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

TRUST BOARD
29th March 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for February 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. 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 Board is asked to:	1. Review the paper; discuss the contents seeking additional assurance as necessary. 2. The Board is asked to approve the priorities outlined above as those upon which the Quality Account should be shaped (section 1.3)
Submitted by:	Dr David Fluck, Medical Director & Suzanne Rankin, Chief Nurse
Date:	21st March 2012
Decision:	For Noting

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1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indictor Definitions

The table is made up of 7 columns namely:

1. Description of Measure - self-explanatory.

2. Outturn 10/11 – this denotes the performance / outcome for last financial year 2010 /11 and is sourced from Dr Foster.

3. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used the 2010/11 year end total less 10% as the target. This sets us a goal of a 10% improvement on last year.

4. Forecast - the calculation is as follows:

   - For month 11, February we divide 2011/12 Total by 2011/12 YTD at month 11 to give us the proportion of activity that has taken place as a guide to how much more activity will take place during the rest of 2011/12. This is then multiplied out by the YTD figure for 2011/12. To further account for recent up or downward trends we have divided the average monthly figure for 2011/12 by the most recent 12 months average and multiplied this by the first figure. If we are improving this will better forecast that improvement, conversely if we are getting worse the forecast will reflect this also.

   - The formula is this 69(SUM(2011_12 up to m7)/SUM(2011_12 Total)) x 2011_12 YTD x (2011_12 Ave/Last 12 Months Ave)

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

6. Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, worse than 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.

7. 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 standards for our patients, exceeding their expectations, in terms of outcome, safety and experience.

	Patient Safety & Quality	Outturn 10/11	Annual Target 11/12	Annual Forecast 11/12	Feb Actual	Performance			YTD 11/12
						Deb	Jan	Feb	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	92	96.7	▼	▲	▼	98.9*
1-02	Crude mortality	1.60%	1.60%	1.60%	1.78%	▼	▼	▲	1.63%
1-03	MRSA (Hospital only)	5	4	2	0	◄►	◄►	◄►	2
1-04	C.Diff (Hospital only)	36	33	20	0	◄►	◄►	▲	17
1-05	Mortality from C.Diff (Hospital Acquired)	10.3%	6.3%	8.5%	0.0%	◄►	◄►	◄►	12.1%
1-06	Mortality from VTE	0.4%	0.35%	0.4%	0.0%	◄►	◄►	◄►	0.5%
1-07	Mortality from Hip fractures	4.8%	4.6%	6.7%	13.9%	▼	▼	▼	6.7%
1-08	National Patient Survey> Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)			59%	58%	▲	▼	▼	57%
1-10	Formal complaints	360	320	471	38	▼	▼	▲	445
1-11	SUIs	14	14	33	2	▼	▼	▲	32
1-12	Falls - resulting in significant injury (grade 3)	16	14	10	2	▼	▲	▼	9
1-13	Hip fractures treated within 36 hrs	93.0%	85%	95%	86%	◄►	▼	▼	95%
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	1737	153	▲	▼	▼	1,599
1-15	Average Bed Occupancy-Actual beds	94%	94%	96%	93%	◄►	◄►	◄►	96%
1-16	Average Bed Occupancy-Planned beds				104%	▼	▲	▼	

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

1-01/02/07/10/11/13/15/16/3-01/3-08/3-09
The Crude Mortality Rate has decreased from 2.09% in January to 1.78% in February. This follows the seasonal variation, although the peak was later and attenuated this year. Looking at table 2.1 this reflects a decrease in crude mortality within Medicine. The Standardised Mortality Ratio (SMR) has remained stable at 96.7%.

The mortality from hip fractures has risen further to 13% with the proportion operated on within 36 hours falling to 86%. This needs further analysis and I have asked the Division to review the service.

Emergency admissions were lower this month (1853 from 2014) although operational pressures occupancy rate remaining high. Elective activity was also maintained. However the emergency readmission rate is lower and the number of complaints has fallen (38 against 64).

