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

TRUST BOARD
26th September 2013

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for August 2013. Please refer to the Executive Summary on page three.
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.
LINK TO STRATEGIC OBJECTIVE	**SO1:** To achieve the highest possible quality of care and treatment for our patients in terms of outcome, safety and experience.
STAKEHOLDER / PATIENT IMPACT AND VIEWS / STAFF VIEWS	Patients' views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience are occurring. Where appropriate staff views are included.
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 and Social Care Act 2012 and failure to do so could affect the Trust's registration and Monitor licence.
The Trust Board is asked to:	Review the paper and discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr David Fluck, Medical Director & Suzanne Rankin, Chief Nurse
Date:	19th September 2013
Decision:	For Assurance

Contents

Appendices

1 Executive Summary

The Trust remains committed to two of its core responsibilities: protect patients from hospital related harm and supporting staff to continuously improve performance in quality and safety. The Board's attention is drawn to three key issues discussed in the paper:

- Quality Quadrant Balanced Scorecard
- NHS Safety Thermometer
- Patient Experience

1.1 Quality Quadrant Balanced Scorecard

The Trust continues to meet the target for VTE risk assessment (>95%); however, the incidence of new, hospital-associated DVT / PE remains a concern. New cases of thrombosis are identified via the return of patients to anti-coagulation clinics. It is difficult to accurately identify actual numbers of patients affected due to the often clinically silent nature of VTE and it is not possible to completely eradicate the risk to patients. There are ongoing, regular training sessions for clinical staff and the Trust has improved its root cause analysis to identify reasons for thrombosis developments with findings shared among clinical teams across the organisation.

1.2 NHS Safety Thermometer (National CQUIN)

Since April 2012 the Trust has submitted data for approximately 8500 patients. There has been a considerable reduction in the percentage of patients with 'new' harms at ASPH since January 2013 (1% in August) and the Trust now sits below the national, acute Trust value (2.88%), and below two local Trusts. The improvement reflects a significant decrease in patients with catheter associated urinary tract infection, which is a local CQUIN deliverable. In addition, from June 2013, there have also been decreases in the incidence of pressure ulcers and falls with harm.

Improvement work continues with strengthened support for the prevention of patient falls with recruitment of a specialist falls nurse and review of Trust processes in light of recent NICE guidance[1].

1.3 Patient Experience

The Trust has seen a significant decrease in complaints in August (26) compared with previous months (43 for July); however we are exceeding the limit set for the year-to-date (201 vs limit = 187). Together with the excellent results from the National A&E patient survey and the response rates and scores for the Friends and Family Test, this indicates that improvement work is becoming more effective in many areas. Further work is focused on actions in response to the National Cancer Patient Experience Survey which highlights that the Trust still has areas of improvement to achieve.

[1] NICE: National Institute for Health and Clinical Excellence; http://guidance.nice.org.uk/CG161

2 Performance Monitoring

2.1 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		Outturn 12/13	YTD Target 13/14	Monthly Target 13/14	Annual Target 13/14	Aug Actual	Performance			YTD 13/14
								Jun	Jul	Aug	
1-01	Summary Hospital-level Mortality Indicator (SHMI)	N	60	<72	<72	<72	57	◄►	▲	▲	62
1-02	Actual deaths (Excludes Neonatal Intensive Care)	L	1134	<430	<86	<1034	74	▼	▲	▲	421
1-03	MRSA (Hospital only)	N	2	0	0	0	0	◄►	◄►	◄►	0
1-04	C.Diff (Hospital only)	N	15	<=5	<=1	<13	1	◄►	◄►	▼	2
1-05	VTE (hospital associated with PE or DVT)	L	24	<10	<2	<24	5	▲	▼	▼	16
1-06	Serious Incidents Requiring Investigation (SIRI)	L	71	<31	<6	<75	6	▲	◄►	▲	33
1-07	Average Bed Occupancy (inc escalation)	L	88.6%	<92%	<92%	<92%	80.9%	▲	▲	▲	86.3%
1-08	Patient Moves (ward changes >=3)	L	7.4%	<7.5%	<7.5%	<7.5%	4.8%	▲	▼	▲	5.7%
1-09	Formal complaints (Total Number)	L	485	<187	<37	<450	26	▲	▼	▲	201
1-10	Friends & Family test score - InPatients	L	-	70	70	70	74.2	▲	▲	▼	73.3
1-10a	Friends & Family test score - A&E	L	-	70	70	70	49.6	▼	▲	▼	48.4
1-11	Falls (Total Number)	L	766	<291	<58	<700	53	▲	▼	▲	336
1-12	Falls - resulting in significant injury (grade 3)	L	18	<6	<1	<15	1	▼	▼	▲	11
1-13	Hospital acquired pressure ulcers grade 2 and above	L	164	<57	<11	<139	7	▲	▲	▲	52
1-14	Catheter associated UTI *	L	-	<1.2%	<1.2%	<1.2%	0.00%	▼	▼	▲	0.53%

1-01 IN-HOSPITAL (SHMI) Monthly figure is a rolling 3 month position, 1 month in arrears & YTD figure is a rolling 12 Month position, 1 Month in arrears
1-08 Patients Moves excluded: To the Discharge Lounge, MAUV-MAU and SAUV-SAU, between Theatres, between Endoscopy
1-14 *Achieved by 6 months then maintained

For indicator definitions see Appendix 1.

(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 for August was 57 which means the rolling twelve month position remains at 62, against a peer average of 72. The actual number of deaths in August was 74 which is within the trajectory of 86. The target within the balanced scorecard has been corrected to ensure that it reflects the CQUIN target agreed with the CCG.

The Trust continues to meet the target for VTE risk assessment (>95%); however, the incidence of new, hospital-associated DVT / PE remains a concern. New cases of thrombosis are identified via the return of patients to anti-coagulation clinics. It is difficult to accurately identify actual numbers of patients affected due to the often clinically silent nature of VTE and it is not possible to completely eradicate the risk to patients. There are on-going, regular training sessions for clinical staff and the Trust has improved its root cause analysis to identify reasons for thrombosis developments with findings shared among clinical teams across the organisation.

There were 26 complaints in August, which was slightly reduced from July. However the Trust is still above its target reduction level.

The FFT score for A&E (49.6) lies well below the target (70) set at the beginning of the year. Recent, published data providing a benchmark against other neighbouring Trusts and the national picture show wide variation in the scores for A&E departments (from 20 to 75). The Trust will reconsider the appropriateness of this target following publication of further data.

