA (Hospital only)	N	1	1	0	◄►	◄►	◄►	1
1-06	C.Diff (Hospital only)	N	20	20	0	▼	▼	▲	9
1-07	VTE (hospital acquired with PE or DVT)	L	14	18	4	◄►	▼	▼	11
1-08	Serious Incidents Requiring Investigation (SIRI)	L	50	69	6	▲	▼	▲	37
1-09	SIRI Grade 2 (proportion of total SIRI)	L	0.0%	7.2%	16.6%	◄►	▼	▼	14%
1-10	Falls (Total Number)	L	462	644	42	▲	▲	▼	339
1-11	Falls - resulting in significant injury (grade 3)	L	<15	14	2	▼	▲	▼	7
1-12	Stroke Patients (90% of stay on Stroke Unit)	N	80.0%	80.0%	81.4%	▲	▼	▲	85.3%
1-13	Average Bed Occupancy (inc escalation)	L	92.0%	-	93.6%	▲	▼	▼	89.2%
1-14	Patient Moves (ward changes >=3)	L	<5%	8.0%	6.7%	▼	▲	▲	7.3%
1-15	Patient Satisfaction (NetPromoter Score)	L	65%	60.3%	71.0%	▼	▼	▲	61%
1-16	Formal complaints (Total Number)	L	<500	427	28	▲	▼	▲	216
1-17	Formal complaints (rate per discharge - IP only)	L	0.44%	-	0.47%	▲	▼	▲	0.50%

1-01 * Provided by CHKS, reported 1 month in arrears.

(T*) Target Type **N, National; L, Local**

Delivering or exceeding Target		Improvement Month on Month
Underachieving Target		Month in Line with Last Month
Failing Target		Deterioration Month on Month

Scorecard Commentary

The SHMI mortality rate is 61.8 bringing the year to date position to 64. This rate is in the middle of our peer group on CHKS.

The rate of complaints has declined significantly in September to 0.47% which reduces the year to date position to 0.5%. The Trust is now significantly below the target level of complaints with the total number of complaints in September being two thirds of the expected level.

With no cases of C-diff in September our total year to date remains at nine which is just below the trajectory. The forecast for the year end is that the Trust will achieve the target.

There was a high number of falls in September with two that resulted in harm. The Trust is predicting that it will not achieve its own target. This remains a key focus for the nursing team and the following actions are being taken:

- Review of paperwork to assist staff in identifying contributory factors to falling, prioritisation, proactively using equipment and documentation;
- Trial of new paperwork and systems of working at Ashford – initially on Fielding Ward. The Ashford Falls Project – due to start 15th October, 2012;

- Falls Champions, Ward Sister and Matron to attend Falls Group meeting and present their own falls data and why it is worse or better and what they are doing about it; and
- Continued individual feedback from Falls Nurse following a fall, copied to the Matrons and Heads of Nursing.

1.3 The Quality Account 2012/13

The Quality Account Dashboard (Appendix 3) provides a visual high level summary of the Trust's performance against the quality priorities set for the current year 2012/13 in our Quality Account 2011/12[1]. The indicators were chosen in collaboration with stakeholders and reflect areas where the Trust is focusing to improve the quality of patient care. The dashboard also contains data to monitor previous priorities from 2011/12.

At the end of quarter two we are achieving targets for:

- Reducing discharge related complaints;
- Reducing the number of falls resulting in serious harm; and
- Reducing the readmission rate for patients with COPD (Chronic Obstructive Pulmonary Disease).

We are maintaining / close to the targets for:

- Nutrition and hydration;
- Outpatient appointment letters revised (with a further 3 Specialties in progress);
- Risk assessment for VTE;
- Communication audit;
- Hospital acquired infection;
- Readmission rates for both elective and emergency patients; and
- SMR for Heart Failure and Pneumonia.

We are failing to meet targets for:

- Patients being discharged by 12:00 noon. There are some improvements since April;
- Percentage of patients providing feedback. The Trust has set a target to capture responses from 652 patients each month. However, the survey is not mandatory and not all patients will wish to complete the questionnaire; there will be occasions where a relative or carer may wish to complete the form. We also had several ward moves and changes to wards during September which could have had an impact on the response rate;
- Hospital acquired VTE[2] - all cases are investigated in detail by the relevant area to see whether the VTE / PE[3] was preventable and to learn and share lessons;
- Total falls – a number of factors explain the difficulty with meeting this target and there is a range of improvement work (see section 3.3. 'Deep Dive' Patient Falls); and
- Hospital acquired Pressure Ulcers stage two and above – the Trust has identified issues relating to data validation and plan for a 'Deep Dive' into this area for reporting to Trust Board in November. The Trust is also presenting work to improve prevention of pressure ulcers at the regional Quality and Safety Network collaborative on 19 October.

[1]Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement. http://www.ashfordstpeters.nhs.uk/quality/quality-accounts
[2]Venous thromboembolism
[3]Pulmonary embolus;

Actions and Comments

The mid-year review with stakeholders will take place on 26th November and it is anticipated that we will have further updates to report relating to data validation and Trust improvement work.

2 Clinical Effectiveness

2.1 Enhancing Quality Programme (part of CQUIN Programme)

The EQ Programme is part of a Kent, Surrey and Sussex programme involving all the acute trusts of the SEC[4]. ASPH is a full participant in the EQ Programme concentrating on five pathways running (Acute MI[5], Pneumonia, Heart Failure, Dementia, Hip and Knee replacements). The Trust is the lead for a new pathway for Acute Kidney Injury (AKI) being developed across the SEC for implementation later in the year.

For the scores across the year (from Jan to May 2012) for each pathway and compared to the target, all results show that we are meeting or exceeding the targets set.

There is a continuous improvement approach to ensure that good performance is sustained and the improvements embedded.

3. Safety Update

3.1 National Patient Safety Agency (NPSA) Safety Alerts

There have been no new alerts reported by the NPSA since the last Board meeting in September 2012.

