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

Council of Governors
17th May 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for April 2012. Delivering quality patient care and an excellent patient experience is a top priority for the Trust Board. The definition of Quality, now used across the NHS was set by Lord Darzi and focuses on 3 components: Safety, effectiveness and patient experience. The Report covers ▪ Quality and Safety Balanced Scorecard and Commentary ▪ The Quality Account 2011/12 ▪ The Quality Account Priorities 2012/13 ▪ CQC Compliance Update ▪ 24 Hour Hospital Insight ▪ National Inpatient Survey Results ▪ NICE Patient Experience Quality Standard
The Council is asked to:	Review the paper and discuss the contents
Submitted by:	Heather Caudle, Associate Director of Quality on behalf of Dr David Fluck, Medical Director & Suzanne Rankin, Chief Nurse
Date:	8th May 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 12,March we divide 2011/12 Total by 2011/12 YTD at month 12 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 m11)/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

BALANCED SCORECARD — **Position as at:** **31 Mar 2012**

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	Mar Actual	Performance			YTD 11/12
						Jan	Feb	Mar	
1-01	Standardised mortality (Relative Risk)*	90.7*	82	**92**	**99.1**	▲	▼	▼	**99.2***
1-02	Crude mortality	1.60%	1.60%	**1.60%**	**1.94%**	▼	▲	▼	**1.65%**
1-03	MRSA (Hospital only)	5	4	**2**	**0**	◄►	◄►	◄►	**2**
1-04	C.Diff (Hospital only)	36	33	**20**	**2**	◄►	▲	▼	**19**
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%**	◄►	◄►	◄►	**0.0%**
1-07	Mortality from Hip fractures	4.8%	4.6%	**6.7%**	**3.1%**	▼	▼	▲	**6.4%**
1-08	National Patient Survey>Avg responses	! New	>3	Annual measure					
1-09	Patient Satisfaction (NetPromoter Score)			**59%**	**55%**	▲	▼	▼	
1-10	Formal complaints	360	320	**471**	**50**	▼	▼	▼	**495**
1-11	SUIs	14	14	**33**	**7**	▼	▼	▼	**41**
1-12	Falls - resulting in significant injury (grade 3)	16	14	**10**	**4**	▼	▲	▼	**13**
1-13	Hip fractures treated within 36 hrs	93.0%	85%	**95%**	**94%**	◄►	▼	▲	**95%**
1-14	Summated Adverse Report Index (SARI)	1,799	1,552	**1737**	**194**	▲	▼	▼	**1,793**
1-15	Average Bed Occupancy-Actual beds	94%	94%	**96%**	**92%**	▲	▲	▲	**96%**
1-16	Average Bed Occupancy-Planned beds				**101%**	▼	▲	▲	

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

The Crude Mortality Rate has increased from 1.78% in February to 1.94% in March, suggesting a flat mortality rate from December and a year end crude mortality rate which has not changed greatly from last year (1.66% against 1.60%). The HSMR finishes the year at 99.2 but this will undergo a benchmarking process and Dr Foster has informed me that this will rise to 110. This is being driven by our palliative care coding which is nationally one of the lowest at 5 against a mean of 100. This is being investigated. Looking at table 2.1, the increase in crude mortality rate reflects an increase in crude mortality within Medicine whereas other specialties have remained static.

The mortality from hip fractures has settled to 3.1% (with an end of year rate of 6.4%) with the proportion operated on within 36 hours rising back to 94%. There was a rise in the number of significant falls with injury which finished at a similar level to last year.

Emergency admissions were again lower this month 1802 from 1853 – in keeping with our drive to meet the emergency cap which we achieved at end of year – although the complexity of these patients appears to be greater than last year. In addition the GP elective referrals are lower than planned for the year: 90 864 rather than the ambitious 98 833, with market share being maintained. This suggests that some of the demand management strategies in primary care are working. The LOS fell marginally from 5.52 to 5.43 for emergency patients with bed occupancy rates improving slightly.

1-03/04/05
Hospital acquired infection rates remain on target with no further MRSA cases but 2 C.Diff cases occurred in March.

1.3 <u>The Quality Account Dashboard 2011/12</u>

The Quality Account Dashboard (Appendix two) provides a visual high level summary of the Trust's performance for the year 2011 – 2012 against plans set in the Quality Account 2010/11. The overall performance reflects the areas where the Trust needs to sharpen its focus and strengthen improvement works.

Improving our Patient Experience
Priority 1 – To provide safe, high quality discharge for patients

Patient Satisfaction
The Net Promoter Score (NPS) is below the target (- 33%) at year end. The outturn against an overly ambitious target of NPS 90% from a baseline of 61%, belies the recovery demonstrated between July 2011 and Dec 2011. Nevertheless the year end score of 57% is disappointing. Work will continue in this area as improvement is known to take sustained focus and time.

National Patient Survey
This is an annual measure taken in July 2011. The publication of results will take place on 24th April 2012.

Discharge Related Complaints.
There was a significant increase in discharge related complaints during Q4 and although the target has not been achieved a small improvement on last year is evident (6%) by 34.4%. The improvement work around the discharge process continues to be a point of focus and improvement for 2012.

Priority 2 - To provide high quality experience relating to nutrition and hydration
Compared with results for 2010, there are improvements in 2011 to the mealtime service and for the completion and effectiveness of nutritional screening to identify those at nutritional risk and therefore the provision of appropriate care such as the use of the red tray system and care and support to eat and drink. The Best Care Dashboard now reports on detailed nutritional ward level audits on a monthly basis which have shown sustained improvement over the course of the year. Some aspects of the nutrition audit undertaken in 2010 were not repeated within the Essence of Care audit in 2011 (these are marked N/A). The Essence of Care audit will be repeated in 2012.

Maintaining High Safety Standards
Priority 3 – To provide confidence and reassurance for patients on infection and other preventable infections
All indicators in this category have achieved the target.

Priority 4 - To improve the quality of nursing care by setting and measuring a number of nursing indicators

Falls
Overall the total number of falls reported by the Trust has reduced and has met the target. The number of falls recorded resulting in harm is the same as the previous year and it is disappointing not to have shown improvement on this indicator. Sustained effort and work will continue to improve on this performance.

