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

TRUST BOARD
29th November 2012

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for October 2012.
ASSURANCE (Risk) / IMPLICATIONS	The Quality Report provides assurance that Quality indicators are being monitored and assessed and that mitigating actions are being put in place as required.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience are occurring.
EQUALITY AND DIVERSITY ISSUES	All of our services give consideration to equality of access taking into consideration disability and age. All matters are dealt with in a fair and equitable way regardless of ethnicity or religion of patients.
LEGAL ISSUES	Poor quality for patients can lead to potential litigation. Poor quality care can lead to non-compliance with essential standards of quality and safety. Compliance with these standards is a legal requirement of the Health Act (2009) and failure to do so could affect the Trust's registration and Monitor licence.
The Trust Board is asked to:	Review the paper; discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr David Fluck, Interim Medical Director & Suzanne Rankin, Chief Nurse.
Date:	22nd November 2012
Decision:	For Discussion

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

Contents

1 Performance Monitoring

1.1 Quality and Safety Balanced Scorecard Indicator Definitions

Table 1 is made up of 6 main columns:

1. Description of Measure

1-01 The SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charleston Comorbidity Index and diagnosis grouping.

CHKS has taken the SHMI model and applied it to our site and peer data to generate the observed and expected deaths. It is important to consider that the expected deaths figure shown has been calculated using data that includes both in-hospital deaths AND out-of-hospital deaths within 30 days. The observed deaths figure includes in-hospital deaths only. Therefore the expected deaths are over-predicted. Any index value will increase when out-of-hospital deaths are included. An index below 100 does not necessarily mean that deaths are lower than expected.

1-02 The CHKS RAMI includes all patients admitted to hospital and excludes palliative care patients and does not adjust for deprivation.

1-03 Crude mortality is the total number of deaths against the total number of patients discharged in the month. (A patient will only be counted once even if they have been admitted more than once in the month). The actual number is in brackets.

1-04 Mortality where the primary diagnosis was UTI (SHMI).

1-05 Number of Hospital acquired MRSA.

1-06 Number of Hospital acquired C-Diff.

1-07 The number of patients with a VTE (Venous Thromboembolism) assessment who then had a Pulmonary Embolism or Deep Vein Thrombosis (during their stay).

1-08 The total number of Serious Incidents requiring Investigation.

1-09 The proportion of Grade 2 incidents against the total number of Serious Incidents Requiring Investigation (SIRI).

1-10 The total number of Falls.

1-11 The number of Falls that were Grade 3 and above of the total number of falls.

1-12 The percentage stroke patients who spent 90% of their stay on a stroke ward of their total admission.

1-13 Average number of beds available (including escalation beds) in the month against the average number of beds occupied taken at midnight from PAS

1-14 The percentage of patients who were transferred between wards, 3 or more times during their admission.

1-15 Patent Satisfaction - Net Promoter.

1-16 The total number of formal complaints received.

1-17 Proportion of formal complaints received (for inpatients only) against the number of discharges.

2. Target (T*) - where possible a national (N) or local (L) 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. Performance - 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 (YTD) - 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	Oct Actual	Performance			YTD 12/13
						Aug	Sep	Oct	
1-01	Summary Hospital-level Mortality Indicator (SHMI)*	N	<100	<100	80	▲	▲	▼	62
1-02	Risk Adjusted Mortality Index (RAMI) **	N	<100	<100	67	▲	▲	▼	67
1-03	Crude mortality (Excluding readmissions)	L	1.6	<1.6	1.7%	▲	▼	▼	1.56%
1-05	MRSA (Hospital only)	N	1	2	1	◄►	◄►	▼	2
1-06	C.Diff (Hospital only)	N	20	18	1	▼	▲	▼	10
1-07	VTE (hospital acquired with PE or DVT)	L	14	21	4	▼	▼	◄►	15
1-08	Serious Incidents Requiring Investigation (SIRI)	L	50	110	9	▼	▲	▼	46
1-09	SIRI Grade 2 (proportion of total SIRI)	L	0.0%	4.6%	0.0%	▼	▼		11%
1-10	Falls (Total Number)	L	462	674	41	▲	▼	▲	414
1-11	Falls - resulting in significant injury (grade 3)	L	<15	15	2	▲	▼	◄►	9
1-12	Stroke Patients (90% of stay on Stroke Unit)	N	80.0%	80.0%	75.7%	▼	▲	▼	84.1%
1-13	Average Bed Occupancy (inc escalation)	L	92.0%	-	85.4%	▼	▼		88.5%
1-14	Patient Moves (ward changes >=3)	L	<5%	8.0%	7.5%	▲	▲	▲	7.3%
1-15	Patient Satisfaction (NetPromoter Score)	L	65%	60.3%	64%	▼	▲	◄►	60%
1-16	Formal complaints (Total Number)	L	<500	447	46	▼	▲	▼	262
1-17	Formal complaints (rate per discharge - IP only)	L	0.44%	-	0.58%	▼	▲	▼	0.59%

(T*) Target Type **N, National; L, Local**

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

Scorecard Commentary

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

- Ensure the emergency pathway is improved to enable an efficient flow of patients and as a result meets all national targets
- Ensure the financial plan is met.

The SHMI mortality rate is 80 bringing the year to date position to 62. This rate is in the middle of our peer group on CHKS.

There were 46 complaints in October bringing the year to date total to 262. Therefore the Trust is forecasting to achieve its target of receiving less than 500 complaints by year end.

With one case of C-difficile in October, our year to date total increased to ten which is just below the trajectory. The forecast for the year end is that the Trust will achieve the target. There was one case of MRSA in October, bringing the year to date total to two against a target of one. Due to the low target level, Monitor does not reduce the governance rating until there are more than six cases in a year.

The number of Falls in October is three above the monthly target however it is one of the lowest monthly figures so far for the year with two that resulted in harm. The Trust is predicting that it will not achieve its own target of total falls. The Falls that are reported follow the Safety Thermometer definition. Consequently Falls in the Emergency Department, although reported and monitored by the Trust internally, are not included in the Falls reported to the Board. Over the past 12-month period, there have been 37 Falls in the Emergency Department with one Grade 3 Fall (Falls Resulting in Significant Injury).

1.3 National Quality Board Report

The National Quality Board (NQB) is a multi-stakeholder board established to champion quality and ensure alignment in quality throughout the NHS. The NQB published a draft report, '*Quality in the New Health System*' in readiness for:

- Implementation of the new Health and Social Care Bill from April 2013.
- Publication of the forthcoming Francis report in January 2013.

The report, which was first presented to the Trust Board in September 2012, aimed to conduct a self-assessment of its capabilities and structures to monitor and assess Quality. In order to do this at an organisational level, a summarised report was presented to Divisional triumvirate teams, asking that they disseminate to their team leaders within the division. Teams held facilitated discussions, in order to focus upon four key questions:

1. *Are you as a team clear about what your roles and responsibilities are in identifying failures in quality?*
2. *Are you as a team clear about what your roles and responsibilities are in learning from failures in quality?*
3. *Are you as a team clear about what your roles and responsibilities are in sharing of best practice in quality?*
4. *How can we as a Trust improve how we learn from failure?*

A full and extended response was received from the Divisions which demonstrates a high level of engagement with the quality agenda across the organisation. The five keys themes from these responses are as follows:

- Consensus amongst Divisions around the importance of utilising patient feedback in conjunction with internal intelligence i.e. audits, to identify failures in service quality
- Divisions emphasise the importance of appropriate training and support for staff in embedding a culture where risks are recognised, reported and responded to
- There is a willingness to find new ways of sharing best practice between teams and Divisions to improve quality
- The importance of senior staff understanding issues faced by front line staff will improve overall capability to address quality agenda
- Ensuring regular communication and feedback at handover, ward, department, and Trust level will maintain and improve focus on quality.

