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

TRUST BOARD
28th June 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for May 2012.
BOARD 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.
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 Board 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:	21st June 2012
Decision:	For Noting

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

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1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indictor Definitions

The table is made up of 6 columns namely:

1. Description of Measure - self-explanatory.

2. Targets - where possible a national or local 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. 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. (to be included from May data)

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

1.2 Quality and Safety Balanced Scorecard and Commentary

Table one: 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	May Actual	Performance			YTD 12/13
					Apr	May	June	
1-01	Summary Hospital-level Mortality Indicator (SHMI)*	<100	<100	89.81	-	▲		95.7
1-02	HSMR**	<100	<100	104	-	▼		100
1-03	Crude mortality (Excluding readmissions)	1.6	-	1.56%	-	▲		1.71%
1-04	Mortality UTI as Primary Diagnosis (SHMI)***	<100	TBC	131.6%	-	◄►		131.6%
1-05	Mortality from Hip fractures (SHMI)***	<90	-	77.8	-	◄►		70.21
1-06	MRSA (Hospital only)	1		0	-	▲		1
1-07	C.Diff (Hospital only)	20		3	-	◄►		6
1-08	Stroke Patients (90% of stay on Stroke Unit)	80.0%	80.0%	89.7%	-	▲		88.0%
1-09	VTE (hospital acquired with PE or DVT)	14	-	0	-	▲		2
1-10	Serious Incidents Requiring Investigation (SIRI)	50	-	1	-	▲		13
1-11	SIRI Grade 2 (proportion of total SIRI)	0.0%	-	0.0%	-	▲		23%
1-12	Falls (Total Number)	462	-	49	-	▼		90
1-13	Falls - resulting in significant injury (grade 3)	<15	TBC	0	-	◄►		0
1-14	Average Bed Occupancy (inc escalation)	92.0%	TBC	87.4%	-	▼		87.7%
1-15	Patient Moves (ward changes >=3)	<5%	5.0%	8.3%	-	▼		8.6%
1-16	Patient Satisfaction (NetPromoter Score)	65%	-	63%	-	▲		60%
1-17	Formal complaints (Total Number)	<500	-	44	-	▼		78
1-18	Formal complaints (rate per discharge - IP only)	10% reduction	-	0.55%	-	▼		0.55%

* Taken from Dr Foster, Month actual is Q2 2011 and YTD is Oct 2010 - Sept 2011

** Taken from Dr Foster, last available month is March 2012, YTD is 2011/12

*** Taken from Dr Foster, reporting period Oct 2010 - Sept 2011

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

The HSMR mortality rate has increased to over 100; this is a cause for concern. The weekly clinical effectiveness meetings have begun which review mortality and Length of Stay (LoS). Departments have been risk assessed and specialities are being reviewed in priority order. In line with the ECSIT recommendations the crude mortality rates will also be reviewed. The palliative care team is undertaking work to improve the palliative care pathway and provide greater choice over place to die.

During May the rate of complaints increased to 0.55%, though the Trust remains below the target number YTD. Detailed analysis across each ward and speciality continues with specific objectives being undertaken to reduce complaints.

Three cases of C-diff in May bring our total year to date to six. This is in line with the previous year's monthly profile. The forecast for the year end is still that the Trust will achieve the target. The root cause analysis of the six cases indicates that none of the cases were preventable by actions within the Trust. The Trust is discussing whether one of the six cases should be attributed to the community.

2. Safety Update

2.1 NHS Safety Thermometer (National CQUIN)

The Safety Thermometer programme of work aims to achieve significant reductions in the four biggest areas of avoidable harm in healthcare:

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

A census captures details for both old and new harms to patients and is run on one specified day each month with submission to the NHS Information Centre within four working days.

Results Summary

CQUIN Target is 100% of areas submitting 100% of inpatients present data; the CQUIN agreement plans for a staged approach and build up to delivering the target by Q4 2012.

	April	**May**
Sample size	434	497
% areas achieving 100% submission	58%	54%

Our current submission rate for areas achieving 100% of patients is 54% which means that we are achieving the internal target for Q2 ahead of schedule.

Harm-free Care[1]	**April**	**May**
National average – harm-free care	89.47%	90.05%
ASPH harm-free care	88.71%	89.94%
ASPH patients with no new harms[2]	93.09%	95.57%

During May the Trust has seen improvements for 'harm-free care' and patients with 'no new harms' but remains below the national average value for 'harm-free care'. (National value for 'no new harms' not available).