Table 2 - Overdue Alerts

Three alerts remain overdue:

Description	Deadline	Lead
Minimizing risks of mismatching spinal, epidural and regional devices with incompatible	02-Apr-12	Divisional Director Michael Imrie
Working Group being formed by the Deputy Medical Director to lead this piece of work; details are contained in the July Quality Report to Trust Board.		
The adult patient's passport to safer use of insulin	31-Aug-12	Deputy Chief Nurse/ Kate Eidens
The Trust has been unable to close this alert by the deadline due to a delay in the recruitment process of Diabetes Specialist Nurses. Two nurses have now been recruited. Part four of the alert requires education to ensure there are systems in place to enable hospital inpatients to self-administer insulin where feasible and safe. The new team will be rolling out this training during October with re-engagement of the Diabetes Link Nurses.		
Harm from flushing of nasogastric tubes before confirmation of placement	12-Sep-12	Dr Michael Parris

[4] South East Coast region
[5] Acute Myocardial Infarction

The working group led by Dr Parris has made good progress with this alert with the introduction of training and competencies on nasogastric placement for nurses and doctors. One aspect of the alert is overdue which relates to providing warning notices with "Do Not Flush" on all current and future stock of nasogastric tubes, until these are provided as standard by manufacturers. The Head of Clinical Quality Improvement is in liaison with Supplies and the Procurement Team to order a sticker.
The Trust currently uses a number of manufacturers to purchase fine bore radio-opaque nasogastric tubes. The Nutrition Team is undertaking a process to ensure uniformity across the wards with just one specific type of tube. The change is anticipated to have cost implications but meets the requirement of the alert. A pilot on two wards will help the team understand what the extent of the cost implications are, which will then have to be considered by the corporate team.

3.2 NHS Safety Thermometer (National CQUIN)

The Safety Thermometer[6] programme of work aims to achieve significant reductions in four types of avoidable harm from which patients are at most risk during episodes of healthcare:

- Pressure ulcers;
- Serious harm from falls;
- Catheter associated Urinary Tract Infections (UTIs); and
- Venous Thromboembolism (VTE).

Table 2 provides the summarised value for 'harm-free' care at the Trust compared to the national picture. Note that the national results include all care settings e.g. nursing homes, community hospitals. Towards the end of 2012 the NHS Information Centre will publish the NHS Safety Thermometer data as 'experimental official statistics'.

Looking at the results in Table 2, there is a gradual improvement nationally in 'harm-free' care and ASPH shows some fluctuation – note that harm-free includes patients with both 'new' and 'old' harms (pre-Trust admission).

For September we had one patient experiencing two new harms and 22 patients experiencing one harm this is an improvement on August where one patient had two new harms and 30 patients had one new harm.

Table 2

Harm-free Care	April	May	June	July	Aug	Sept
National average – harm-free care	90.01%	90.33%	90.44%	91.08%	91.21%	91.65%
ASPH harm-free care	89.18%	89.86%	86.12%	90.66%	89.13%	89.43%
National - patients with no **new** harms	95.35%	95.62%	95.76%	95.95%	96.08%	96.24%
ASPH - patients with no **new** harms	93.38%	95.54%	93.92%	94.81%	93.87%	95.50%

Results for each ward for 'harm-free care' and 'new harms' (hospital acquired) are presented in the Best Care dashboard (Appendix 3); actions to improve patient care are outlined in Appendix 5.

3.3 'Deep Dive': Patient Falls

A review of falls data and the Trust processes for falls reporting has been undertaken.

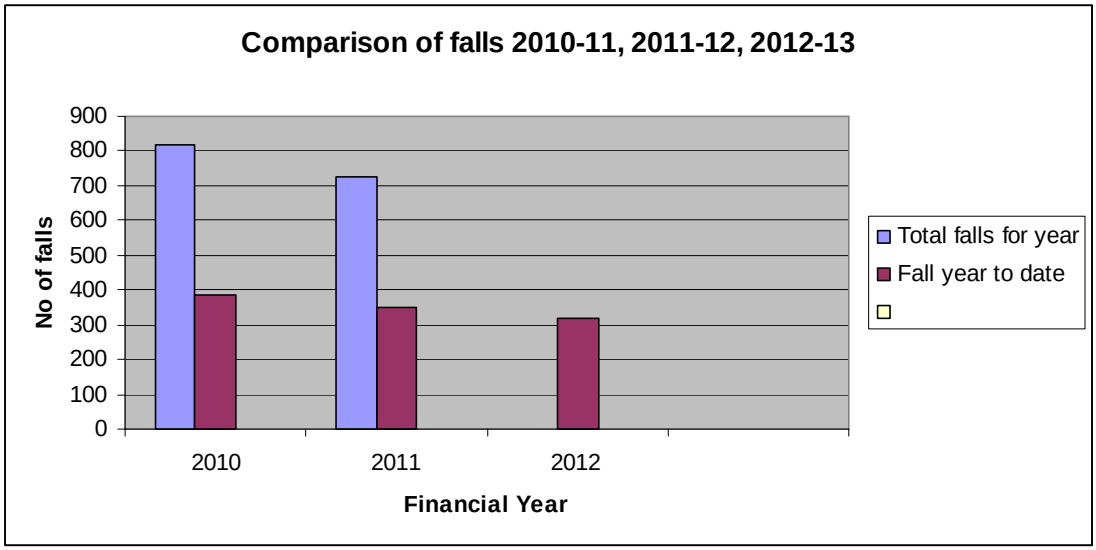
[6]The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. http://www.ic.nhs.uk/services/nhs-safety-thermometer

Over the last three years, although there is considerable monthly variation, falls data appear to show an overall reduction each year (Chart 1).

Other factors need to be better understood, in particular the relationship between the level of dependency and falls.

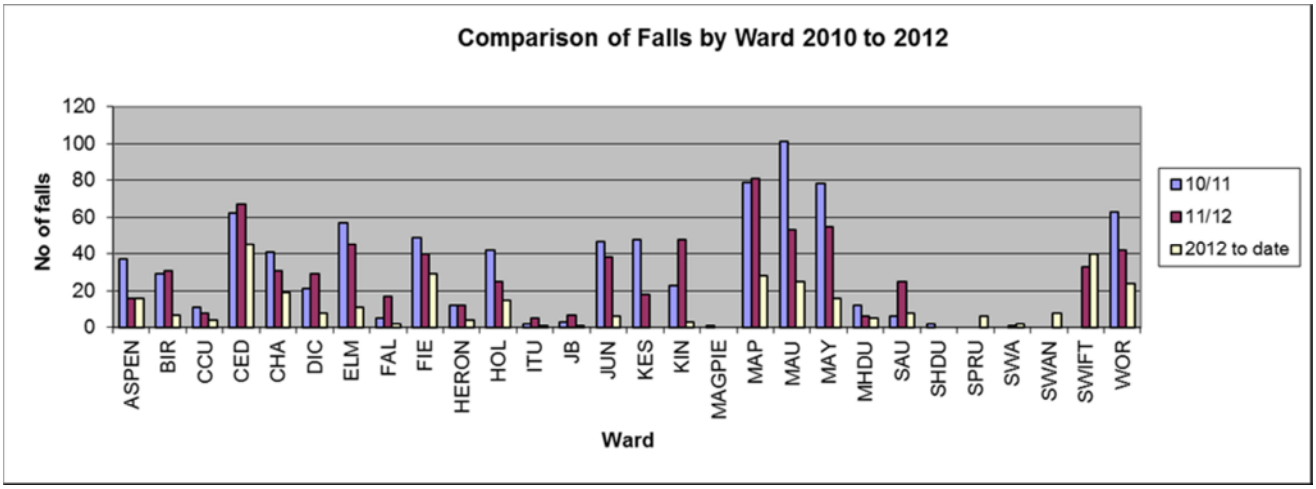
The current data for April to end of August indicates that there is also a slight reduction in 2012 in comparison with the same period for 2011 and 2010.