The Trust is in the process of contacting leaders of other provider organisations to coordinate efforts to assess capabilities and structures across the local health economy to welcome the new Health and Social Care Bill.

2 Clinical Effectiveness

2.1 Enhancing Quality Programme (part of CQUIN Programme)

The EQ Programme is part of a Kent, Surrey and Sussex improvement programme involving all the acute trusts of the SEC[1]. ASPH is a full participant in the EQ Programme with five pathways running (Acute MI , 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 region for implementation later in the year.

Clinical leaders collaboratively set out what the best care measures are for specific conditions; these five or six measures per pathway are implemented within each Trust and monitored monthly enabling us to benchmark across the region. Each Trust has agreed improvements to achieve each year to secure CQUIN payments, whilst improving clinical outcomes for patients.

To achieve the CQUINs for Enhancing Quality (EQ), the Trust needed to demonstrate improvements in the EQ measure scores from last year's results. This has been achieved for quarter two.

Five key messages and achievements are:

- Steady improvements continue month on month in the measures for dementia with July figures being our best ever
- There have been significant improvements for Heart Failure on last year's score, keeping the Trust above the CQUIN requirement
- Hips and knee replacements remain at a high level for all patients i.e. above CQUIN requirement
- Pneumonia cases have remained steady, above 90% EQ scores and have improved on last year's score
- There is a pilot taking place on four wards aimed at reducing hospital acquired pneumonias which is already showing a reduction of newly acquired pneumonias on these wards. Full results will be published in December 2012.

[1]South East Coast region

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 October 2012.

Overdue Alerts

Three alerts remain overdue and a corporate risk has been raised until all mitigating steps have been taken to ensure the actions detailed in the alerts have been closed. The alerts are as follows:

Description	Deadline	Lead
Minimizing risks of mismatching spinal, epidural and regional devices with incompatible	02-Apr-12	Divisional Director Michael Imrie
The Anaesthetics Department are to start some clinical tests on the devices soon and the clinical areas chosen are to be Labour ward and Elective Orthopaedics at Ashford. This will be a Consultant-only exercise and only one variety of needles will be in the Trust at any given time to try to reduce the risk. The Deputy Medical Director has had feedback from the majority of local trusts (only Croydon and Epsom Orthopaedic Centre have introduced these devices); and will host a meeting of trusts to try to broker a common local solution. The undertaken given was to be able to implement a solution by 1st April 2013.		
The adult patient's passport to safer use of insulin	31-Aug-12	Deputy Chief Nurse/ Kate Eidens
The Trust has been unable to close this alert by the deadline due to a delay in the recruitment process of Diabetes Specialist Nurses. Two nurses have now been recruited. Part four of the alert requires education to ensure there are systems in place to enable hospital inpatients to self-administer insulin where feasible and safe. The Head of Nursing has anticipated that this alert will be able to be closed by the end of December 2012.		
Harm from flushing of nasogastric tubes before confirmation of placement	12-Sep-12	Dr Michael Parris
The working group led by Dr Parris has made good progress with this alert with the introduction of training and competencies on nasogastric placement for nurses and doctors. One aspect of the alert is overdue which relates to providing warning notices with "Do Not Flush" on all current and future stock of nasogastric tubes, until these are provided as standard by manufacturers. Delivery of the warning stickers is expected this month and this alert is anticipated to be closed by the end of November 2012.		

3.2 NHS Safety Thermometer (National CQUIN)

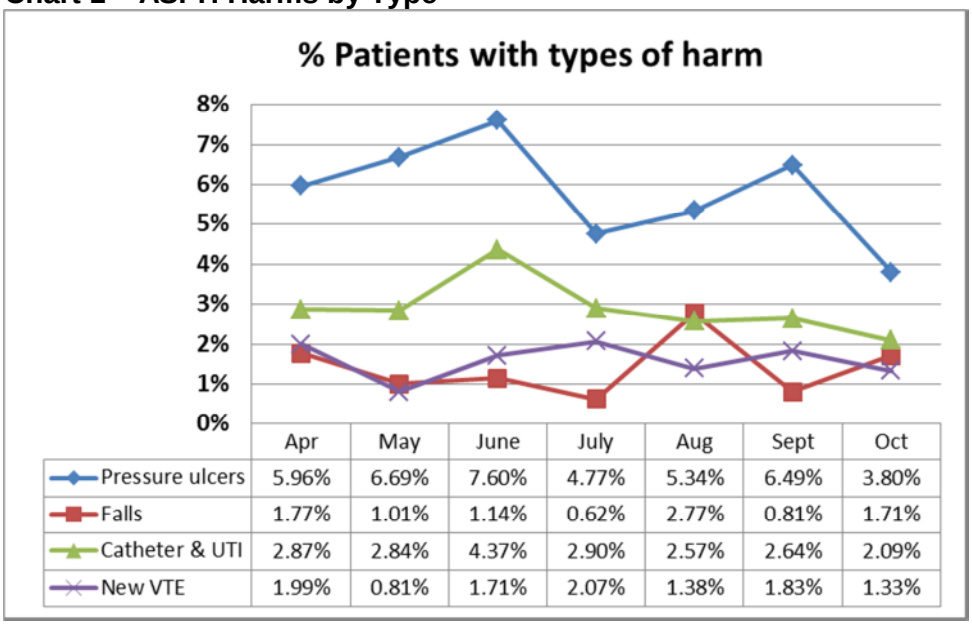
The Safety Thermometer[2] programme of work aims to achieve significant reductions in four types of avoidable harm: Pressure Ulcers, Falls, Catheter Associated Urinary Tract Infections (UTI) and Venous Thromboembolism (VTE). These are types of harm which patients are at most risk during episodes of healthcare.

In October 2012 the Trust's safe care improved with no patients being reported as having more than one new harm (there was one patient in September); 24 patients had one new harm compared with 22 patients in September; this could reflect the increase in number of patients surveyed (493 in September and 526 in October). In October a new mechanism was introduced to improve the monitoring of our participation rates and we now have more robust evidence of 100% participation across the Trust.

[2]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

Our results for patients with harm-free care are in a similar range to the national picture; harm-free care refers to patients who have neither 'old' harms present on admission or 'new' harms acquired when in hospital.

