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

TRUST BOARD
28th May 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for April 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:	21st May 2012
Decision:	For Noting

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indictor Definitions

The table is made up of 6 columns namely:

1. Description of Measure - self-explanatory.

2. Targets - where possible a national or local strategic health authority target has been used, but where this is not available, we have used a percentage improvement on the 2011/12 year end total.

3. Forecast - the calculation is as follows:

   - The forecast is calculated for individual targets using the performance to date, any foreseen changes and then extrapolated over the year.

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

5. Monthly Trend Indicator - The arrows represent one of three states, improvement on the previous month, deterioration on the previous month, or the same. It must be noted that this does not necessarily mean that higher numbers are represented by an up arrow as higher numbers may be worse and thus will be represented by a down arrow. (to be included from May data)

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

1.2 Quality and Safety Balanced Scorecard and Commentary

Table one: Quality Performance Dashboard

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

	Patient Safety & Quality	Annual Target 12/13	Annual Forecast	April Actual	Performance			YTD 12/13
					Apr	May	June	
1-01	Summary Hospital-level Mortality Indicator (SHMI)*	<100	<100	95.7	-			95.7
1-02	HSMR*	<100	<100	98.8	-			98.8
1-03	Crude mortality (Excluding readmissions)	1.6	-	1.86%	-			1.86%
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	Stroke Patients (90% of stay on Stroke Unit)	80.0%	80.0%	82.9%	-			82.9%
1-07	VTE (hospital aquired with PE or DVT)	14	-	2	-			2
1-08	Serious Incidents Requiring Investigation (SIRI)	50	-	12				12
1-09	SIRI Grade 2 (proportion of total SIRI)	0.0%	-	25%	-			25%
1-10	Falls (Total Number)	462	-	41				41
1-11	Falls Rate - resulting in significant injury (grade 3)	<15	TBC	0	-			0
1-12	Average Bed Occupancy (inc escalation)	92.0%	TBC	90.3%	-			90.3%
1-13	Patient Moves (ward changes >=3)	<5%	5.0%	7.6%	-			7.6%
1-14	Patient Satisfaction (NetPromoter Score)	60%	-	57%	-			57%
1-15	Formal complaints (Total Number)	<500	-	34				34
1-16	Formal complaints (rate per discharge - IP only)	10% reduction	-	0.44%	-			0.44%

* These metrics are taken from Dr Foster and are reported 2 months in arrears (Currently Feb)

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

The Medical Director has continued to lead improvements in data quality and ensuing the tracking of clinical outcomes e.g. PROMs data, Dr Foster data, mortality reviews. These improvement streams will continue with a targeted focus on reported deaths in Urinary Tract Infection (UTI).

Mortality is demonstrated by the 3 metrics CMR, HSMR and SHMI. The CMR has fallen to the year average last year at 1.67%. The HSMR and SHMI are below 100 but the HSMR figure has not been re-benchmarked this year. We will be reconsidering the targets or these metrics over the next month. The palliative coding has now been resubmitted in line with the new guidelines but has not been uploaded to SUS. We have used a SHMI for hip fractures which remains excellent and we are also monitoring our mortality from patients with a primary diagnosis of UTI which has been highlighted as high by Dr Foster. Rather than an absolute rate we may revert to a SHMI figure for this metric.

2. Clinical Effectiveness

2.1 Therapeutic Endoscopy

In November 2011 Ashford & St Peter's NHS Foundation Trust received notification from Dr Foster concerning mortality rates for patients in this Trust who had undergone therapeutic endoscopic procedures on the upper GI tract within the 30 days before death. There appeared to be an excess of expected deaths in their cumulative sum (CUSUM) analysis between September 2010 and September 2011. Thus an alert was triggered. Work to look more closely into this alert had already started when an enquiry from the CQC was received in mid-January .

The Trust's response contained the results of an audit of all deaths in the Trust within 30 days of their procedure of patients undergoing therapeutic upper GI endoscopy between September 2010 and September 2011 (n=33). The main findings of the report were:

1. No examples of substandard care were identified.
2. There had been a 47% increase in the number of PEG procedures done within the Trust in 2011 compared with 2010, coinciding with an increase in 30-day mortality (to 18.6%). A correlation that is well described in the literature.[1]
3. Documentation in the notes regarding antibiotic prophylaxis, MRSA screening and ward-based preparation and after-care of PEG.
4. Every death within 30 days that has been examined occurred in the context of terminal illness, expected death, or very high risk of mortality due to underlying disease.

Given the inherent risk to patients, the increase in PEG usage in the Trust and the general culture around this practice is being looked into. The action plan, which was developed addresses this issue and is being actively managed through Endoscopy Users Group, chaired by Dr Stephen Evans. The group will, in particular, re-consider the existing guidelines and protocols for PEG insertion in the Trust.

In April 2012, the CQC confirmed in writing that they were assured by the report. Whilst they said they felt there was no need to make further enquiries, they advised that they will be following up the progress of the actions that were put in place to address the issues raised. A progress report on the action plan will return to Board in July, six months after the submission of the report to the CQC.

3. Safety Update

3.1 NHS Safety Thermometer

Background
The NHS Safety Thermometer is a system of measuring and improving the delivery of harm-free care and was selected for incentivisation as a national measurement instrument and a Commissioning for Quality and Innovation (CQUIN) target.