The Falls steering group and recent recruitment to the vacancy for the falls nurse specialist role will support review and implementation of new recommendations from NICE to reduce the number of falls and falls with harm within the Trust.

There was one case of C-difficile in August, but no cases of MRSA. This leaves the year to date number of cases at two and zero respectively. This reflects the on-going focus on implementing infection control strategies.

3. Clinical Effectiveness

3.1 Enhancing Quality and Recovery (EQ&R)[2] Programme

Since moving to the new "care bundle" methodology in 2013/14 where each patient must be provided with all care measures in order to meet the regional target, there has been an anticipated dip in performance. E-learning modules are pending final approval and aim to support the improvement needed.

4. Safety

4.1 National Patient Safety Agency (NPSA) Safety Alerts

There have been no new alerts reported by the NPSA since March 2012.

4.2 NHS Safety Thermometer (National CQUIN) (Charts 1 - 4)

The Safety Thermometer[3] 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, falls, catheter associated urinary tract infections (CAUTI) and venous thromboembolism. Data is collected on all inpatients on one day per month, approximately 500 patients, to provide a 'snapshot' of harms.

Since April 2012 the Trust has submitted data for approximately 8500 patients. In total, more than 700 organisations: acute Trusts, nursing homes, care homes, independent sector care providers and community care, have submitted data for over 2.5 million patients. National results for the Safety Thermometer are published and used for benchmarking with other, similar acute Trusts. The Department of Health has confirmed that ASPH has shown a 25% reduction in all of the harms for the period June 2012 to June 2013. This reduction refers to both community-acquired and 'new', hospital-associated harms.

There has been a considerable reduction in the percentage of patients with 'new' harms at ASPH since January 2013 (1% in August) and the Trust now sits below the national, acute Trust value (2.88%), and below two local Trusts (Chart 1). The improvement reflects a significant decrease in patients with CAUTI (Chart 2) which is a local CQUIN[4] deliverable for 2013. From June 2013, there have also been decreases in the incidence of pressure ulcers (Chart 3) and falls with harm (Chart 4).

The Trust remains committed to reducing the incidence of avoidable harms. The Trust Falls Steering Group is reviewing the current falls prevention plan based on improvement strategies from recent NICE guidance[5] and a new, falls prevention nurse commences work at the Trust in September. Additional staff have been recruited to support prevention of pressure ulcers: a tissue viability nurse and a specialist nutriton support nurse and the Trust's annual pressure ulcer conference is being held on 30th October. There is also

[2] Enhancing Quality and Enhanced Recovery website: http://nww.enhancingqualitycollaborative.nhs.uk/
[3] The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care see: http://www.hscic.gov.uk/thermometer)
[4] CQUIN: Commissioning for Quality and Innovation payment framework, http://www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf
[5] NICE: National Institute for Health and Clinical Excellence; http://guidance.nice.org.uk/CG161

ongoing training and education of all clinical staff with regular sessions on risk assessment and prevention of VTE.

5. Patient Experience

The Patient Feedback Dashboard, Appendix 2, provides an overview of key patient experience metrics and these results are explored in further detail here.

5.1 Complaints/Ombudsman Reports (Charts 5 – 8)

There were 26 formal complaints received, representing a decrease of 40% compared with July (43) and a 28% decrease compared with June (36).

Chart five shows a breakdown of complaints received by month and demonstrates the number of complaints received in August is the lowest since April 2011 (25). The reduction in complaints this month fits with the overall pattern of seasonal variation.

Chart six shows a breakdown of complaints by Service Area and the date of the episode relating to each complaint. The highest number of complaints received in August relate to inpatient episodes (13). The highest number of inpatient complaints relate to episodes in June (four), followed by inpatient episodes in August (three).

The main themes in inpatient complaints regarding episodes in June, July and August relate to treatment and care and communication, including communication with families and carers.
The Trust is currently working with the Patients Association to design a project aimed at improving communication with families and carers.

Chart seven shows discharge related complaints by month. There were three formal discharge related complaints received in August, compared with six in July and five in June. Of these two relate to episodes in July. No single theme relating to discharge was raised and issues included the involvement of families and arrangements on the day.

Performance against timescale

There was a decrease in performance against timescale for all Divisions, giving an overall Trust performance against agreed timescale of 76%. Actions to improve this performance are in place. In response to this there will be increased support to Divisions, with a particular focus on increasing facilitation to doctors in investigating and responding to formal complaints.

PALS concerns

There was an increase in PALS concerns (103), compared with the previous month. The main issue raised through PALS was timeliness of communication.

Parliamentary and Health Service Ombudsman (PHSO) cases (Table 2)

Table 2 below provides a summary of cases that were active with the PHSO in August 2013. Five cases are carried forward and there is one, new case in August.

Ref	Division	Stage	Status
07.13/2	EM&MED	The Trust has sent a further response and awaits decision.	Open
07.13/3	EM&MED	The Trust has provided further information and awaits decision.	Open
07.13/5	EM&MED	The PHSO has requested information for initial review	Open
07.13/4	TASCC	The Trust has provided further information and awaits decision. (Expected to close in August, awaiting PHSO confirmation.	Open
07.13/6	TASCC	The PHSO has requested information for initial review	Open
09.13/1	WH&P	The PHSO has requested information and commenced investigation	New

5.2 Patient Feedback

5.2.1 Friends and Family Test (FFT)[6]

Chart eight shows improvement in the response rate for the FFT in August, with a combined Trust rate of 24%, compared with 22.5% in July. Chart nine shows that the inpatient Net Promoter Score (NPS)[7] of 74 exceeds the Trust target of 70. The NPS for the Emergency Department was 50, compared with 48 in July.

Some early, benchmarked data against neighbouring Trusts and the national picture are shown in charts 10 to 15. This data has been taken from the published data at: www.england.nhs.uk. For response rates, ASPH sits around second position against the neighbouring Trusts and is 6% above the national response rate (chart 10). For the net promoter score (NPS), chart 13, the overall Trust score dipped in July, reflecting the impact of the lower A&E score (chart 15) compared with a relatively high inpatient score (chart 14). Note that there is a lack of published data for April and May for the combined response rate and NPS.

Work continues to support Divisions in identifying themes from the FFT comments in order to make early changes and improvements.