Chart 1 – ASPH Harms by Type



	Apr	May	June	July	Aug	Sept	Oct
Pressure ulcers	5.96%	6.69%	7.60%	4.77%	5.34%	6.49%	3.80%
Falls	1.77%	1.01%	1.14%	0.62%	2.77%	0.81%	1.71%
Catheter & UTI	2.87%	2.84%	4.37%	2.90%	2.57%	2.64%	2.09%
New VTE	1.99%	0.81%	1.71%	2.07%	1.38%	1.83%	1.33%

3.3 Prevention of Pressure Ulcers

Appendix 1 contains a detailed analysis of the pressure ulcer prevention and strategies in the Trust. Six key messages emerge:

1. The Trust's Zero Tolerance of the development of pressure ulcers is tangible in sense and action.

2. ASPH reports pressure ulcer in accordance with the European Pressure Ulcer Advisory Panel and current NICE Guidance. In those pressure ulcers present on admission but that deteriorate to a stage 3 or stage 4 it is felt important to report these cases for review in order to capture the learning required to improve care.

3. There has been a decrease in the number of trust-acquired pressure ulcers since 2009 with a marked improvement in 2010/11 (35% reduction), but no further improvement in 2011/12.

4. It is not yet clear whether the lack of continued improvement in 2011/12 is a result of improved awareness and recognition and thus reporting or a failure to sustain improvements in care. The notable improvement in reporting is likely to be, at least, partly responsible.

5. Systems and processes to collect pressure ulcer data have been reviewed and are in the process of being strengthened.

6. The Safety Thermometer audit shows that the number of patients with pressure ulcers as a new harm is decreasing.

The Board is aware that a corporate action plan to address the concern arising from the number of patients in the Trust with pressure ulcers. The plan has been reviewed and commended by NHS Surrey and shared with others as an example of best practice. Nevertheless, there is not yet absolute evidence of the efficacy of the plan. There are however, early signs of impact and improvement. The key indicator of improvement at this stage is that the proportion of the most severe pressure ulcers does not appear to have increased in line with the rise in reporting of all

pressure ulcers. This would seem to indicate that improved assessment, treatment and care planning and intervention are being effective but the impact must continue to be monitored to give full assurance.

The Trust is committed to the eradication of pressure ulcers and hosted a regional event called *Stop the Pressure* on Tuesday 13th November to mobilise acute and community providers as well as commissioners against pressure ulcers. This was well attended by representatives from the Clinical Commissioning Group, nurses from the Trust as well as other providers and the PCT. Feedback from the event was extremely positive.

4. Patient Experience

4.1 Complaints/Ombudsman Reports

There were 46 complaints received compared with 28 in September and 38 in August. Chart two shows a breakdown of complaints received by month.

Chart 2

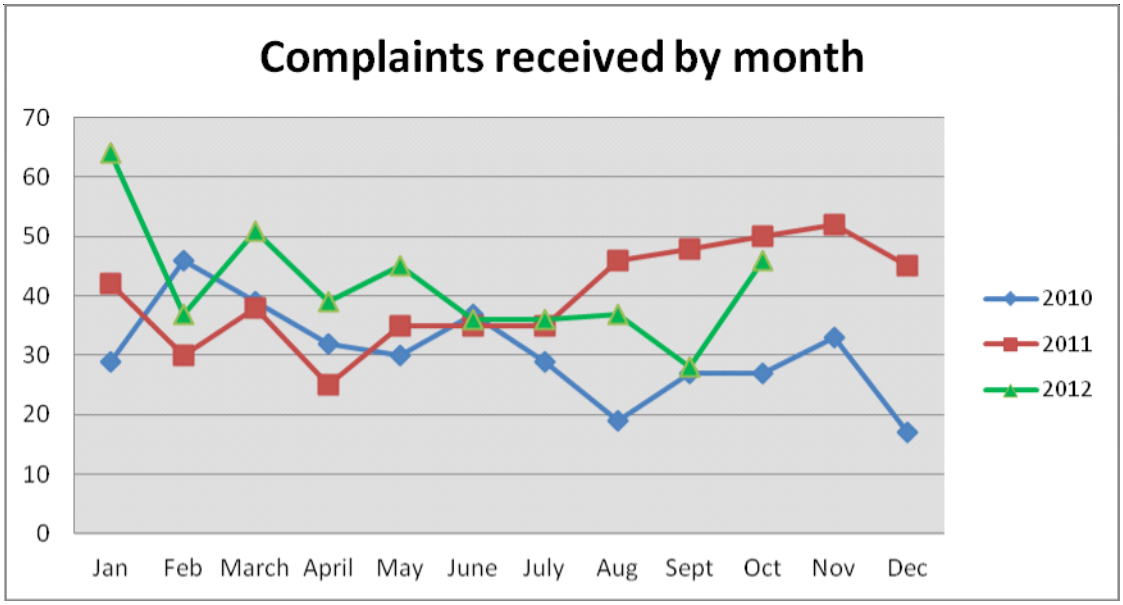


Chart three shows a breakdown of complaints by service area.

Chart 3

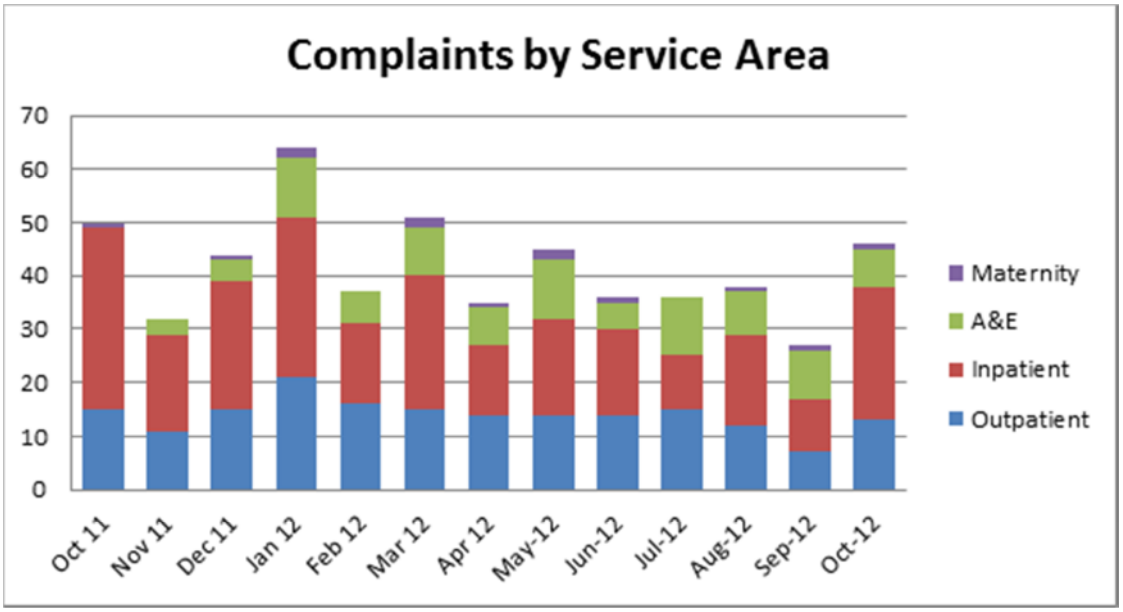
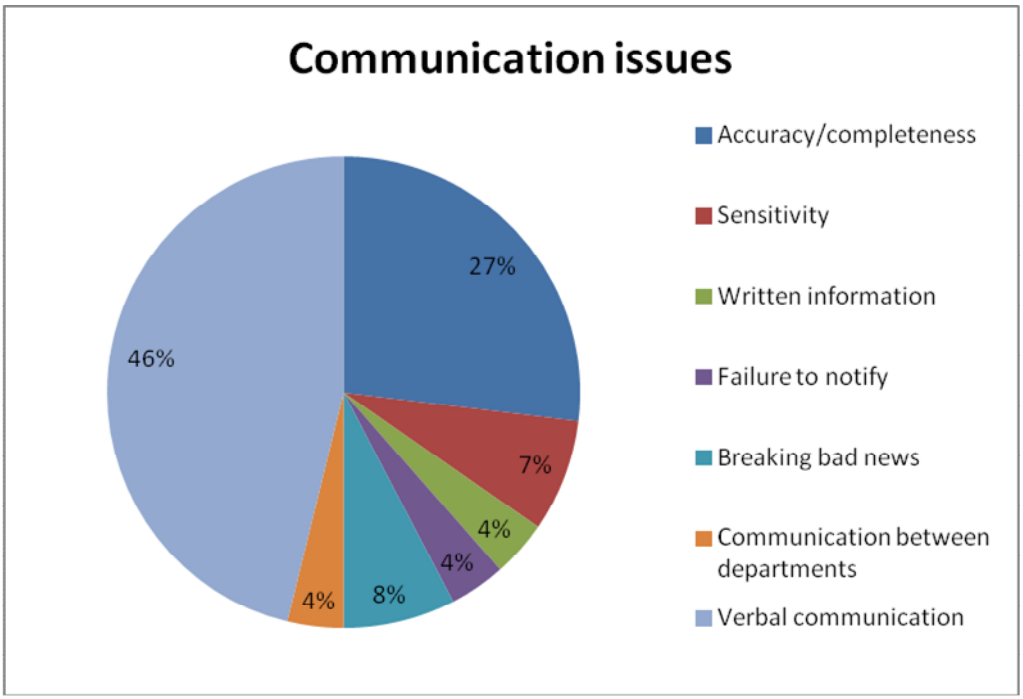