Important features of the NHS Safety thermometer are:

- It measures four high-volume patient safety issues (pressure ulcers, falls in care, urinary infection in patients with catheters and new cases being treated for a venous thromboembolism);
- it contains clinically valid and pragmatic operational definitions for each focus area, which means it can be used across a range of settings;
- it gives a timely summary of results which can be used for teams in their improvement work and
- the data collected is easy to aggregate at ward level, organisationally, cluster or region level and nationally.

[1] Janes SE, Price CS, Khan S. Percutaneous endoscopic gastrostomy: 30-day mortality trends and risk factors. J Postgrad Med 2005;51:23-9

Methodology
The NHS Safety Thermometer measures the proportion of patients in the Trust with any of the four patient safety issues using a point estimate methodology (on one day per month). The number of patients admitted on the day of the census is extracted from the Patient Administration System (PAS). The expectation is that every patient with an overnight stay is assessed for the absence of all four harms and so embeds and promotes the delivery of 'harm free' care.

Outcome
The Trust conducted its first run of this data on the 18 April 2012. The results are presented below and show the percentage of 'harm free' care associated with the four measures as described above.

Trust Submission:	15/28 = 54% of all areas with 100% patients.
Harm-free Care:	88.71 = percentage of patients without any one of the four harms which means our Trust is below the national average of 89.43.
No New Harms:	93.09 = percentage of patients without any harms associated with their hospital admission.

Achievement of the CQUIN payment will be secured with three consecutive months of the Trust submitting 100% of all areas with 100% of patients and so month one with 54% submission with the levels of harm-free care is a good starting point.

3.2 NPSA Safety Alerts

There have been no new alerts reported by the NPSA since the last Board meeting in April 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 three: NPSA Alert Update

Description	Deadline	Lead
Minimizing risks of mismatching spinal, epidural and regional devices with incompatible	02-Apr-12	Divisional Director Michael Imrie
STATUS		
• Contact made with the National Patient Safety Agency (NPSA), there is no plan to extend the deadline of the alert. However, their view is that independent testing is desirable, but is not required by European Device Legislation. The NHS in England is not willing to pay for independent testing. Medical devices of all types are introduced onto the market without independent testing. • Risk placed on the risk register • Spinal packs are used throughout the Trust which includes syringes and needles this helps to mitigate the risk • 3 incumbent suppliers are in the process of being invited to test their products • NPSA News Letter which highlights the importance of designing, labelling and packaging to minimize risk of incompatible connectors has been circulated to all divisions.		

4. Patient Experience

4.1 Complaints/Ombudsman reports

There were 34 complaints received in April compared with 51 in March and 37 in February. Chart one shows a breakdown of complaints received by month (Series 1), monthly target (Series 2) and overall trend line (red).

Chart one

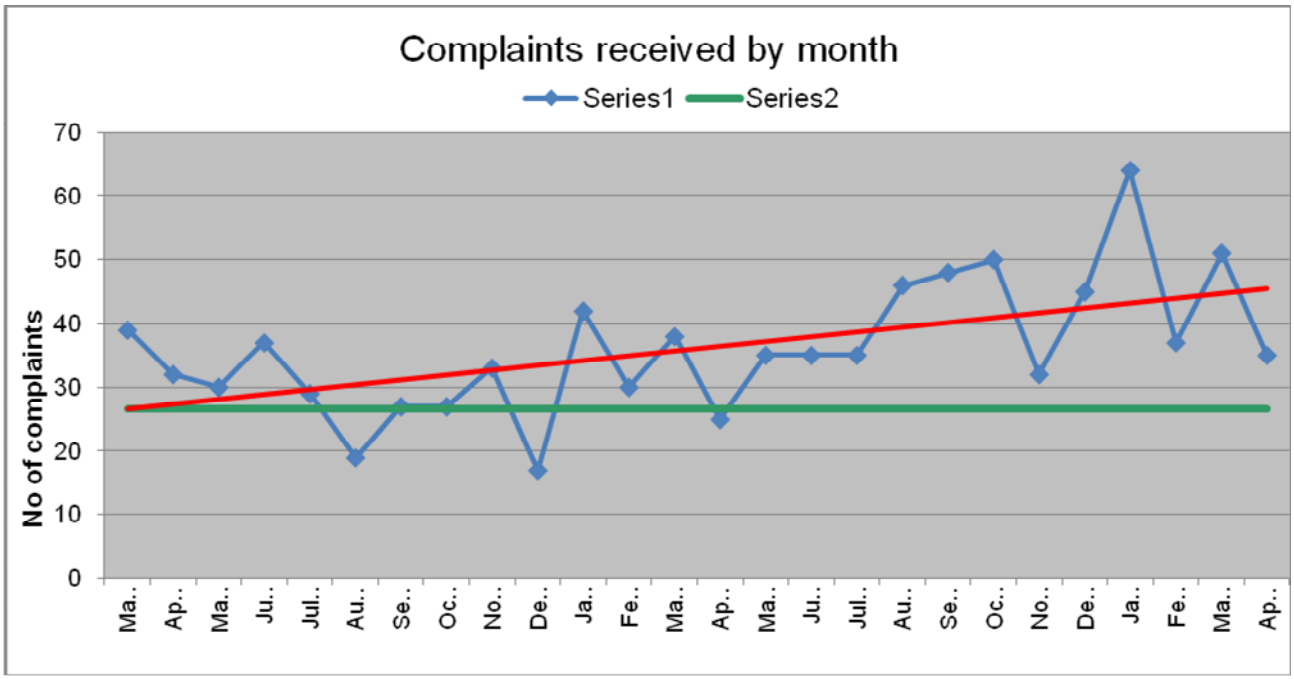
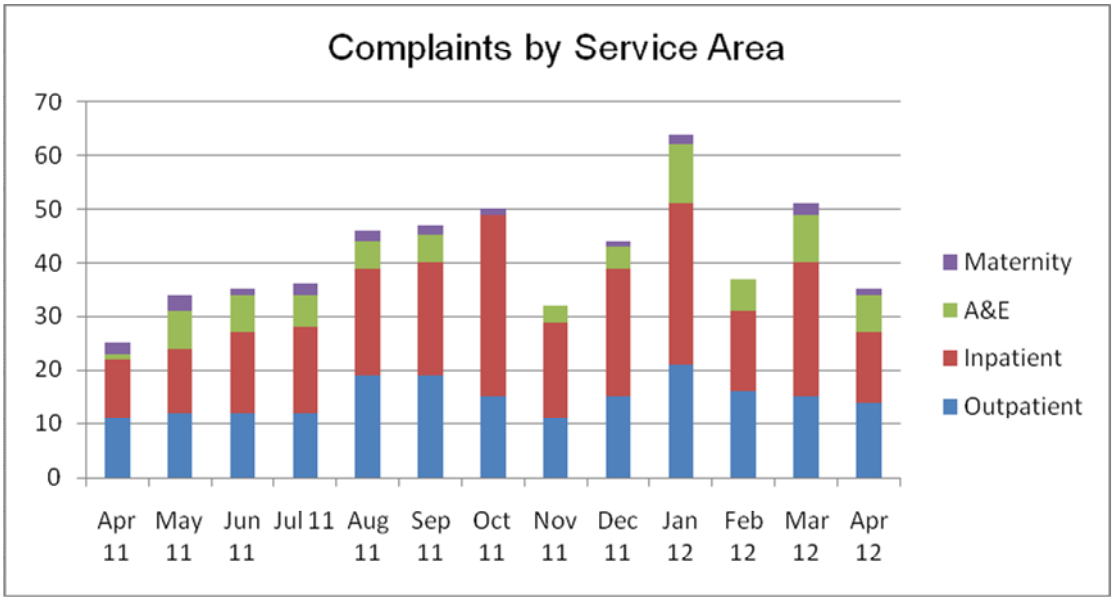