Prevention of Pressure Ulcers (hospital acquired)
Over the last quarter, there has been a significant rise in pressure ulcers reported. The 10% reduction planned has not been delivered. The Quality Account pledged a year on year reduction of 10% until 2014 and so next year a 20% reduction must be achieved.

Achieving High Quality Clinical Care
Priority 5 – To reduce the hospital emergency and elective readmission rate

Readmission in 28 days – Elective
This target has not been achieved (61.2%) but an improvement on the outturn for 10/11 is evident.

Readmission in 28 days – Emergency
This target was achieved (-6.8%), which suggests that work to improve this indicator has had impact.

Priority 6 – To improve the effectiveness of care for those with conditions most commonly associate with death in hospital and hear failure
SMR for Heart Failure
The Trust performance on heart failure has not been achieved; 0.065% against a target of 0.048%. The Enhancing Quality Programme will continue to drive improvement in this area throughout next year.

SMR Pneumonia
This target has been achieved.

Priority 7 – to improve the experience and clinical outcomes for those with long term conditions
Recent improvements in this outcome have been sustained and the target achieved. (YTD figure of 0.7% against a trajectory of 0.78%).

1.4 Quality Account Priorities for 2012/2013

Five priorities have been developed in partnership with key stakeholders, and have been agreed by the Board.

Progress against the priorities will be monitored regularly via: the Patient Experience Group, the Patient Panel, the Clinical Effectiveness and National Audit Review Group, the Clinical Outcomes Steering Group and with reports to Trust Board and the Council of Governors' Patient Experience Group.

The priorities for 2012/13 are listed with potential measures and targets outlined.

1.4.1 Patient Experience To provide safe and high quality discharge for patients (continues from 2011/12)

Improvement will be measured by: monitoring discharge and readmission rates, the number of complaints relating to discharge and patient experience via the Net Promoter Score and the National Patient Survey.

Targets:

- Reduce the number of patient concerns measured through formal complaints relating to discharge by 15% of the 2011/12 value. Targets for discharge set at ward level.

1.4.2 Patient Experience To improve all aspects of communication with patients

Improvement will be measured by considering:

1. Results from the National Inpatient Survey and internal surveys for the question: "*Were you involved as much as you wanted to be in decisions about your care and treatment?"*
2. Written feedback from our internal survey which is available to inpatient, outpatients and patients attending diagnostics and therapeutic areas.
3. Audits against the Essence of Care benchmark for communication.
4. The quality of written patient information and 6 monthly audits of discharge letters.
5. Feedback through complaints or PALS contacts and via online and social media including NHS Choices, Patient Opinion, Twitter.

Targets:

- Reduction from 50% to 40% of patients responding negatively to the measure for shared decision making
- Increase to 60% patients who know how to access PALS / make a formal complaint (currently 10%-40% in internal audit and 38% in the National Survey)
- Numbers of written patient comments (surveys and NHS Choices, Patient Opinion, Twitter) – review and themes of positive and negative feedback
- Overall improvements to scores within the Essence of Care communication audit
- Improvements in the quality of discharge letters.

1.4.3 Patient Safety To provide effective risk assessment and prophylaxis for VTE and reduce mortality from DVT

Improvement will be measured via monthly reports to the Department of Health and the "Safety Thermometer"[1] audit.

Targets:

- To meet and / or exceed the national benchmark for risk assessment (currently 90%) and for prophylaxis (prevention of VTE).

1.4.4 Clinical Effectiveness To reduce the hospital emergency and elective re-admission rate (continues from 2011/12)

Improvement will be measured by reduction in readmissions within 28 days of discharge for elective and emergency procedures.

Targets:

- Reduction in readmissions for an elective procedure of 25% of the 2011/12 value
- Reduction in readmissions for an emergency procedure of 25% of the 2011/12 value.

1.4.5 Clinical Effectiveness To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure (continues from 2011/12).

[1]The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care relating to: pressure ulcers, falls, catheters with UTIs and VTEs.

The Enhancing Quality Programme has continuous data collection with improvement targets and milestones to benchmark performance.

Targets:

- Reduction of 5% SMR for Heart Failure by 2013/14
- Reduction for hospital acquired Pneumonia of 1% SMR year on year.

1.4.6 Table two: Timeline for production of the Quality Account 2011/12

Stakeholder engagement	January / February 2012
Draft text produced following final guidance from Department of Health and circulation for comments	March
Final text provided to Trust Board for approval	April
Copy to be sent to PCT, LINks and OSC for review	By 10 April
Review by PCT, LINks, and OSC and returned	By 10 May
Production of Quality Account	May/June
Publication	30 June

2. CLINICAL EFFECTIVENESS

2.1 CQC Compliance Update

2.1.1 Introduction

Following the unannounced CQC compliance review (Dec 2011), the Trust has been implementing and monitoring a CQC compliance action plan which covers:

- the immediate capacity management action plan to address the issues identified with regard to the accommodation of patients during episodes of high demand;
- the compliance action plan for Outcomes; 1 (Respecting and Involving People who use Services), 4 (Care and Welfare of People who use Services) and 14 (Supporting Workers);
- the improvement action plan for Outcome 2 (Consent to Care and Treatment) and Outcome 7 (Safeguarding People who use Services from Abuse).

The first milestone of the tripartite action plan was reached on the 31st March 2012 and all process improvements are now complete and implemented. Robust, weekly monitoring of the effectiveness of those actions is supporting improved compliance.

Some key achievements are:

- the Day Surgery Unit has not been used as an escalation area for inpatients since the 16 January 2012
- an increase to 77% (at the time of writing) of compliance with mandatory training levels
- the strengthening of processes and practice in involving patients in their care, particularly in making decisions about their treatment and care planning.

2.1.2 Self – Assessment

Detailed self-assessment of the Trust's compliance with the Essential Standards is being undertaken at regular intervals and areas for improvement targeted. This will ensure the Trust is well positioned and prepared for the unannounced follow-up visit to be conducted by the CQC in due course. Work will continue to embed the CQC action plan and monitor effectiveness.