Type of Harm	**April**	**May**
Total pressure ulcers (new ulcers)	27 (10)	33 (8)
Falls	8	5
Total catheters & UTIs (new UTIs)	13 (10)	14 (8)
New VTEs	9	4
Total number of harms	57	56

[1] Harm-free Care – patients with harm-free care will not, on the census day, be exhibiting any of the four specified harms.
[2] New Harms – patients with a new harm will, on the day of census, be exhibiting signs of one of the four harms that were not present on their admission to hospital (hospital acquired harm).

The table below provides details by ward for 'harm-free care' and the number of patients with individual harms per ward / area for May.

Table two: Harm-free care 95% - 100% | 85% - <95% | <85%

				Number patients with number of harms				
Ward	**April**		**May**	**1 harm**	**2 harms**	**3 harms**	**4 harms**	
Aspen	88%		80%	5				
Birch	93%		87%	2				
CCU	75%		63%	2			1	
Cedar	73%		96%	1				
Chaucer	87%		85%	2				
Fielding	50%		76%	5				
Holly	97%		93%	2				
Maple	N/S		N/S					
MAU	84%		82%	6	1			
May	91%		76%	5				
MHDU	100%		100%					
Swift	91%		77%	5	2			
Wordsworth	95%		85%	3				
Falcon + SHDU	96%		91%	2				
Heron	100%		90%	1				
Kingfisher	92%		100%					
SAU	N/S		100%					
Dickens	N/S		100%					
Rowley Bristow UE	93%		96%	1				
Rowley Bristow UW + ES	82%		90%	3				
Ash	100%		100%					
NICU + SCU	100%		100%					
Joan Booker	100%		100%					
Labour Ward	100%		100%					
Critical Care	86%		86%	1				
Clinical Decisions Unit, A&E	N/S		100%					
TOTAL	88.7%		89.9%	**46**	**6**		**4**	**56**

N/S = no submission

One patient had four harms; 1 of which a pressure ulcer was pre-existing and a further 3 hospital acquired, a fall, a urinary tract infection and a pulmonary embolism.

The rates of Harm-free care will be added to the Best Care Dashboard by ward from July 2012 as a useful additional triangulation and indicator of the quality of care.

2.2 NPSA Safety Alerts

There have been no new alerts reported by the NPSA since the last board meeting in May 2012. There are four on-going alerts where there is an identified lead and working groups established all are on target. A report is presented at the safety & Risk Committee on a quarterly basis to monitor progress.

Overdue Alerts

One alert remains overdue and is as follows:

Description	Deadline	Lead
Minimizing risks of mismatching spinal, epidural and regional devices with incompatible	02-Apr-12	Divisional Director Michael Imrie
STATUS		
• Risk placed on the risk register • 3 incumbent suppliers have been invited to test their products on the 27th June/10th July 2012 • All mitigating risks in place		

The process for the closure of NPSA alerts has been reviwed and it is necessary for the Trust to confirm that all actions associated with the alert action plan are complete prior to closure of the alert.

3. Patient Experience

3.1 Complaints/Ombudsman reports

There were 45 complaints received compared with 39 in April and 51 in March. Chart one shows a breakdown of complaints received by month (Series 1), monthly target (Series 2) and overall trend line (red).