5.2.2 National Patient Surveys

Cancer Patient Experience Programme National Survey

The Trust was one of 155 NHS Trusts, providing cancer services to take part in the Cancer Patient Experience Survey 2012/13. Participation in this survey is congruent with the NHS National Operating Framework 2012/13; the NHS Business Plan 2013-16 and "Everyone Counts", Planning for Patients 2013-14.

All patients aged 16 or over with a primary diagnosis of cancer that had an episode of treatment between 1 September and 30 November 2012 were included in the survey. Our response rate fell in 2012/13 (61%) compared to 2011/12 (66%). However, this is similar to the national average response rate (64% in 2012/13 compared to 68%).

Table 3 shows the Trust performance in 2012/13 compared with the previous year; both surveys contained 70 questions.

Table 3 National Cancer Survey Performance

Performance	**2011/12**	**2012/13**
Response rate	**66%**	**61%**
Number of questions where the Trust improved compared with previous year	**33**	**26**
Number of questions where Trust was worse than previous year	**16**	**22**
Significantly improved questions	**3**	**2**
Significantly worse questions	**1**	**0**
Number of questions where Trust in bottom 20% of Trusts	**27**	**27**

[6] The FFT asks the following standardised question: "How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?

[7] Calculation of the FFT score: the Proportion of respondents who would be extremely likely to recommend (response category: "extremely likely") minus the proportion of respondents who would not recommend (response categories: "neither likely nor unlikely", "unlikely" & "extremely unlikely").

The Trust significantly improved in two questions, compared with three questions the previous year. These questions referred to understanding the explanation of what was wrong and being given written information about the type of cancer the patient had. There were no significantly worse questions in 2012/13, compared with one the previous year. There were overall improvements in:

- Finding out what was wrong,
- Deciding the best treatment,
- Support from the Clinical Nurse Specialist (CNS),
- Explanations and information relating to operations,
- Communication with doctors,
- Information on discharge and home support,
- Hospital care as a day patient or outpatient.

Whilst there are only two questions that had significantly changed from the previous year it is important to review all of the responses to build a picture of the overall experience of the patients who used our cancer services towards the end of 2012. Results have been presented to the Cancer Steering Group and the Cancer User Group and an action plan is in development.

National Accident and Emergency Department Survey 2013

Results from the National A&E 2013 Survey indicate that the Trust performed better than in the 2012 survey and compares well with other A&E departments.

This report is being reviewed in detail and the overall findings and actions to address issues will be reported at a future meeting.

5.2.3 Compliments

The Trust received 13 formal compliments during August. All formal compliments received in the Executive Offices are responded to personally in writing.

NHS Choices website: the patient gave a 5 out of 5 star rating to the Coronary Care Unit and Cardiac Rehabilitation Team.

"I had 2 short stays in CCU at St Peter's in May 2013 after a heart attack, the insertion of 2 stents and then a false alarm. On both occasions the cardiology and CCU teams were marvellous. I felt they really cared about me as an individual and that I was in safe hands. Thank you to the team.

I then followed the cardiac rehab programme at St Peter's for 6 weeks which was fantastic. The nurses and physiotherapist were so friendly, supportive and informative, it really helped me

rebuild confidence and develop a more healthy routine to carry forward. The programme is a real community and it was good to meet other people with a similar experience, discuss concerns and exchange tips. I believe my recovery was improved significantly and I highly recommend it to anyone offered a place. In my view it is a MUST. Many thanks - you are a great team!"

5.3 Best Care Audits August

In August four areas were re-audited. The accreditation levels achieved are shown below; for detailed results refer to the dashboard in Appendix 3.

ITU has improved from level two to level 3; Labour ward remains at level 2 and DSU and Theatres have achieved level 1 for Ashford and level 3 for St. Peter's. The Trust now has six areas at level 3, eight at level 2, nine at level 1 and four at level zero (due to be re-audited in September). A range of actions have been devised and improvement plans have been presented to senior nursing staff.

Table 4 Best Care Accreditation Levels, August 2013

		April	June	July	Aug	Re-audit
Acute Medicine & Emergency Services	Aspen	1		0		Sept
	CCU & Birch	0	1			Sept
	Cedar	0	2			Oct
	Holly	0	3			Dec
	May	1		2		Nov
	MAU	1		1		Oct
	MSSU	1		1		Oct
	Maple	3				Oct
	Fielding	1		0		Sept
	WWW/Chaucer	1		0		Sept
	ED	0	1			Sept
	Swift	0	N/A	N/A	N/A	N/A
	Endoscopy	2			N/A	TBC
Theatres Anaesthetics Surgery & Critical Care	Kingfisher	1		1		Oct
	Falcon & SDU	1		1		Oct
	Heron	0	2			Oct
	SAU	1		0		Sept
	ITU	2			3	Feb
	MHDU	3				Oct
	DSU & Theatres ASH				1	Nov
	DSU & Theatres SPH	0			3	Feb
T & O	Dickens	1		2		Nov
	SWAN	1		1		Oct
Women's Health & Paediatrics	Oak	3				Jan
	Ash	1		1		Oct
	NICU	2		2		Nov
	Paeds ED	*				TBC
	Labour Ward	2			2	Dec
	Joan Booker	1		2		Nov

Notes: Swift ward is not currently in operation; Endoscopy – the measures within the audit are being reviewed to ensure they are appropriate for the area. (TBC to be confirmed).