Chart four shows a breakdown of the 19 complaints where communication was raised. Twenty-six separate issues were raised; of these 46% relate to verbal communication.

Chart 4



PALS

Of the 108 contacts to PALS; 76 (70%) related to concerns, of these one went onto become a formal complaint, a conversion rate of 1% and compared with September (1%) and August (5%).

Parliamentary and Health Service Ombudsman (PHSO) cases

The table below provides a summary of cases that were active with the PHSO in October 2012.

Table 2

Issue	Stage
Care and treatment relating to bile duct dilation.	Investigation commenced February 2012, awaiting outcome. OPEN
Care and treatment at end of life.	On 5 October 2012 the Trust was advised of the PHSO decision not to investigate. CLOSED

4.2 <u>Patient Feedback</u>

Appendix 5 outlines the Trust's patient experience performance.

Performance against agreed timescale for responding to formal complaints was 80%, compared with 77% in September, with Specialist Medicine & Specialist Surgery and Trauma and Orthopaedics achieving 100%.

Divisional Complaints Handling Workshops will be held throughout November and these will focus on process and documentation updates, engaging with complainants and the quality of written responses.

The Net Promoter Score (NPS) for the Trust was 64%.

Compliments

The Trust received 17 formal compliments during October. All formal compliments received in the Executive Offices are responded to personally in writing.

NHS Choices Website Comment regarding the Cardiology Service:

"I found all the staff delightful, communicative, and demonstrated teamwork. My stay was brief, but I was made to feel special."

Five of the seven positive comments on the NHS Choices website relate to experience of the Cardiology Service.

4.3 Friends and Family Test

The Prime Minister announced on the 25th May 2012 the plans to implement the Friends and Family Test (FFT). This is a requirement by provider Trusts to ask their patients whether they would recommend the ward or Emergency Department in which they were treated to a friend or family member. Acute providers are in the first phase of the national delivery programme with a deadline for implementation of the question by 31st March 2013.

The Department of Health issued the guidance document on the 4th October 2012 and the full document can be found here http://www.dh.gov.uk/health/2012/10/guidance-nhs-fft/.

As part of this process a state of readiness has been completed and submitted to the South East Coast Strategic Health Authority outlining our approach to this implementation and readiness to do so. Based on this assessment the Trust will be ready to make a successful implementation in accordance with the national time table.

The SHA will benchmark the Trust's state of readiness against other acute providers in the region and the outcome of this benchmarking together with an update on the implementation plan and risk assessment will be reported early in the new year.

It is anticipated that the FFT should begin in shadow form from Q3 and the key milestones for delivery are.

- 30th November 2012 – ASPH will start asking the national FFT question in the Emergency Department and MAU.
- February 2013 – ASPH will start asking 100% of patients the question.
- December 2012 – APSH will be reporting this information regularly to the Board.

APPENDIX 1

Pressure Ulcer In-depth Analysis

The purpose of this paper is to provide assurance to the Trust Board on strategies to reduce the incidence of hospital-acquired pressure ulcers. The main driver for reduction is the Trust Corporate Action Plan which was developed as a result of several serious incidents of trust-acquired stage 3 and stage 4 pressure ulcers.

Prevention of pressure ulcers has never been higher on the care agenda with an emphasis on reporting both at regional and national levels. The PCT has set the Trust a target of 80% reduction of hospital-acquired pressure ulcers over 4 years from 2011/12. The Trust target published in the annual Quality Account aimed for 5% reduction i.e. no more than 108 stage 2 and above pressure ulcers; in the first six months of the year we have reported 82 pressure ulcers. Although we consider that the increased incidence could be due to improvements in the accuracy of our reporting, the Trust has a Zero Tolerance for development of pressure ulcers and is continuously working to improve patient care. This poses the question as to whether figures for this year should be used as our baseline going ahead.

When patients are admitted to hospital it is recorded if they already have pressure ulcers and all patients are risk-assessed for development of pressure ulcers. Appropriate actions are then taken to care for the patient and reduce the risk of further deterioration or development of new pressure ulcers. This includes ensuring appropriate equipment (mattresses, cushions etc) is available and completion of a body map with a care plan and daily skin assessment.

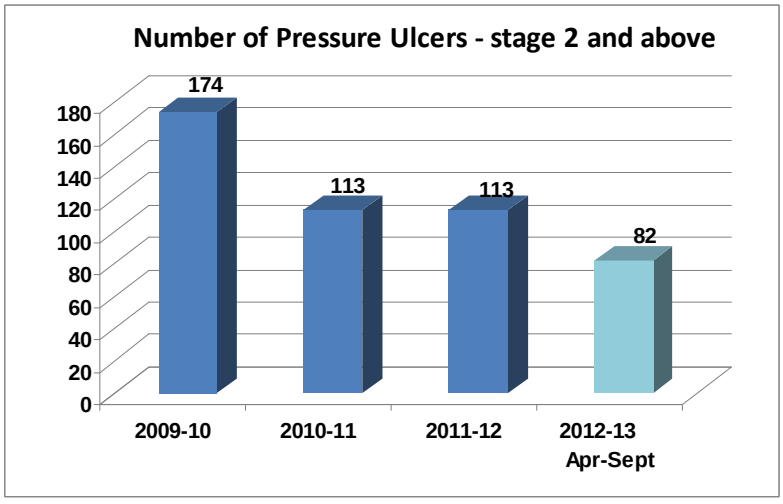
Pressure Ulcer Data Review

Data on pressure ulcers is reported in a number of ways:

- Weekly reporting via a data submission form which informs the Best Care Dashboard. This is a 'live' form with all pressure ulcers being captured throughout the week i.e. both old and new pressure ulcers and follow-up of patients.
- Serious Incidents if a stage 3 or 4 pressure ulcer develops (this will not be captured on the Best Care Dashboard as a pressure ulcer is reported when it is first discovered)
- Safety Thermometer a monthly point prevalence recording pressure ulcer by most severe stage (old developed within 72 hours of admission, new developed 72 hours after admission). (See section 3.2 for further information on the Safety Thermometer).