1-03/04/05
Hospital acquired infection rates remain on target with no further MRSA cases or C.Diff although there have been a number of cases for norovirus which can be a precursor for C Diff.

1.3 The Quality Account Priorities 2012/13

A Quality Account is required by statute from all NHS organisations. Monitor also requires a Quality Report from foundation trusts.

The Quality Account has a formal 30 day consultation period with PCT and Overview and Scrutiny Committee with a requirement to publish by 30 June. The Quality Report must be completed by 31 May. The Auditors need to see the results of the consultation.

A stakeholder engagement event for the Trust's Quality Account consultation took place on Monday 5th March. The Quality Account workshop was attended by four representatives from the Council of Governors, four members of LINks, five members of the Patient Panel and one representative from Runnymede Borough Council.

Trust experts were present to provide information relating to progress with previous priorities and support discussion to identify potential priorities for 2012/13. The attendees separated into three smaller workgroups to consider priorities for improvement under the headings of:

- Patient Experience
- Patient Safety and
- Clinical Effectiveness.

The following have been recommended by our key stakeholders as their significant priorities for the Trust for 2012/2013 and recommend that the Trust's Quality Account define the actions and associated metrics. The priorities are:

Patient Experience	Priority 1	To provide safe and high quality discharge for patients (continues from 2011/12).
	Priority 2	To improve all aspects of communication with patients.
Patient Safety	Priority 3	To provide effective risk assessment and prophylaxis for VTE and reduce mortality from DVT.
Clinical Effectiveness	Priority 4	To reduce the hospital emergency and elective re-admission rate (continues from 2011/12).
	Priority 5	To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure (continues from 2011/12).

These include a number of priorities identified last year which will continue to be tracked within the Quality Account.

In accordance with the governance arrangements for the maintenance of the Quality Account the Trust is required to nominate one of the mandatory measures for data stream validation by the external auditor. The Trust has selected the C Difficile measure for scrutiny.

The Board is asked to approve the priorities outlined above as those upon which the Quality Account should be shaped. The priorities identified align with the Trust's business plan and internally identified priorities for the forthcoming year. Whilst these priorities might receive particular attention within the Quality Account they do not replace or reduce the importance of the many other improvement projects and variety of work underway to improve the quality of the patient care and experience.

2. Clinical Effectiveness

2.1 Mortality and Morbidity

Table two: Crude Mortality Rate by Specialty

	2011/12							2010/11						
	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11
Trust total	▲	▲	▼	◄►	▼	▼	▲							
Percentage reported	1.37	1.36	1.48	1.48	1.9	2.1	1.78	1.6	1.5	1.4	1.7	2.3	1.9	1.5
Actual Number of deaths	80	82	89	94	113	128	106	99	100	99	115	142	120	91
Total Admissions All (EL/DC/NEL)	5854	6054	5992	6329	5846	6101	5954	6240	6639	6610	6776	6233	6311	6062
MortalityRateAll	1.37%	1.35%	1.49%	1.49%	1.93%	2.10%	1.78%	1.59%	1.51%	1.50%	1.70%	2.28%	1.90%	1.50%
Specialty included in Medicine mortality rate: 300 General Medicine; 301 Gastroenterology; 302 Endocrinology; 314 Rehabilitation; 320 Cardiology; 340 Respiratory Medicine; 430 Geriatric Medicine														
MEDICINE	▲	▲	▼	▲	▼	▼	▲							
Actual Number of deaths	62	62	71	80	89	107	80	74	78	68	103	119	100	77
Total Admissions All (EL/DC/NEL)	1500	1595	1401	1594	1604	1813	1499	1521	1626	1638	1652	1603	1559	1426
MortalityRateAll	**4.13%**	**3.89%**	**5.07%**	**5.02%**	**5.55%**	**5.90%**	**5.34%**	**4.87%**	**4.80%**	**4.15%**	**6.23%**	**7.42%**	**6.41%**	**5.40%**
Specialty included in Surgery mortality rate: Breast Surgery, General Surgery, Colorectal Surgery, Urology, Vascular, and Upper GI.														
SURGERY	▼	▼	▲	▲	▼	▲	▼							
Actual Number of deaths	13	14	13	8	14	9	15	16	14	21	7	15	11	7
Total Admissions All (EL/DC/NEL)	1203	1241	1254	1378	1197	1226	1176	1204	1326	1331	1320	1175	978	1082
MortalityRateAll	**1.08%**	**1.13%**	**1.04%**	**0.58%**	**1.17%**	**0.73%**	**1.28%**	**1.33%**	**1.06%**	**1.58%**	**0.53%**	**1.28%**	**1.12%**	**0.65%**
Specialty included in Orthopaedics mortality rate: Trauma & Orthopaedics														
Orthopaedics	▼	▲	◄►	◄►	▲	▼	▼							
Actual Number of deaths	3	2	2	2	1	3	5	2	0	3	2	6	4	2
Total Admissions All (EL/DC/NEL)	586	605	587	599	522	553	583	519	579	572	554	539	443	475
MortalityRateAll	**0.51%**	**0.33%**	**0.34%**	**0.33%**	**0.19%**	**0.54%**	**0.86%**	**0.39%**	**0.00%**	**0.52%**	**0.36%**	**1.11%**	**0.90%**	**0.42%**
Specialty included in Paediatrics mortality rate: Paediatrics														
Paediatrics (Specialty Code 420)	◄►	◄►	▼	▲	◄►	◄►	◄►							
Actual Number of deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Total Admissions All (EL/DC/NEL)	187	229	269	299	267	253	238	227	319	288	328	310	320	302
MortalityRateAll	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%

