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

TRUST BOARD
26th July 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for June 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:	Review the paper; discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr David Fluck, Medical Director & Suzanne Rankin, Chief Nurse
Date:	20th July 2012
Decision:	For Noting

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indictor Definitions

Table 1 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.

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 1: Quality Performance Dashboard

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

	Patient Safety & Quality	Annual Target 12/13	Annual Forecast 12/13	Jun 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	90.2	-	▼	▲	100
1-03	Crude mortality (Excluding readmissions)	1.6	-	1.83%	-	▲	▼	1.72%
1-04	Mortality UTI as Primary Diagnosis (SHMI)***	<100	TBC	131.6%	-	◄►	◄►	131.6%
1-05	Mortality from Hip fractures (SHMI)***	<90	-	77.8	-	◄►	◄►	77.8
1-06	MRSA (Hospital only)	1		0	-	▲	◄►	1
1-07	C.Diff (Hospital only)	20		0	-	◄►	▲	6
1-08	Stroke Patients (90% of stay on Stroke Unit)	80.0%	80.0%	84.9%	-	▲	▼	86.7%
1-09	VTE (hospital acquired with PE or DVT)	14	-	1	-	▲	▼	3
1-10	Serious Incidents Requiring Investigation (SIRI)	50	-	5	-	▲	▼	18
1-11	SIRI Grade 2 (proportion of total SIRI)	0.0%	-	0.0%	-	▲	◄►	17%
1-12	Falls (Total Number)	462	-	53	-	▼	▲	191
1-13	Falls - resulting in significant injury (grade 3)	<15	TBC	2	-	◄►	▲	2
1-14	Average Bed Occupancy (inc escalation)	92.0%	TBC	88.0%	-	▼	▲	89.0%
1-15	Patient Moves (ward changes >=3)	<5%	5.0%	7.4%	-	▼	▲	8.0%
1-16	Patient Satisfaction (NetPromoter Score)	65%	-	63%	-	▲	◄►	61%
1-17	Formal complaints (Total Number)	<500	-	37	-	▼	▲	115
1-18	Formal complaints (rate per discharge - IP only)	10% reduction	-	0.66%	-	▼	▼	0.63%

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

As with the previous month the Trust's underlying internal objectives for 2012/13 remain as:

- Ensure the emergency pathway is improved to ensure good patient experience and outcomes
- Ensure the financial plan is met.

In June the Trust met both these core objectives with the emergency access target being 96.8% and a larger than planned surplus being delivered, which brings the Trust back to budget year to date.

The HSMR[1]has declined to 90.2, which is good performance, but the current interventions which have supported this improvement will continue. This includes the weekly clinical effectiveness meetings which began last month. Crude mortality is higher than the Target and this is to be focused on by the Medical Director, with a particular emphasis on deaths following a UTI[2].

During June the rate of complaints increased to 0.66% from 0.55% in May, though the Trust continues to remains below the target number YTD[3]. Detailed analysis across each ward and speciality continues with specific objectives being undertaken to reduce complaints.

With no cases of C-diff in June our total year to date remains at six, which is slightly above plan. The forecast for the year end is still that the Trust will achieve the target. The falls in June that resulted in injury to the patient are being investigated.

[1]Hospital Standardised Mortality Rate.
[2]Urinary Tract Infection.
[3] Year to date.

The Trust should achieve all its Q1 CQUIN[4] objectives, though validation work continues around the VTE target. The Trust was required to submit a report on the 13th July to receive Q1 payments which it achieved. The scorecard has maintained the prudent assessment of 75% achievement of all CQUINs for the year as the significant elements of the CQUIN programme are to be delivered from Q2 onwards.

1.3 The Quality Account 2012/13

The Quality Account Dashboard (Appendix 3) provides a visual high level summary of the Trust's performance against the quality priorities set for the current year 2012/13 in our Quality Account 2011/12[5]. The indicators were chosen in collaboration with stakeholders and reflect areas where the Trust is focusing to improve the quality of patient care. The dashboard also contains data to monitor previous priorities from 2011/12.

Results for quarter one indicate that we are on target for:

- Discharge related complaints
- Hospital acquired PE[6] or DVT[7]
- MRSA[8] and C.Difficile
- Falls resulting in harm
- Prevention of pressure ulcers
- Admission rate for Chronic Obstructive Pulmonary Disease (COPD).

Indicators where we are not meeting targets are:

- % Patients discharged by 12.00 noon
- Response rates for numbers of patients completing our local inpatient survey, "Your Feedback" – each ward has been set a target for number of surveys completed
- Outpatient appointment letter templates revised (by Specialty)
- Completion of risk assessments for VTE[9] has not met the 90% target, however, we are reducing the number of patients acquiring PE or DVT whilst in hospital
- Total number of patient falls, however, we are managing to keep serious falls resulting in harm low

Actions and Comments
Leads are being assigned for each priority and meetings are underway to review progress and implement action plans.

For readmissions, actions include Specialty leads reviewing their readmissions and examining the variation in readmission rates of individual surgeons[10].

Although we are not achieving our target reduction in total number of patient falls we are seeing a reduction (191 falls) compared to the same period last year (201 falls).

A Quality Account Mid-Year Workshop with our stakeholders is planned for Monday 22 October.

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[4] Commissioning for Quality and Innovation.
[5] Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement. http://www.ashfordstpeters.nhs.uk/quality/quality-accounts
[6] Pulmonary embolus;
[7] Deep vein thrombosis
[8] Methicillin resistant staphylococcus aureus
[9] Venous thromboembolism
[10] http://www.institute.nhs.uk/scenariogenerator/tools/reduce_readmissions.html

2.1 Enhancing Quality Programme (part of CQUIN Programme)

The Enhancing Quality (EQ) Programme is part of a Kent, Surrey and Sussex programme involving all the acute trusts of the SEC[11]. Clinical leaders collaboratively set out what the best care measures are for specific conditions; these 5 or 6 measures per pathway are implemented within each trust and monitored monthly. Results of the achievement against each measure are loaded into a regional database. Results show the achievement of each trust against each of the measures providing us with ASPH attainment and enables benchmarking across all organisations in the SEC. Each trust has agreed improvements to achieve each year to secure CQUIN payments, whilst improving clinical outcomes for patients.

ASPH is a full participant in the EQ Programme with 5 pathways running (Acute MI[12], Pneumonia, Heart Failure, Dementia, Hip and Knee replacements), plus is the Lead Trust for a new pathway for Acute Kidney Injury (AKI) being developed across the SEC for implementation later in the year.