Charts 1 to 4 Safety Thermometer

Chart 1 Percentage with new harms

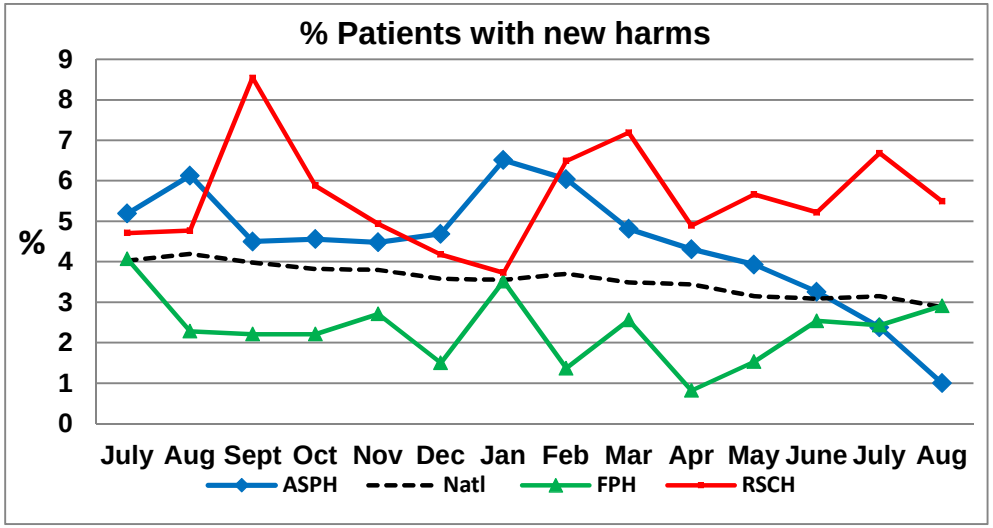


Chart 2 Indicence of new CAUTI

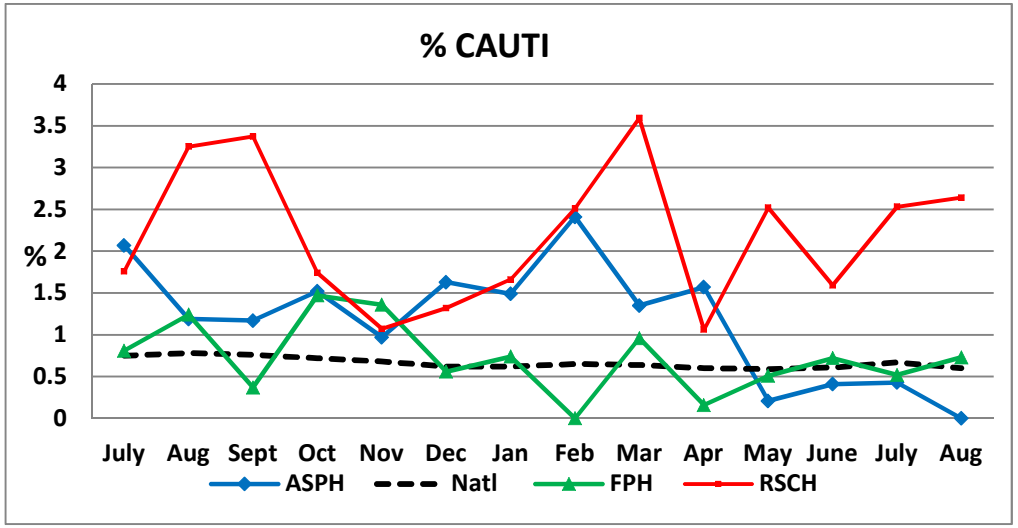


Chart 3 Incidence of pressure ulcers

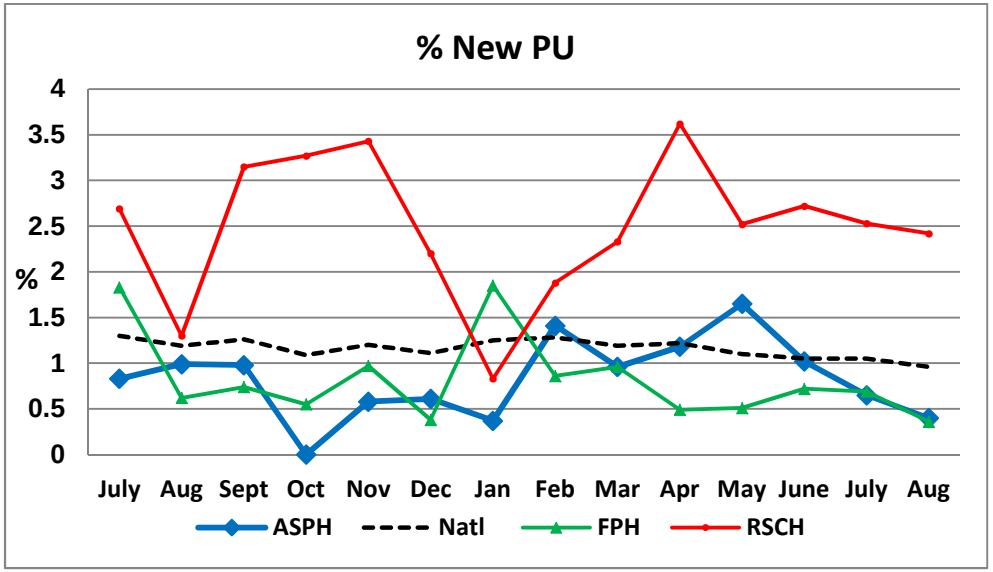
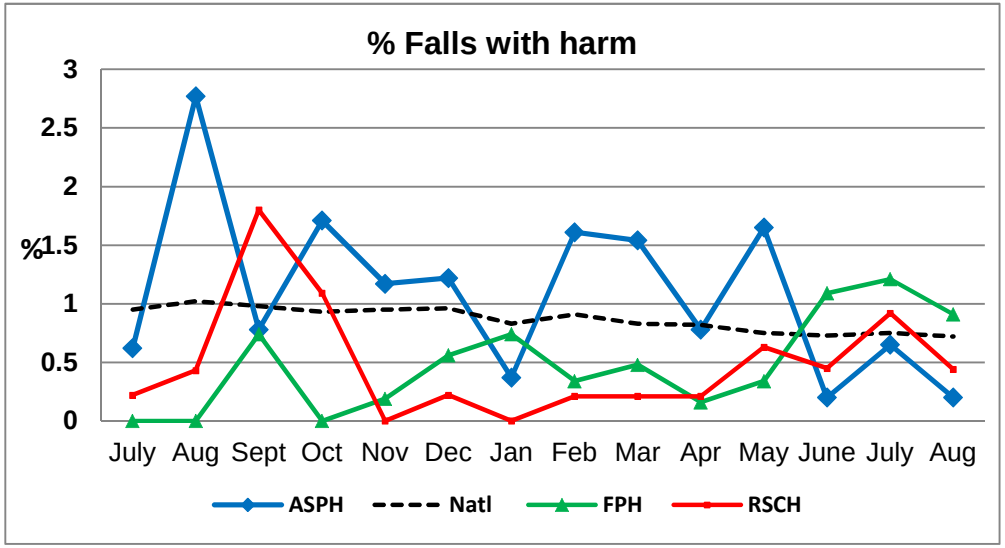