Chart 1



A comparison of falls by ward for 2010-2012 is shown in Chart 2.

Chart 2



Most wards show year on year improvement but direct comparisons are not always easy to make service ward configurations and patient acuity and dependency changes.

A significant finding is that the majority of falls occur when most wards have the highest staffing levels during the day, at 10am. Tasks such as completing the drug round or behind curtains caring for individual patients can result in staff having less opportunity to 'watch' patients.

Falls Reporting

Currently, the Trust captures numbers of falls as incidents on paper forms but there are delays with receipt of forms which impacts processing. This issue will be resolved with the introduction

of a new web-based incident reporting system, Datixweb, which will capture the falls at the source and provide real time falls data.

Conclusion

There are a number of factors that need to be taken into consideration when analysing falls data including the number of 'complex' patients at increased risk of falling, time of day, the size of the ward and staff training and awareness.

Actions

1. Review of paperwork to assist staff in identifying contributory factors to falling, prioritisation, proactively using equipment and documentation;
2. Trial of new paperwork and systems of working at Ashford – initially on Fielding Ward. The Ashford Falls Project is planned to begin on the 15th October, 2012;
3. Falls Champions, Ward Sister and Matron to attend Falls Group meeting and present their own falls data, including the reasons why it is worse or better and what actions are planned;
4. Continued individual feedback from Falls Nurse following a fall, copied to Matron and Head of Nursing;
5. Escalation where there are repeated lapses of good documentation and safe care with disciplinary procedures when required; and
6. A 'Falls during the Day' Awareness campaign aimed at doctors, allied health professionals, porters, pharmacists, patients' carers and relatives that builds awareness of risk factors including patient acuity, dependency, time of day, medication and protocols.

4. Patient Experience

4.1 Complaints/Ombudsman reports

There were 28 complaints received compared with 38 in August and 36 in July. Chart one shows a breakdown of complaints received by month.

Chart one

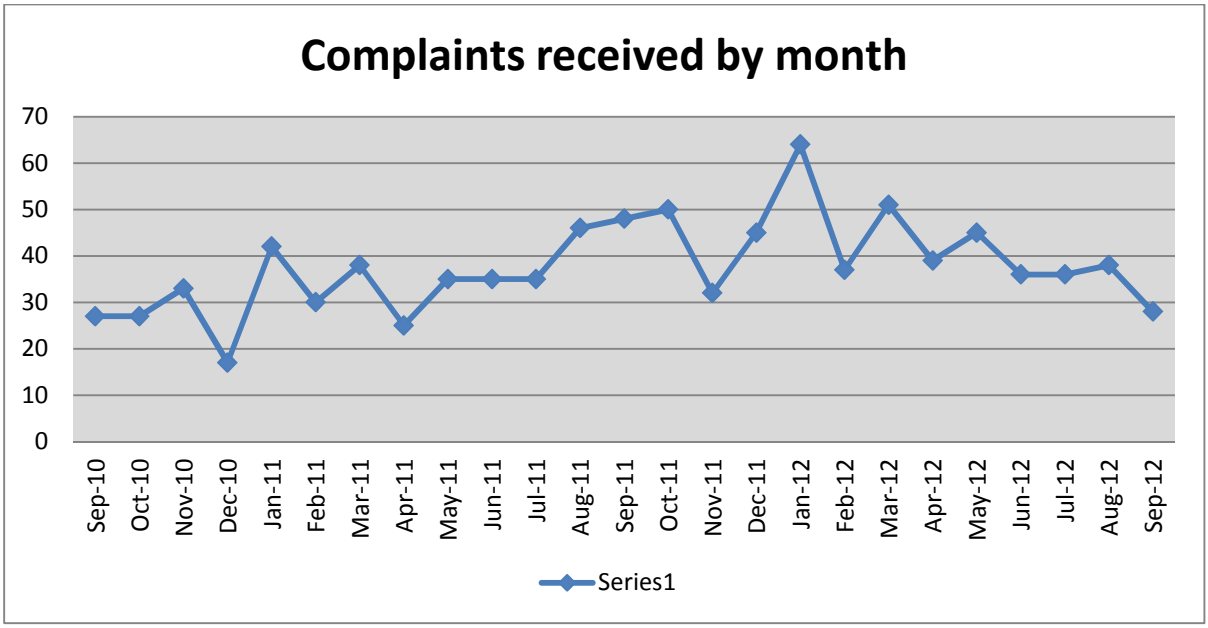


Chart two shows a breakdown of complaints by service area.