The self-assessment is aided by the continuous assessment of a CQC compliance dashboard which outlines three views of assessment of the Trust's compliance with the Essential Standards.

The dashboard is a visual report on the summative assessment of compliance through triangulation of:

1. Trust standards owners' self-assessment of policy and procedure.
2. The Trust's Quality Risk Profile provided by the CQC.
3. The Compliance in Practice Review (uses an internally developed tool to check compliance across the Trust. Carried out on a peer review basis by matrons)

The Trust's Executive and Divisional Directors have met to consider and collectively advise on the Trust's current level of compliance, based on an "in the round" assessment of all hard and soft intelligence together with all the data outlined above.

The view at this time is that compliance is much improved since December 2011 when the CQC visited but that full compliance with all Essential Standards is not yet achieved. This was discussed and agreed at the April Board meeting.

The level of compliance self-assessment at this point is below.

Table three: Self-assessment of Compliance with the Essential Standards

Essential Standard	CQC Judgement from Dec 2011	Trust Recommendation of Current Status
Outcome 1 (Respecting and involving people who use services)	Non-compliant with **moderate** concerns	Minor concerns
Outcome 2 (Consent to care and treatment)	Compliant with **minor** concerns	Fully compliant
Outcome 4 (Care and Welfare of people who use services)	Non-compliant with **major** concerns	Minor concerns
Outcome 7 (Safeguarding people who use services from abuse)	Compliant with **minor** concerns	Minor concerns
Outcome14 (Supporting workers)	Non-compliant with **moderate** concerns	Minor concerns

2.2 24-hour Hospital Insight

2.2.1 Introduction

Colleagues in the Trust undertook a 24 hour observation of the hospital "Hospital Insight - what's the story" from 8am on Wednesday 28th March and ended at 8am on Thursday 29th March.

The purpose of the exercise was to give staff the opportunity to share the experience in the hospital - whether that was at night in the Emergency Department, lunchtime in maternity, or evening in theatres; whether the perspective was that of a doctor, nurse, or porter.

2.2.2 The 24-hour Insight Exercise

The exercise was one of the actions from the CQC action plan and was inspired by a similar exercise carried out at Heatherwood and Wexham Hospitals. However, the audit format was changed to make it very observational in order to simply relay what was seen, felt and heard and retell anonymously back to organisation.

2.2.3 The Next Step – Telling the story in context

The next step is to relay this in a coherent manner. The three main themes were:

- Documentation - helpful, although there's quite a lot of it!
- Workload - a general feeling of high workloads in most areas.
- Dedication - it's very clear that staff want to do their best.

The evidence is being analysed to pick out some more subtle yet important themes and will be told in some detail and a Trust wide event will be held at the end of May. So far the information gathered has been subjective. The context will be added to give a full picture. The Trust activity, such as ambulance attendances, admissions and discharges, will be triangulated with the story.

3. PATIENT EXPERIENCE

3.1 Complaints/Ombudsman reports

3.1.1 Complaints and PALS

There were 51 complaints received in March compared with 37 in February and 64 in January. A total of 504 complaints have been received during 2011/12, +40% compared with 2010-11 (361).

Chart one shows a breakdown of complaints received by month (Series 1), monthly target (Series 2) and overall trend line (red).