Table two demonstrates the crude mortality within the Trust. There is little change in crude mortality rates from August to February in Surgery, Orthopaedics and Paediatrics. The total crude mortality rate continues to show the same seasonal variation that was seen in the previous year, but we have seen a later and attenuated peak. This is mainly reflected by the seasonal variation seen within Medicine.

2. CQUINs

The Trust is currently negotiating a range of CQUINs (Commissioning for Quality and Innovation) with the PCT. CQUINs can be divided into 3 categories:

Nationally mandated- these include

- VTE prevention
- The Safety Thermometer
- Patient experience
- Dementia

Regionally mandated- Enhancing Quality Programme

Locally agreed-

- promoting choice of place of death
- Reducing emergency admissions
- Reducing length of stay
- Increasing weekend discharges

Detailed indicators to be measured are being developed with the PCT. A Programme Management Office approach will oversee delivery of the programme.

3. Safety Update

31 National Patient Safety Alerts (NPSA)

There have been no new alerts reported by the NPSA since the last Trust Board report in January 2012.

Overdue Alerts

One alert remains overdue and is as follows:

Description	Deadline	Lead
Early identification of failure to act on radiological imaging reports	05-Feb-07	**Associate Director of Informatics**
STATUS		
The new Code 5 Tracker system has been deployed across the Trust. All alerts are being captured and dealt with. Refinements to process are currently in progress. TEC agreed the alert could be closed		

3.2 Pseudomonas Aeruginosa in High Risk Areas

Three neonates have died due to Pseudomonas Aeruginosa infection in a neonatal unit in Belfast. Pseudomonas Aeruginosa was identified in the taps.

At ASPH we have a test regime , as dictated by the relevant national and local guidance, whereby water samples are taken and tested for Legionella and a Total Viable Count (TVC). We do not look specifically for Pseudomonas Aeruginosa , as at this time the guidance does not require us to (following the incident in Belfast national guidance is expected to be reviewed). The water samples are selected from a number of locations in order to get a cross site review of both hospitals. The water tanks are sampled once a year and there are weekly water checks and chlorine dioxide analysis.