Chart 4 Percentage of falls with harm



Charts 5 to 9 Complaints and Patient Feedback

Chart 5 Complaints received by month

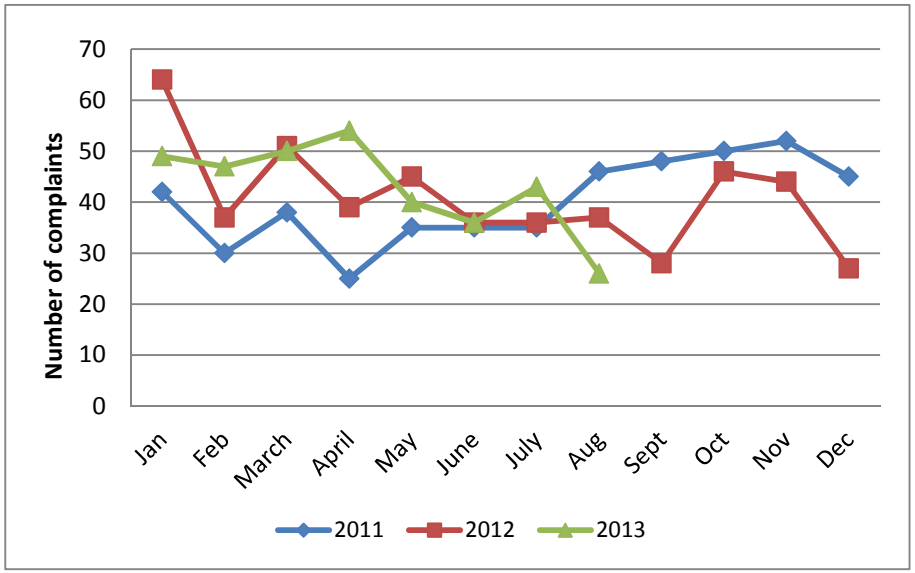


Chart 6 August complaints - service area by date of episode

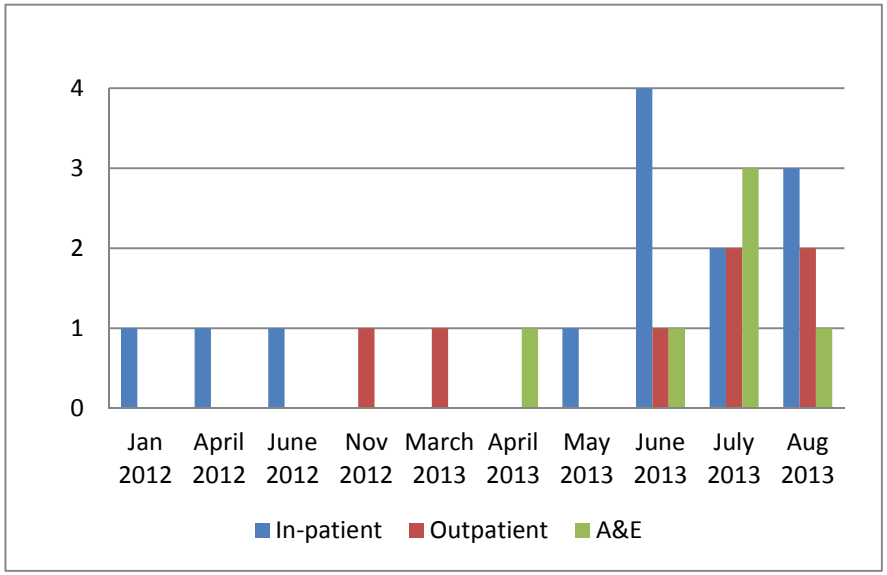


Chart 7 Complaints relating to discharge

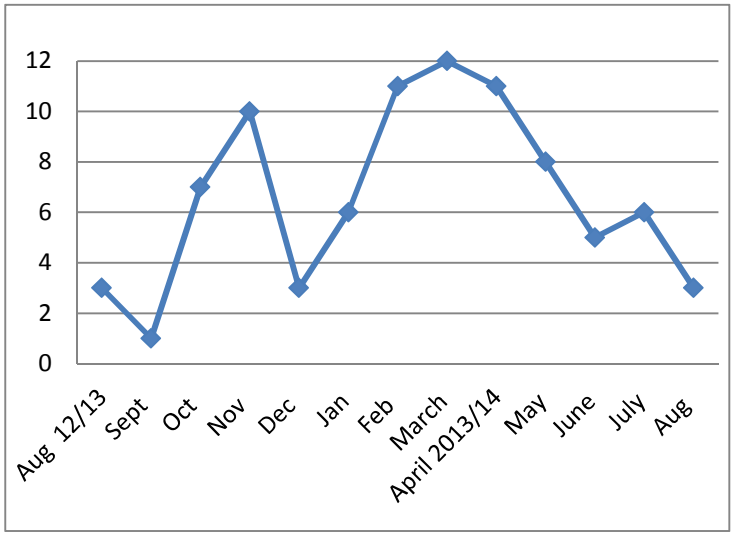


Chart 8 FFT response rate

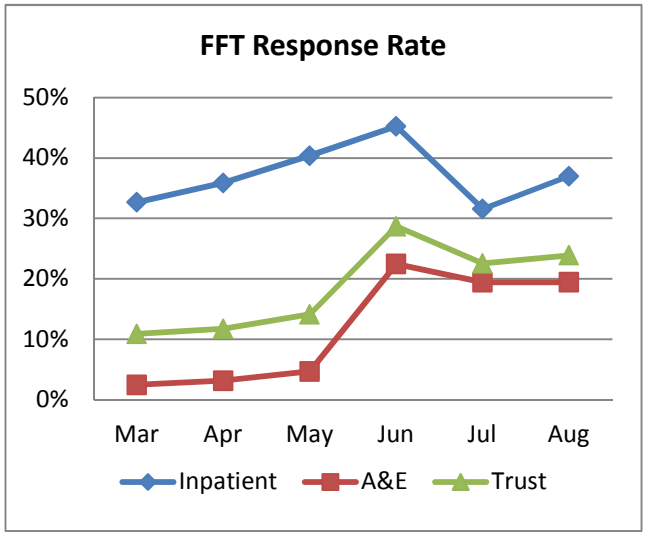
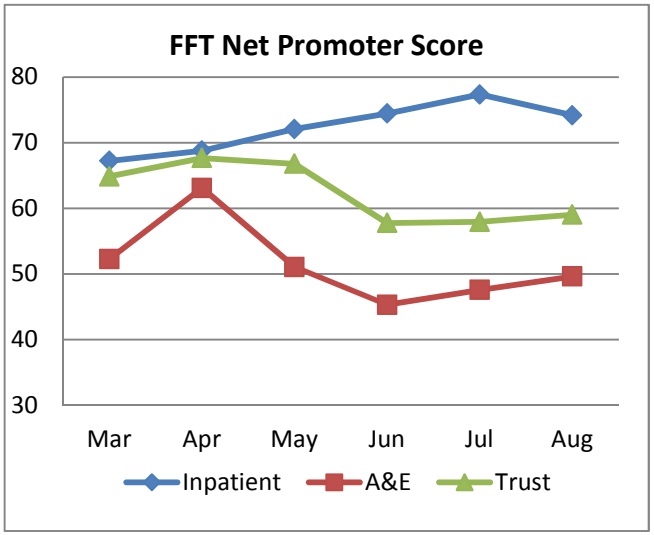