Chart one

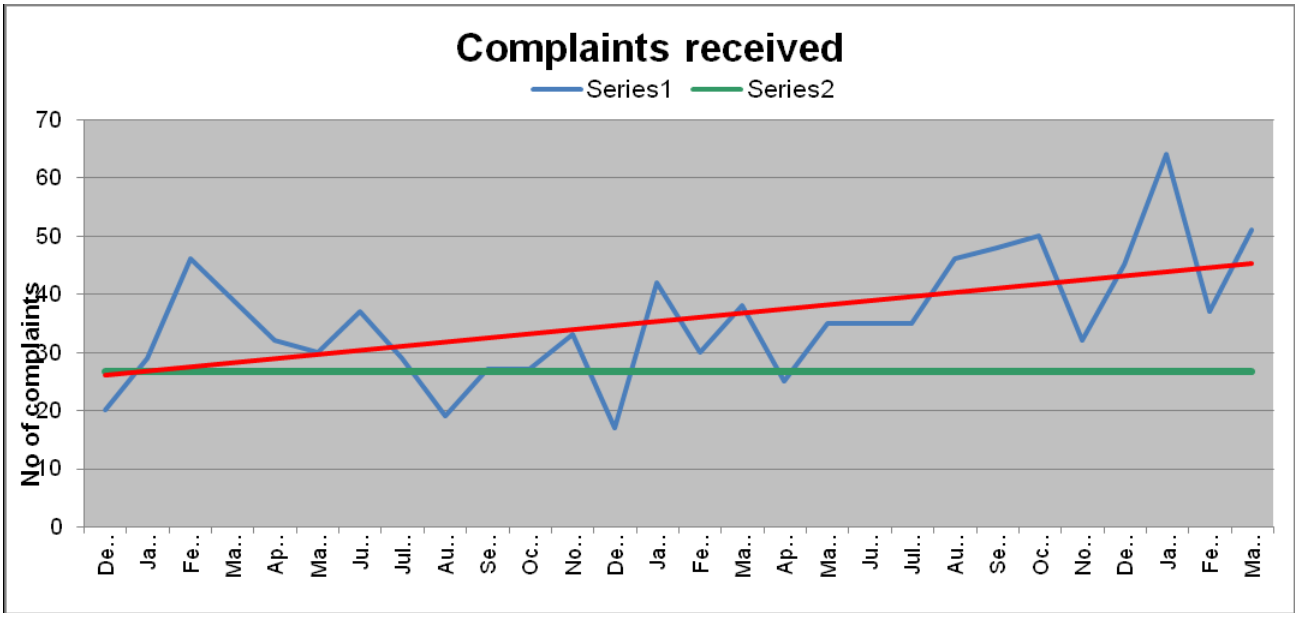
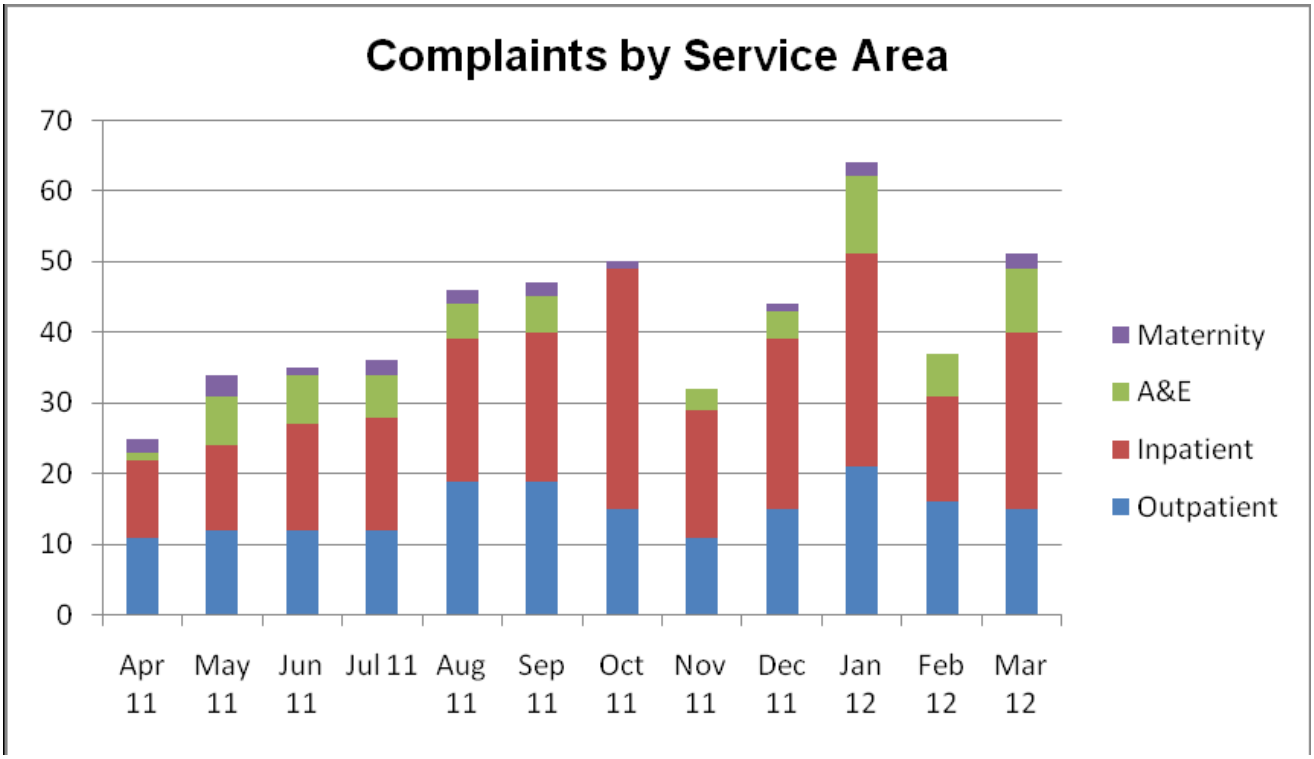


Chart two shows a breakdown of complaints by service area and demonstrates that there has been a larger relative increase the proportion of complaints relating to care as an inpatient and in the Accident & Emergency Department.

Chart two



There were 103 informal (PALS) concerns raised during March, of these five went onto become formal complaints which demonstrates a conversion rate of 4.9% compared with 3% in February.

There were 46 formal complaint responses due in March, of these, 30 responses were sent within the agreed timescale. This equates to a monthly performance of 65% within agreed timescales. Action to recover and sustain improved performance is on-going.

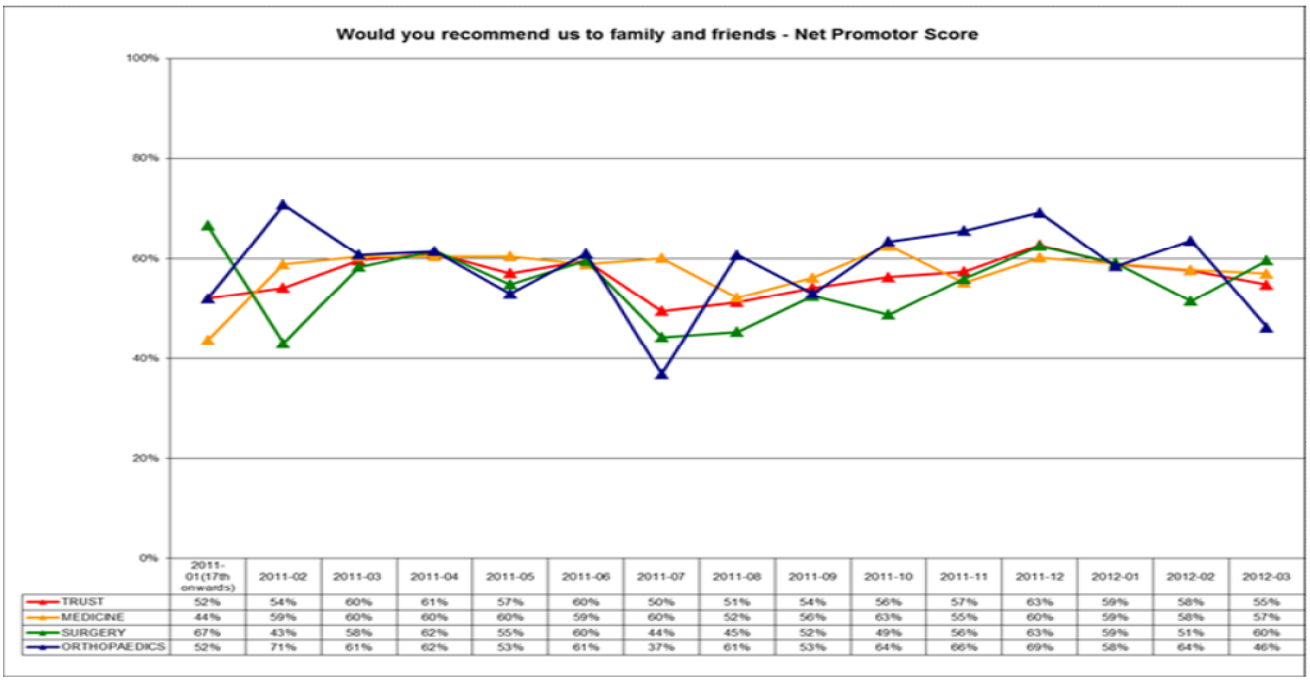
At the end of the reporting period the backlog of complaints totals 15, as follows:

Table four

Acute & Emergency Medicine	6
Surgery	5
Trauma & Orthopaedics	1
Women's Health and Paediatrics	3

3.1.2 Net Promoter Score

The Net Promoter Score has reduced from 59% to 55% during the reporting period.