Chart two

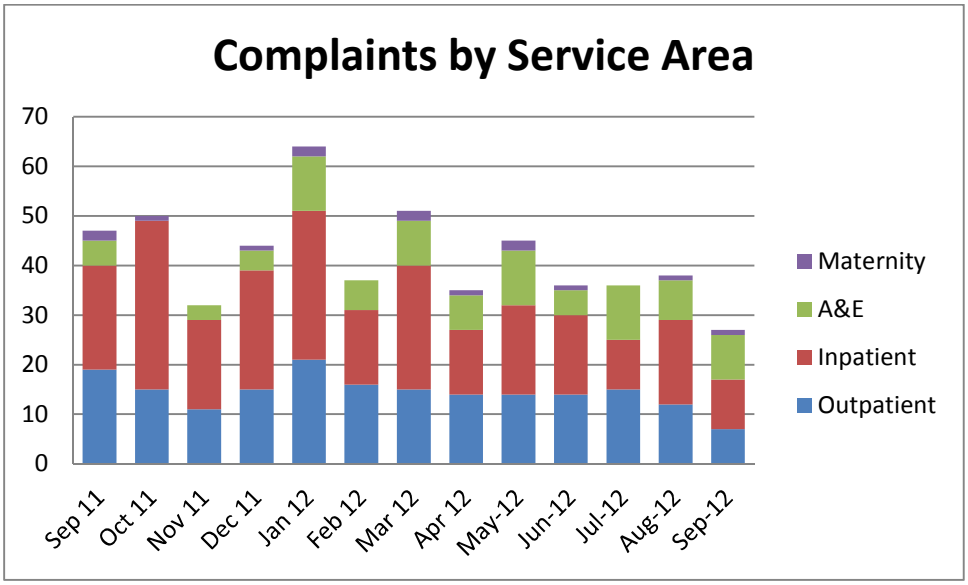
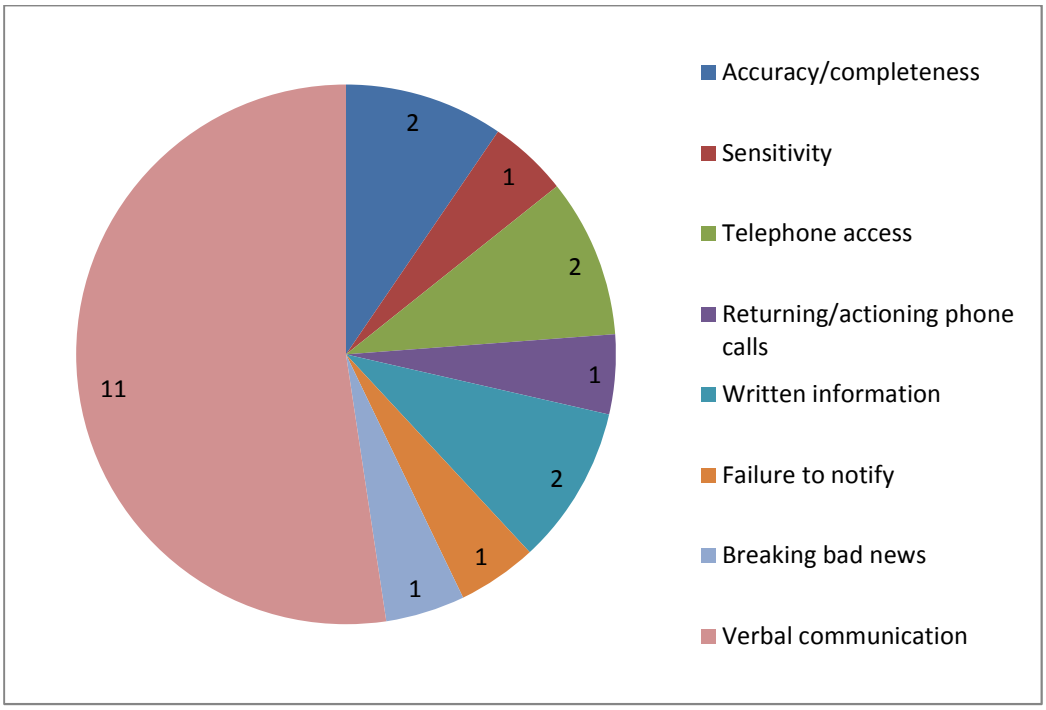


Chart three shows a breakdown of the 17 complaints where communication was raised. 21 separate issues were raised; of these 52% relate to verbal communication.

Chart three



Of the 93 contacts to PALS; 67 (72%) related to concerns, of these one went on to become a formal complaint, which is a conversion rate of 1.5% compared with August (5%).

Parliamentary and Health Service Ombudsman (PHSO) cases

No new notifications for referral to the PHSO were received in the reporting period. The PHSO have undertaken an assessment of complaint 11/497 and have decided not to investigate; case 09/039 remains under full review.

4.2 Patient Feedback

Patient Feedback Dashboard

Appendix 6 provides an overview of patient feedback and complaints performance across the Trust for the reporting period. The number of complaints in Acute and Emergency Medicine remained the same as the previous months and Surgery saw an increase in complaints, the other divisions saw a decrease in complaints. There was one complaint relating to discharge compared with four the previous month.

The overall Trust performance in response to formal complaints against timescale was 77% compared with 91% in August. This was largely due to the quality of responses and the degree of rework that was required to ensure they were of an appropriate standard to send from the Trust. Divisional Complaints Handling Workshops will be held throughout November and these will focus on process and documentation updates, engaging with complainants and the quality of written responses.

The Net Promoter Score (NPS) for the Trust saw an increase to 64% compared with August (55%). All divisions saw an improvement in the NPS, with Acute and Emergency Medicine scoring the lowest at 53% and Orthopaedics, where there has been continued improvement from July (44%), scoring the highest at 72%.

A&E Department Picker Survey

Picker have shared the results of the survey of patients who attended A&E in Quarter four 2011/12.

Compared with 2008 there was significant improvement on one question, which related to privacy at reception.

The results were significantly worse for 7 questions, with themes relating to:

- waiting time and communication around this;
- explanations around condition and treatment;
- refreshments;
- who to contact if worried; and
- being given a choice of follow up appointment times.

An action plan has been developed to ensure that the feedback from patients in this survey is used to make sustained improvements to the service and to patient experience.

Compliments

The Trust received seven formal compliments during September. All formal compliments received in the Executive Offices are responded to personally in writing.

Patient Choices Website Comment regarding the Cardiology Service

"The Demonstration that efficiency and knowledge does not get in the way of care and friendliness. I found all the staff delightful, communicative, and demonstrated teamwork. My stay was brief, but I was made to feel special".

4.3 Patient Engagement and Experience Strategy

The Patient Engagement and Experience Strategy is a major component of the Quality, Safety and Risk Management Strategy 2012 – 2017. Wide stakeholder engagement has already begun and a brief presentation setting out how the Trust was considering shaping and developing the strategy was given to the Patient Experience Group and the Patients Panel. The strategy would draw on other strategies, for example, the Communication and Engagement Strategy.

A joint workshop has been arranged in order to ensure that the Patient Panel and the Patient Experience Group are fully consulted and involved in the development of this strategy. This will be followed by widening the discussion to other stakeholder groups.