Chart two shows a breakdown of complaints by service area and demonstrates a significant decrease in the proportion of complaints relating to Inpatient care (-44%).

Chart two



There were 87 informal (PALS) concerns raised during April, of these four went onto become formal complaints which demonstrates a conversion rate of 4.6% compared with 4.9% in March.

There were 46 formal complaint responses due in April, of these, 34 responses were sent within the agreed timescale. This equates to a monthly performance of 74% with agreed timescales for response in comparison to 65% performance in March.

At the end of the reporting period there were six complaints overdue for response by the Trust, all within the Acute Medicine and Emergency Services Division.

On average between 10-15% of complaints received relate to care received within that same month, 55-70% relate to care received the previous three months and on average 20% relate to events older than 3 months.

The analysis is that a high number of complaints received within a certain month is not reliably linked to events/ operational issues within that month but is more reflective of the previous 2 – 3 months cumulative activity/patient experience. The Board should be assured that where a specific live issue or trend is picked up – this is flagged immediately to appropriate staff.

Ombudsman cases

The Trust has received one notification of a complaint referred to the Ombudsman for review. The complaint, relating to Maternity care, was first investigated in 2003 and is currently under initial assessment as to whether it will proceed to full review.

4.2 Patient Environment Action Team (PEAT) Result 2012

The Trust has received the initial results of the PEAT 2012 programme for environment, food and privacy and dignity for Ashford and St Peter's sites. The results are as follows:

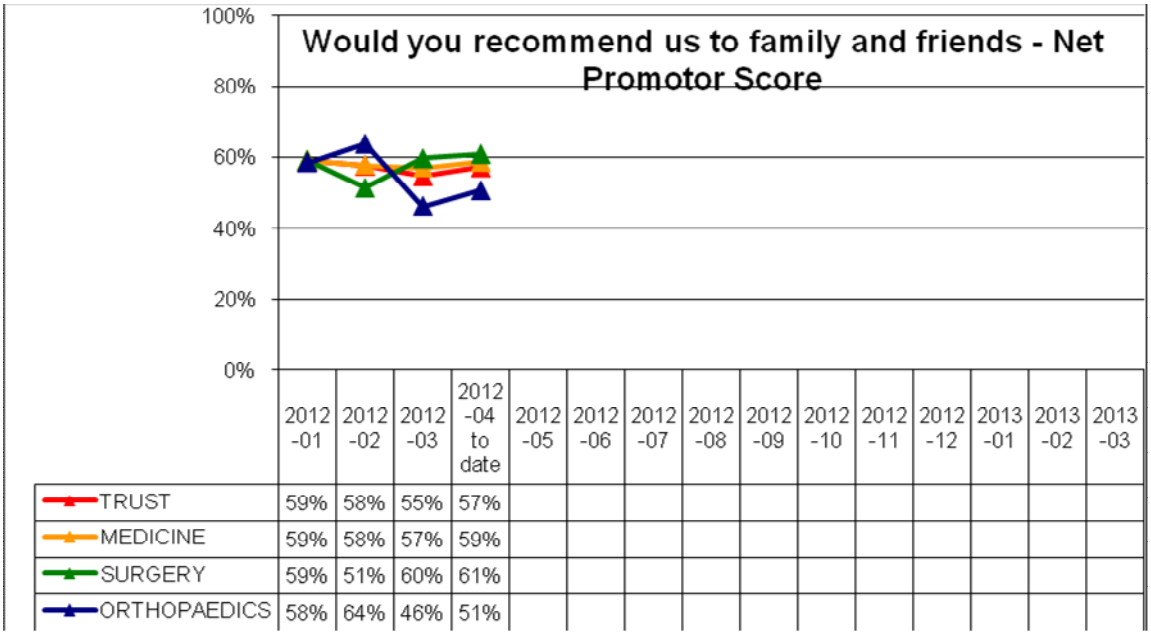
Table four: PEAT 2012 Results

Site	Environment		Food		Privacy & Dignity	
	2011	2012	2011	2012	2011	2012
SPH	Excellent	Good	Excellent	Excellent	Good	Good
Ash	Good	Good	Excellent	Excellent	Good	Excellent

The Trust has improved from Good to Excellent in Privacy and Dignity on the Ashford site. Whilst the result for Environment has gone from Excellent to Good on the SPH site, the scoring has been changed and a score of >96% is now required to achieve an Excellent score (previously >90%). National publication of the individual PEAT scores will take place in July.

4.3 Patient Feedback

The Net Promoter Score has increased from 55% to 57% during the reporting period.



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

The Trust received 14 formal (written) compliments during April, of these four related to care received on Dickens ward. All formal compliments received in the Chief Executive/Chief Nurse's office are responded to personally in writing.

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

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

4.4 National Inpatient Survey Results 2011 - update

The CQC published the nationally CQC benchmarked Trust specific report on 24 April. The benchmarked report score descriptors changed from previous years' reports where the Trust was scored on a scale of 0 –100 and results (presented as scores out of 10) were indicated as being in the top 20% of performance, the lowest 20% of performance or, more average, within the remaining 60% of Trusts.

Each Trust now receives a rating for different aspects (categories) of the care and treatment; a high score is better. The rating 'better' means that the Trust is better than most other trusts who took part in the survey for that particular question as opposed to the previous benchmark comparison of being in the top 20%'. A rating of 'about the same' means that the Trust is about the same as most other trusts as opposed to the previous benchmark of the middle 60% of Trusts. A rating of 'worse' means that the Trust did not perform as well as most other trusts for that question, whereas previously this would have been presented as being in the lower 20%.

Further to the initial analysis previously circulated to the board in April 2012, the following analysis demonstrates the Trust performance compared to itself between 2011/12 and compared with other Trusts.

Table Five: Comparison with other trusts

Aspect of care (score out of ten)	Ashford & St Peter's Hospital	Royal Surrey County Hospital	Frimley Park Hospital	Heatherwood & Wexham Park Hopsital
Emergency Dept	About the same (7.0)	About the same (7.6)	About the same (7.8)	Worse (6.8)
Waiting lists/admissions	About the same (6.1)	About the same (6.6)	About the same (6.5)	About the same (6.1)
Wait for a bed on a ward	Worse (6.4)	About the same (8)	About the same (8.5)	About the same (6.9)
Hospital & Ward	About the same (7.8)	About the same (8)	About the same (8.3)	Worse (7.6)
Doctors*	About the same (8.8)*	About the same (8.4)	About the same (8.7)	About the same (8.1)
Nurses	About the same (7.9)	About the same (8.1)	About the same (8.4)	About the same (7.9)
Care & Treatment	About the same (7.2)	About the same (7)	About the same (7.6)	About the same (7.1)
Operations and procedures	About the same (8.2)	About the same (8.2)	About the same (8.2)	About the same (8.0)
Leaving hospital	About the same (6.7)	About the same (6.8)	About the same (7.3)	About the same (6.5)
Overall quality of care	About the same (5.7)	About the same (5.8)	About the same (6.2)	About the same (5.6)

*ASPH scored better by comparison on this aspect of care with surrounding trusts

Overall, the CQC report indicates that the Trust performance has improved. Out of 64 questions, the Trust demonstrated an 'about the same' performance on 60 questions and a 'worse' performance on

4 questions this compares with 12 below average scores in 2010. Analysis is presented in Table six. Questions in italics indicate an on-going trend.

It is most likely that the actions to promote positive staff behaviours prior to the 2011 Survey had a positive impact upon the Trust scores. The continuation of this work through the Living Our Values programme is anticipated to have a further positive impact.

NB. It should be noted that direct comparison between questionnaires is not fully possible as, year on year, there is some variation in the questions.

Table six: Comparison between 2010 and 2011 of scores in worse category

Question scores worse than most Trusts	
2010	**2011**
Were you given enough privacy when being examined or treated in the A & E Department?	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?
Overall, how long did you wait from being referred to hospital to be admitted?	
Were you ever bothered by noise at night from other patients?	*Were you ever bothered by noise at night from other patients?*
Did you feel threatened during your stay in hospital by other patients or visitors?	Did you feel you were involved in decisions about your discharge from hospital?
As far as you know, did doctors wash or clean their hands between touching patients?	
Did hospital staff explain the purpose of the medicines you were to take home?	*Did a member of staff tell you about medication side effects to watch for when you went home?*
When you had important questions to ask a nurse, did you get answers that you could understand?	
Did you find someone on the hospital stall to talk to about your worries and fears?	
Were you given enough privacy when discussing your condition or treatment?	
Were you given enough privacy when being examined or treated?	
Did a member of staff explain the risk and benefits of the operation or procedure?	
Were you told how to take your medication in a way you could understand?	