Please see Appendix 4 for the monthly achievement for each measure in each pathway since the start of the programme in 2010/11. The blue line is the Composite Quality Score (the % of achievement against the measures within each condition pathway), and the maroon line is the Appropriate Care Score (the % of patients each month who had all of the measures for that pathway achieved for them).

Summary of results to date:

- Acute MI has been a high performer from the early days in 2012, but ASPH has shown an improvement with near perfect attainment of the AMI measures by the end of 2011. This pathway is no longer a CQUIN condition, as all trusts across the SEC have achieved highly, showing gross improvements to AMI care across the region.
- The heart failure (HF) pathway has shown steady improvements during 2011 from its relatively low scores at the start of the programme. Of particular note, at the end of 2011 over 40% of patients had all the HF measures achieved for them (ACS), which was an improvement of more than 30% since the start of the programme. The clinical measures are achieved to a high level, but ASPH has had an issue with recording that information is given to patients on discharge and smoking cessation advice is offered. However, work has occurred to improve on this, and the early results in 2012 show steady and marked improvements.
- The Hip and Knee surgery pathway also shows a steady improvement in measure achievement over the year, and recent work within the orthopaedic team regarding VTE and antibiotic prophylaxis timing will improve this still further, so ASPH can maintain above 95% on the measures going forwards.
- Pneumonia has 2 pathway results; one where a CURB score is recorded (CURB = a risk score of mortality used for patients with pneumonias) and one where there is no CURB score recorded. Both Pneumonia pathways have again shown steady improvements in the achievement of the clinical measures during 2011 and are maintaining scores above 85%. More work is taking place regarding awareness education in the A/E setting for appropriate antibiotic use that will improve scores still further.

Table 3 shows the monthly cumulative Composite Quality Score (CQS) for each pathway, which is the cumulative % achievement of all the measures each month as the year unfolds, for 2012.

NB: EQ data runs behind by 4 months, so in July we can only give the January and February results for the year, as the March database has not yet closed for the SEC.

[11] South East Coast region
[12] Acute Myocardial Infarction

Table 3 EQ Programme results per month against target

Pathway	Jan-Dec 2011 score	Jan-12	Feb-12
Acute MI	**97.44%**	**Awaiting EQ Data**[13]	**Awaiting EQ Data**
Dementia Antipsychotic	**24.58%**	**22.73%**	**17.50%**
Heart Failure *(target 69.16% for CQUIN full payment)*	**56.37%**	**71.01%**	**73.28%**
Hip & Knee *(target 94.16% for CQUIN full payment)*	**91.16%**	**96.46%**	**96.78%**
Pneumonia (CURB) *(target 83.02% for CQUIN full payment)*	**81.46%**	**89.81%**	**89.32%**
Pneumonia (No CURB) *(target 92.88% for CQUIN full payment)*	**89.88%**	**95.53%**	**94.43%**

For the dementia pathway there are issues with GPs not being asked to review medications for patients who are on Antipsychotic Drugs, within 3 months of discharge. However the discharge template for all patients has now been updated to include this, so we expect this to improve from July onwards.

3. Safety Update

3.1 National Patient Safety Agency (NPSA) Safety Alerts

There have been no new alerts reported by the NPSA since the last board meeting in June 2012. There are four ongoing 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:

Table 4

Description	Deadline	Lead
Minimizing risks of mismatching spinal, epidural and regional devices with incompatible	02-Apr-12	Divisional Director Michael Imrie
STATUS		
This NPSA Alert requires that all NHS healthcare organisations ensure that from 1 April 2012 all spinal (intrathecal) bolus doses and lumbar puncture samples are performed using syringes, needles and other devices with connectors that cannot connect with intravenous Luer connectors. Currently many Trusts including Ashford and St Peters are non-compliant with this alert because of concerns surrounding the multiplicity of devices and the lack of any coordinated safety testing. A joint statement by the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists came to the following conclusions:		

[13]NB: Acute MI data is entered into MINAP for the Trust, and the SEC EQ Programme extracts the AMI data from MINAP; this extraction has not yet been completed by the SEC EQ Programme, hence AMI data not yet available

1. *The elected Councils of our specialty membership organisations and our patient liaison representatives believe that the current process of introducing new spinal needles and connectors into the NHS without published independent evaluation in the clinical setting may increase risks to patients undergoing spinal anaesthesia.*

2. *Centralised or other published independent testing would remove the difficulties with this process, but is not planned in England because of concerns about competition law. Data from the national assessment in Wales will become available in 2012 and would be useful to guide clinicians in England in their adoption of new needles and connectors.*

3. *If departments in England wish to test new connectors in accordance with NPSA recommendations, this should be done in a robust and organised way with results being published so that information is available to the whole NHS. We do not believe that informal assessment by a few individuals trying out a few needles is of benefit to patients or the NHS.*

4. *We remain of the view that a single, satisfactory, tested design of neuraxial and regional anaesthesia connector should be introduced into the UK NHS and private healthcare. The specialty has always supported this. We recognise the major investment by manufacturers but we question whether there is any overall benefit for patients in the NHS if spinal anaesthesia is performed with multiple, non-standard connectors.*

5. *We recognise the need to complete the work to improve the safety of intrathecal chemotherapy injections, but in anaesthesia the risk of infusion/injection of fatal doses of local anaesthetics intravenously is greater.*

6. *We recommend that decisions about spinal, epidural and regional anaesthesia connectors are made at the same time in a co-ordinated manner after formal independent clinical testing in patients.*

The independent assessment process in Wales has been abandoned as manufacturers were unable to supply the required range and numbers of devices for testing. Other centers are undertaking similar though smaller scale assessments (Bristol and Leicester).

Non- compliance with the alert cannot be maintained indefinitely waiting for these assessments and therefore a suggestion would be the Trust undertakes the following;

1. Establish a User Group to oversee the testing of the devices and implementation of the NPSA Alert
2. Document non- compliance and monitor progress via the Risk Register
3. Carefully monitored in-house testing of the main devices.
4. Close liaison with neighbouring Trusts and Epsom (also non -compliant) with the aim to adopt a single local solution.
5. Aim to introduce a single Spinal and Epidural Solution prior to the Alert Part 2 deadline of April 2013.

3.2 NHS Safety Thermometer (National CQUIN)

The Safety Thermometer[14] programme of work aims to achieve significant reductions in four types of avoidable harm from which patients are at most risk during episodes of healthcare:

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

An increase in our submission rate is seen during the three months of quarter one (Table 5).