Chart 1

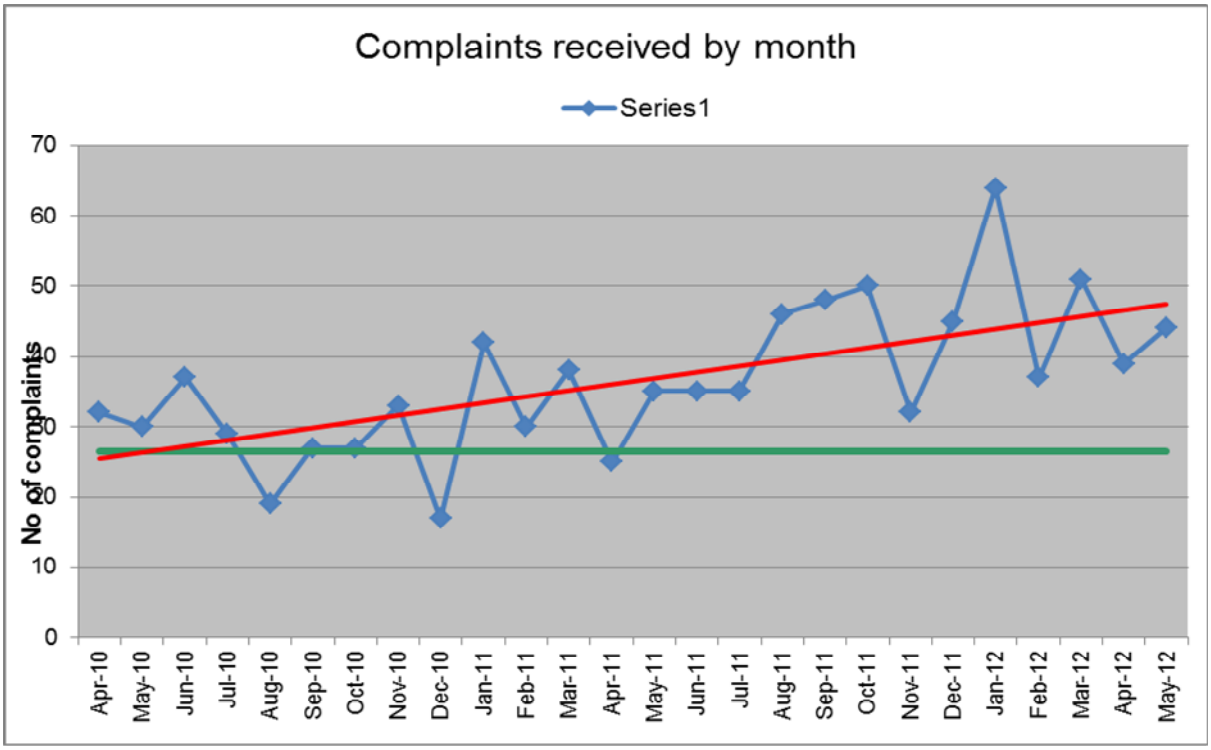


Chart two shows a breakdown of complaints by service area.

Chart 2

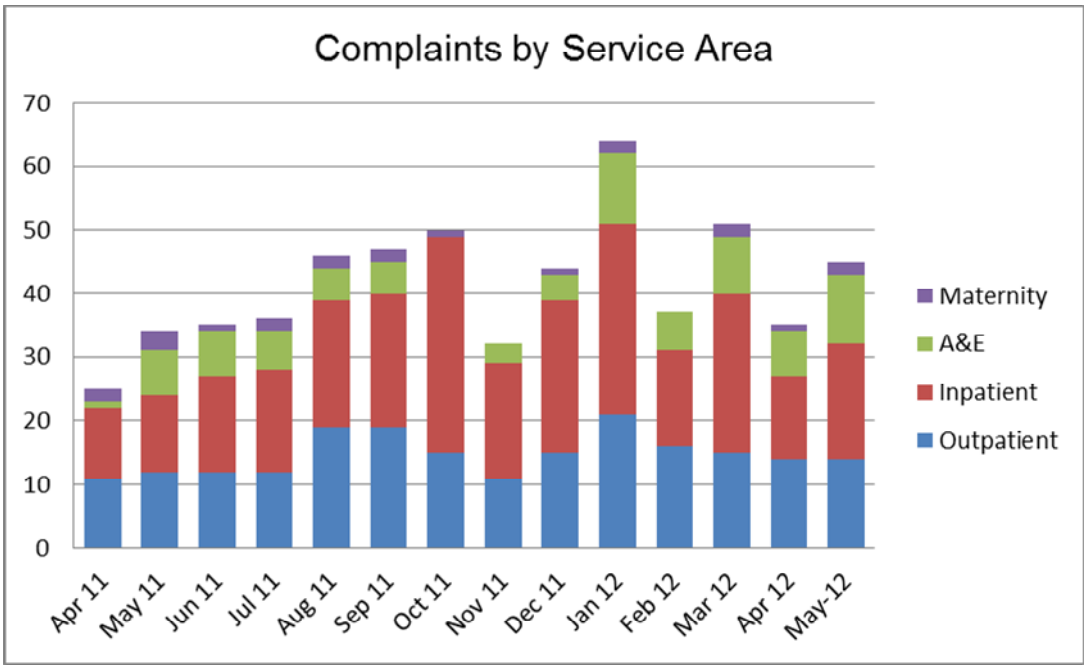
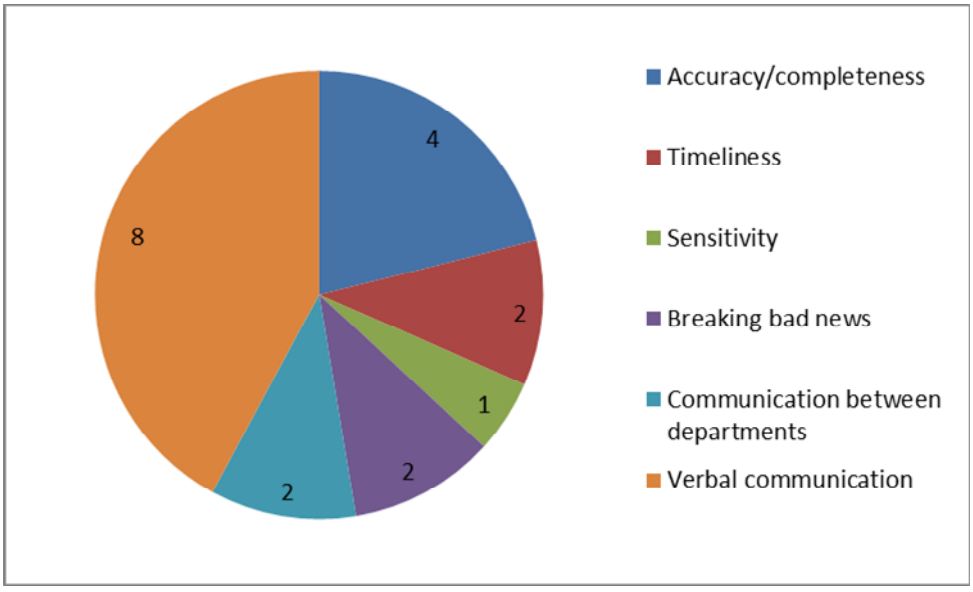