The Trust has not maintained the 3 ‘better than most Trusts’ scores from the previous year relating to:

- Receiving copies of letters
- Being asked to give views on the quality of care
- Somewhere to keep personal belongings

The Trust performed significantly worse on seven questions when compared with Trust results for 2010 and significantly better on one question. These are detailed in table seven.

Table seven: Comparison between 201 and 2011 of seven significantly different scores

Question	2010 Score	2011 Score	Significant
Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?	5.8	4.9	worse
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.8	6.4	worse
Were hand-wash gels available for patients and visitors to use?	9.7	9.4	worse
Did you have confidence and trust in the nurses treating you?	8.6	8.0	worse
Did nurses talk in front of you as if you weren't there?	8.9	8.4	worse
In your opinion, were there enough nurses on duty to care for you in hospital?	7.7	6.8	worse
Overall, how would you rate the care you received?	7.6	7.2	worse
Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.0	8.8	better

4.4.1 The way forward

Currently, Divisional action plans to address themes and areas of improvement are on-going. The results of the Trust Inpatient Spotlight Survey will become available on 28 May and the following actions are then recommended:

- Spotlight survey results shared with divisional teams in order to update and refine action plans
- Completion of corporate updated 10 point plan
- Countdown to next Inpatient Survey on Aspire to raise awareness across June.

Divisional action plans will continue to be monitored monthly through the Clinical Governance Committee.

4.5 The Best Care Dashboard

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

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

Trauma and Orthopaedics

Table 8

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Dickens, Rowley Bristow East & West	Failure to fully complete nursing documentation and assessments in a timely manner	Staff are completing some areas well but are failing to update assessments	Regular audit/spot checks by the Matron. Increased visit from the Matron to 2 days a week to Dickens Ward. Shift leaders to do regular spot checks on care plans Staff will be spoken to on an individual basis when care plans are found to be inadequately completed

Table 9

Area	Achievement	Explanation
Dickens, Rowley Bristow East & West	All wards have seen an upward trend in communication	There has been a continuous improvement in patient feedback responses. Ward Sisters and Matron are ensuring and monitoring the ward and board round commence on time

Surgery
Table 10

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Falcon, Heron, Kingfisher, SDU & SAU	All areas have achieved less than 71% compliance with documenting height and weight on drug charts	Staff are documenting height and weight in the SAP documentation but failing to record on the drug charts	Sisters will raise awareness at handovers. Spot checks will be carried out by the sisters and matron.

			CPE will teach all new staff on local induction to the wards

Table 11

Area	Achievement	Explanation
Kingfisher, Falcon, Heron, SDU & SAU	Kingfisher, Falcon, Heron, have achieved 98% and above for nutrition and SAU and SDU have scored 87% and 85%	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.

Theatres

Table 12

Division and area ACCT	Reported underperformance	What is driving the underperformance	Actions to improve performance
ICU	Medication	High reporting mechanism for drug errors, Administration	Medicine Management training for nurses with annual drug calculation test with 100% pass mark implemented from next week
ICU	Patients weight not recorded	Not always able to weigh patients on admission to ICU	Discussed with Teams 100% for May
ICU	Personal Hygiene Documentation -3hrly PAC/mouth care.	oral care not always well documented despite PO fluids given	Personal e-mail sent to all team leaders giving a comprehensive rationale to explain need
ICU	Patient observations	Pain assessment on admission, needs to be on awake awake as some scores were on sedated & ventilated	Again highlighted on communication board -now changed.
ICU	VTE:	Yellow forms completed but checkbox on IPL not.	Different system on ICU. Now training in place to manually check box and has improved
Theatres/ DSU	Nutrition Time patient is nil by mouth -ward issue	Nil by mouth is often not recorded on ward notes.	Matron to discuss with Matron for surgery Continuing issue particularly orthopaedic surgeons changing list order

Theatres	Documentation Clear documentation- date print sign Consent not legible	Legibility of signatures dates and times.	Encourage staff to sign, date and record designation appropriately on legal documentation. Discussions held regarding correct procedures for consent at newly convened theatre team leaders meetings which will be followed up.
Theatres	Pre op Documentation:.	VTE risk assessment not performed in Admission Lounge	Surgical team advised No assessment, no Operation. Communication still filtering through and Adm/L now aware.
Endoscopy	Consent	Patients name not printed.	Discussed at Endo users meeting. Consultants/Nurses aware
Endoscopy	Privacy & Dignity	Signs not visible	Signs changed

Table 13

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 Bluspier.	A more comprehensive acceptance that Bluspier is a tool designed to enhance the clinical experience.
Endoscopy	2 nurses trained in consent 3 in training. Next day patient follow up phone calls	Improving patient flow, accurate consenting process. Positive patient feedback
DSU	Net promoter score 77%	Patients scored DSU a 9 or 10 to recommend the service

Medicine –

1. Pressure Ulcer In-depth analysis

Table 14: Increased number of hospital acquired pressure ulcers on Chaucer, Fielding and Wordsworth in April 2012

Ward	January	February	March	April
Chaucer	0	1	1	2
Fielding	0	0	1	1
Wordsworth	2	0	3	3
Total	2	1	5	6

Analysis
A review of the last three months' pressure ulcer weekly returns demonstrates an increase in grade 1 & grade 2 pressure ulcers. April data shows a further six pressure ulcers across all three wards. Table 14 shows the breakdown of Pressure Ulcers by ward for the period January to April 2012. Root Cause Analysis will be conducted to identify specific causes and reasons.