Table 5

Submission	April	May	June
Patient sample size	434	497	526
Beds occupied	492	507	TBC
% Submission	88.2%	98%	TBC

Table 6 shows the rate of patients receiving harm-free care at Ashford and St Peter's Hospitals compared to the national average per month.

Table 6

Harm-free Care	April	May	June
National average – harm-free care	89.47%	90.05%	TBC
ASPH harm-free care	88.71%	89.94%	86.12%
ASPH patients with no new harms	93.09%	95.57%	93.92%

Detailed results are available for all areas and actions are underway to reduce avoidable harm to our patients. We have instigated the mechanism of raising an incident form to report when a patient has two or more new harms and treating a patient with four hospital acquired harms as a Serious Incident Requiring Investigation (SIRI).

Results for each ward for 'harm-free care' and 'new harms' (hospital acquired) are presented in the Best Care dashboard (Appendix 6). For the month of June we had one patient with two new harms on Maple ward and a review of nursing care is underway.

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

4. Patient Experience

4.1 Complaints/Ombudsman reports

There were 37 complaints received in June compared with 45 in May and 39 in April. Chart one shows a breakdown of complaints received by month (Series 1), monthly target (Series 2) and overall trend line (red).

Chart one

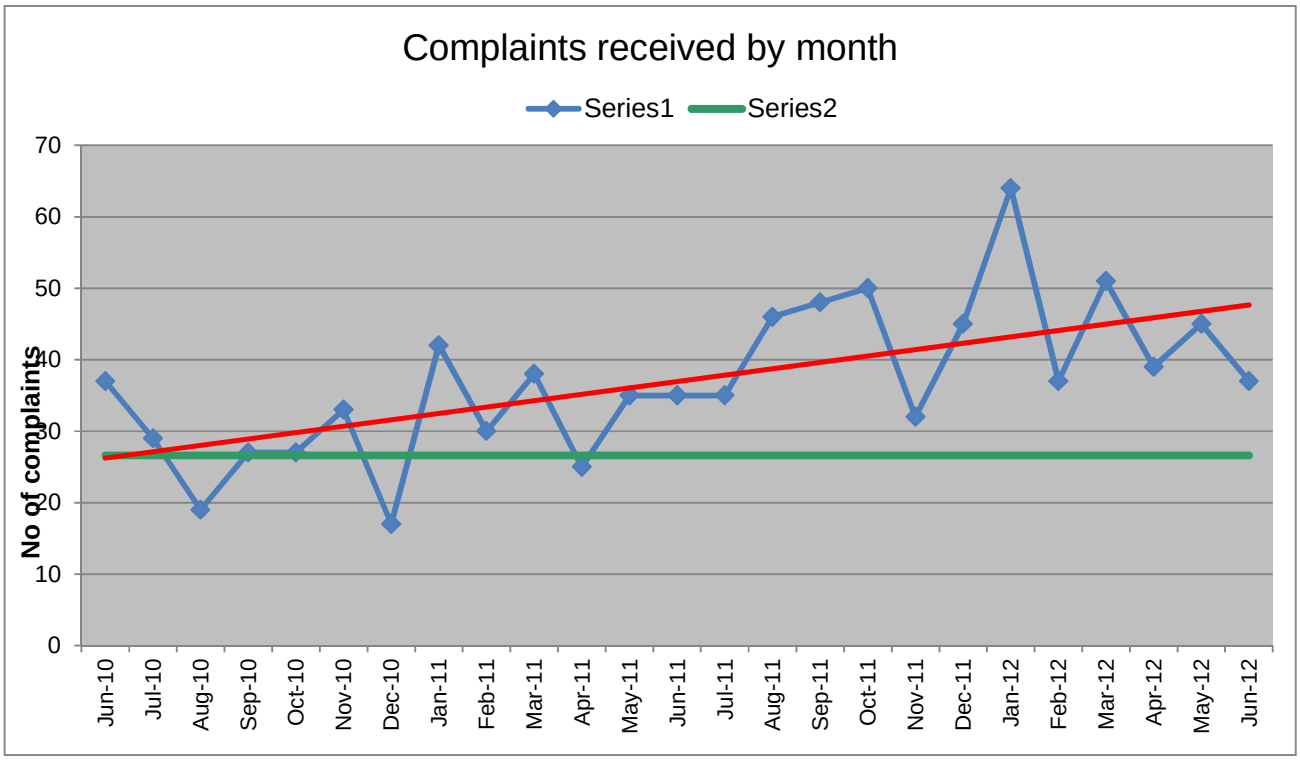


Chart two shows a breakdown of complaints by service area and demonstrates a decrease in the proportion of complaints relating to inpatient care.

Chart two

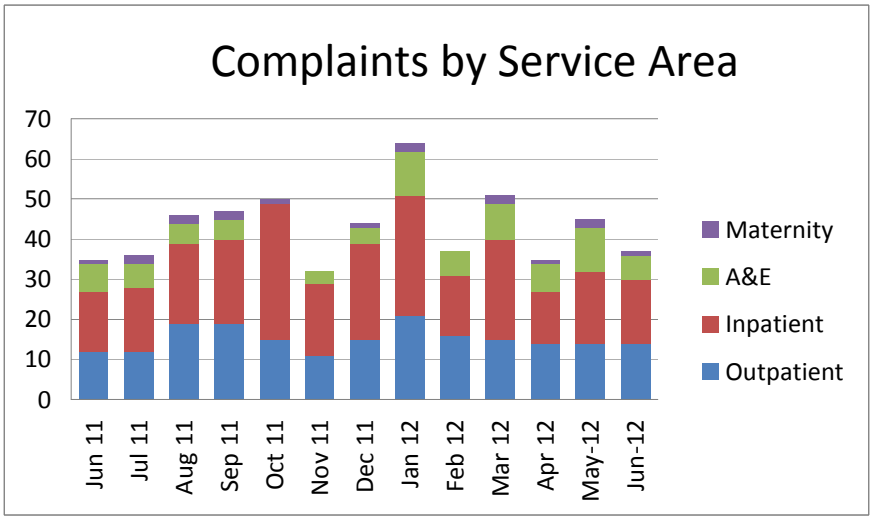
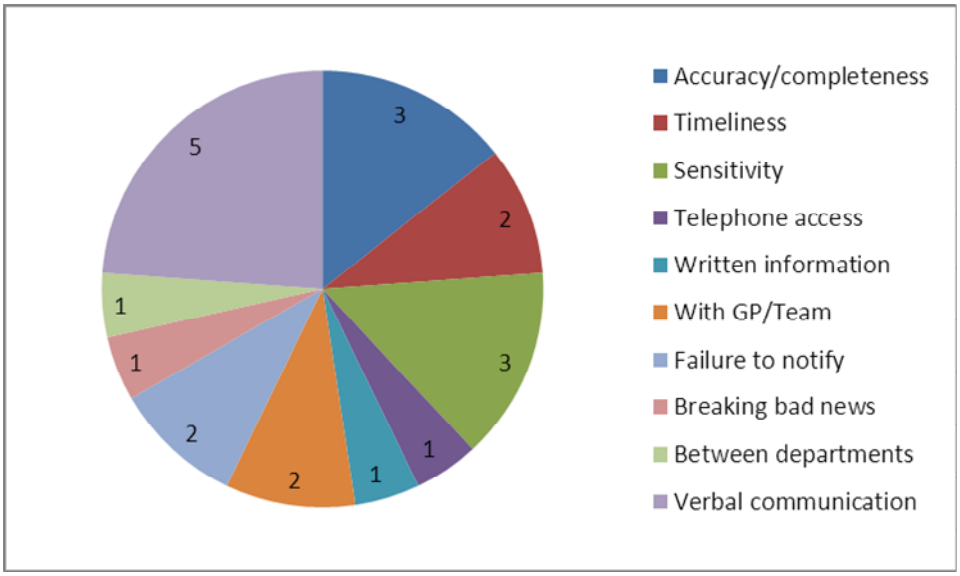