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5. APPENDICES

APPENDIX 1

Quality Account Dashboard Definitions

Patient Experience

Priority 1: To provide safe, high quality discharge for patients

1. Timely discharge of patients: before 12 noon
2. Number of patient concerns measured through formal complaints

Priority 2011/12: To provide high quality experience relating to nutrition and hydration

Six monthly Essence of Care audit:

3. Service to patients – patient survey of mealtimes
4. Patients nutritionally at risk – patients at risk are identified by the red tray system and appropriate support is provided to patients at mealtimes

Priority 2: To improve all aspects of communication with patients

5. Response rates for patients completing "Your Feedback" surveys Revision of the outpatient appointment letter templates for 18 specialties.
6. Six monthly Essence of Care communication audit – the Best Care monthly audits have been utilised to provide this measure (criteria include aspects of communication with patients and between staff)
7. Six monthly audit of the quality of discharge letters against national standards.
8. % patients who know how to access PALS (Patient Advice & Liaison Service) / make a formal complaint; this is an annual target
9. Annual target for shared decision-making against CQC benchmarked results

Maintaining High Safety Standards

Priority 3: To provide effective risk assessment and prophylaxis for VTE and reduce hospital acquired VTE

10. % Patients risk assessed for venous thromboembolism
11. % Patients acquiring a venous thromboembolism related to their hospital stay

Priority 2011/12: To provide confidence and reassurance for patients on infection control and other preventable infections

12. Number of C.Diff cases (Hospital post 72 hours): Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.
13. Number of MRSA bacteraemia (hospital acquired) isolated in a blood culture therefore present in the patient's blood stream

Priority 2011/12: To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators

14. Total Falls: total number of falls
15. Falls – resulting in harm (grade 3 or above): number of falls resulting in serious harm to the patient
16. Prevention of Pressure ulcers (hospital acquired grade 2 and above): number of pressure ulcers acquired in hospital of grade 2 and above

Clinical Effectiveness

Priority 4: To reduce the hospital emergency and elective re-admission rate

17. Readmission in 28 days – Elective: reduction in readmissions following an elective procedure within 28 days of discharge
18. Readmission in 28 days – Emergency: reduction in readmissions following an emergency admission within 28 days of discharge

Priority 5: To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure

19. SMR for Heart Failure
20. SMR for Pneumonia

The Standardised Mortality ratio (SMR) compares the expected rate of death with the actual rate of death taking into account patient demographics and severity of illness etc.

Priority 2011/12: To improve the experience and clinical outcomes for those with long term conditions

21. Admission rate for Chronic Obstructive Pulmonary Disease (COPD): rates of attendance and subsequent admission for patients with COPD.

APPENDIX 2
Best Care Dashboard Definitions

1. Patient Observations
   Documentation of patient observations includes: MEWS(Modified Early Warning Score), 24h cumulative fluid balance, pain assessment on admission and referral /escalation for "at risk" patients.
2. Cardiac arrest calls
   This is being considered as an outcome measure related to the process of patient observations since calls to the resuscitation team would not be expected if observations are being undertaken at the appropriate frequency and escalation of the deteriorating patient is happening according to Trust policy.
3. SIRI – Serious Incident Requiring Investigation
   The number of serious incidents reported by ward.
4. Matron Environment Audit
   Considers cleanliness of the area, storage of equipment and other items held on the ward, whether any maintenance is required.
5. Hand Hygiene Compliance
   Audits of members of staff cleaning/decontaminating their hands between procedures.
6. Saving Lives
   The compliance measurements that indicate the use of High Impact Interventions in key clinical procedures with the aim of decreasing the risk of infection. Process measures include insertion and continuing care relating to central venous catheters, peripheral intravenous cannulae, care of ventilated patients, care to reduce healthcare associated infections.

   Outcome measures are:

   - Number of MRSA bacteraemia: MRSA isolated in a blood culture therefore present in the patient's blood stream
   - Number of C Diff cases (Hospital post 72 hours): Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.
   - Catheter Associated Urinary Tract Infections (CAUTI (STp.p)): Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections – this figure is taken from the monthly Safety Thermometer census held on one day on all inpatients i.e. this is a 'point prevalence' figure.
   - Catheter >29 days after care (ST p.p): Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections – this figure is taken from the monthly Safety Thermometer census held on one day on all inpatients i.e. this is a 'point prevalence' figure.
7. Skin Integrity
   Waterlow risk assessment on admission and further reassessment with a care plan in place for "at risk" patients; the care plan shows evidence of progression with interventions as appropriate and the care rounding chart completed; where required there is referral to tissue viability nurse.
8. Hospital Acquired Pressure Ulcer (PU) stage 2 and above. New pressure ulcers which develop after 72 hours of the admission date.
9. VTE (Venous Thromboembolism) Assessment
   Patient has been risk assessed for development of VTE (Deep vein thrombosis, pulmonary embolism
10. VTE Mortality – outcome measure number of patients who have died following development of a venous thromboembolism or pulmonary embolism related to their hospital stay.
11. Falls / Manual Handling Assessment

Assessments carried out on admission with care plan in place for "at risk" patients; the care plan shows evidence of progression; where appropriate the post fall protocol is implemented.

12. Falls outcome measures
    Total Falls: total number of falls
    Falls – resulting in serious harm to the patient (grade 3 or above)

13. Nutrition
    BMI / weight recorded on admission; MUST assessment on admission and reassessment with a care plan in place for "at risk" patients; the care plan shows evidence of progression and referral as appropriate to dietician.

14. Nutrition outcome measure – percentage of patients who were appropriately referred to a dietician.

15. Nursing documentation
    Bed side folders are up to date and tidy; there is clear, contemporaneous documentation which is dated, printed and signed; property disclaimer and discharge sections are completed.

16. Nursing documentation outcome measure – self-certification by ward managers that documentation has been regularly reviewed and that quality is assured.

17. Medication assessment
    Documentation is legible and completed appropriately, omission codes are utilized and allergies identified.

18. Medication outcome measure – number of medicine administration errors

19. Harm-free Care
    Outcome measure from the Safety Thermometer monthly census of patients on one day identifying patients who do <u>not</u> have an harm – this includes both hospital and community acquired harms; harms are: pressure ulcers, serious harm from falls, catheter associated UTIs (urinary tract infection), VTE.

20. Hospital acquired harm
    Outcome measure from the Safety Thermometer monthly census of patient on one day identifying patients who have acquired two or more harms whilst in hospital; harms are: pressure ulcers, serious harm from falls, catheter associated UTIs (urinary tract infection), VTE.