Chart three shows a breakdown of the 17 complaints relating to communication; of the 19 issues raised 42% relate to verbal communication. No complaints relating to written communication were received.

Chart 3



There were 108 informal (PALS) concerns raised during May, of these three went onto become formal complaints which demonstrates a conversion rate of 2.7% compared with 4.6% in April.

There were 34 formal complaint responses due in May, of these, 19 responses were sent within the agreed timescale. This equates to a monthly performance of 56% with agreed timescales for response in comparison to 74% performance in April.

In order to achieve and sustain a complaints performance of 95% or above by the end of July 2012, a number of actions are underway, these include:

- Dedicated team brief session – 29 June
- 95% Event – to focus upon sharing good practice
- Complaints performance included in patient feedback dashboard.

The majority of the poor performance is sitting within a single clinical area and tailored work to support the team is underway. The team currently predicts achievement of all deadlines in June.

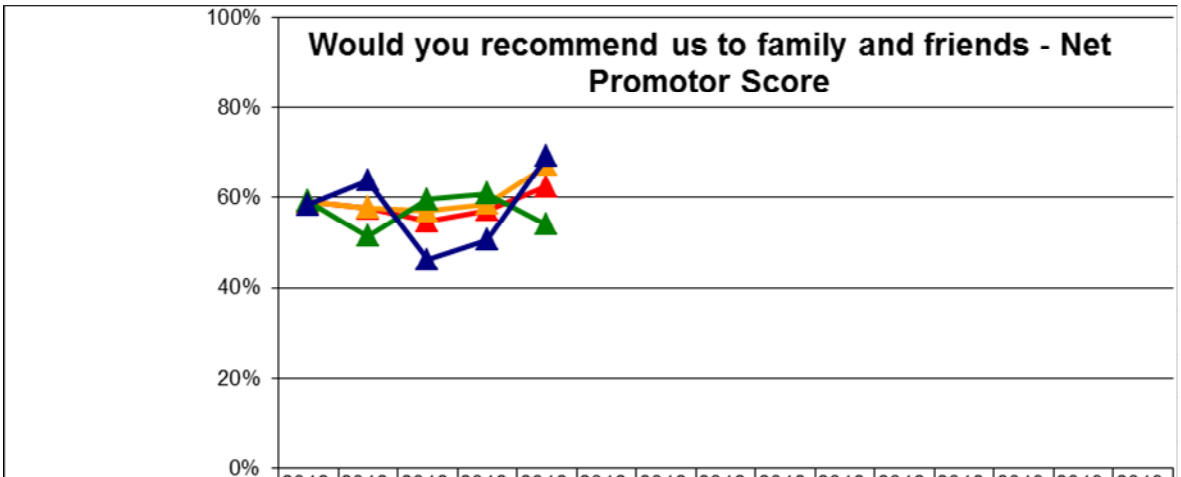
Ombudsman cases

There were no new referrals to the Ombudsman for review during May. One case, a maternity complaint initially raised in 2003 has now undergone an initial assessment and the Trust has been notified that the Ombudsman will not investigate this case.

Patient Feedback

The Trust is working towards a composite Trust wide Net Promoter Score which incorporates in-patient and out-patient areas and all divisions. Currently data is being collected by all these areas but is not always achieving the necessary level of response to ensure the data can be integrated reliably into the existing in-patient score. The soon to be launched electronic feedback collection system is anticipated to support the collection of a bigger number of feedbacks which will add reliability to the whole process.

The Inpatient Net Promoter Score has increased from 57% to 63% during the reporting period.