Additional water sampling was undertaken early in February from all the clinical sinks in the high risk areas and at present there are no signs that Pseudomonas Aeruginosa is present in our critical care areas, including neonatal critical care . As frequent swabs and other specimens from all patients in these areas are taken, even before signs of infection , it is likely that any increase in particular organisms, including Pseudomonas would be quickly identified. In any event the best protection against the spread of Pseudomonas and all other organisms is good infection control practice which is monitored robustly in all areas

4. Patient Experience

4.1 Complaints/Ombudsman Reports

There were 38 complaints received in February compared with 64 in January and 45 in December. A total of 454 complaints have been received year to date, +40% compared with the same period 2010-11. Chart one shows a breakdown of complaints received by month (Series 1), monthly target (Series 2) and overall trend line (red).

Chart one

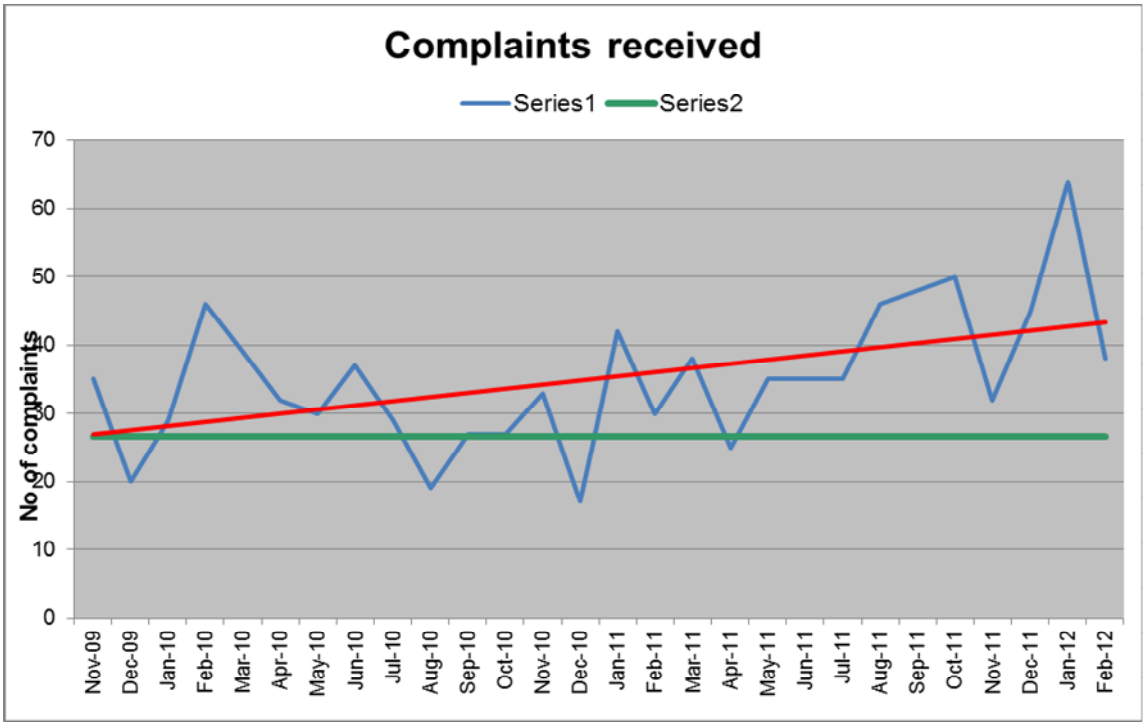
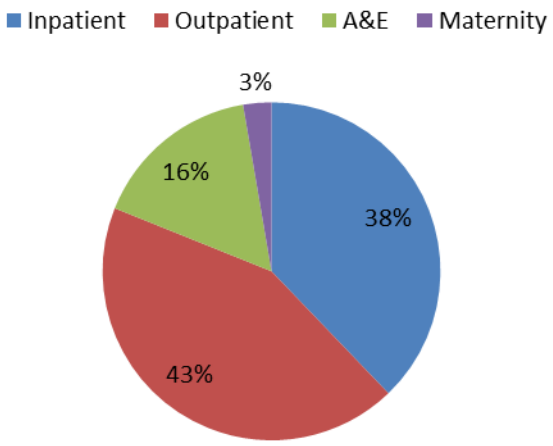


Chart two shows a breakdown of complaints by service area

Chart two – Complaints by Service Area



There were 99 informal (PALS) concerns raised. Of these, three went onto become formal complaints which demonstrates a conversion rate of 3% compared with 6.6% in January.