	2011-01(17th onwards)	2011-02	2011-03	2011-04	2011-05	2011-06	2011-07	2011-08	2011-09	2011-10	2011-11	2011-12	2012-01	2012-02	2012-03
TRUST	52%	54%	60%	61%	57%	60%	50%	51%	54%	56%	57%	63%	59%	58%	55%
MEDICINE	44%	59%	60%	60%	60%	59%	60%	52%	56%	63%	55%	60%	59%	58%	57%
SURGERY	67%	43%	58%	62%	55%	60%	44%	45%	52%	49%	56%	63%	59%	51%	60%
ORTHOPAEDICS	52%	71%	61%	62%	53%	61%	37%	61%	53%	64%	66%	69%	58%	64%	46%

3.1.3 Compliments

A central point for collation of formal compliments has been introduced and collation and reporting will commence at the start of quarter one.

The Trust received four positive comments via NHS Choices during March, one of which was: ***'Very professional and caring service'.***

3.1.4 Ombudsman cases

The Trust has received no new notifications of complaints referred to the Ombudsman for review. There is one case under full review and the Trust currently awaits the outcome and final report.

3.1.5 *Patients Matter* Newsletter

A new *Patients Matter* newsletter has recently been initiated and published (Appendix 3). The newsletter will be published at least 6 monthly and has been distributed across the local area and aims to engage local patients and residents, to give them a taste of patient experience at ASPH and to sign-post ways that patients and carers can give feedback.

3.2 National Inpatient Survey Results 2011

3.2.1 Background

In accordance with national guidance, the Trust has recently completed the 9th mandatory Inpatient Survey. The Care Quality Commission (CQC) administers the survey programme, the results of which provide an important source of data for cross checking against Trust's self-assessment of compliance with the CQC's Essential Standards of Quality and Safety. The surveys are expected to inform local improvement activity and are seen as an important source of information for both users of health services, to help them choose between providers, and for commissioners of service.

On 24 April, the CQC published a nationally benchmarked Trust specific report to allow Trusts, and the population they serve, to make meaningful comparisons between organisations based on the reported experience of surveyed patients.

The survey of adult inpatients involved 161 Acute and Specialist NHS Trusts with responses received from more than 70,000 patients. A sample of 845 inpatients were surveyed from the Trust and patients were eligible if they were aged 16 years or older, had at least one overnight stay in July 2011 and were not admitted to Maternity or Psychiatric units.

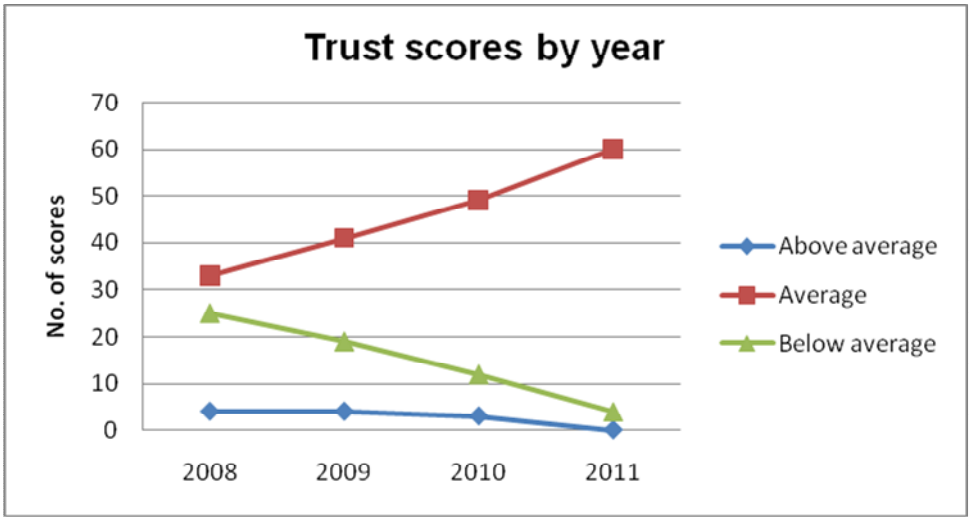
A total of 378 patients responded which equates to a survey response rate of 46% (same as previous year) compared with a national average of 53%. For the Trust, 63% of respondents were aged over 66 years compared with an average of 53% aged over 66 years across all Trusts.

3.2.2 The Results

The Trust is scored on a scale of 0 –100 and results (presented as scores out of 10) indicate whether the Trust is 'better' than most Trusts, 'about the same' as most Trusts or 'worse' than most Trusts. Overall, the CQC report indicates the Trust performance has improved. Out of 64 questions, the Trust was about the same on 60 questions and worse than most Trusts on 4 questions:

1. Noise at night from other patients
2. Patients involved in decisions about their discharge from hospital
3. Explanations around side effects of medications following discharge
4. Wait to be allocated a bed on a ward (the Trust also scored worse than the previous year on this question)

Graph one: Graphical presentation of the spread of Trust Scores by year: 2008 - 2011



The way forward

A presentation of the Trust results will take place on 1 May 2012 following which action planning will commence in preparation for the 2012 Inpatient Survey. Consideration will be given to the three scores which have fallen from above average to average and to problem areas identified. :

Current actions include:

- a business case to implement a “Shared Decision Making” approach has been approved and project design is underway.
- a new discharge booklet and day of discharge summary sheet has been developed and is given to patients on admission.
- Communication with patients, in all forms, is an agreed priority of the 2012/13 Quality Account and a number of measures have been developed to inform improvement activity.