Chart 5 shows the decrease in the number of trust-acquired pressure ulcers since 2009 with a marked improvement in 2010/11 (35% reduction). This reduction has not continued and it is not yet clear whether this is a consequence of improved awareness, recognition and reporting or a failure to sustain improvement in care. However, the indication is that the accuracy of our reporting has greatly improved and that this could be partly responsible for the increase in pressure ulcers.

Chart 5



A review of pressure ulcer data for 2012-13 has identified issues with the data being reported; the implication is that figures for previous years were also inaccurate. The current process is that wards complete a 'live' form weekly as outlined above. For new, hospital-acquired pressure ulcers; the weekly data is then summed by the Matron and entered into the monthly spreadsheet. This is the data used by Information Services to record on the Best Care dashboard and in the Quality Account dashboard.

Issues with the quality of the data have been identified including missing weekly returns and missing monthly submissions i.e. under-reporting and also over-reporting when the same patient with the same new ulcer has been reported as a new incidence in several months' data.

Recommendations are for a further, formal review of the data for 2012-13 to validate data and correct reports and to revise the current process for data collection and reporting:

1. Clinical audit facilitators to monitor weekly submissions and escalate missing submissions to Matrons and Heads of Nursing
2. Facilitators will also summarise the weekly data to produce the monthly submission
3. The monthly submission will be reviewed by Matrons and Heads of Nursing and the Lead Nurse for Tissue Viability.
4. When validated, the data will be available for reporting by Information Services to meet the required deadlines.

Further suggestions are:

5. Electronic data capture and reporting at ward level by all nursing staff
6. Development of a trust database to monitor all patients with pressure ulcers
7. Need to capture where pressure ulcer damage improves as a result of our care
8. Need to capture number of patients with pressure ulcers as well as number of pressure ulcers as one patient may have several pressure ulcers of varying stages
9. Need to capture location of the pressure ulcer to enable a targeted response i.e. heels, sacrum – this would also enable us to determine if strategies were effective i.e. introduction of heel protectors having a correlation with reduction in heel pressure ulcers

Following the current level of validation the year to date total moves from 82 to 84 see the table below. It is these figures that are reported to the South East Coast Quality Observatory.

Table 3 Number of Pressure Ulcers Stage 2 and above

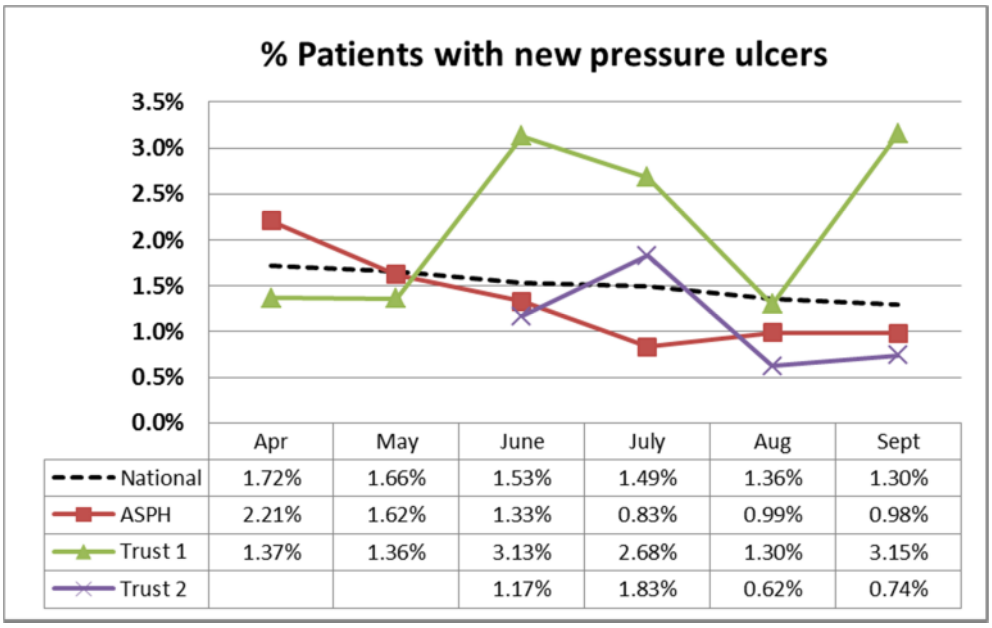
	April	May	June	July	Aug	Sept	**Total (6 months)**
Hospital Acquired Totals from weekly forms – *following review*	9	19	16	15	10	15	**84**
Hospital Acquired Totals from weekly forms – *prior to review* (Quality Account dashboard)	11	12	9	18	14	18	**82**
Community Acquired Totals from weekly forms	28	95	76	62	69	60	**390**

The results presented in the Best Care Dashboard for Skin Integrity have also been reviewed and there does not appear to be a correlation with wards that have an amber or red RAG rating for completion of documentation relating to prevention of pressure ulcers and an increased level of pressure ulcer development.

In addition to our internal process, the trust also captures data which is reported nationally within the Safety Thermometer (as outlined above and in section 3.2). This is a 'point prevalence' mechanism, collecting the data on one day per month across all inpatient areas. The Safety Thermometer data does not triangulate with our dashboard figures and shows a marked

reduction from April to September (Chart 6). Note that the data is reported by most severe pressure ulcer rather than all pressure ulcers therefore a patient with multiple stages of pressure ulcers will only have the most severe stage recorded.

Chart 6



	Apr	May	June	July	Aug	Sept
National	1.72%	1.66%	1.53%	1.49%	1.36%	1.30%
ASPH	2.21%	1.62%	1.33%	0.83%	0.99%	0.98%
Trust 1	1.37%	1.36%	3.13%	2.68%	1.30%	3.15%
Trust 2			1.17%	1.83%	0.62%	0.74%

Chart 6 shows Safety Thermometer figures for the percentage of patients with hospital-acquired pressure ulcers, April to September 2012 comparing ASPH with national figures and two local trusts.

The other key data stream used to aid understanding is the number of stage 3 and stage 4 pressure ulcers reported as Serious Incidents since this represents severe harm and failures of care to heal stage 1 and stage 2 pressure ulcers or prevent deterioration. Data for this has only been collected since September 2011 following a mandatory remit to report stage 3 and stage 4 pressure ulcers as Serious Incidents.