	2012-01	2012-02	2012-03	2012-04	2012-05	2012-06	2012-07	2012-08	2012-09	2012-10	2012-11	2012-12	2013-01	2013-02	2013-03
TRUST	59%	58%	55%	57%	63%										
MEDICINE	59%	58%	57%	59%	67%										
SURGERY	59%	51%	60%	61%	54%										
ORTHOPAEDICS	58%	64%	46%	51%	69%										

The Trust reviwed its NHS Choices Patient Recommendation Rate as at the 31 May against 8 other local acute hospital Trusts. At that time ASPH was achieving the highest Patient Recommendation Rate of all Trusts reviwed scoring 91%. The range for the other Trusts was 62 – 86%.

The Trust received 17 formal (written) compliments during May, of these five related to care received on Dickens ward. All formal compliments received in the Chief Executive / Chief Nurse's office are responded to personally in writing.

There were three positive comments received via NHS Choices and Patient Opinion during April, a recent comment regarding A&E was:

'*I found the staff to be professional and courteous and kind. This has also been the case when my children have gone to this department. I would highly recommend it'.*

3.2 Patient Feedback Dashboard

The following Patient Feedback Dashboard is under development but is shared with the Board at this time to give assurance on the level of detail that is now becoming available. This captures a range of patient feedback measures upon perceived quality of care. The dashboard provides an overview by Division and shows Trust performance against targets where applicable.

The Net Promoter Score recorded for the Trust is different from the in-patient score because the Women's Health and Paediatric data is included.

In the future, it is anticipated the dashboard will be generated within the Mercury system, which will use IPad technology to gather real-time patient feedback and produce meaningful reports around how patients perceive their quality of care.

Patient Feedback Dashboard

May-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	1	2	▶	15	34	▼	2	3	▲	0	0	▶	6	11	▲	5	10	▶	8	9	▲	8	15	▲	45	84	84	<500
Discharge related complaints	0	0	▶	2	5	▼	0	0	▶	0	0	▶	0	0	▶	0	0	▶	2	3	▼	0	0	▶	4	8	12	<73
% Response timescales met	n/a	100%	▶	37%	48%	▲	100%	100%	▶	n/a	0%	▶	75%	79%	▼	50%	55%	▼	100%	80%	▲	84%	67%	▲	56%	65%	95%	>95%
PALS Concerns	2	5	▲	33	58	▼	11	14	▼	5	11	▲	24	44	▼	16	29	▼	7	21	▼	10	13	▼	111	88	tba	tba
Formal compliments	1	2	▶	2	6	▼	1	1	▲	0	0	▶	1	1	▲	6	10	▲	6	15	▼	0	0	▶	15	33	n/a	n/a
Your feedback				82.2%	81.8%	▲	Null	Null					Null	Null		80.4%	80.5%	▶	82.4%	79.6%	▲	Null	Null	▶	81.6%	80.6%	n/a	n/a
NPS* see key below	80.0%	77.5%	▲	67%	63%	▲	Null	43%	▼				Null	69.0%	▶	54%	56%	▼	69%	60%	▲	67.5%	67.5*%	▶	67.5%	66%	65%	65%
Intimations of claims	1	1	▲	0	0	▶	0	0	▶	0	0	▶	1	1	▲	4	6	▲	1	1	▲	0	2	▼	7	11	n/a	n/a
Reported claims	0	0	▶	0	0	▶	0	0	▶	0	0	▶	1	1	▲	0	1	▼	2	2	▲	2	2	▲	5	6	n/a	n/a
% staff attended LOV (cumulative)		78%			73%			82%			79%			93%			62%			83%			82%		83%	83%		100%
NHS Choices +ve rec rate																										89%		n/a

*April scores not available

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 are comprised:		
ACCT	Day Surgery Unit	Trust Inpatient NPS score
Acute Med & Emerg Servs	Medical Wards x 12	Trust Inpatient NPS score
WH & Paedaitrics	Maternity & Paed Inpatient	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/no data provided or IT systems not yet online to collate	

3.3 The Best Care Dashboard

Ashford and St. Peter's Hospitals NHS
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Trauma and Orthopaedics
Table three

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Dickens, Rowley Bristow East & West	Failure to fully complete nursing documentation and assessments in a timely manner	Staff are completing some areas well but are failing to update assessments. High vacancy factor across surgery. High numbers of temporary staffing used. Vacancies unfilled	Regular audit/spot checks by the Matron. Increased visit from the Matron to 2 days a week to Dickens Ward. Shift leaders to do regular spot checks on care plans Staff will be spoken to on an individual basis when care plans are found to be inadequately completed Sample care plans available for reference. Teaching support given by Matron and Clinical Practice Educator.