There were 53 formal complaint responses due in February. Of these, 46 responses were sent within the agreed timescale. This equates to a monthly performance of 87% with agreed timescales for response in comparison to 46% performance in January.

At the end the time this report was submitted the backlog of complaints overdue for response for was 6. Breakdown as follows:

Acute & Emergency Medicine	3
Surgery	2
Diagnostics and Therapeutics	1

The Net Promoter Score has seemed to settle between 59% and 58% during the reporting period. The Trust received 6 positive comments via NHS Choices, a recent comment was:
'The staff are a credit to the hospital'.

A central point for collation of formal compliments is being developed to allow more accurate reporting by ward are going forward.

Ombudsman cases

The Trust has received notification of a complaint which will proceed to full review. This complaint relates to general surgery. The Ombudsman has reopened the case on appeal, having previously declined to review the complaint. The Trust has provided further detailed comments and awaits the outcome of the review.

4.2 Improving Dignity in Care

The draft report from the Commission on Improving Dignity in Care, recommends "fundamental changes to culture, leadership, management, staff development, clinical practice and service delivery". The work links to the NHS Ombudsman report on Care of the Elderly in 2011, the Francis inquiry into the breakdown of care at hospitals in Mid-Staffordshire and to NICE quality standards for patient experience and dementia.

The report places an emphasis on:

- Staff values such as compassion and capacity to engage with older people, improvements to clinical supervision, the crucial role of the nursing sister as leader being empowered to act on behalf of patients, practice-based development of staff relating to dignity in care and maintaining patient independence
- Comprehensive geriatric assessment and coordinated care planning
- Working in partnership with patients and their families and understanding the needs and preferences of patients
- Daily feedback from patients discussed by the ward team with reports on the patient experience going up to Trust Boards.

The recommendations from this report and the quality standards provided by NICE span our 6 Trust-wide change programmes to improve patient experience, provide the highest quality of care and develop our staff. Current work includes:

1. Nurse leadership programme
2. Programme of nursing care audits reported monthly to Trust Board
3. Living Our Values project enabling staff to reflect on compassionate care, communication and shared decision-making in partnership with patients and their family and carers.
4. Continuous patient experience surveys across all areas with regular reports to the Trust Board
5. Dementia Steering Group work includes recruitment of new consultant geriatrician and specialist nurse for safeguarding / care of the elderly and training and education of staff to deliver dignified care whilst maintaining patient independence.
6. South East Coast Enhancing Quality CQUIN (Commissioning for Quality and Innovation) for 2012/13 is currently being negotiated with the inclusion of improvement targets for reduction of antipsychotics and further measures to improve the care and experience of patients with dementia.

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NHS Foundation Trust

4.3 The Best Care Dashboard

The Best Care Dashboard definitions are found at Appendix one and the Best Care Dashboard is found at Appendix two. The following narrative is provided by the relevant Heads of Nursing.

Division of Women's Health and Paediatrics Service

Paediatrics

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Paediatric ED	**Saving lives**	Poor documentation	Improved documentation undertaking weekly documentation audits
NICU	**Skin integrity**	Poor documentation of assessment	Rewording of dashboard to accurately reflect NICU improved recording and documentation of the assessment of skin integrity on admission
NICU	**Nursing Documentation**	No agreed nursing paperwork	Currently developing and standardising nursing documentation within the unit with the creation of a Neonatal Assessment Process and individualised care plan

Women's Health and Paediatrics

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Joan Booker ward/La	**Patient Observations**	Failure to add up meows scores and failure to complete respiratory rates on chart.	Completed sample obstetric MEOWs documents are kept on the ward for reference. Matron and Ward Team Leaders asked to do notes checks in addition to monthly audits
	VTE Risk Assessment	Failure to complete IPL data Failure to complete antenatal risk assessments	Matron to complete monthly audits

	Midwifery Documentation	Failure to fully complete fluid balance charts and total at the end of the day. Hospital number for mothers and babies not completed at the top of every page.	Matron working with staff to provide training on the ward Completed sample chart kept on the ward for reference. Matron completing spot checks. Matron to complete monthly audits.