Chart 7 Pressure Ulcer Serious Incidents by month

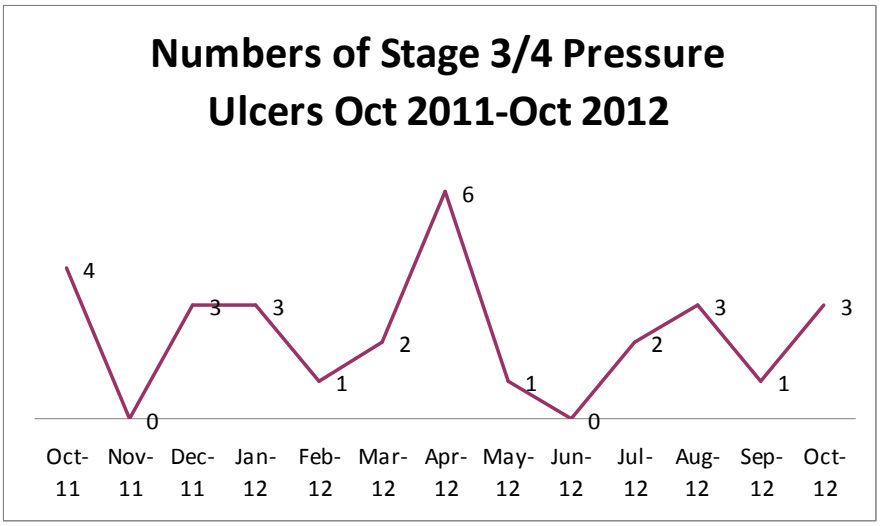
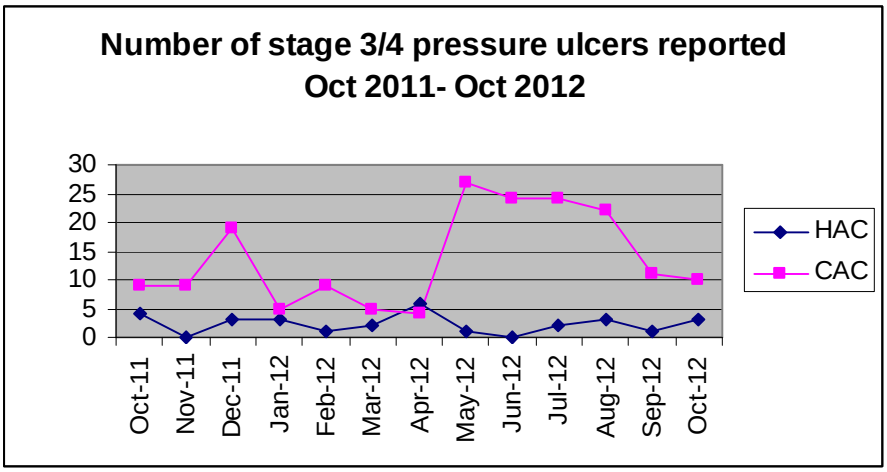


Chart 8 comparing number of Stage 3 and stage 4 pressure ulcers by month for both hospital (HAC) and community acquired (CAC).

Chart 8



Reflections on the Corporate Action Plan

Thus far despite increased awareness and tangible improvements in recognition and reporting, the number of pressure ulcer Serious Incidents has remained largely flat. A peak in April reflects a peak in National reporting although it is unclear why this is.

It is of note that some trusts class pressure ulcers as 'unstageable' or as a 'deep tissue injury' and therefore do not report them as a Serious Incident. For example, one trust in the South East has reported approx 40 'unstageable' and 'deep tissue injury' cases in the last year – categories which we would report as either a stage 3 or a stage 4.This practice is not supported by the European Pressure Ulcer Advisory Panel at present or by current NICE Guidance. In addition, many trusts do not report pressure ulcers that were present on admission and deteriorated to a stage 3 or stage 4. The ASPH approach is to recognise deterioration as a consequence of poor hospital care and therefore report it. This variation in approach has been discussed at the NHS Surrey Chief Nurses Forum.

The action plan has ensured that zero tolerance and a focus on prevention of pressure ulcers are high on the agenda throughout the trust (e.g. all trust PCs show screen savers advising on best practice for skin care). This has resulted in an increase in reporting and a trustwide approach to the prevention and early detection of pressure ulcers. An example showing the most positive effect has been that four patients identified with the first signs of developing deep tissue injury, which can progress to a stage 4 pressure ulcer, have been promptly referred to the Lead Nurse for Tissue Viability. The instigation of appropriate strategies has ensured that these do not deteriorate and indeed have improved. This is particularly true for heel pressure ulcers with the development of the decision tree for 'at risk' heels and the introduction of heel protectors throughout the Trust. This would suggest that the action plan is having a positive impact in care provision.

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. SIRI – Serious Incident Requiring Investigation
   The number of serious incidents reported by ward.
4. Matron Environment Audit
   Considers cleanliness of the area, storage of equipment and other items held on the ward, whether any maintenance is required.
5. Hand Hygiene Compliance
   Audits of members of staff cleaning/decontaminating their hands between procedures.
6. Saving Lives
   The compliance measurements that indicate the use of HighImpact Interventions in key clinical procedures with the aim of decreasing the risk of infection. Process measures include insertion and continuing care relating to central venous catheters, peripheral intravenous cannulae, care of ventilated patients, care to reduce healthcare associated infections.

   Outcome measures are:

   - 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 (STp.p)): Ensures the insertion and after care are undertaken in line with good practice to reduce urinary catheter related infections – this figure is taken from the monthly Safety Thermometer census held on one day on all inpatients i.e. this is a 'point prevalence' figure.
   - Catheter >29 days after care (ST p.p): Ensures the insertion and after care are undertaken in line with good practice to reduce catheter related bloodstream infections – this figure is taken from the monthly Safety Thermometer census held on one day on all inpatients i.e. this is a 'point prevalence' figure.
7. 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.
8. Hospital Acquired Pressure Ulcer (PU) stage 2 and above. New pressure ulcers which develop after 72 hours of the admission date.
9. VTE (Venous Thromboembolism) Assessment
   Patient has been risk assessed for development of VTE (Deep vein thrombosis, pulmonary embolism
10. VTE Mortality – outcome measure number of patients who have died following development of a venous thromboembolism or pulmonary embolism related to their hospital stay.
11. 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.

12. Falls outcome measures
    Total Falls: total number of falls
    Falls – resulting in serious harm to the patient (grade 3 or above)

13. 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.

14. Nutrition outcome measure – percentage of patients who were appropriately referred to a dietician.

15. 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.

16. Nursing documentation outcome measure – self-certification by ward managers that documentation has been regularly reviewed and that quality is assured.

17. Medication assessment
    Documentation is legible and completed appropriately, omission codes are utilized and allergies identified.

18. Medication outcome measure – number of medicine administration errors

19. Harm-free Care
    Outcome measure from the Safety Thermometer monthly census of patients on one day identifying patients who do <u>not</u> 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.

20. 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.

21. 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.