21. Communication
    Handover quality, co-ordinating care-plans are maintained; there is good interpersonal skills of staff with medications being clearly explained and resources to aid communication being used where appropriate; ward rounds commencing appropriately.

22. Complaints
    Actual number of complaints registered to the clinical area in the reporting month.

23. Privacy & dignity and SSA breaches
    There are strategies in place to prevent disturbing, personal boundaries are not compromised; modesty is maintained within the ward and on patient transfer; there is appropriate communication with patients; the white board maintains confidentiality and there are no breeches of single sex accommodation (SSA).

24. Net Promoter Score (NPS)
    NPS is a business loyalty metric developed by Fred Reichheld and adapted to ask patients within the Trust "Your Feedback" survey. Patients are asked: "Would you recommend the Trust to family and friends?" and asked to provide a score between 0 and 10.

    Respondents are classified as:

    - 0-6 = "Detractors"
    - 7-8 = "Passives"
    - 9-10 = "Promoters"

NPS = % of Promoters – % of Detractors

25. Number of Ward Transfers
    Number of patients transferred to another ward three or more times.

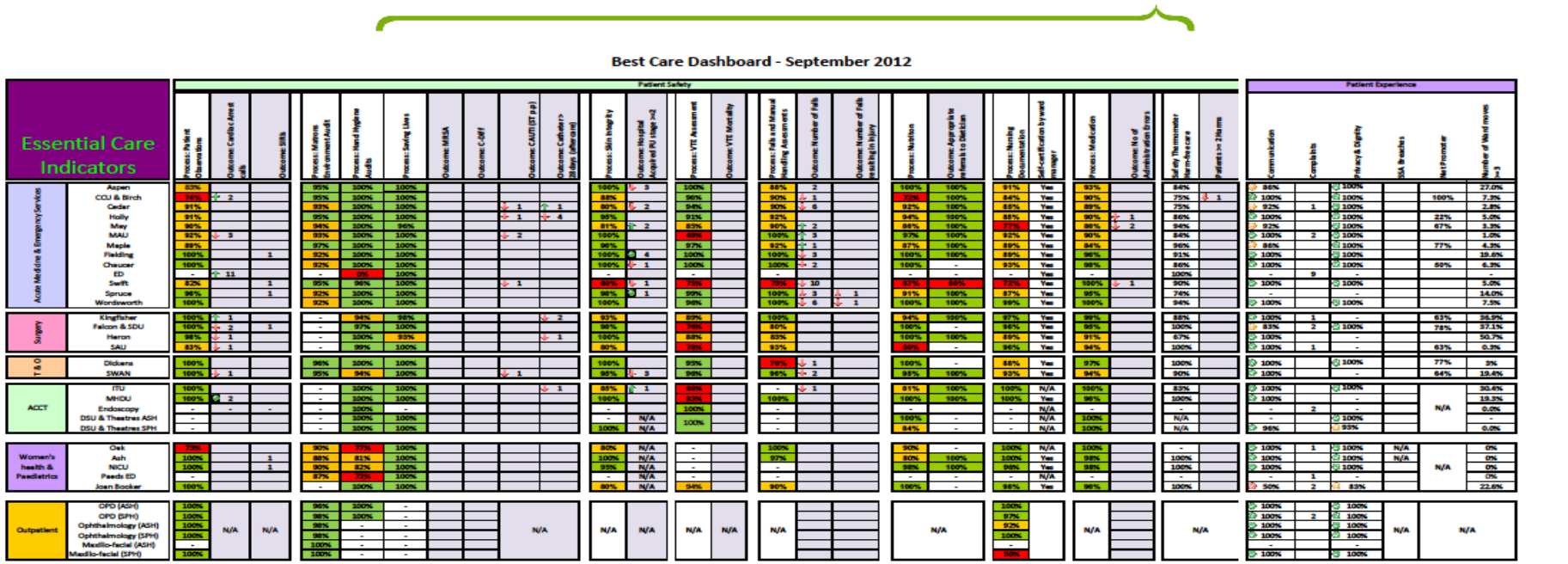
Appendix 3 Quality Account Dashboard: April – September 2012

QUALITY ACCOUNT											
		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Year to Date 2012/13	Trend	Target YTD	Actual YTD vs Plan YTD
Improving our Patient Experience											
Priority 1 - To provide safe, high quality discharge for patients											
	Patients Discharged by 12:00 noon (%)	14.5%	13.8%	14.6%	18.2%	18.4%	18.7%	18.7%		25.0%	-6.3%
	Discharge Related Complaints	4	4	5	6	3	1	23		36	-13
Priority 2011/12 - To provide high quality experience relating to nutrition and hydration											
	Essence of Care - Service to patients (6 mth)						95.8%	95.8%	-	-	-
	Essence of Care - Patients nutritionally at risk (6 mth)						95.6%	95.6%	-	-	-
Priority 2 - To improve all aspects of communication with patients											
	% Response against target no. of "Your Feedback" completed surveys	47%	70%	47%	50%	57%	37%	52%		100%	-48.0%
	Outpatient appointment letter templates revised (Quarterly)			3*			5	8	-	9	-1
	Essence of Care Communication Audit (6 mth)						91%	91%	-	100%	-9%
	Audit of Discharge Letters (6 mth)						64%	64%	-	100%	-36.0%
	Patients knowing how to access PALS (annual)							N/A	-	60%	-
	Shared decision-making (annual)							N/A	-	6.9	-
Maintaining High Safety Standards											
Priority 3 - To provide effective risk assessment and prophylaxis VTE											
	Risk Assessment for VTE (%)	90.91%	90.07%	90.26%	91.27%	91.35%	90.24%	90.44%		91.00%	-0.6%
	Hospital acquired VTE (hospital acquired with PE or DVT)	2	0	1	1	3	4	11		7	4
Priority 2011/12 - To provide confidence and assurance on infection control											
	C.Diff (Hospital acquired)	3	3	0	1	2	0	9		9	0
	MRSA Bacteraemia (Hospital acquired)	1	0	0	0	0	0	1		1	0
Priority 2011/12 - To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators											
	Total Falls	70	70	63	69	40	43	355		231	124
	Falls - resulting in harm (grade 3 or above)	0	0	2	3	0	2	7		8	-1
	Prevention of pressure ulcers (hospital acquired stage 2 and above)	11	12	9	18	14	18	82		54	28
Achieving High Quality Clinical Care											
Priority 4 - To reduce the hospital emergency and elective readmission rate											
	Readmission in 28 days - Elective	3.2%	2.4%	2.9%	2.8%	2.9%	3.0%	2.9%		-	-
	Readmission in 28 days - Emergency	17.0%	17.7%	18.2%	16.9%	17.6%	17.2%	17.4%		-	-
Priority 5 - To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure											
	SMR for Heart Failure (2 months in arrears - Dr Foster)	41.1	-	-	50.0	-	-	50.1		-	-
	SMR for Pneumonia (2 months in arrears - Dr Foster)	89.5	-	-	63.7	-	-	80.3		-	-
Priority 2011/12 To improve the experience and clinical outcomes for those with long term conditions											
	Admission Rate for Chronic Obstructive Pulmonary Disease (COPD)	0.58%	0.51%	0.60%	0.34%	0.48%	0.44%	0.59%		0.69%	-0.1%