Chart 9 FFT net promoter score



Charts 10 to 15 Friends and Family Test Benchmarked Data

Chart 10 Trust combined response rates (%)

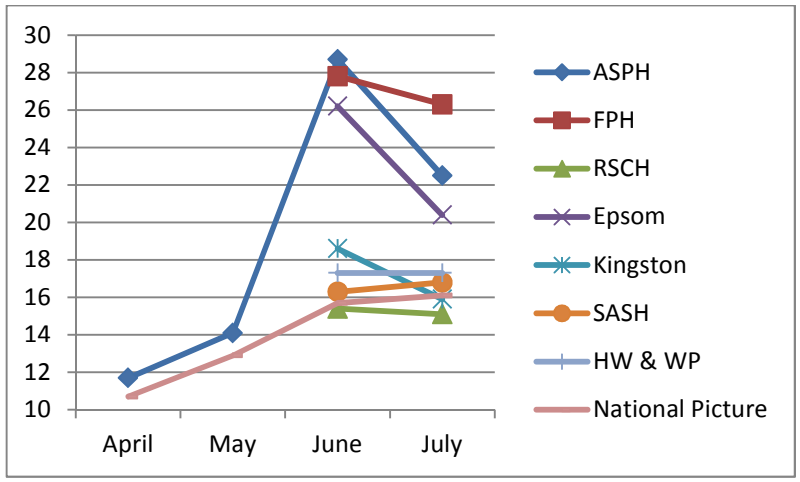


Chart 11 Inpatient response rates (%)

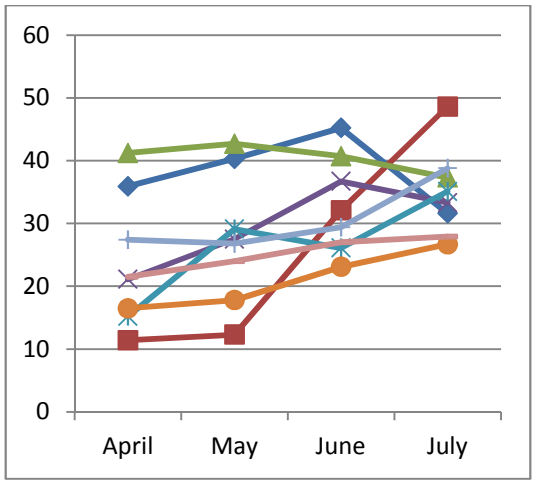


Chart 12 A&E response rates (%)

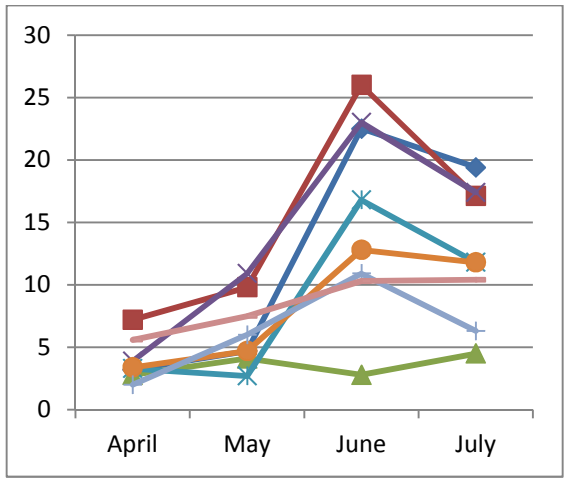


Chart 13 Trust combined Net Promoter Score (NPS)