3.3 National Institute for Health and Clinical Excellence (NICE) ‘patient experience standard’

3.3.1 Introduction

NICE quality standards are a set of specific, concise statements and associated measures derived from the best available evidence to address the three dimensions of quality: clinical effectiveness, patient safety and patient experience. NICE clinical guidelines are usually shaped around both clinical and economic evidence, and include recommendations concerned with ensuring a good patient experience.

The NICE patient experience quality standard aims to ensure that patients are given the opportunity to discuss their health beliefs, concerns and preferences in order to individualise their care and that care delivered across services is truly integrated and seamless. An integrated approach to provision of services is fundamental to the delivery of high-quality care to patients.

The guidance promotes person-centred care that takes into account a patient's needs, concerns and preferences.

NICE have also produced quality standards for dementia and end of life care for adults. The Department of Health and National Quality Board have produced a framework to guide measurement of patient experience across the NHS.

3.3.2 Dignity and Care

A draft report has been published by the Commission on Improving Dignity in Care and 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, dementia and end of life care.

3.3.3 NICE Patient Experience Quality Standard and NICE Clinical Guidance

NICE clinical guideline CG138 provides guidance on patient experience, listing 68 recommendations. Many of the recommendations overlap with recommendations from policy documents and codes of professional organisations. The inclusion of these items in quality standards will allow the NHS to be held to account for the delivery of these key areas for patient experience.

It is recognised that some people or groups may have had poor experiences of healthcare and need additional consideration in the delivery of high quality care (e.g. because of their age, disability, race, religion or belief). The specific needs for these groups are not addressed within the guidance and quality standard but the principles may be of use in local strategies to narrow inequalities in patient experience.

Within the quality standard there are 14 quality statements:

1. Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
2. Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.
3. Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
4. Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.
5. Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.
6. Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them.
7. Patients are made aware that they have the right to choose, accept or decline treatment and these decisions are respected and supported.
8. Patients are made aware that they can ask for a second opinion.
9. Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.
10. Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.
11. Patients experience continuity of care delivered, whenever possible, by the same healthcare professional or team throughout a single episode of care.
12. Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.
13. Patients´ preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.
14. Patients are made aware of who to contact, how to contact them and when to make contact about their on-going healthcare needs.

3.3.4 Implications for Ashford and St Peter's Trust

The recommendations from the Commission on Improving Dignity in Care report and the guidance and quality standards produced by NICE have far reaching implications spanning the broad spectrum of services delivered by the Trust. NICE has also produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of these recommendations.

We already have a range of projects underway within the Improving Patient Experience programme including:

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.

Despite these initiatives, further work is needed to perform a gap analysis against the recommendations.

A programme will be designed to deliver the NICE standards but also blend in with existing work streams.

A summary of the NICE Patient Experience Quality Standard has already been discussed with the Council of Governors' Patient Experience Group, and this Group will receive regular reports on progress.

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

3.3 The Best Care Dashboard

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

Table 6.1: Trauma and Orthopaedics

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
T & O	**Nursing Competencies** All of the Band 5 Staff Nurses have their Nursing competencies paperwork but not yet completed.	None of the Band 5 Staff Nurses on all Orthopaedic Ward completed their nursing competencies. The issue affects delivering an efficient and effective patient care.	Matrons/Ward Sister's/Deputy Sister's/CPE working together to monitor and assess Band 5 nurses for completion of their Nursing Competencies.
T & O	**Medication Assessment** Height and Weight not being recorded on the drug charts (All Wards)	Height and weight is a must to be recorded on every patient drug chart for patient's drug calculation reference (Efficiency and Effectivity).	Matron had a meeting with the doctors on 20/03/2012 regarding the issue and monitor progress by the end of April 2012. Matron discussed the issue with the Ward Sister's on their monthly meeting (21/03/2012) and agreed that all nurses have to enter the height and weight on patient's drug chart and the Matron together with the Ward Sister has to monitor the progress by doing a daily spot check.
T & O	**Nursing Documentation** Upward trend – Goal to achieve a 100%	CQC guidance for delivering the best quality of care.(Individualised Care Plan)	Matron and the Ward Sister have to continue a daily spot check, training and staff awareness for a continuous improvement.
T & O	**Nutrition** MUST scoring – (RBWards) has to achieve a 100%	A must for all patients to have a baseline assessment of their nutrition status.	Matron and the Ward Sister have to continue a daily spot check, training and staff awareness. All wards to achieve a 100% by the next monthly audit.

Table 6.2

Area	Achievement	Explanation
T & O	**Patient Observation** Fluid balance chart has improved on all the wards.	Matron daily spot checks Updated training and meeting with the staff (Dickens) – Updated notice board wherein staff are being named

		if assessment is not complete.
T & O	**Skin Integrity** Hourly Care Rounding has improved on Dickens Ward	(Dickens) – Updated notice board wherein staff are being named if assessment is not complete.
T & O	**Communication** Upward trend on all the wards	Patient feedback returns are being monitored weekly.

Table 7.1 Surgery

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Falcon, Heron & SAU	All areas have achieved less than 79% compliance	Heron has not had the support from the ward clerk who has been on long term sick. Falcon has staff vacancies and shifts are not being covered by temporary staff. SAU requires increased compliance from the doctors in completing the risk assessments.	Ward Clerk has now returned to work and is supporting the nursing staff. Vacancies out to recruitment and staff being moved to support the staffing when possible. Nursing staff continue to remind medical staff and enter details onto IPL

Table 7.2

Area	Achievement	Explanation
Kingfisher, Falcon & SAU	All areas have achieved over 95% for documentation	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.