Chart three shows a breakdown of the 16 complaints where issues about communication were raised; of the 21 issues raised 24% relate to verbal communication.

Chart three



Of the 112 contacts to PALS; 86 related to informal concerns, of these 9 went onto become formal complaints which demonstrates a conversion rate of 10% compared with 2.7% in April. This is a significant alteration in PALs performance against a consistent backdrop of recent months of less than 3% per month, and will be monitored carefully.

Complaints Performance

There were 41 formal complaint responses due in June, of these, 33 responses were sent within the agreed timescale. This equates to a monthly performance of 80% within agreed timescales for response in comparison to 56% performance in May and 74% in April.

At the end of the reporting period there were five complaints overdue for response by the Trust, two of these relate to Trauma & Orthopaedics and two relate to Acute Medicine and Emergency Services; Anaesthetics, Critical Care & Theatres and Specialist Medicine & Specialist Surgery Divisions each have one overdue response.

Ombudsman Cases

No new notifications for referral to the Ombudsman were received. One case previously referred which related to Maternity care in 2003 has been closed following initial assessment and will not proceed to full review. There is no further action for the Trust.

Internal Audit

An Internal Audit is currently underway to assess whether the Trust is a learning organisation from complaints and compliance against complaints policy and guidance. The findings will be reported to September Board.

Patient Experience Dashboard

Appendix 5 provides an overview of patient feedback across the Trust for the reporting period and shows an overall reduction in PALS concerns and formal complaints. The dashboard also shows that in Surgery performance in responding to formal complaints within agreed timescales improved from 50% in May to 100%; in Acute and Emergency Medicine performance improved from 37% in May to 71%.

Net Promoter Score (NPS)

The Trust NPS (for inpatients) remained at 63% during the reporting period. The dashboard shows an overall Trust NPS of 63%; despite the NPS of 79% reported by Trauma & Orthopaedics and the

76% by Outpatient Department (SMSS), the overall position is impacted by the comparatively low NPS of 45% in Women's Health and Paediatrics. Orthopaedics again saw the greatest increase in NPS during the reporting period.

Comments on the measures reported in the Patient Experience dashboard (Appendix 5) are welcomed in advance of the planned technological solution, that will enable electronic patient experience reporting in real time..

Compliments

The Trust received 22 formal (written) compliments during June, of these four related to Ophthalmology Services. All formal compliments received in the Chief Executive/Chief Nurse's office are responded to personally in writing.

Three recommendations were made on NHS Choices and four positive comments were posted on Patient Opinion.

"I cannot fault the care, treatment, surgeons skill, anaesthetist and theatre team skills and standard of accommodation & food during my stay. Everyone gave me respect, consideration and the best possible care. I am very grateful.

*I also witnessed very great kindness and compassion in the care of an elderly frail patient in my 4 bedded ward" .*Comment regarding the Uro-gynaecology Service on Patient Opinion.

"In my own particular case it would be impossible to improve on the service provided". Comment regarding Cardiology Services on NHS Choices.

4.2 Best Care Review

The monthly Best Care Audits form a detailed programme to review the quality of patient care focusing on a number of key nursing measures selected in conjunction with CQC standards, Essence of Care[15] and Trust policy. A summarised dashboard is presented to the Trust Board on a monthly basis (see Appendix 6 for June results) and this report includes actions and achievements per division (Appendix 7).

Each ward and area receives their detailed results and charts showing trends in their performance. A poster is presented to the Board showing an example of the feedback provided to areas.

Conclusions:

Results for individual wards are not statistically robust due to small sample sizes. The value of the audits lies with the immediate face-to-face feedback provided to staff during the audit and debrief of findings to the ward manager and the Matron for the area. Ward teams have the opportunity to reflect on the care that they provide which drives improvements in behaviour and nursing practice.

A workshop was held on 26 June to review the audit tool and process. Actions include:

- Clear definitions of standards to reflect national guidance and Trust policies
- Design of explicit measures to reduce individual interpretation
- New section to capture actions in response to audit findings.
- Pilot of revised tool in August

Further work is planned to strengthen the impact of the audits with the intention that ward managers will provide self-certification by signing to confirm that their area is following Trust standards.

[15] Essence of Care is guidance issued by the Department of Health to enable localised quality improvement. A set of 12 benchmarks are provided (including continence, communication, personal hygiene, food and drink) to support front line care across care settings at a local level.
The benchmarking process outlined in Essence of Care 2010 helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.