It would appear that there is an increase in the number of Hospital Acquired ulcers at Ashford with the highest increase on Wordsworth Ward. On a positive note the ulcers did not deteriorate to a stage 3 or 4 due to early detection, effective intervention and treatment by the ward staff once identified, which demonstrates good management.

2. Medicine – Best Care Narrative

Table 15

Area	**Reported underperformance**	**What is driving the underperformance**	**Actions to improve performance**
Aspen	Observations	Ineffective leadership	Specific objectives to address this underperformance
Aspen Cedar Swift	Documentation VTE Nutrition Documentation	Ineffective leadership and vacancy constraints Unfunded beds so more bank and agency use	Specific objectives set to address this underperformance. Clinical support provided by the Matron. Divisional Plan in progress to address indicators that are underachieving which will incorporate more performance management of the Ward Managers. Bed modelling will drive decision re future of Swift bed numbers

Table 16

Area	**Reported Achievement**	**Explanation**
Complaints	3 for the month	Improvement in patient experience
Aspen Chaucer	Net promoter score 84-100%	

Paediatrics

Table 17

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Oak ward	**Hand Hygiene**	Not high on agenda of some professional groups	Continue to raise profile and encourage good practice hand hygiene among all professions who visit clinical area.
Ash Ward	**Nutrition**	No agreed paediatric nutrition assessment tool	Working with paediatric dietician to develop appropriate nutrition tool for children. Roll out of tool will take place once staff have been trained.

Table 18

Area	Achievement	Explanation
Ash	Hand Hygiene	
NICU	Nursing Documentation	Implementation of new nursing documentation. Gradual Improvement see.

Women's Health
Table 19

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Privacy & dignity	50%.	some limitations on visiting during labour during labour	Practices to ensure this is in place are, open visiting for partners and close family with. Patient confidentiality maintained with wipe boards in offices and notes filed securely. Offices used for sharing/discussion of confidential information and curtains around all beds to maintain modesty

Communication	50%	Documentation incomplete	Bedside handover instigated recently and local audit demonstrates improvement in this practice. Further audit is planned in 3 months to ensure this becomes embedded in practice. Introduction of SBAR tool for escalation on the telephone and handover/ review of care. Currently in pilot phase. Plan of care documented in the notes but further work is required on care planning in the postnatal period. This will be subject to on-going work.

Table 20

Area	**Achievement**	**Explanation**
VTE	A point of merit with 100% compliance for April	On-going feedback to staff of rates and follow up of any omissions in a timely fashion. This has been a gradual improvement over a number of months sustained communication. VTE is also subject to spot check audit

5. CQC Performance Indicators Relating to Learning Difficulties

This report reflects the fourth quarter assessment made against the CQC performance indicators relating to Learning Disabilities. These indicators now form part of the Monitor Compliance Framework.

The current Trust position is that it is compliant in meeting the six criteria. Criteria are scored 1 to 4 dependent upon the level of protocol and mechanism ratification and implementation[2]. The Trust has made a self-assessment that scores each criterion either 3 or 4. Much progress has been made. The approach to the self-assessment has been shared with other local Trusts and appears to be consistent with their approach. The detailed self-assessment is at Appendix 3.

Two years on from the development and introduction of the Acute Nurse Liaison service strong progress has been made. This has included:

- PAS Flag for patients with a learning disability
- IT progress and webpage access
- LD protocol and patient passport
- Operational policy across the sector
- Carer representative on the newly formed Disability Group
- Commendations of organising reasonable adjustments
- Further enhancing reasonable adjustments such as case conference prior to surgery to ensure plan is robust and meets the individuals special needs
- Accessible patient information and this being developed further
- Patient experience feedback
- Staff feedback regarding the Acute Nursing Liaison service
- Staff training.
- Peer review in June 2012
- There is a new Acute Liaison Nurse starting in the Trust in June

[2] A score of 1 indicating that protocols and mechanisms are not in place and a score of 4 indicating that they are fully implemented.

6. APPENDIX 1

Best Care Dashboard Definitions

1. Patient Observations
   Documentation of patient observations includes: MEWS(Modified Early Warning Score), 24h cumulative fluid balance, pain assessment on admission and referral /escalation for "at risk" patients.
2. Hand Hygiene Compliance
   Audits of members of staff cleaning/decontaminating their hands between procedures.
3. Saving Lives
   The compliance measurements that indicate the use of High Impact Interventions in key clinical procedures with the aim of decreasing the risk of infection.

   - Number of MRSA bacteraemia: MRSA isolated in a blood culture therefore present in the patient's blood stream
   - Number of C Diff cases (Hospital post 72 hours): Clostridium Difficile toxin isolated from a patients stool specimen following episodes of diarrhoea.
   - Catheter Associated Urinary Tract Infections (CAUTI): Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections
   - Catheter >29 days after care: Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections.
4. Skin Integrity
   Waterlow risk assessment on admission and further reassessment with a care plan in place for "at risk" patients; the care plan shows evidence of progression with interventions as appropriate and the care rounding chart completed; where required there is referral to tissue viability nurse.
5. VTE (Venous Thromboembolism)
   Patient has been risk assessed for development of VTE (Deep vein thrombosis, pulmonary embolism
6. Falls / Manual Handling Assessment
   Assessments carried out on admission with care plan in place for "at risk" patients; the care plan shows evidence of progression; where appropriate the post fall protocol is implemented.
7. Nutrition
   BMI / weight recorded on admission; MUST assessment on admission and reassessment with a care plan in place for "at risk" patients; the care plan shows evidence of progression and referral as appropriate to dietician.
8. Nursing documentation
   Bed side folders are up to date and tidy; there is clear, contemporaneous documentation which is dated, printed and signed; property disclaimer and discharge sections are completed.
9. Medication Assessment
   Documentation is legible and completed appropriately, omission codes are utilized and allergies identified.
10. Communication
    Handover quality, co-ordinating care-plans are maintained; there is good interpersonal skills of staff with medications being clearly explained and resources to aid communication being used where appropriate; ward rounds commencing appropriately.
11. Complaints