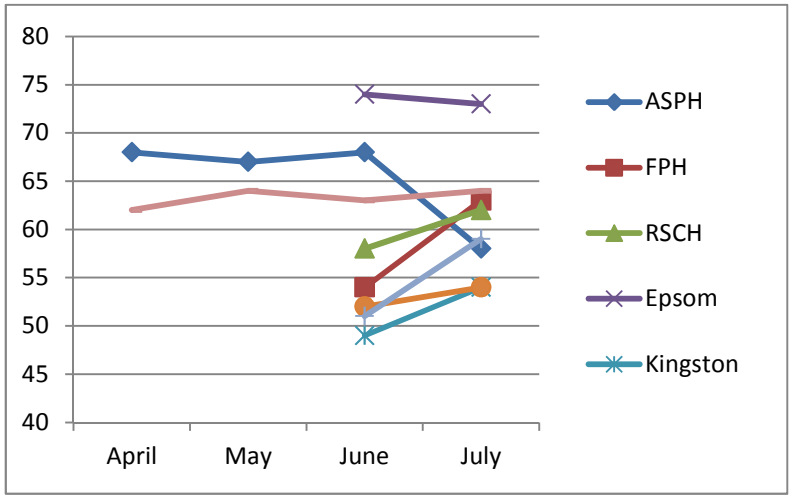


Chart 14 Inpatient NPS

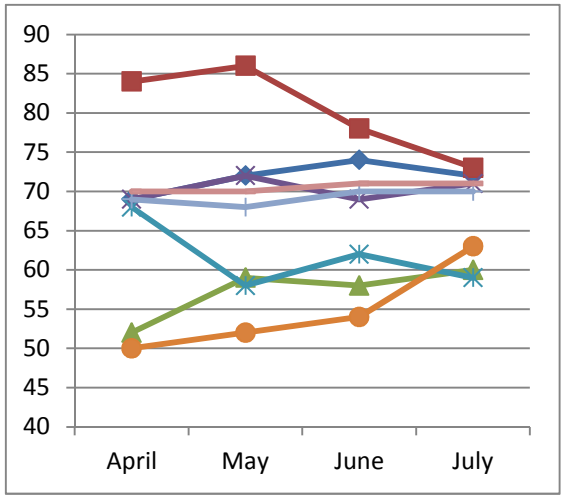
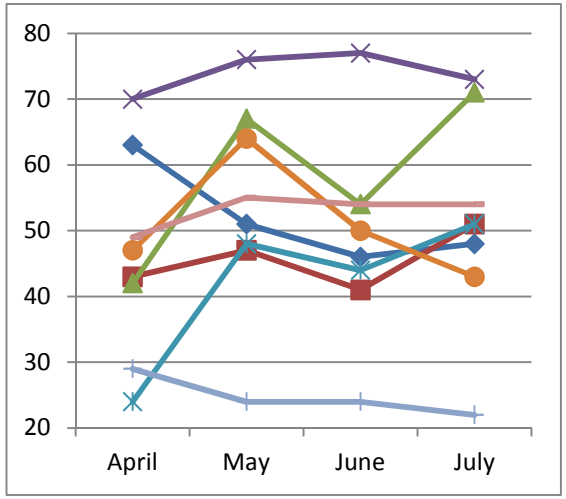


Chart 15 A&E NPS



APPENDIX 1 Quality and Safety Balanced Scorecard Indicator Definitions

Table 1 is made up of 9 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 three year dataset is used to create the risk adjusted models. A one year dataset is used to score the indicator. The one year dataset used for scoring is a full 12 months up to, and including, the most recently available data. The three years used for creating the dataset is a full 36 months up to, and including, the most recently available data.

1-02 The total number of deaths.

1-03 Number of Hospital acquired MRSA

1-04 Number of Hospital acquired C-Diff

1-05 The number of patients with a VTE (Venous Thromboembolism) assessment who then had a Pulmonary Embolism or Deep Vein Thrombosis (during their stay)

1-06 The total number of Serious Incidents Requiring Investigation

1-07 Average number of beds available (including escalation beds) in the month against the

average number of beds occupied taken at midnight from PAS

1-08 The percentage of patients who were transferred between wards, 3 or more times during their admission.

1-09 The number of formal complaints

1-10 Friends and Family Test score for Inpatients

(Test asks following standardised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?"

1-10a Friends and Family Test score for A&E

(Test asks following standardised question: "how likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?"

1-11 The total number of falls

1-12 The total number of falls resulting in significant injury grade 3 or above

1-13 The number of hospital-acquired pressure ulcers grade 2 or above

1-14 New Catheters and UTI's as a rate of total sampled patients

2. Target (T*) - where possible a national (N) or local (L) strategic health authority target has been used; where not available, we have used a percentage improvement on the 2012/13 year end total.

3. Outturn 12/13 – the overall results for 2012-13.

4. YTD (Year-to-date) Target 13/14 – the sum of the monthly target from the beginning of the financial year (April).

5. Monthly Target 13/14 – the target for each month

6. Annual Target 13/14 – the target for the entire year.

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

8. 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.

9. YTD 13/14 - The sum of the actual activity from the beginning of the financial year (April).

APPENDIX 2 Patient Experience Dashboard – August 2013

Complaints Rec'd	EMED	YTD		Fac (mth)	YTD		TASCC (mth)	YTD		TODT (mth)	YTD		WH & P (mth)	YTD		A&E FFT		Inpt FFT			Trust (mth)	YTD	YTD target	Annual target
Complaints Rec'd	11	86	▼	1	3	▼	7	50	▼	4	25	▼	3	33	▼					▼	26	200	187	<450
Discharge related complaints	3	23	▲	0	0		0	6	▼	0	3	▼	0	2	▼					▼	3	33	28	<68
% Response timescales met	77%	87%	▼	100%	100%		33%	63%	▼	80%	84%	▼	100%	88%	▲					▼	76%	82%	95%	>95%
PALS Concerns	41	179	▲	1	17	▼	29	137	▲	24	102	▼	6	27						▲	103	476	tba	tba
FFT* returns	44%	43%	▲				26%	33%	▼	42%	33%	▲				20%		37%	▲		24%	20%	15%	20%
FFT* Score	77		▲				64	72	▼	78	80	▼				50	▲	74	▲		60	60	70%	70%
Intimations of claims	2	10	▲	0	0		3	11		3	11		4	12	▼						12	31	tba	tba
Reported claims	3	4	▲	0	0		2	11	▼	1	3	▲	0	2							6	17	tba	tba

Decrease compared to previous month	▼
Increase compared to previous month	▲
Improvement compared to previous month/100% target	
Same or no change	
Deterioration compared to previous month or risk to targ	
Not applicable	

**Friends and Family Test. Consolidate score of response to the question "how likely are you to recommend our Ward [A&E department] to friends and family if they needed similar care or treatment?" For FFT results A&E is reported seperately - therefore EMED excludes A&E for this measure only.