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

23. Privacy & dignity and SSA breaches
    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).

24. 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

25. Number of Ward Transfers
    % of patients transferred to another ward three or more times.

APPENDIX 3 Best Care Dashboard – October 2012

Essential Care Indicators		Patient Safety																						Patient Experience					
		Process: Patient Observations	Outcome: Cardiac Arrest calls	Outcome: SIRIs	Process: Matrons Environment Audit	Process: Hand Hygiene Audits	Process: Saving Lives	Outcome: MRSA	Outcome: C-Diff	Outcome: CAUTI (ST p.p)	Outcome: Catheter > 28days (aftercare)	Process: Skin Integrity	Outcome: Hospital Acquired PU stage >=2	Process: VTE Assessment	Outcome: VTE Mortality	Process: Falls and Manual Handling Assesments	Outcome: Number of Falls	Outcome: Number of Falls resulting in injury	Process: Nutrition	Outcome: Appropriate referrals to Dietician	Process: Nursing Documentation	Self-certification by ward manager	Process: Medication	Outcome: No of Administration Errors	Safety Thermometer Harm-free care	Patients >= 2 Harms	Communication	Complaints	Privacy & Dignity	SSA Breaches	Net Promoter	Number of Ward moves >=3
Acute Medicine & Emergency Services	Aspen	91%	↓ 2		95%	NS	100%					76%		100%		71%	→ 2		67%	100%	70%	Yes	88%		92%		65%	2	55%	0	-	19.0%
	CCU & Birch	90%	↓ 4	↓ 1	96%	96%	100%					100%	↓ 1	93%		96%			69%	100%	83%	Yes	94%		94%		94%	1	85%	0	78%	9.8%
	Cedar	90%	↓ 2	↓ 1	93%	100%	100%	↓ 1			↓ 2	100%		96%		94%	↓ 9		86%	100%	85%	Yes	88%		100%		79%	0	70%	0	-	8.8%
	Holly	90%			95%	100%	100%					100%	→ 2	80%		97%	↓ 2		91%	100%	87%	Yes	91%		100%		83%	1	73%	0	10%	8.8%
	May	91%			98%	NS	NS					90%		88%		96%	↓ 7		92%	100%	80%	Yes	88%	↑ 1	90%		57%	0	92%	0	100%	2.0%
	MAU	100%	→ 3		90%	95%	85%					97%		73%		100%	↑ 1		100%	-	100%	Yes	81%		76%		100%	2	82%	0	-	1.0%
	MSSU	92%	↓ 2		93%	100%	100%					100%		96%		100%			97%	100%	63%	Yes	69%		77%		75%	0	100%			4.8%
	Maple	89%	↓ 2		95%	100%	100%			↓ 1		92%		93%		96%			90%	100%	87%	Yes	92%	↓ 1	93%		58%	3	75%	0	81%	4.5%
	Fielding	94%		→ 1	90%	100%	100%			↓ 1		100%	↑ 2	100%		83%	↓ 4	↓ 1	100%	100%	81%	Yes	83%		76%		93%	2	36%	0	-	13.2%
	Chaucer	100%		↓ 1	93%	100%	100%			↓ 1		100%		-		69%	↓ 4	↓ 1	100%	100%	97%	Yes	93%		92%		94%	1	95%	0	100%	0.0%
	ED	-	→ 11		-	NS	-					-		-		-	-		-	-	-	Yes	-		100%		-	9	-	0	-	-
	Swift	80%	↓ 4	→ 1	93%	100%	93%			↓ 2		95%	↓ 2	100%		91%	↑ 6		72%	75%	78%	Yes	87%		74%		100%	2	100%	0	-	9.3%
	Wordsworth	100%	-		90%	100%	100%					100%		-		76%	↑ 5		100%	100%	93%	Yes	92%		80%		100%	1	93%	0	60%	12.5%
Surgery	Kingfisher	100%	↓ 2		-	98%	98%		↓ 1		→ 2	88%		96%		100%			100%	100%	100%	No	94%		100%		100%	0	100%	0	57%	37.4%
	Falcon & SDU	100%	↓ 3		-	97%	91%					79%		62%		89%	↓ 1		95%	100%	86%	Yes	93%		100%		92%	0	71%	0	50%	34.5%
	Heron	93%			-	100%	100%					91%		82%		83%			92%	100%	77%	Yes	87%		83%		86%	0	92%	0	-	45.9%
	SAU	81%			-	100%	100%					100%		79%		100%			96%	-	100%	Yes	94%		93%		100%	4	100%	0	54%	1.6%
T & O	Dickens	95%			97%	100%	100%			↓ 1		100%		83%		100%			99%	-	98%	Yes	74%		96%		100%	0	95%	0	82%	2%
	SWAN	98%			95%	97%	100%			↓ 2		95%	→ 3	90%		54%			85%	100%	80%	Yes	82%		90%		71%	0	60%	0	-	19.4%
ACCT	ITU	100%			-	100%	100%				→ 1	100%		83%		-			100%	100%	100%	N/A	100%	↓ 1	86%		100%	0	100%	0		33.3%
	MHDU	100%	↑ 1		-	100%	100%					100%		84%		81%			100%	100%	92%	Yes	90%		75%		93%	0	100%	0		30.2%
	Endoscopy	-			-	100%	100%					-		100%		-			40%	-	-	N/A	-		-		100%	1	100%		N/A	0.0%
	DSU & Theatres ASH	-			-	100%	100%					-		92%		-			93%	-	-	N/A	100%		N/A		100%	0	100%	0		-
	DSU & Theatres SPH	-			-	100%	100%					25%				-			97%	-	-	N/A	100%	↓ 2	N/A		100%	0	100%	0		-
Women's health & Paediatrics	Oak	96%			-	74%	100%					100%	N/A	-		100%			88%	-	100%	N/A	96%		-		92%	0	100%	N/A		0%
	Ash	96%			-	80%	100%					100%	N/A	-		100%			90%	100%	100%	Yes	93%	↓ 1	100%		83%	0	100%	N/A		0%
	NICU	100%		↓ 2	-	81%	100%					100%	N/A	-		-			96%	100%	98%	Yes	98%		100%		100%	0	100%	0	N/A	2%
	Paeds ED	-			-	76%	100%					-	N/A	-		-			-	-	-	N/A	-		-		-	2	-	0		0%
	Joan Booker	90%			97%	100%	100%					80%		96%		80%			100%	-	88%	Yes	100%		100%		50%	2	58%	0		18.9%
Outpatient	OPD (ASH)	100%			77%	100%	-														85%						100%	0	100%			
	OPD (SPH)	100%			100%	100%	-														87%						100%	5	100%			
	Ophthalmology (ASH)	100%	N/A	N/A	100%	98%	-			N/A		N/A	N/A	N/A	N/A	N/A			N/A		100%	N/A	N/A		N/A		100%	0	100%	N/A	N/A	
	Ophthalmology (SPH)	100%			96%	NS	-														60%						100%	0	100%			
	Maxillo-facial (ASH)	-			98%	98%	-														-						-	0	-			
	Maxillo-facial (SPH)	100%			98%	-	-														65%						100%	0	100%			

** 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 4 <u>Best Care Actions and Achievements per Division</u>

The Best Care Dashboard definitions are found at Appendix 2 and the Best Care Dashboard at Appendix 3. The following narrative is provided by the Matrons and Heads of Nursing for the areas.