Table four

Area	Achievement	Explanation
Dickens, Rowley Bristow East & West	All wards have seen an upward trend in recording of height and weight on every patients drug chart	Ward Sisters and Matron conducting spot check reviews

Surgery
Table five

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Falcon, Heron, Kingfisher, SDU & SAU	Patients not signing care plans to demonstrate participation in their care	Practice inconsistent at present with many new starters to surgical wards requiring local induction and SAP training.	Sisters will raise awareness at handovers. Spot checks will be carried out by the Sisters and Matron. CPE will teach all new staff on local induction to the wards

Falcon, Heron, Kingfisher, SDU & SAU	Incomplete documentation and nursing assessments	High vacancy factor across surgery. High numbers of temporary staffing used. Vacancies unfilled	Matron and the Ward Sisters have been conducting spot checks. Sample care plans available for reference. Teaching support given by Matron and Clinical Practice Educator. Good practice is acknowledged and poor practice is highlighted to staff and support given. Staff recruited but do not start until September
Heron & SDU	Poor completion rate of VTE assessments	Doctors not completing assessments Failure of nurses to record correctly	Doctors encouraged to complete assessments and prescribe appropriate treatment Nurses to enter on IPL and Realtime Spot checks will be carried out by Matron and HON

Table six

Area	Achievement	Explanation
Kingfisher, Falcon, Heron, SDU & SAU	All surgical areas have achieved 100% with regards to privacy and dignity provision for May 2012	Some substantive staff now in post

ACCT

Table seven

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Theatres/ DSU	Nutrition Time patient is nil by mouth -ward issue amber/ red	Patients requested to come in at 07.30 Surgery is in the afternoon/ Surgeons changing list order	Matron has discussed with Matron for orthopaedics. Staff to agree a procedure time for the patient and offer a drink if time allows
Theatres	Documentation Clear documentation- date print sign Consent not legible	Legibility of signatures dates and times.	Encourage staff to sign, date and record designation appropriately on legal documentation. Discussions held regarding correct procedures for consent at newly convened theatre team leaders meetings which will be followed up.

Theatres	Waterlow score	Not being re-assessed intra-operatively	Waterlow score training for theatre staff by CPE
Endoscopy	Nutrition	4 patients nil by mouth for an extended period of time	Discussed with staff to inform ward if procedure delayed and to offer drinks
Endoscopy/ Theatres DSU	Consent	Legibility of consent Surgeons name not printed on consent form Patients coming to theatre without consent	Nurses are now trained to take consent from patients which should improve correct and complete consent forms as well as expedite the process overall Staff in theatre informed not to accept patients without a completed consent in the department

Table eight

Division and area	Achievement	Explanation
ICU	Continued high amount of compliments and positive patient feedback in the Follow up clinic regarding nursing and medical care	1:1 nursing and particular attention to communication has proved very beneficial to the department.
Theatres	Good attention to safer surgery checklist on Bluespier.	A more comprehensive acceptance that Bluespier is a tool designed to enhance the clinical experience.

Medicine
Table nine

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
All medical wards	**Documentation** • Plan of care not signed • Entries not signed, dated or timed	Ineffective leadership	Education & Training in place for documentation standards in progress, clinical support provided by the Matrons & CPE. Trust wide action plan in place for documentation to be cascaded to all areas
Aspen & Ashford Wards	**Environment**	Poor standards of cleaning	Addressed with OCS re cleaning schedules and expected standards
CCU & MAU	**Nutrition** no MUST reassessment	Ineffective leadership	Divisional Plan in progress to address indicators that are underachieving which will incorporate more performance management of the Ward Managers.

			Education & Training in progress
All medical wards	**Communication** boxes not available on every ward	Ineffective leadership	Divisional Plan in progress to address indicators that are underachieving which will incorporate more performance management of the Ward Managers Education & Training in progress
Cedar & Fielding	**Patient Observations** 24hr cumulative fluid balance	Ineffective leadership and vacancy factor on Cedar	Divisional Plan in progress to address indicators that are underachieving which will incorporate more performance management of the Ward Managers Education & Training in progress
Birch & Cedar	**Skin integrity** no care plans in place for Patients at risk following assessment	Vacancy factor on Cedar, ineffective leadership on Birch	Divisional Plan in progress to address indicators that are underachieving which will incorporate more performance management of the Ward Managers Education & Training in progress All staff to complete 0-3 Competency for pressure ulcers. Local pressure ulcer action plan adapted from Corporate pressure ulcer action plan for all medical wards

Table ten

Area	Reported Achievement	Explanation
Aspen Birch & Wordsworth	Net promoter score 90 -100%	

Paediatrics
Table 11

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Oak ward Ash ward NICU	**Hand Hygiene**	Not submitted for May	Will explore why?
Ash Ward	**Nutrition**	No agreed paediatric nutrition assessment tool	Working with paediatric dietician to develop appropriate nutrition tool for children. Roll out of tool will take place once staff have been trained.