APPENDIX 3 Best Care Dashboard – August 2013

		Accreditation			Quality & Safety																				Experience						
		Best Care Accreditation Level	Month Assessed	Reassessment Month	Process: Patient Observations		Outcome: Cardiac Arrest calls	Process: Nutrition		Outcome: Appropriate referrals to Dietician	Process: Skin Integrity	Number of Pressure ulcers Inherited grade 2>	Outcome: Hospital Acquired PU stage >=2	Process: Falls and Manual Handling Assessments	Outcome: Number of Falls no harm	Process: Medication	Outcome: No of Administration Errors	Process: Nursing Documentation	Outcome: Wards Self Assessment	Process: Environment & Infection Control	Outcome: Hand Hygiene Audits	Outcome: Saving Lives	Process: Safe Guarding	Process: End of Life Care		Process: Dementia Care		Privacy & Dignity		Complaints	Family & Friends Test	Communication	Consent		Leadership
Acute Medicine & Emergency Services	Aspen	0	JUL	SEP	88%		4	94%		NS	97%	2	1	79%	2	86%	0	72%		100%	100%	100%	80%	NA		NA		86%		0	20%	90%		82%		67%	
	CCU & Birch	1	JUN	SEP	77%		1	88%		NS	100%	0	0	54%	2	98%	0	93%		100%	99%	97%	85%	100%		NA		92%		0	81%	93%		100%		71%	
	Cedar	2	JUN	OCT	96%		0	100%		NS	100%	3	2	81%	8	100%	1	82%		100%	NS	100%	93%	83%		88%		82%		1	12%	100%		100%		100%	
	Holly	3	JUN	DEC	100%		0	100%		NS	100%	3	0	100%	4	100%	0	98%		100%	100%	100%	100%	100%		100%		88%		0	97%	100%		100%		100%	
	May	2	JUL	NOV	89%		0	97%		NS	100%	2	1	89%	4	97%	0	80%		86%	100%	98%	100%	NA		NA		93%		1	31%	100%		100%		100%	
	MAU	1	JUL	OCT	87%		1	78%		NS	72%	5	0	82%	4	93%	1	69%		94%	98%	90%	100%	83%		53%		99%		0	78%	94%		90%		100%	
	MSSU	1	JUL	OCT	83%		2	88%		NS	84%	3	0	66%	10	93%	0	85%	NS	88%	100%	100%	88%	100%		53%		99%		1	33%	94%		97%		94%	
	Maple	3	APR	OCT	92%		1	88%		NS	97%	1	0	97%	1	97%	1	95%	NS	97%	98%	100%	96%	97%		100%		98%		0	36%	98%		100%		99%	
	Fielding	0	JUL	SEP	73%		0	81%		NS	57%	0	0	81%	5	80%	0	72%		100%	98%	100%	85%	67%		100%		87%		0	60%	97%		97%		100%	
	WWW/Chaucer	0	JUL	SEP	50%		0	73%		NS	62%	1	0	62%	6	84%	2	65%		92%	100%	100%	83%	67%		67%		92%		0	21%	96%		93%		100%	
	ED	1	JUN	SEP	90%		12	92%		NS	38%	NA	NA	54%	0	98%	0	72%		88%	96%	NA	100%	100%		NA		100%		7	19%	92%		100%		100%	
	Endoscopy	2	Apr	TBC	83%		0	100%		NS	NA	NA	NA	NA	0	100%	0	96%	NA	100%	NS	NA	78%	NA		NA		100%		1	NA	100%		83%		100%	
T & O	Dickens	2	JUL	NOV	58%		0	98%		NS	86%	0	0	40%	1	84%	0	86%		100%	100%	100%	98%	100%		NA		100%		1	26%	100%		100%		100%	
	SWAN	1	JUL	OCT	90%		1	57%		NS	95%	0	0	62%	0	84%	0	84%		94%	NS	NS	98%	100%		NA		96%		0	54%	92%		100%		98%	
Theatres, Anaesthetics, Surgery & Critical Care	Kingfisher	1	JUL	OCT	78%		1	87%		NS	100%	0	0	53%	0	92%	0	93%		93%	98%	100%	78%	100%		NA		94%		0	17%	96%		95%		75%	
	Falcon & SDU	1	JUL	OCT	72%		2	77%		NS	86%	4	1	96%	0	93%	3	84%	NS	81%	97%	100%	82%	67%		NA		88%		0	17%	98%		95%		94%	
	Heron	2	JUN	OCT	89%		0	77%		NS	71%	0	1	70%	1	91%	0	80%	NS	97%	100%	100%	100%	100%		NA		99%		0	42%	93%		100%		100%	
	SAU	0	JUL	SEP	81%		1	80%		NS	80%	0	0	66%	4	98%	0	81%	NS	94%	100%	95%	80%	83%		75%		96%		2	49%	92%		88%		93%	
	ITU	3	**AUG**	FEB	100%		0	100%		NS	98%	0	1	95%	0	95%	0	97%	NA	100%	100%	100%	100%	NA		NA		100%		0	NA	100%		100%		100%	
	MHDU	3	APR	OCT	100%		0	100%		NS	100%	0	0	100%	0	96%	0	88%		100%	100%	100%	100%	83%		NA		100%		0	NA	100%		NA		100%	
	DSU & Theatres ASH	1	**AUG**	NOV	77%		2	70%		NS	70%	NA	NA	*	0	100%	0	78%	NA	90%	100%	100%	85%	*		*		100%		2	NA	57%		93%		95%	
	DSU & Theatres SPH	3	**AUG**	FEB	100%			100%		NS	100%	NA	NA	*	0	89%	1	97%	NA	100%	66%	100%	94%	*		NA		100%			NA	100%		100%		100%	
Women's Health & Paediatrics	Oak	3	JUL	JAN	93%		0	100%		NS	100%	NA	NA	100%	0	71%	0	100%	*	93%	NS	NA	96%	100%		NA		100%		1		94%		100%		93%	
	Ash	1	JUL	OCT	94%		0	57%		NS	100%	NA	NA	100%	0	89%	0	64%	NS	100%	NS	NA	75%	67%				93%		0		79%		66%		71%	
	NICU	2	JUL	NOV	100%		0	100%		NS	95%	NA	NA	NA	0	97%	0	83%		100%	100%	100%	100%	91%				100%		1	*	100%		86%		100%	
	Paeds ED	*	*	*	*		2	*		*	*	*	*	*	*	*	0	*	*	*	*	*	*	*				*		0		*		*		*	
	Labour Ward	2	**AUG**	DEC	95%		0	100%		NS	89%	NA	NA	52%	0	99%	0	86%		100%	NS	NA	96%	100%				100%		0		100%		100%		95%	
	Joan Booker	2	JUL	NOV	84%		0	100%		NS	90%	NA	NA	90%	0	95%	0	96%		97%	100%	100%	100%	100%				100%		0		100%		100%		100%	

PLEASE NOTE THAT THIS DASHBOARD HAS BEEN PARTIALLY UPDATED. ONLY WARDS DUE FOR REASSESSMENT HAVE A NEW ACCREDITION AND SCORE. THIS IS HIGHLIGHTED IN BOLD

The Sparkline incorporate the previous results looking at 4 audit cycles

** The Patient Experience measures are calculated from the results of observational audits

Key:
NA = Not Applicable
NS = Non - Submission
WN = Ward Not Open
* = Indicator Not Established

RAG Scores		Level	
93%>	Green	3	6 Monthly
82%-92%	Yellow	2	5 Monthly
71%-81%	Amber	1	3 Monthly
< 70%	Red	0	2 Monthly

Outcome:	Source:	Description:
MRSA	Infection Control	Number of Hospital acquired MRSA
C. Diff	Infection Control	Number of Hospital acquired C. Diff
Hospital Acquired PU	Ward managers	Number of hospital acquired pressure ulcers
Number of Falls	Datix	Number of falls
Number of Falls resulting in injury	Datix	Number of falls resulting in Injury
Appropriate referrals to Dietician	PAS	Percentage of patients who were appropriately referred to a dietician
No of Incidents of poor documentation	TBC	TBC
No of Administration Errors	Datix	Number of errors in drug administration