Patients first • Personal responsibility • Passion for excellence • Pride in our team

Prepared by Information Services

Appendix 4 Best Care Dashboard – September 2012



Appendix 5
Best Care Actions and Achievements per Division

The Best Care Dashboard definitions are found at Appendix 2 and the Best Care Dashboard at Appendix 3. The following narrative is provided by the Matrons and Heads of Nursing for the areas.

Acute Medicine, Head of Nursing, Justine Hillier

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Birch	**Patient Observation** **Nutrition**	Failure to complete documentation Ward Manager not checking documentation and challenging poor practice	• Ward Manager set clear objectives re checking documentation. • Poor practice highlighted to individual staff and discussion with ward manager if continues after this meeting with HoN. • Nutrition nurse to support Ward Manager to carry out nutrition action plan. • Weekly checks by Matron to ensure compliance. • Performance management if no measurable improvement.
Swift	**Nursing observation** **Nutrition** **Skin integrity** **Manual handling** **Nursing documentation**	Ineffective leadership High number of untrained nurse vacancy.	• Ward Manager given clear objectives and expectations. • Action plan for targeted improvement • Head of Nursing to attend Ward meeting re expectations and personal accountability. • Matron to meet with Ward Manager daily and support development • Head of Nursing & Matron to meet weekly with Ward Manager to evaluate improvement progress. • Nutrition nurse to assist in nutrition action plan. • Staff failing to meet required standards referred to Head of Nursing. • Experienced HCA moved from within medicine to support new starters. • Nine beds will close on 5th November thus reducing vacancy rate. • Completion of operational policy.
All medical wards	**Nursing documentation** - Failure of patient to sign care plan and disclaimer	Failure to complete	• Ward Managers expected to check documentation daily. • Ward Manager's monthly self certification for standards of documentation. • If repeat offenders then referral to Head of Nursing for discussion re accountability. • Matrons to monitor on daily basis.
All medical wards	**Medication Assessment** Medication not prescribed appropriately	Drs not prescribing correctly	• Poor practice highlighted to individual Drs. • If no improvement consultant informed • Matrons and ward Managers to perform spot checks. • Pharmacy to be involved and possible teaching at junior Drs Forum.

Anaesthetics, Critical Care, Theatres (ACCT) and Outpatients, Head of Nursing, Kate Eidens, Matron Den Hallett

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
DSU/Theatres Ashford	**Pre list brief red**	Clinicians are not always engaged in carrying out pre list brief	Safer Surgery week raised profile with Clinicians of the weakness in this area .Divisional director and
	Patients consent red	Consent illegible at times	Matron to reinforce policy to nurse that no patient go leave DSU for Theatre without consent form compliance
DSU Sph	**Patient nil by mouth red**	Booking of patients	Orthopaedics have agreed to review booking processes
	Safer Surgery red		
Theatres SPH	**Pre-Operative documentation**	Documentation Illegible	Reinforce message re:legibility of patient and Dr's details
	No Weight recorded	Wards/Adm lounge not recording	Matron to Matron surgery conversation
ICU	**Nutrition**	Paperless system records in a different place	Matron ICU to advise auditor of location of details
MHDU	**Medication assessment**	Height/weight not recorded	Recent merge, Matron to re clarify expectations

Area	Achievement	Explanation
Day Surgery and Theatres Ashford	Overall very good compliance with documentation standard	Poor practise is being consistently challenged
ICU/MHDU	No single sex breaches despite capacity problems	Improved compliance o/s CC
Theatres SPH	Safer Surgery Checklist improvements	Divisional push and personal responsibility

Paediatrics, Head of Nursing, Julie-Anne Dowie

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Nicu	**Batch numbers for breast milk collection**	Incorrect documentation	Ward Manger will highlight the issue again with staff to ensure correct documentation of the batch numbers.
Oak Ward	**Documentation** **Pain assessment on admission** **WT/ Ht/ BMI** **Skin integrity**	Observation were not all documented Children admitted prior to elective surgery did not have the no pain score underlined Not all BMI'S were documented Skin integrity wasn't documented in all cases	Ensuring all staff are aware of correct documentation and the importance of documentation. Pain management is everyone's concern and the staff need to ensure pain scores are highlighted. Staff on Oak ward are aware of the importance of correct nutrition screening and usually document this very well .I will ensure the good practise will remain but talking to the staff again. Discuss with staff the importance of skin integrity and ensure all columns are filled in.
Ash Ward	**Wt/Ht and BMI**	Ht and BMI's are not been recorded.	Height machine is now installed on Ash ward and there should be a better result next month

Area	Achievement	Explanation
Nicu, Oak and Ash	Overall the audit looks promising and shows improvements.	Staff are aware of the importance of quality and therefore improvement of patient experience.