5. APPENDIX 1

Quality Account Dashboard Definitions

Patient Experience

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

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

Priority 2: To improve all aspects of communication with patients

3. Response rates for patients completing "Your Feedback" surveys
4. Revision of the outpatient appointment letter templates for 18 specialties.
5. Six monthly Essence of Care communication audit
6. Six monthly audit of the quality of discharge letters against national standards.
7. % patients who know how to access PALS (Patient Advice & Liaison Service) / make a formal complaint; this is an annual target
8. Annual target for shared decision-making against CQC benchmarked results

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

Six monthly Essence of Care audit:

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

Maintaining High Safety Standards

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

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

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

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

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

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

Clinical Effectiveness

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

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

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

20. SMR for Heart Failure
21. SMR for Pneumonia

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

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

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

5. APPENDIX 2

Best Care Dashboard Definitions

1. Patient Observations
   Documentation of patient observations includes: MEWS(Modified Early Warning Score), 24h cumulative fluid balance, pain assessment on admission and referral /escalation for "at risk" patients.
2. Cardiac arrest calls
   This is being considered as an outcome measure related to the process of patient observations since calls to the resuscitation team would not be expected if observations are being undertaken at the appropriate frequency and escalation of the deteriorating patient is happening according to Trust policy.
3. Hand Hygiene Compliance
   Audits of members of staff cleaning/decontaminating their hands between procedures.
4. 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.
5. 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.
6. VTE (Venous Thromboembolism)
   Patient has been risk assessed for development of VTE (Deep vein thrombosis, pulmonary embolism
7. 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.
8. 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.
9. 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.
10. Medication Assessment
    Documentation is legible and completed appropriately, omission codes are utilized and allergies identified.

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

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

13. 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.

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

15. Discharge and Nurse Facilitated Discharge
    To be defined

16. 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).

17. 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"

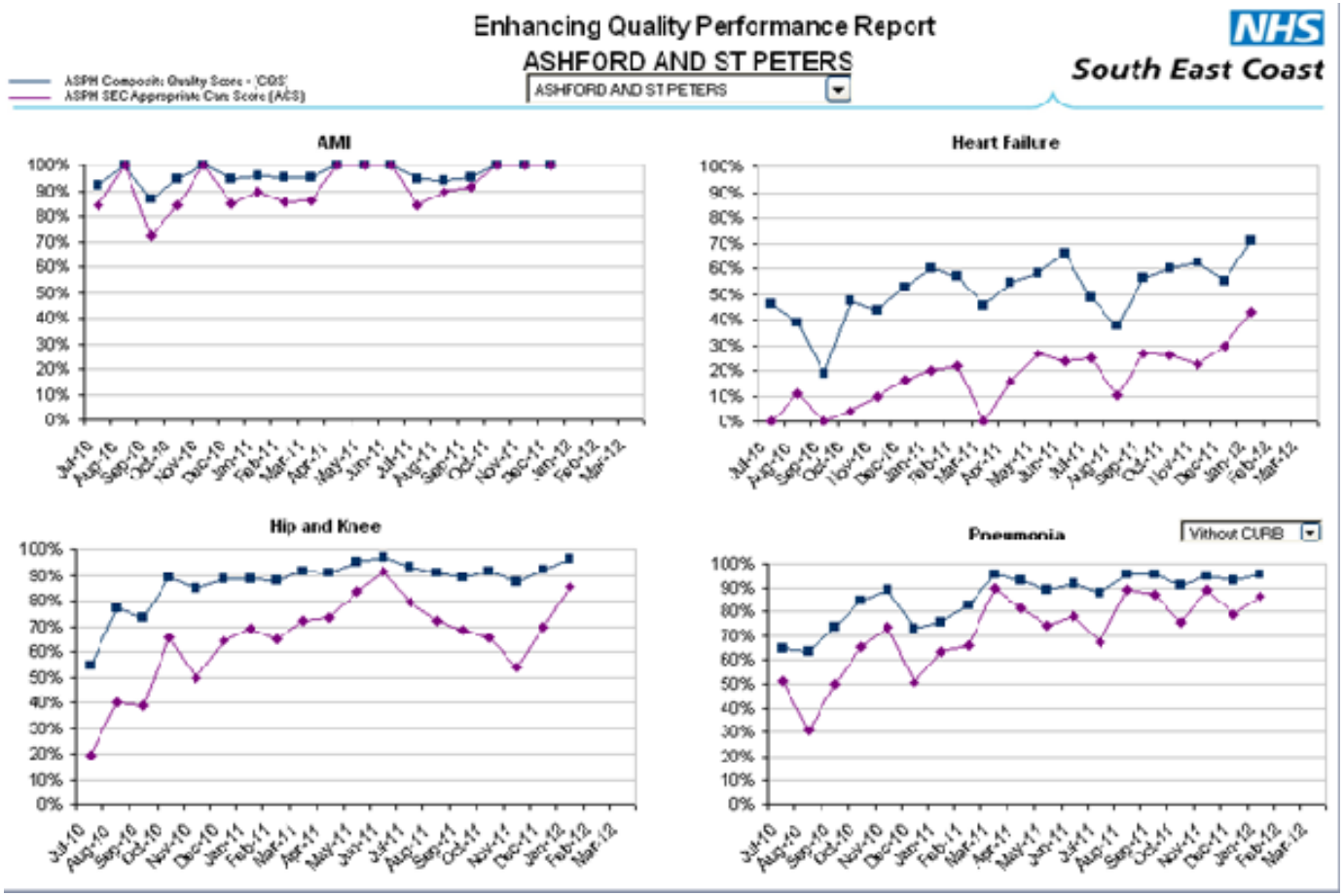
    NPS = % of Promoters – % of Detractors

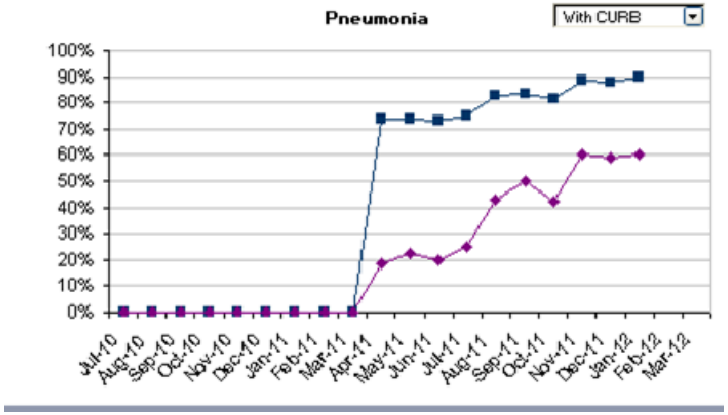
18. Number of Ward Transfers
Number of patients transferred to another ward.