Significant achievements relating to Best Care

Area	Achievement	Explanation
Joan Booker Ward	VTE assessment/ documentation has increased from 56% to 93 % Manual handling assessments has also increased from 60% in January to 100% in February	This improvement has been led by better communication with staff, spot check audits by matron and ward team leader.

Medicine and Emergency Services:

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
MAU	**Patient observation showing as red**	24 hour fluid balance charts not completed	Matron doing spot checks in between audits and all staff have a greater awareness of the need for accurate and timely completion .This is also part of the 0-3 month competency which all band 5 nurses are undertaking
MHDU, Cedar May , MAU, Maple	**VTE Assessment and compliance**	This data was completed monthly at this time, since this report this information is now collated weekly and has improved upon these figures.	All staff are now more focused upon their compliance and completion is being reviewed at the morning board rounds
Aspen, May, MAU	**Communication**	Witnessed conversations that could have been phrased differently	Challenging poor communication between Doctors and patients
Aspen. MHDU, Birch, CCU, Fielding, Chaucer, Swift & Wordsworth	**Privacy and Dignity**	Rehab goals related to washing and dressing not being adhered which would have an impact upon on the patient progression and their experience	Matrons observing the patients that are in gowns instead of own night clothes and challenging this. Nurses on Fielding Ward are trialling key workers and this is being seen to make a difference , improving experience and communication

Surgery & Orthopaedics: -

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
T & O	**Medication Assessment**	Failure to complete documentation – (drug chart height, weight) Documentation needs to be in black ink.	Matron spot checks. Completed sample documents are kept on the ward for reference. Matron to complete monthly audits Matron's meeting with all medical staff regarding the result February 23, 2012.
T & O	**Skin Integrity** Failure to complete hourly care rounding. Failure to complete waterlow score	Failure to complete hourly care rounding. Failure to complete waterlow score	All Ward Sisters & Matron to carry out spot checks. Dickens Ward failed to have a complete hourly care rounding – meeting held on February 09, 2012 to raise the issue and reinforce to the Sister's and Charge nurses to ensure 100% compliance. Matron to complete monthly audits *There is an improvement on the hourly care rounding on the March Best Care Audit (Dickens Ward)
T & O	**Nursing Documentation** Clear documentation print/sign Updated individualised care plan	Failure to print the name on the accountability. Failure to complete the Discharge section on the SAP document Failure to update individualised care plan	Planned purchase of a name stamp for Rowley Bristow wards.(Observed improvement from the last audit) All Ward Managers to raise the issue with all staff (Ward Meeting held February 08,2012) Matron informed all Ward sister the results of the audit on their monthly Sister Meeting (February 22, 2012) Matron completing spot checks.(Naming and having one to one with the Matron) Dickens – Updated Staff Reminder Board, wherein all ward staff can see the latest Best Care audit. Matron raised the issue in Dickens on their ward meeting held on February 09, 2012. Matron to complete monthly audits. *There is a further improvement on the individualised nursing documentation on the March Best Care Audit
Dickens Ward	**Patient Observation**	Failure to complete Fluid Balance Chart	Training sessions lead by CPE and Matron

	Fluid Balance Chart		A sample of completed fluid balance chart to put in place for staff reference. Matron to spend more time in Dickens Ward for monitoring and spot checks. Matron raised the issue on February 09, 2012. Communication (White Board) Board was implemented and placed on the Staff room for the updated summary of the Best care Audit. – February 13, 2012.

Area	**Achievement**	**Explanation**
T & O	All 3 orthopaedic wards have seen an upward trend in their Nutrition Scores for the month of February.	MUST scores and BMI are well recorded.