Table 8: Theatres

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Theatres SPH	58% Skin Integrity	Failing to record an operative Waterlow score	Laminated Waterlow charts placed in all theatres on SPH and disseminated through department.
ICU	83% VTE scored	ICU Doctors were recording VTE's on the yellow forms but not recording on IPL as they do not use these lists in ICU.	Admin personnel have now received training to complete IPL lists on VTE's completed.
Theatres SPH	64% Nutrition scored	Hours recorded NBM from wards exceeded 6 hours	No control for theatre staff. Therefore standard has changed to offering liquids and/or mouth care to patients prior to leaving recovery.
DSU/Theatres	Nil by mouth times too long	Orthopaedic booking requesting all	Day Surgery speciality Lead to address with Clinical

Ashford		patients arrive at 0730 for all day lists	Director of Orthopaedics

Table 9.1: Medicine

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Maple/Aspen	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 . Wards have shown significant improvement though further reinforcement required.
Aspen, Birch, Swift, MAU, May, Maple.	Nursing documentation	Pts not signing to show involvement in their plan of care. Old SAP document still in circulation which does not have area for pt to sign.	Ward managers to ensure that patients are fully involved in plan of care and that this is reflected on documentation. Removal of old SAP documentation Matrons to spot check
All medical wards	Medication	Weight and Height required on front of medication charts. Most wards did not record height on front of medication chart as it is recorded in admission documentation	Ward mangers to inform all staff re need height as well as weight on front of medication chart. Matrons to spot check compliance. Ward pharmacists asked to monitor.

Table 9.2

Area	Achievement	Explanation
All medical wards	VTE compliance	All wards have shown a significant improvement in VTE compliance. Due to increased focus from wards and non compliance being flagged weekly.

Table 10.1: 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
Oak ward	Skin integrity	Not on Day Surgery ICP	Not recorded as has not been included in the Day

	Nutrition Nursing Documentation??	Not on Day Surgery ICP Do not understand score ICP being used	Surgery ICP. ICP currently being trialled. Will be included in ICP following trial review. Oversight in development. ICP still in development. ICP is CQC compliant and is a path of care for children undergoing day case surgery. Do not feel that the auditor understood document.
Ash Ward	Skin Integrity VTE Falls and Manual Handling Assessment Nutrition	Nowhere on admission paper work to record. Not applicable to children. Not applicable to children No dedicated paediatric nutrition tool	New document in development Child Assessment Process in the interim recorded on the nursing evaluation. Nutrition assessed and recorded on admission sheet.

Table 10.2

Area	Achievement	Explanation
NICU	Amber green on all measures	Significant improvement across all outcomes

Table 11.1: Women's Health

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Joan Booker	Communication scored 92%	Co-ordinating care plans maintained by named midwife: Care plans require timely updating in relation to Breast feeding and baby care.	Local Spot check audits already in place and have demonstrated improvement in care plans. These Spot check audits will be refocused over the next quarter to drive improvement in specific areas of underperformance noted. Staff meetings to highlight this aspect of care.

Table 11.2

Area	Achievement	Explanation
Joan Booker	Completion of full MOEWs scores has improved	Spot Check Audits and highlighted to staff in practice.

Appendix 1

Quality Account Dashboard Definitions

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

1. Patient Satisfaction (Net Promoter Score (NPS)
   Internal measure at Trust level provided from continuous "Your Feedback" survey of adult inpatients. The NPS is a measure of patient loyalty, patients are asked: "Would you recommend the Trust to family and friends?" and asked to give a score between 0 and 10.

   Respondents are classified as:

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

   NPS = % of Promoters – % of Detractors

2. National Patient Survey
   Results relating to discharge from the annual, national survey of July inpatients available March 2012.
3. Discharge Related Complaints
   The number of complaints received by the Trust that relate to discharge issues and practice
   Number of complaints received during the month relating to patient discharge.

Priority 2 – To provide high quality experience relating to nutrition and hydration
Essence of Care Nutritional Audit (quarterly) – Measures refer to 2010/11 are under revision

1. Ward environmental results
   Results from the observation of the ward environment relating to patient care for nutrition and hydration.

2. OCS service
   OCS is the external contractor providing a professional staff and patient meal service to the Trust

3. Service to patients – patient survey of mealtimes

4. Patients nutritionally at risk
   Patients at risk are identified by the red tray system and appropriate support is provided to patients at mealtimes

Priority 3 – To provide confidence and reassurance for patients on infection control and other preventable infections

1. Prevention of peripheral acquired infections
   Prevention of central line acquired infections
   % patients without evidence of infection

2. Hand hygiene
   Audits of members of staff cleaning/decontaminating their hands between procedures.

3. C.Diff (hospital acquired)
   Number of C.Diff cases (Hospital post 72 hours): Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.

4. MRSA Bacteraemia (hospital acquired)
   Number of MRSA bacteraemia isolated in a blood culture therefore present in the patient's blood stream

Priority 4 – To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators

1. Total Falls
   Total number of falls

2. Falls – resulting in harm (grade 3 or above)
   Number of falls resulting in serious harm to the patient

3. Prevention of Pressure ulcers (hospital acquired grade 2 and above)
   Number of pressure ulcers acquired in hospital of grade 2 and above

Priority 5 – To reduce the hospital emergency and elective readmission rate

1. Readmission in 28 days – Elective
   Reduction in readmissions following an elective procedure within 28 days of discharge

2. Readmission in 28 days – Emergency
   Reduction in readmissions following an emergency admission within 28 days of discharge

Priority 6 – To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure

1. SMR for Heart Failure
2. SMR for Pneumonia

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

Priority 7 – To improve the experience and clinical outcomes for those with long term conditions

Admission rate for Chronic Obstructive Pulmonary Disease (COPD)
Reduction to the rates of attendance and subsequent admission for patients with COPD.