Appendix 3 Quality Account Dashboard: April – June 2012

QUALITY ACCOUNT								
		Apr-12	May-12	Jun-12	Year to Date 2012/13	Trend	Target YTD	Actual YTD vs Plan YTD
Improving our Patient Experience								
Priority 1 - To provide safe, high quality discharge for patients								
	Patients Discharged by 12:00 noon (%)	14.5%	13.8%	14.6%	14.3%		25.0%	-10.7%
	Discharge Related Complaints	4	4	5	13		18	-5
Priority 2011/12 - To provide high quality experience relating to nutrition and hydration								
	Essence of Care - Service to patients (6 mth)				N/A	-	-	-
	Essence of Care - Patients nutritionally at risk (6 mth)				N/A	-	-	-
Priority 2 - To improve all aspects of communication with patients								
	% Response against target no. of "Your Feedback" completed surveys	47%	70%	47%	55%		100%	-45.0%
	Outpatient appointment letter templates revised			3*	3		5	-2
	Essence of Care Communication Audit (6 mth)				N/A	-	-	-
	Audit of Discharge Letters (6 mth)				N/A	-	-	-
	Patients knowing how to access PALS (annual)				N/A	-	60%	-
	Shared decision-making (annual)				N/A	-	6.9	-
Maintaining High Safety Standards								
Priority 3 - To provide effective risk assessment and prophylaxis VTE								
	Risk Assessment for VTE (%)	90.91%	90.07%	85.52%	88.78%		90.00%	-1.2%
	Hospital acquired VTE (hospital acquired with PE or DVT)	2	0	1	3		4	-1
Priority 2011/12 - To provide confidence and assurance on infection control								
	C.Diff (Hospital acquired)	3	3	0	6		5	1
	MRSA Bacteraemia (Hospital acquired)	1	0	0	1		1	0
Priority 2011/12 - To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators								
	Total Falls	70	68	53	191		116	76
	Falls - resulting in harm (grade 3 or above)	0	0	2	2		3	-1
	Prevention of pressure ulcers (hospital acquired stage 2 and above)	9	8	9	26		27	-1
Achieving High Quality Clinical Care								
Priority 4 - To reduce the hospital emergency and elective readmission rate								
	Readmission in 28 days - Elective	3.5%	2.7%	3.3%	3.1%			
	Readmission in 28 days - Emergency	14.1%	14.0%	13.4%	13.8%			
Priority 5 - To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure								
	SMR for Heart Failure (2 months in arrears - Dr Foster)	41.1	-	-	41.1			-
	SMR for Pneumonia (2 months in arrears - Dr Foster)	89.5	-	-	89.5			-
Priority 2011/12 To improve the experience and clinical outcomes for those with long term conditions								
	Admission Rate for Chronic Obstructive Pulmonary Disease (COPD)	0.58%	0.51%	0.60%	0.63%		0.69%	-0.1%

Appendix 4 Enhancing Quality Performance Report since July 2010





Appendix 5 Patient Experience Dashboard

Jun-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	2	4	▲	13	47	▼	5	8	▲	0	0	►	4	15	▼	5	15	►	3	12	▼	5	19	▼	**37**	**120**	84	<500
Discharge related complaints	0	0	►	3	8	▲	0	0	►	0	0	►	0	0	►	0	0	►	0	3	▼	2	2	▲	**5**	**13**	12	<73
% Response timescales met	67%	89 %	▼	71%	57%	▲	100%	100 %	►	n/a	0%	►	75%	83%	►	100%	70%	▲	83%	81 %	▼	100%	85%	▲	**80%**	**68%**	95%	>95%
PALS Concerns	2	7	►	13	71	▼	5	19	▼	0	11	▼	4	48	▼	5	34	▼	3	24	▼	5	18	▼	111	88	tba	tba
Formal compliments	3	5	▲	9	15	▲	0	1	▼	1	1	▲	1	2	▲	7	17	▲	1	16	▼	0	0	►	22	57	n/a	n/a
Your feedback				78.9%	80.9 %	▼	Null	Null					Null	Null		80.9%	80.6 %	▲	82.0%	###	▼				81.0%	81.0 %	n/a	n/a
NPS* see key below			□	54%	60%	▼	Null	Null	□				79.0%	70.0 %	▲	60%	58%	▲	76%	65 %	▲	45.0%	49.0 %	▼	63.0%	60%	65%	65%
Intimations of claims	0	1	►	0	0	►	0	0	►	0	0	►	0	0	►	0	6	▼	0	1	▼	2	4	▲	2	11	tba	tba
Reported claims	1	1	►	0	0	►	0	0	►	0	0	►	1	2	▲	0	1	▼	0	2	▲	0	2	▼	2	8	tba	tba
% staff attended LOV (cumulative)		82 %			81%			84%			88 %			96%			69%			87 %			86%			86%		100%
NHS Choices +ve rec rate Ashford																										100%		n/a
NHS Choices +ve rec rate St Peter's Hospital																										89%		n/a

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

Divisional NPS scores comprise:

ACCT	Day Surgery Unit	Trust Inpatient NPS score	
Acute Med &EmergServs	Medical Wards x 12	Trust Inpatient NPS score	
WH &Paedaitrics			
	WH &Paedaitrics	Maternity &PaedInp	Trust Inpatient NPS score
Surgery	Surgery	Surgical Wards x 5	Trust Inpatient NPS score
Trauma & Orthopaedics	Trauma & Orthopaedics	Orthopaedic Wards x 3	Trust Inpatient NPS score
Spec Med & Spec Surgery	Spec Med & Spec Surgery	Outpatient - rolling dept survey	Trust Outpatient NPS score
Diagnostics & Therapeutics	Diagnostics & Therapeutics	Outpatient Areas	Trust Outpatient NPS score
Null	Insufficient or no data provided		