SAU	Scored red for 2 aspects of skin integrity – 1 incomplete care rounding chart and one care plan not re-evaluated for a session of care regarding a wound. Also scored red for manual handling/ falls assessments – care plan not completed for patient identified to be at risk of falls.		Successful recruitment to all trained vacancies on SAU. Successful candidates due to start shortly. Staff made aware that if patients are transferred from another part of the hospital with incomplete documentation, then this needs to be rectified by all receiving areas.

Rowley Bristow Wards East and West	Improvement in completing Fluid Balance Chart (Patient Observation Chart).	Spot checks and identifying staff not completing the form efficiently. Continuous improvement in completion of Fluid Balance Chart.
T & O	Communication	A continuous improvement in patient feedback responses. Ward Sisters and matron are ensuring and monitoring ward rounds commence on time
Kingfisher Ward	High numbers of positive feedback forms received. One example provided above.	Good leadership and teamwork
Your “Feedback” score for Division of Surgery	Score for February is the highest in the Trust and has been for 3 months running.	Consistent effort from team leaders

ACCT, Ambulatory Care, Diagnostics & Therapeutics

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Theatres/ DSU AH	**Nutrition** Time patient is nil by mouth - ward issue	Booking of patients: Orthopaedics not always scheduling Day Surgery patients first on Theatre lists and asking all patients to arrive at 07.30	Work with Speciality Lead for Day Surgery and Clinical Director to resolve
Theatres SPH	**Nutrition** Time patient nil by mouth	Theatres currently records the NBM time pre theatre, this starvation time is not within the control of the theatre staff directly.	Dialogue is on-going between the matron for AH theatres, the surgery Matron and theatres SPH Matron to influence these hours pre operatively.
ITU	**VTE** assessment incomplete	VTE assessment forms were being completed but the IPL checkbox was not being ticked as the medics don't use IPL lists in ICU.	We now have access to this list to be able to update this manually. The scores will now improve from March.
ITU		Current nutritional assessment process is not relevant to critical care patients	The tool has now been changed to record BMI which is a much better tool for accurate recording of patients nutritional state in ITU

Significant achievements relating to Best Care

Area	Achievement	Explanation
All areas	Improvement on the outcome of all elements of Best Care audit for all departments in the ACCT Division	The process of the Matron completing the audits and the team Leaders developing the action plan has given a more focused approach and producing improving outcomes. The matrons will be auditing each other's areas for the next audit period.