	Skin Integrity **Falls and Manual Handling Assessments** **Medication**		Auditor did not identify in nursing paper work. Auditor did not identify in nursing paper work. Not sure what has been assessed as there has been improvement previously.

Table 12

Area	**Achievement**	**Explanation**
Ash	Hand hygiene	
Ash	Nursing Documentation	On-going Development of Nursing Documentation.
NICU		Implementation of new nursing documentation. Gradual improvement seen.

Women's Health
Table 13

Area	**Reported underperformance**	**What is driving the underperformance**	**Actions to improve performance**
Joan Booker Ward	78% Process for Falls and manual handling assessment	The majority of woman on Joan Booker ward are well and fully mobilised so the midwife does not normally consider a manual handling assessment	There needs to be a cultural change to ensure that midwives complete the documentation in the care plans to support this assessment. It is being discussed at all staff meetings and the ward team leader is carrying out spot checks to encourage the midwives with their documentation.
Area	**Achievement**	**Explanation**	
Joan Booker Ward	100% VTE assessment	This has become embedded in practice now and we expect to remain 100% for the next 3 months and would like to have it removed from monitoring.	

4. APPENDIX 1

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. Hand Hygiene Compliance
   Audits of members of staff cleaning/decontaminating their hands between procedures.
3. 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.

   - 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): Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections
   - Catheter >29 days after care: Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections.
4. 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.
5. VTE (Venous Thromboembolism)
   Patient has been risk assessed for development of VTE (Deep vein thrombosis, pulmonary embolism
6. 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.
7. 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.
8. 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.
9. Medication Assessment
   Documentation is legible and completed appropriately, omission codes are utilized and allergies identified.
10. 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.
11. Complaints
    Actual number of complaints registered to the clinical area in the reporting month.
12. Discharge and Nurse Facilitated Discharge