Appendix 6 Best Care Dashboard – June 2012

Best Care Dashboard - June 2012

Essential Care Indicators		Patient Safety																						Patient Experience							Action Plan
		Process: Patient Observations	Cardiac Arrest calls	Process: Matrons Environment Audit	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	Safety Thermometer Harm free care	Patients >= 2 Harms	Communication	Complaints	Discharge	Nurse Facilitated Discharge	Privacy & Dignity	SSA Breaches	Net Promoter	Number of Ward transfers	
Acute Medicine & Emergency Services	Aspen	75%	0	95%	100%	100%	0	0			88%	1	83%	0%	72%	2	0	75%	100%	58%		87%	0	96%	0	67%	0			100%	0	-		
	Aspen HDU	100%	0	95%	100%	100%	0	0			100%		71%	0%	100%	1	0	96%	-	100%		100%	0	60%	0	100%	0			100%	0	-		
	CCU	95%	3	95%	97%	100%	0	0			100%		93%	0%	100%	0	0	90%	-	75%		93%	1	88%	0	78%	0			100%	0	-		
	Birch	97%	2	95%	100%	100%	0	0			100%		87%	0%	100%	0	0	100%	-	88%		86%	0	71%	0	100%	0			100%	0	85%		
	Cedar	91%	1	93%	100%	100%	0	0			93%		82%	0%	83%	8	0	91%	-	85%		93%	0	81%	0	0%	1			0%	0	38%		
	Holly	98%	2	95%	100%	100%	0	0			80%		97%	0%	92%	5	0	94%	100%	68%		95%	0	87%	0	100%	2			100%	0	36%		
	May	93%	0	95%	99%	95%	0	0			89%	4	93%	0%	97%	3	0	97%	100%	67%		94%	1	73%	0	88%	0			100%	0	67%		
	MAU	98%	4	97%	100%	100%	0	0			100%		57%	0%	100%	1	0	100%	100%	70%		87%	0	69%	0	75%	0			100%	0	-		
	Maple	88%	0	97%	100%	100%	0	0			82%	1	91%	0%	93%	4	0	85%	100%	73%		90%	0	68%	1	63%	0			100%	0	58%		
	Fielding	73%	0	92%	100%	100%	0	0			89%	1	100%	0%	90%	8	1	100%	100%	84%		88%	0	90%	0	67%	0			100%	0	-		
	Chaucer	72%	0	94%	0%	100%	0	0			87%		100%	0%	90%	1	0	98%	-	77%		83%	0	100%	0	90%	1			100%	0	-		
	ED	-	0	-	0%	100%	0	0			-		-	0%	-	3	0	-	-	-		-	0	60%	0	-	5			-	0	-		
	Swift	80%	2	95%	0%	-	0	0			87%	1	90%	0%	78%	5	1	64%	40%	47%		91%	0	76%	0	67%	1			100%	0	-		
	Wordsworth	90%	0	92%	100%	100%	0	0			87%	3	100%	0%	91%	4	0	100%	0%	68%		82%	0	84%	0	75%	0			100%	0	60%		
Surgery	Kingfisher	87%	0		96%	100%	0	0			98%		99%	0%	90%	1	0	100%	100%	86%		99%	0	96%	0	100%	3			100%	0	53%		
	Falcon	100%	3		100%	94%	0	0			38%		89%	0%	98%	0	0	80%	100%	89%		93%	0	96%	0	100%	1			100%	0	89%		
	SDU	100%	0		97%	90%	0	0			100%		-	0%	100%	0	0	97%	100%	83%		98%	0	96%	0	100%	0			100%	0	-		
	Heron	100%	0		100%	100%	0	0			100%		95%	0%	96%	2	0	100%	-	86%		94%	0	83%	0	100%	1			88%	1	100%		
	SAU	87%	0		100%	100%	0	0			67%		79%	0%	100%	0	0	90%	-	95%		96%	0	100%	0	75%	0			100%	0	58%		
T & O	Dickens	96%	0		100%	100%	0	0		-	90%	N/A	91%	0%	100%	0	0	75%	100%	85%		100%	0	100%	0	75%	1			88%	0	77%		
	RBE	77%	2	91%	98%	98%	0	0		-	88%	N/A	88%	0%	88%	0	0	87%	100%	79%		93%	0	85%	0	94%	0			100%	0	68%		
	RBW	82%	0	91%	82%	98%	0	0		-	97%	N/A	93%	0%	83%	4	0	72%	0%	77%		94%	0	75%	0	94%	0			100%	0	90%		
ACCT	ITU	95%	0		100%	100%	0	0			70%	N/A	75%	0%	-	0	0	86%	-	100%		100%	0	88%	0	100%	0			83%	0	-		
	DSU & Theatres ASH	97%	0		100%	100%	0	0		-	100%	N/A	75%	0%	-	0	0	70%	-	100%		100%	0	N/A	0	100%	0			100%	0	-		
	DSU & Theatres SPH	88%	1		99%	100%	0	0		-	73%	N/A		0%	-	0	0	76%	-	92%		100%	0	N/A	0	92%	0			97%	0	-		
Women's health & Paediatrics	Oak	92%	0		85%	-	0	0			86%	N/A	-	0%	0%	0	0	86%	-	97%		97%	0	N/A	0	100%	0			100%	N/A	-		
	Ash	97%	0		91%	100%	0	0			100%	N/A	-	0%	19%	0	0	69%	67%	100%		93%	0	100%	0	90%	1			100%	N/A	-		
	NICU	100%	0		100%	100%	0	0			80%	N/A	-	0%	-	0	0	100%	100%	96%		98%	0	100%	0	92%	0			92%	0	-		
	Paeds ED	-	0		98%	80%	0	0			-	N/A	-	0%	-	0	0	-	-	-		-	0	N/A	0	-	1			-	0	-		
	Joan Booker	100%	0	97%	100%	100%	0	0			100%	N/A	99%	0%	88%	0	0	100%	100%	100%		100%	0	100%	0	50%	1			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

Appendix 7 Best Care Actions and Achievements per Division

The Best Care Dashboard definitions are found at Appendix 2 and the Best Care Dashboard at Appendix 6. The following narrative is provided by the Matrons and Heads of Nursing for the areas.