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

12. Discharge and Nurse Facilitated Discharge
    To be defined

13. Privacy & dignity
    There are strategies in place to prevent disturbing, personal boundaries are not compromised; modesty is maintained within the ward and on patient transfer; there is appropriate communication with patients; the white board maintains confidentiality and there are no breeches of single sex accommodation (SSA).

14. Net Promoter Score (NPS)
    NPS is a business loyalty metric developed by Fred Reichheld and adapted to ask patients within the Trust "Your Feedback" survey. Patients are asked: "Would you recommend the Trust to family and friends?" and asked to provide a score between 0 and 10.

    Respondents are classified as:

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

    NPS = % of Promoters – % of Detractors

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

Appendix 2 Best Care Dashboard – April 2012

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

Best Care Dashboard - April 2012

Essential Care Indicators		Patient Safety																					Patient Experience							Action Plan
		Process: Patient Observations	Outcome: To be defined	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 Assesments	Outcome: Number of Falls	Outcome: Number of Falls resulting in injury	Process: Nutrion	Outcome: Appropriate referrals to Dietician	Process: Nursing Documentation	Outcome: No of incidents of poor documentation	Process: Medication	Outcome: No of Administration Errors	Communication	Complaints	Discharge	Nurse Facilitated Discharge	Privacy & Dignity	SSA Breaches	Net Promoter	Number of Ward transfers	
Acute Medicine & Emergency Services	Aspen	75%		100%	90%	100%	0	0			87%		100%	0%	80%	3	0	96%	-	70%		94%	0	93%	0	Data Unavailable		100%	0	84%	Data Unavailable	
	Aspen HDU	96%		N/S	100%	N/S	1	0			91%		88%	0%	100%	2	0	100%	100%	82%		95%	0	100%	0			100%	0	-		
	CCU	100%		98%	100%	100%	0	0			100%		99%	0%	100%	1	0	100%	-	80%		100%	0	100%	0			100%	0			
	Birch	87%		98%	100%	100%	0	0			100%		100%	0%	100%	1	0	100%	-	77%		99%	0	100%	0			100%	0	69%		
	Cedar	72%		95%	99%	100%	0	1			85%		75%	0%	90%	4	0	87%	100%	72%		86%	0	92%	0			100%	0	57%		
	Holly	88%		93%	100%	100%	0	1			96%		100%	0%	91%	1	0	92%	100%	80%		93%	2	100%	0			100%	0	35%		
	May	85%		100%	100%	100%	0	0			91%		91%	0%	90%	5	0	92%	100%	70%		83%	0	93%	0			100%	0	33%		
	MAU	75%		98%	100%	100%	0	0			80%		90%	0%	100%	2	0	100%	-	78%		98%	0	100%	1			100%	0	-		
	Maple	82%		95%	100%	100%	0	1			93%		100%	0%	95%	3	0	86%	71%	78%		89%	0	83%	1			100%	0	58%		
	Fielding	80%		100%	99%	100%	0	0			94%		100%	0%	88%	3	0	89%	100%	67%		84%	0	93%	1			100%	0			
	Chaucer	83%		90%	100%	100%	0	0			83%		94%	0%	91%	4	0	80%	100%	75%		90%	0	93%	0			100%	0	100%		
	ED	-		-	97%	100%	0	0			-		-	0%	-	2	0	-	-	-		-	0	-	6			-	0	-		
	Swift	80%		100%	96%	100%	0	0			79%		99%	0%	93%	3	0	59%	50%	77%		90%	2	100%	0			100%	0	-		
	Wordsworth	83%		97%	100%	100%	0	0			92%		100%	0%	100%	3	0	92%	100%	68%		90%	0	93%	0			100%	0	40%		
Surgery	Kingfisher	100%		94%	98%		0	0			97%		97%	0%	100%	0	0	98%	100%	82%		74%	0	100%	0	Data Unavailable		100%	0	66%	Data Unavailable	
	Falcon	83%		92%	100%		0	0			83%		81%	0%	95%	0	0	100%	-	74%		90%	0	-	1			100%	0	67%		
	SDU	100%		98%	99%	N/S	0	0			83%		-	0%	93%	0	0	85%	100%	67%		83%	0	100%	0			83%	0	-		
	Heron	80%		92%	100%		0	0			67%		73%	0%	93%	0	0	100%	100%	70%		95%	0	50%	0			100%	0	47%		
	SAU	90%		94%	100%		0	0			53%		75%	0%	80%	0	0	87%	100%	82%		83%	0	100%	0			86%	0	58%		
T & O	Dickens	81%			100%		0	0		-	76%	N/A	95%	0%	75%	0	0	95%	100%	58%		64%	0	100%	0	Data Unavailable		100%	0	58%	Data Unavailable	
	RBE	94%		N/S	96%	N/S	0	0		-	97%	N/A	91%	0%	70%	2	0	68%	100%	63%		83%	0	100%	0			93%	0	50%		
	RBW	97%			85%		0	0		-	100%	N/A	95%	0%	98%	1	0	100%	100%	77%		88%	0	100%	1			93%	0	14%		
ACCT	ITU	90%		-	100%	100%	0	0			100%	N/A	88%	0%	-	0	0	90%	-	100%		88%	0	100%	0	Data Unavailable		100%	0	-	Data Unavailable	
	DSU & Theatres ASH	100%		98%	100%	100%	0	0		-	100%	N/A	79%	0%	-	0	0	82%	-	99%		100%	0	100%	0			100%	0	-		
	DSU & Theatres SPH	95%		100%		100%	0	0		-	36%	N/A		0%	-	0	0	76%	-	94%		100%	0	100%	0			97%	0	-		
Women's health & Paediatrics	Oak	100%			69%		0	0			-	N/A	-	0%	-	0	0	95%	-	100%		89%	0	90%	0	Data Unavailable		100%	N/A	-	Data Unavailable	
	Ash	100%		N/S	84%		0	0			100%	N/A	-	0%	100%	0	0	60%	-	100%		95%	0	88%	1			100%	N/A	-		
	NICU	100%			86%	N/S	0	0			90%	N/A	-	0%	-	0	0	93%	-	84%		72%	0	100%	0			100%	0	-		
	Paeds ED	-		97%	NS		0	0			-	N/A	-	0%	-	0	0	-	-	-		-	0	-	1			-	0	-		
	Joan Booker	-		NS	100%		0	0			-	N/A	100%	0%	-	0	0	-	-	-		-	0	-	1			-	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 3 CQC Learning Disabilities Performance Indicators