APPENDIX 2 Quality Account Dashboard 2011 – 2012

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD 11/12	Trend	YTD 11/12 Plan	Actual v Plan	Annual 11/12 Plan	10/11 Outturn	11/12 Outturn
Improving our Patient Experience																			
Priority 1 - To provide safe, high quality discharge for patients																			
Patient Satisfaction (NetPromoter Score)	61.0%	57.0%	60.0%	50.0%	51.0%	54.0%	57.0%	57.0%	63.0%	59.0%	58.0%	55.0%	57.0%	⟷	*70.0%*	-13.0%	70.0%	-	57.0%
National Patient Survey>Avg responses	Annual																		
Discharge Related Complaints	3	8	4	0	5	7	12	4	9	10	12	8	82	↓	*61*	34.4%	61	87	82
Priority 2 - To provide high quality experience relating to nutrition and hydration																			
Essence of Care Nutrational Audit: Quarterly																			
1. Ward Environment results													N/A					67.5%	N/A
2. OCS service													N/A					82.2%	N/A
3. Service to Patients													88.0%					64.8%	88.0%
4. Patients nutritionally at risk													82.4%					57.0%	82.4%
Maintaining High Safety Standards																			
Priority 3 - To provide confidence and reassurance for patients on infection control and other preventable infections																			
Prevention of peripheral acquired infections	100.0%	97.2%	97.3%	97.0%	96.6%	98.0%	100.0%	98.0%	98.0%	96.0%	97.0%	96.9%	97.7%	⟷	*95.0%*	2.7%	95.0%	-	97.7%
Prevention of central line acquired infections	97.2%	97.8%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	99.0%	99.0%	99.4%	99.2%	⟷	*95.0%*	4.2%	95.0%	-	99.2%
Hand hygiene	98.7%	98.6%	99.0%	99.0%	97.1%	99.0%	97.2%	98.0%	99.0%	97.0%	97.0%	97.0%	98.0%	⟷	*90.0%*	8.0%	90.0%	-	98.0%
C.Diff (hospital acquired)	2	6	0	1	2	1	2	1	1	1	0	2	19	⟷	*30*	-37%	33	36	19
MRSA Bacteraemia (hospital acquired)	0	0	0	0	1	1	0	0	0	0	0	0	2	⟷	*4*	-50%	4	5	2
Priority 4 - To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators																			
Total Falls	67	75	59	49	50	52	65	56	47	62	47	69	698	⟷	*748*	-7%	748	831	698
Falls - resulting in harm (grade 3 or above)	0	0	0	2	2	1	1	0	1	0	3	6	16	↓	*15*	7%	15	17	16
Prevention of Pressure Ulcers (hospital acquired stage 2 above)	14	4	5	8	15	8	5	14	8	16	6	10	113	↓	*103*	10%	103	113	113
Achieving High Quality Clinical Care																			
Priority 5 - To reduce the hospital emergency and elective readmission rate																			
Readmission in 28 days - Elective	60	71	55	56	74	64	72	73	61	79	67	61	793	↓	*492*	61.2%	492	984	793
Readmission in 28 days - Emergency	290	294	278	243	257	260	223	215	197	276	198	191	2922	↓	*3134*	-6.8%	3134	3687	2922
Priority 6 - To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure																			
SMR for Heart Failure	0.087%	0.066%	0.032%	0.100%	0.034%	0.066%	0.067%	0.047%	0.059%	0.049%	0.067%	0.000%	0.065%	⟷	*0.048%*	0.017%	0.048%	0.050%	0.065%
SMR for Pneumonia	0.398%	0.279%	0.223%	0.383%	0.290%	0.264%	0.267%	0.332%	0.195%	0.414%	0.218%	0.432%	0.347%	⟷	*0.316%*	0.031%	0.316%	0.320%	0.347%
Priority 7 - To improve the experience and clinical outcomes for those with long term conditions																			
Admission Rate for Chronic Obstructive Pulmonary Disease (COPD)	0.78%	0.92%	0.67%	0.95%	0.63%	0.66%	0.48%	0.52%	0.83%	0.74%	0.45%	0.48%	0.70%	⟷	*0.78%*	-0.08%	0.78%	0.8%	0.70%

Target achieved		Improvement from last Quarter	↑
Underachieving Target		In Line with Last Quarter	⟷
Target not achieved		Deterioration from last Quarter	↓

APPENDIX 3 Patients Matter Newsletter

Spring 2012

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

Patients Matter

Welcome ...

to our first edition of Patients Matter.

At Ashford and St Peter's we want to do the very best we can for our patients, every single day.

As Chief Nurse it's my responsibility to make sure the care we give is the best it can be and, through this regular newsletter, I want to keep local people updated on how we are doing and, importantly, how you can help us to improve.

By listening to what you tell us about you or your loved one's experience in our hospitals we can keep improving and, importantly, learn if things do go wrong. We really want to encourage patients to 'tell us how it is' and to foster a culture of openness. We take all your comments seriously, good or otherwise and I frequently meet with individual patients to hear about their experiences directly.

Suzanne Rankin
Chief Nurse

"Everything was outstanding"

Geredine Smalling is no stranger to St Peter's after her mother, Joyce Smalling, fell over in the garden five years ago and damaged her arm. Geredine said: "Mum's arm got increasingly bad, so last year she went to see Orthopaedic surgeon Mr Kalil, who was very kind and explained all the options. Mum then had her operation in September."

Unfortunately, after Joyce went home, she developed an infection and had to return to the Emergency Department. Geredine said: "We have now spent time in lots of different areas of the hospital – A&E, the Day Surgery Unit and Rowley Bristow and I can honestly say that everything has been outstanding."

"Everyone has been so helpful - the receptionists, nurses and doctors seem to go out of their way to help you."

Recently, Joyce went back to have the frame removed. Geredine said: "Once the doctor agreed it could come off, Mum had an appointment within a few days and a nurse even called the day after the operation to make sure everything was OK."

"The caring attitude of the staff made a huge difference – they really made my Mum comfortable and helped her to get better quicker."

NHS choices

Would you like to tell others about your hospital experience, good or otherwise? It's really easy to do - simply log onto www.nhs.uk and search for either of our hospitals to leave your feedback.

Current numbers recommending our hospitals via NHS Choices are:

Ashford - 100% (7 out of 7 people)
St Peter's - 84% (41 out of 49 people)

Data collated on 2nd April 2012

Ward Manager Gail Roberts with a patient on Aspen Ward

CATEGORY
FINALIST

We were recently National Finalists in the **Patient Experience Network National Awards** for our *Living our Values* programme. Aimed at every single member of our staff, sessions use real patient feedback to encourage staff to think about how their individual actions impact on a patient's experience.

In subsequent feedback the judges described the entry as a 'fantastic and innovative project'.

PEN

APPENDIX 4

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