Anaesthetics, Theatres and Critical Care (ACCT), Head of Nursing – Kate Eidens

Table 7

Division and area ACCT	Reported underperformance	What is driving the underperformance	Actions to improve performance
Day Surgery Unit (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' frequently changing order of the operating list.	Further discussion at the Day Surgery focus group meeting. Staff to agree a procedure time for the patient and offer a drink if time allows
DSU	VTE assessment	DSU SPH some patients started in admissions lounge transferred to DSU post op	VTE assessments only to be measured on DSU patients who were admitted there in Best Care audit review
DSU	Privacy and dignity	DSU Sph- limited space to recover patients in DSU as Angio have ward area	Ensure CSNP's are aware of limited space Sister attends capacity meetings to agree admissions to DSU SPH
Theatres	Skin integrity	Not being re-assessed intra-operatively	Waterlow score training for theatre staff by CPE
ITU	Skin integrity	Not being re-assessed after admission	No criteria on when re-assessment should occur for ITU
ITU	VTE assessment	Assessment completed , but not added to IPL	Reminders to staff

Table 8

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, Head of Nursing – Vanessa Avlonitis

Table 9

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
All Medical Wards	**Nursing Documentation**	Design of document and lack of following due policy	New documentation being developed with guidance and clarification to steer best practice
Aspen ward Aspen/ MAU Aspen/Cedar Aspen	**Patient observation** **VTE** **Falls** **Nutrition**	• Ward leadership/ pressures operationally and bed moves • High use of temporary staffing due to vacancy factor	• Objectives set and being managed and monitored • All trained vacancies filled for September • Bed moves managed and completed successfully

Table 10

Area	Reported Achievement	Explanation
Privacy and Dignity	100% compliant	Staff awareness and embedded practice
Complaints	Reduced nursing complaints	Improved leadership

Outpatients, Matron Diane Lashbrook *(Note that summarised results are not yet available in the Trust Board Dashboard)*

Table 11

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
OPD, Ashford OPD, SPH	**Patient Records**	Patients notes with inappropriate files, documents etc	Feedback will be provided to Medical Records to support improvements to patient medical records.
Ophthalmology, SPH	**Personal Boundaries compromised**	Current environment is unsuitable for maintaining patient modesty	These areas are being addressed in the refurbishment at SPH all rooms will be single rooms

Table 12

Area	Reported Achievement	Explanation
OPD, Ashford, SPH	Patient Observations	All areas are showing good practice.

Maxillofacial, Ashford, SPH Ophthalmology, Ashford, SPH	Communication Nursing Documentation Patient Records Privacy & Dignity Environment and Infection Control & OPD Management	

Surgery, Matron Terri Hess
Table 13

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Surgery – Falcon ward/SAU	**Skin Integrity** – Care plans for patients identified at risk of developing PU'2 – e.g. WLS>15	Patients admitted with high risk (WLS>15) of developing PU's but otherwise well, skin intact and mobile are not having care plans completed by ward staff.	• All nursing staff to completed care plans for all patients with a WLS >15 despite their condition on admission. • CPE to continue with in/bedside teaching • Matrons monthly audits to monitor progress
Surgery - SAU	**VTE assessment**	• Failure to complete assessments on admission by medical staff after prompting to do so by nursing team. • High turnover and admission rate of patients. • Varying specialities – nursing staff struggle to ensure prompt review of patients. .	• Issue raised at Surgical Directorate Meeting for all Clinical Leads to advise their teams accordingly to comply with requirement to complete VTE assessments for patients on SAU. • SAU shift leaders to escalate to Matron, DGM, HoN when teams non compliant with reviews and/or VTE assx.
Surgery – Falcon ward (red) Kingfisher ward SDU Heron- all amber	**Nursing Documentation –** Carer/patient involvement in care.	• Key problem identified is that there is no documentation to state that patients and carers are being directly involved with care and care planning. • Large number of new starters on falcon ward inducting during June	• New SAP document now readily available which provides prompts and facility to record patient/carer involvement in care planning. • CPE/ward Sisters to educate all staff and large numbers of new starters on surgical wards. • Matrons monthly audits to monitor.

Table 14

Area	Achievement	Explanation
Surgery - Heron Ward	**Net Promotor Score –** 100% for June	Heron Ward is now a vascular ward where patients have access to daily senior ward rounds – often twice daily which amounts to greater continuity of care and effective communication with MDT's.

Trauma and Orthopaedics, Matron Romel Mendoza

Table 15

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Dickens Ward	**NURSING DOCUMENTATION** **NUTRITION** -No care plan for at risk patient **SKIN INTEGRITY** No care plan for at risk patient	Failure to complete the necessary document. Failure to complete the sign care plan.	• Continue to conduct training sessions lead by CPE and Matron • A sample of completed fluid balance chart to put in place for staff reference. • Continue with Matron and shift leader spot checks. • Matron continues to work on shifts with staff for monitoring the quality of their nursing documentation and assessment.
Rowley Bristow East	**PATIENT OBSERVATION** -Fluid Balance Chart **SKIN INTEGRITY** -No care plan for at risk patient **NUTRITION** -BMI not completed	Failure to complete the fluid balance chart. Failure to complete the patient sign care plan.	• Training sessions lead by CPE and Matron • A sample of completed fluid balance chart to put in place for staff reference. • All Ward Sister & Matron to carry out spot checks. • Matron will work on rostered shifts to monitor the quality of staff documentation. • Issues will be closely monitored after the move to the new ward.
Rowley Bristow West	**OBSERVATION** -Fluid balance chart **NUTRITION** -No care plan for at risk patient **MANUAL HANDLING** -No care plan for at risk patient	Failure to complete the fluid balance chart Failure to complete the patient sign care plan	• All Ward Sister & Matron to carry out spot checks. • Issues will be closely monitored after the move to the new ward.

Table 16

Area	Achievement	Explanation
Dickens Ward	**PATIENT OBSERVATIONS**	Informed the ward of the improvement they made and action plan agreed to sustain the level of their achievements.
All Wards	Upward trend on consent form review	Doctors are fully aware of the consent form review.
All Wards	Upward trend on Medication assessment	All nurses are fully aware of ensuring that height and weight is written on every patient drug chart.

Paediatrics, Head of Nursing – Julie-Anne Dowie

Table 17

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Ash Ward	**Nutrition**	No agreed paediatric nutrition assessment tool (however all patients are assessed for nutrition on admission is the auditor familiar with paperwork on area?)	Working with paediatric dietician to develop appropriate nutrition tool for children. Roll out of tool will take place once staff have been trained. This work will take a few months to develop.
Ash Ward	**Appropriate referrals to dietician**	There is no paediatric referral form. Dietician contacted via telephone when referral made.	All children reviewed by paediatric dietician daily. We may need another way of auditing this outcome in paediatrics. A referral form will be incorporated into nutrition tool.

Table 18

Area	Achievement	Explanation
All	All outcomes	All outcomes seem to have an on-going upward trend of improvement.

Women's Health, Head of Nursing – Sandra Houston

Table 19

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Communication	**50%**	Unsure at this point	Matron to review details of underperformance with auditor in this instance to better understand which elements require improvement. This may relate to

Table 20

Area	Achievement	Explanation
Falls& Manual handling.	Red to amber	This has improved over a period of 3 months as expectations in relation to the risk assessments requiredhave been consistently communicated to staff. Work is on-going to improve this further.