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 – February 2012

Paper 5.3

Ashford and St. Peter's Hospitals NHS

NHS Foundation Trust

Best Care Dashboard - February 2012

Essential Care Indicators		Patient Safety																				Patient Experience										Action Plan
		Process: Patient Observations	Outcome: To be defined	Process: Hand Hygiene Audits	Process: Saving Lives	Outcome: MRSA	Outcome: C-Diff	Outcome: CAUTI	Outcome: Catheter > 29days (aftercare)	Process: Skin Integrity	Outcome: Hospital Aquired PU	Process: VTE Assessment	Outcome: VTE Mortality	Process: Falls and Manual Handling Assessments	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	90%		94%	92%	0	0			98%	0	96%	0%	100%	1	0	95%	100%	92%	Data Unavailable	100%	63%	0	Data Unavailable		100%	0	83%	Data Unavailable		
	Aspen HDU	100%		100%	100%	0	0			100%	0	71%	0%	100%	0	0	100%	100%	-		100%	88%	0			42%	0	-			
	CCU	100%		100%	100%	0	0			100%	0	81%	0%	100%	1	0	90%	-	96%		100%	92%	0			79%	0	-			
	Birch	97%		100%	100%	0	0			100%	0	81%	0%	100%	1	0	93%	100%	94%		100%	83%	0			100%	0	73%			
	Cedar	91%		100%	98%	0	0			100%	0	58%	0%	100%	6	0	95%	100%	94%		100%	80%	0			100%	0	57%			
	Holly	93%		100%	100%	0	0			100%	3	90%	0%	100%	0	0	100%	100%	96%		100%	100%	1			100%	0	56%			
	May	90%		99%	100%	0	0			100%	0	54%	0%	100%	5	1	100%	100%	88%		100%	75%	0			100%	0	62%			
	MAU	76%		100%	100%	0	0			100%	0	43%	0%	100%	0	0	100%	-	86%		100%	75%	1			100%	0	-			
	Maple	92%		100%	100%	0	0			100%	1	74%	0%	100%	0	0	98%	100%	92%		100%	80%	0			93%	0	37%			
	Fielding	97%		99%	100%	0	0			100%	0	100%	0%	98%	4	0	98%	100%	82%		98%	83%	0			57%	0	-			
	Chaucer	85%		100%	100%	0	0			97%	1	100%	0%	100%	3	1	97%	100%	100%		100%	100%	0			57%	0	50%			
	ED	-		97%	-	0	0			-		-	0%	-	2	0	-	-	-		-	-	4			-	0	-			
	Swift	100%		96%	100%	0	0			100%	0	100%	0%	100%	8	0	95%	100%	90%		100%	100%	1			67%	0	-			
	Wordsworth	100%		100%	100%	0	0			96%	0	100%	0%	100%	2	0	89%	100%	100%		100%	83%	0			71%	0	75%			
Surgery	Kingfisher	100%		98%	98%	0	0			99%		100%	0%	94%	0	0	97%	100%	96%	Data Unavailable	90%	93%	2	Data Unavailable		100%	0	69%	Data Unavailable		
	Falcon	100%		88%	82%	0	0			91%		86%	0%	100%	0	0	98%	98%	100%		93%	93%	0			100%	0	10%			
	SDU	100%		97%	95%	0	0			100%		94%	0%	100%	0	0	100%	100%	100%		92%	100%	0			100%	0	-			
	Heron	100%		-	100%	0	0			98%		75%	0%	98%	0	0	88%	67%	94%		98%	93%	0			100%	0	100%			
	SAU	100%		96%	100%	0	0			58%		72%	0%	73%	0	0	92%	100%	96%		93%	93%	0			93%	0	53%			
T&O	Dickens	88%		100%	100%	0	0		-	93%	1	92%	0%	100%	0	0	97%	-	80%	Data Unavailable	88%	86%	0	Data Unavailable		100%	0	77%	Data Unavailable		
	RBE	100%		86%	100%	0	0		-	93%	1	87%	0%	92%	0	0	97%	100%	84%		83%	86%	3			100%	0	62%			
	RBW	96%		94%	100%	0	0		-	95%	0	96%	0%	94%	0	0	100%	100%	80%		80%	86%	1			100%	0	25%			
ACCT	ITU	88%		100%	100%	0	0			87%	7	38%	0%	-	0	0	82%	-	100%	Data Unavailable	100%	88%	0	Data Unavailable		100%	0	-	Data Unavailable		
	DSU & Theatres ASH	100%		100%	100%	0	0		-	-		94%	0%	-	0	0	65%	-	92%		100%	90%	3			100%	0	-			
	DSU & Theatres SPH	98%		100%	100%	0	0		-	100%	0			-	0	0	64%	-	95%		93%	100%	4			100%	0	-			
Women's health & Paediatrics	Oak	100%		90%	100%	0	0			100%		-	-	100%	0	0	100%	-	100%	Data Unavailable	93%	50%	0	Data Unavailable		50%	0	-	Data Unavailable		
	Ash	100%		90%	95%	0	0			90%		-	-	90%	0	0	95%	-	100%		100%	41%	0			79%	0	-			
	NICU	100%		88%	100%	0	0			40%		-	-	-	0	0	81%	-	72%		85%	57%	0			75%	0	-			
	Paeds ED	-		100%	63%	0	0			-		-	-	-	0	0	-	-	-		-	-	1			-	0	-			
	Joan Booker	91%		100%	100%	0	0			95%		93%	-	100%	0	0	100%	-	93%		100%	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
80% - 94%	Amber
< 79%	Red

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

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