Surgery, Head of Nursing, Sue Sexton

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
SAU	Medication Assessment	Pharmacist is failing to complete medicines reconciliation chart and attach it to the drug chart	Sister has spoken to pharmacist
Falcon & SDU	Medication Assessment	Nurses are failing to record height & weight on drug charts	The ward has recently purchased and erected a height measuring aid and staff have been made aware to document in the SAP and on the drug chart
Heron	Medication Assessment Nursing Documentation	Nurses are failing to record height & weight on drug charts Nurses are failing to complete discharge section 1 on admission and are failing to sign & date all entries High numbers of temporary staffing used due to maternity leave and sickness	Sister is identifying staff responsible by daily checking of documentation and meeting with them to discuss reasons for non-completion Matron to complete spot check audits Substantive staffing levels are improving as new starters commence and staff are now returning from maternity leave
Kingfisher	Nutrition Skin Integrity	Nurses are failing to accurately complete fluid balance charts Nurses are failing to personalise and evaluate care plans High numbers of temporary staffing used and vacancies unfilled Duplication of documentation on wards as the new was being implemented	New documentation has now been implemented on wards and all staff aware of personal accountability Sister is completing daily checks and additional spot checks are being carried out by the matron

Area	Achievement	Explanation
Kingfisher, Falcon, Heron, SDU	All areas have seen an improvement in their overall scores in month improving from 28 red scores in August to 16 red scores in September	Increase in the number of substantive staff now in post Vigilant monitoring by the Ward Sister and Matron

Trauma & Orthopaedics, Head of Nursing, Sue Sexton

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Dickens Ward	Manual Handling	Nurses are failing to complete the bed rail assessment on admission	Sister is identifying staff responsible by daily checking of documentation and meeting with them to discuss reasons for non-completion
	Nursing Documentation	Nurses are not asking the patients to sign the care plan to identify that care has been discussed with them	Matron to complete spot check audits
Swan Ward	Skin Integrity	Nurses are failing to re assess Waterlow Scores	Sister is identifying staff responsible by daily checking of documentation and meeting with them to discuss reasons for non-completion. HR processes being followed where applicable
	Manual Handling / Falls	Nurses are failing to carry out lying & standing blood pressure readings	
	Medication Assessment	Nurses are failing to record height & weight on drug charts	Matron to complete spot check audits
	Nursing Documentation	Nurses are not asking the patients to sign the care plan to identify that care has been discussed with them	
		Nurses are failing to sign & date all entries	

Area	Achievement	Explanation
Dickens Ward	Dickens have seen an upward trend in Patient Observations, Skin Integrity and Nutrition in month	Sister sent all staff individual letters setting out her expectations and spot checks all observation charts. Nurses are completing body maps fully when patients are transferred from other areas
Swan Ward	Swan have seen an improvement in Nursing Documentation in month with the red scores reducing from three to two areas	Implementation of new care plans and staff are taking more responsibility and accountability for their own actions

Maternity, Matron Alison Howker

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Joan Booker Ward Waterlow risk assessment on admission	This had not been completed for two of the ten women assessed on admission. 80%	This should be completed on admission to the ward and reassessed after surgical procedures such as caesarean or manual removal of placenta.	Midwives are being followed up by the ward sister to ensure it is completed for all women on admission as part of the ward sisters daily record check
Privacy and dignity Joan Booker	This was scored as 83% over all by the reporting matron but only good for maintaining modesty	Comments document that women are happy with care, dignity is protected and help and support given.	Score was only 50% for modesty in the ward and when being transferred. It is usual to cover women with a blanket if they are transferred to the ward in a chair after delivery and all women are supported to have the curtains around them when any procedure is undertaken or they are breast feeding. This has not been an issue in the feedback from women.
Communication Joan Booker	Two women were in beds and waiting for the labour ward midwife and Joan Booker midwife to do the bedside hand over of care	This should happen as soon as women are admitted to the ward, but can delay midwives from completing other tasks when the ward is busy, or delay the Labour Ward midwife returning to the labour Ward	Labour Ward should ensure they inform the ward that they plan to bring a woman down with notice that enables the ward to prepare for women coming. Ward manager to discuss with Labour Ward the process for bringing women down in a timely way Handover of care and the discharge process are being looked at as part of the beyond good to great.

Area	Achievement	Explanation
Documentation	98% of records complete	This is now being assessed on a daily basis by the ward manager and any omisssions are addressed with staff at the time
Medication Assessment	96% achieved, the shortfall was due to two Doctors signatures which were not legible and has been addressed.	Midwives documentation complete

Appendix 6
Patient Experience Dashboard

Sep-12	ACCT (per month)	YTD		Ac & Em (per month)	YTD		D&T (per month)	YTD		Fac (per month)	YTD		SMSS (per month)	YTD		Surg (per month)	YTD		T&O (per month)	YTD		WH & P (per month)	YTD		Trust (per month)	YTD	YTD target	Annual target
Complaints Rec'd	0	6	▶	12	135	▶	0	12	▼	0	2	▼	2	27	▼	6	29	▲	2	19	▼	5	33	▼	**28**	**222**		<500
Discharge related complaints	0	0	▶	1	16	▼	0	0	▶	0	0	▶	0	0	▶	0	2	▼	0	4	▼	0	2	▶	**1**	**24**		<73
% Response timescales met	100%	86%	▶	75%	65%	▼	100%	100%	▶	50%	50%		100%	90%	▶	0%	63%	▼	100%	81%	▶	83%	89%	▶	**77%**	**88%**	95%	>95%
PALS Concerns	0	19	▶	14	141	▼	7	57	▶	3	30	▼	14	103	▼	16	87	▶	10	60	▲	3	32	▼	**67**	538	tba	tba
Your feedback				80.8%	80.5%	▼										82.0%	80.9%	▲	82.5%	80.3%	▲				81.9%	80.7%	n/a	n/a
NPS* see key below				53%	57%	▲										65%	59%	▲	72%	63%	▲				**64.0%**	**60%**	65%	65%
Intimations of claims	0	1	▶	2	4	▲	0	0	▶	0	0	▶	0	3	▼	1	11	▼	1	3	▲	1	9	▲	5	30	tba	tba
Reported claims	0	2	▼	1	0	▶	0	0	▶	0	0	▶	0	2	▶	2	1	▲	0	2	▶	2	5	▶	5	17	tba	tba
NHS Choices +ve rec rate Ashford																										100%		n/a
NHS Choices +ve rec rate St Peter's Hospital																										92%		n/a

No change from previous month	▶
Decrease compared to previous month	▼
Increase compared to previous month	▲
Improvement compared to previous month	
Same or no change	
Deterioration compared to previous month	
Not applicable	

Divisional NPS scores comprise:		
ACCT	Day Surgery Unit	Trust Inpatient NPS score
Acute Med & Emerg Servs	Medical Wards x 12	Trust Inpatient NPS score
WH & Paedaitrics	Maternity & Paed Inp	Trust Inpatient NPS score
Surgery	Surgical Wards x 5	Trust Inpatient NPS score
Trauma & Orthopaedics	Orthopaedic Wards x 3	Trust Inpatient NPS score
Spec Med & Spec Surgery	Outpatient - rolling dept survey	Trust Outpatient NPS score
Diagnostics & Therapeutics	Outpatient Areas	Trust Outpatient NPS score
Null	Insufficient or no data provided	