Scoring guide for all questions
(1) Protocols/ mechanisms are not in place
(2) Protocols /mechanisms are in place but have not yet been implemented
(3) Protocols /mechanisms are in place but only partially implemented
(4) Protocols/ mechanisms are in place and are fully implemented

Indicators	Score	Quarter 4 progress to date
1.Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? (1-4)	4	The Trust is assured that a mechanism is in place on Pas to flag up patients who use our services with a learning disability. Due to consent issues, this is still in process, ready to go live and input referrals from last year. To support this process, IT, Clinical Governance ,Acute LD Liaison , LD Lead and clinical coding are to develop an information governance protocol and a process map for ongoing ratification A learning disability protocol is in place alongside the learning disability passport. The Acute learning disability Liaison service has now been in place for two years. This has proved to be highly effective. The nurse allocated to ASPH has left the Trust and this is being covered by the lead Acute Liaison Nurse until June 2012 when the newly recruited Learning Disability Nurse commences.. Reasonable adjustments can be demonstrated such as first or last appointments, pre-assessment MDT meeting prior to admission.

2. In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), does the trust provide readily available and comprehensible information (jointly designed and agreed with people with learning disabilities, representative local bodies and/or local advocacy organisations) to patients with learning disabilities about the following criteria: • treatment options (including health promotion) • complaints procedures, and • appointments Scoring: 1. Accessible information not provided 2. Accessible information provided for one of the criteria 3. Accessible information provided for two of the criteria 4. Accessible information provided for all three of the criteria.	4	• Disabilities Action Group has a carer of a patient who had a learning disability following a complaint. This is advantageous as the group ratifies information for patients with a learning disability. • The Trust is waiting for standardised information for patients with a learning disability which is being developed through the Learning Disability Sector.. Easy read Cancer Books distributed to the cancer nurses and palliative care service • The Trust has links to accessible information on the intranet and access to the Surrey Health web site and a bank of information on the shared drive . • "Easy Read Patient Information" is in development designed specifically for patients with. The Patient Experience Team and Communication and Media Department are working closely alongside the Mike Leat – an external company – in order to ensure that the booklets are designed in the Trusts style. These booklets will be provided to the Trust free of charge..
3. Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation and carers' rights? (1-4)	4	The Trust has a Learning Disability protocol which includes guidance around carers roles and rights. The Acute Nurse liaison service supports the carers and families of patients with a learning disability. The patient passport addresses any needs that are required by the patient. A carer sits on the Disability Action Group to represent carers of patients with a learning disability Over the year the Trust has reviewed its compliance and are aiming to develop a bank of carers information . Expectations of the carers ./partnership working there is a planned Peer review in 2012 which will include service users and carers in evaluating progress of partnership working todate.

		Education for staff (currently evaluating an e-learning package re education around the role and the right of carers)
4. Does the trust have protocols in place to routinely include training on learning disability awareness, relevant legislation, human rights, communication techniques for working with people with learning disabilities and person-centered approaches in their staff development and/or induction programmes for all staff? (1-4)	4	The Trust provides training for staff who care for patients with a learning disability by • Learning Disability stands with users and carers at the learning disability awareness week • Road shows to the wards • Communication days • Induction for all staff • E-learning modules on the intranet • Deanery provides training for Doctors • Recent review of safeguarding training will incorporate Learning Disabilities
5. Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carer's within Trust Boards, local groups and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services? (1-4)	4	• Learning Disability Carer on the Disability Action Group. This person was asked to be a member of the group following a complaint. The carer also presented his sons experience to the Trust Board as a patient story. • Membership of Valuing People and Welmead Housing Association.. • Attends MENCAP Board
6. Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? (1-4)	3	• Evaluation of the questionnaires in the final stage of development . This has been reviewed at service user level and will be trialled from April 2012 for 6months and then will be audited • Audit of Ld Liaison service to taker place in July 2012 • This year a peer review across the 5 acute Trusts in Surrey will be carried out between June and August .