To be defined

13. Privacy & dignity
    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).

14. 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

15. Number of Ward Transfers
    Number of patients transferred to another ward.

Appendix 2 Best Care Dashboard – May 2012

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

Best Care Dashboard - May 2012

Essential Care Indicators		Patient Safety																Patient Experience						
		Process: Patient Observations	Process: Matrons Environment Audit	Process: Hand Hygiene Audits	Process: Saving Lives	Outcome: MRSA	Outcome: C-Diff	Process: Skin Integrity	Outcome: Hospital Aquired PU	Process: VTE Assessment	Outcome: VTE Mortality	Process: Falls and Manual Handling Assesments	Outcome: Number of Falls	Outcome: Number of Falls resulting in injury	Process: Nutrion	Outcome: Appropriate referrals to Dietician	Process: Nursing Documentation	Outcome: No of incidents of poor documentation	Process: Medication	Outcome: No of Administration Errors	Communication	Complaints	Discharge	Nurse Facilitated Discharge	Privacy & Dignity	SSA Breaches	Net Promoter	Number of Ward transfers
Acute Medicine & Emergency Services	Aspen	85%	92%	99%	100%	0	0	83%	2	100%	0%	70%	2	0	78%	100%	68%	Data Unavailable	95%	0	89%	0	Data Unavailable	100%	0	100%	Data Unavailable
	Aspen HDU	100%	92%	100%	100%	0	0	100%		88%	0%	97%	1	0	100%	100%	96%		98%	0	100%	0		100%	0	-	
	CCU	96%	98%	99%	100%	0	0	100%		99%	0%	92%	2	0	23%	0%	67%		90%	0	86%	0		100%	0	-	
	Birch	100%	98%	100%	100%	0	0	48%		100%	0%	45%	2	0	100%	-	97%		98%	0	100%	0		100%	0	90%	
	Cedar	67%	93%	100%	100%	0	0	70%	2	75%	0%	91%	3	0	87%	86%	70%		88%	0	75%	0		93%	0	47%	
	Holly	93%	93%	100%	100%	0	0	93%	3	100%	0%	92%	4	0	95%	100%	57%		89%	1	88%	0		93%	0	58%	
	May	85%	97%	100%	98%	0	0	86%	3	91%	0%	85%	0	0	90%	100%	70%		90%	0	63%	1		100%	0	61%	
	MAU	80%	98%	99%	100%	0	1	100%		90%	0%	100%	4	0	55%	-	74%		87%	0	100%	1		100%	0	-	
	Maple	93%	97%	100%	100%	0	1	95%		100%	0%	96%	2	0	91%	88%	70%		85%	0	75%	1		93%	0	50%	
	Fielding	73%	86%	100%	100%	0	0	85%	4	100%	0%	81%	5	0	80%	100%	68%		85%	0	72%	2		100%	0	-	
	Chaucer	98%	92%	100%	100%	0	0	96%	3	94%	0%	100%	5	0	100%	100%	72%		93%	0	72%	0		100%	0	83%	
	ED	-	-	94%	100%	0	0	-		-	0%	-	1	0	-	-	-		-	0	-	5		-	0	-	
	Swift	80%	95%	98%	-	0	1	100%	3	99%	0%	100%	6	0	93%	100%	82%		89%	1	100%	1		100%	0	-	
	Wordsworth	80%	92%	100%	100%	0	0	88%		100%	0%	96%	1	0	100%	-	67%		89%	0	72%	0		100%	0	100%	
Surgery	Kingfisher	100%	99%	97%	96%	0	0	100%		97%	0%	68%	0	0	100%	-	83%	Data Unavailable	99%	0	100%	0	Data Unavailable	100%	0	65%	Data Unavailable
	Falcon	98%	90%	100%	93%	0	0	60%		81%	0%	95%	1	0	98%	100%	81%		94%	0	86%	0		100%	0	40%	
	SDU	97%	98%	97%	92%	0	0	93%	1	-	0%	100%	0	0	100%	100%	77%		100%	0	100%	0		100%	0	-	
	Heron	100%	92%	100%	100%	0	0	100%		73%	0%	96%	1	0	100%	100%	79%		94%	0	83%	0		100%	0	38%	
	SAU	83%	95%	95%	100%	0	0	90%		75%	0%	100%	4	0	95%	-	82%		100%	1	50%	0		100%	0	42%	
T&O	Dickens	95%	96%	100%	100%	0	0	100%	N/A	95%	0%	100%	0	0	100%	-	93%	Data Unavailable	100%	0	50%	2	Data Unavailable	93%	0	73%	Data Unavailable
	RBE	89%	96%	95%	93%	0	0	92%	N/A	91%	0%	83%	2	0	97%	100%	78%		98%	0	100%	1		93%	0	63%	
	RBW	85%	95%	90%	95%	0	0	100%	N/A	95%	0%	90%	2	0	92%	-	75%		95%	0	100%	1		93%	0	68%	
ACCT	ITU	100%	N/S	100%	100%	0	0	N/A	N/A	88%	0%	-	0	0	100%	-	100%	Data Unavailable	100%	0	100%	0	Data Unavailable	100%	0	-	Data Unavailable
	DSU & Theatres ASH	100%		100%	100%	0	0	100%	N/A	79%	0%	-	0	0	100%	-	100%		100%	0	92%	0		100%	0	-	
	DSU & Theatres SPH	80%		100%	100%	0	0	79%	N/A		0%	-	0	0	80%	-	99%		100%	0	100%	3		100%	0	-	
Women's health & Paediatrics	Oak	100%	N/S	N/S	-	0	0	100%	N/A	-	0%	-	0	0	100%	-	100%	Data Unavailable	100%	0	100%	0	Data Unavailable	92%	N/A	-	Data Unavailable
	Ash	72%			N/S	0	0	60%	N/A	-	0%	50%	0	0	78%	100%	100%		75%	0	83%	0		100%	N/A	-	
	NICU	100%		100%		0	0	100%	N/A	-	0%	-	0	0	93%	100%	93%		79%	0	100%	0		100%	0	-	
	Paeds ED	-		99%	80%	0	0	-	N/A	-	0%	-	0	0	-	-	-		-	0	-	5		-	0	-	
	Joan Booker	95%	95%	100%	100%	0	0	95%	N/A	100%	0%	78%	0	0	100%	-	100%		96%	0	75%	0		100%	0	-	

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

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

RAG Scores		
95% +	Green	Green
80% - 94%	Amber	Amber
< 79%	Red	Red

Outcome:	Source:	Description:
MRSA	Infection Control	Number of Hospital aquired MRSA
C-Diff	Infection Control	Number of Hospital aquired C-Diff
CAUTI	Infection Control	Number of catheter associated urinary tract infections
Catheter > 29days (aftercare)	Infection Control	Number of indwelling catheters
Hospital Aquired PU	Ward managers	Number of hospital aquired pressure ulcers
VTE Mortality	PAS	Number of patients whose death is related to VTE
Number of Falls	Datex	Number of falls
Number of Falls resulting in injury	Datex	Number of falls resulting in Injury
Appropriate referrals to Dietician	PAS	Percentage of patients who were appropriately reffered to a dietician
No of Incidents of poor documentation	TBC	TBC
No of Administration Errors	Datex	Number of errors in drug administration