Acute Medicine, Head of Nursing, (HoN), Justine Hillier

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Chaucer and Wordsworth	Manual Handling/Falls assessment	Failure to complete documentation	• Ward Manager given clear objectives and expectations • Falls nurse specialist carrying out focused project on both areas. • Matron placed at Ashford daily for 8 weeks to give focused support and development to Rehab wards. • Falls nurse to support Ward Managers to develop action plan relating to fall prevention • Falls Champions to be given non rostered time to work with Falls specialist nurse. • Ward manager to check documentation daily and challenge poor practice. • Staff repeatedly failing to meet required standards (3 occasions) referred to Head of Nursing.
Aspen	Nutrition Skin integrity Manual handling Nursing documentation	Ineffective leadership. (New Ward Manager recruited to start beginning Jan 2013)	• Present ward manager given clear objectives and expectations. • Head of Nursing to meet Leadership team, Matron, Band 7 and Band 6s to support development of action plan for targeted improvement. • Head of Nursing to attend Ward meeting re expectations and personal accountability. • Matron to meet with Ward Manager daily and support development • Head of Nursing & Matron to meet weekly with Ward Manager to evaluate improvement progress. • Nutrition nurse to assist in nutrition action plan. • Staff failing to meet required standards referred to Head of Nursing. • Daily documentation spot checks by Matron /Head of Nursing..
All medical wards	Nursing documentation -Failure of patient to sign care plan and disclaimer	Failure to complete	• Ward Managers expected to check documentation daily. • Ward Manager's monthly self certification for standards of documentation. • If repeat offenders then referral to Head of Nursing for discussion re accountability. • Matrons to monitor on daily basis.
Holly and MAU	VTE Assessment	Failure to complete/record	• Ward Manager to take responsibility for managing VTE recording. • Responsibility allocated to Ward Clerk to ensure recording. • Medical teams failing to complete VTE assessment raised with DD for follow up. • Compliance figures sent weekly to Ward Manager.

Anaesthetics, Critical Care, Theatres (ACCT) and Outpatients, Head of Nursing, Kate Eidens, Matrons Den Hallett and Jane Ryman

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
DSU/Theatres Ashford	**Nutrition**	Booking	Currently working with Orthopaedics to improve admission times of patients
All areas	**Environment audits**	IT data submission error	Matrons to liaise with IT
Critical Care	**VTE Assessment**	Information info error	Matrons to liaise with Information dept
	Safety Thermometer	Nil: reflection of acuity of patients	Monitor ICU & MHDU pt's
Theatres SPH	**Skin Integrity**	Poor recording of Intra operative Waterlow	Matrons 1:1 & attendance in theatre

Area	Achievement	Explanation
DSU/Theatres Ashford	VTE green	No patient goes to Theatre from DSU without VTE complete assessment
DSU/Theatres Ashford	No medication errors	Exemplary practise in prescribing and administering medications to Day Case patient
Critical Care	No complaints for the year	High Levels of communication & feedback
Theatres SPH	High completion of operative lists despite staffing shortfalls	Commitment from staff

Paediatrics, Head of Nursing, Julie-Anne Dowie – Exception report – reporting on reds only

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Oak Ward and Paediatric A&E	Hand hygiene	Non compliance of some staff	Continue to raise profile and encourage good practice hand hygiene among all professions who visit clinical area. Discussed with Clinical Lead to continue to raise the profile and importance amongst all medical staff and junior doctors.
NICU	X2 SI's initiated	Investigation underway	Investigation commenced. Terms of Reference agreed

Maternity, Matron Alison Howker

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
Joan Booker Ward	Amber for communication and privacy and dignity	We did not have written objective standards to measure this before and there was discussion over whether doing what we do well should be recorded as amber -good or excellent –green	Objective standards to observe for in maternity have now been written to give the Matron who assesses the area a clear framework to assess how we are doing.
Joan Booker Ward	Amber for manual handling and waterlow score 80%	This needs to be recorded as soon as women come to the ward	Ward manager is checking this is completed as part of her daily check and addressing with individuals when she sees record keeping isssues

Surgery, Head of Nursing, Sue Sexton

Area	Reported underperformance	What is driving the underperformance	Actions to improve performance
SAU	Medication Assessment	Patients are being admitted after the pharmacist has completed ward round, therefore the medicines reconciliation chart is not being completed	Sister has spoken to pharmacist and will ensure this is completed the following day
	Patient Observation	The location of charts does not support nurses to accurately complete fluid balance charts	Charts will be kept at the end of patients beds and not in the notes
Falcon & SDU	Risk Assessments	Nurses are not accurately complete and reassess risk assessments which may be due to insufficient Clinical Practice Educator support	CPE post has now been recruited to (Acting Position) Increased spot checks in between monthly audits by Sister, Matron & CPE
Heron	Nursing Documentation	Nurses are not completing discharge section 1 on admission and are not signing & dating all entries. Hand writing is not always legible.	Sister is identifying staff responsible by daily checking of documentation and meeting with them to discuss reasons for non-completion Matron to complete spot check audits in between monthly audits

Kingfisher	Skin Integrity	Nurses are not personalising and evaluating care plans High numbers of temporary staffing used and vacancies unfilled	Sister to ensure that patients are more involved in care planning process and need to be encouraged to sign documentation to provide evidence Sister is completing daily checks and additional spot checks are being carried out by the matron

Area	**Achievement**	**Explanation**
Kingfisher & SAU	Both areas have seen an improvement in their overall scores in month and both have only one red score for October	Increase in the number of substantive staff now in post Vigilant monitoring by the Ward Sister and Matron

Trauma & Orthopaedics, Head of Nursing, Sue Sexton

Area	**Reported underperformance**	**What is driving the underperformance**	**Actions to improve performance**
Dickens Ward	Medication Assessments	Doctors are not using capital letters to prescribe medicines	Sister is checking the prescription charts daily Matron to complete spot check
Swan Ward	Manual Handling Privacy & Dignity	Nurses are not completing or updating the assessments in a timely manner Nurses are not introducing themselves to patients or giving them the option of wearing their own clothes	Sister is identifying staff responsible by daily checking of documentation and meeting with them to discuss reasons for non-completion Matron to complete spot check audits in between monthly audits Sister to ensure that nurses document that the patients have been asked if they would like to dress in their own clothes

Area	**Achievement**	**Explanation**
Dickens Ward	Dickens have seen an upward trend in all elements of the dashboard and have reduced to 2 red scores in month	Sister sent all staff individual letters setting out her expectations
Swan Ward	Swan have seen an improvement in Patient Observation and Skin Integrity in month with no red scores in these areas	Implementation of new care plans and staff are taking more responsibility and accountability for their own actions

APPENDIX 5 Patient Experience Dashboard

Oct-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	0	6	▶	25	160	▲	0	12	▶	1	3	▲	3	30	▲	5	34	▼	3	22	▲	9	42	▲	**46**	**268**		<500
Discharge related complaints	0	0	▶	6	22	▲	0	0	▶	0	0	▶	0	0	▶	1	3	▲	0	4	▶	0	2	▶	**7**	**31**		<73
% Response timescales met	N/A	86%	▶	82%	68%	▲	N/A	92%	▶	N/A	50%		100%	91%	▶	71%	64%	▲	100%	85%	▶	86%	88%	▲	**80%**	**76%**	95%	>95%
PALS Concerns	1	20	▲	16	157	▲	13	70	▲	10	40	▲	17	120	▲	4	91	▼	7	67	▼	8	40	▲	**76**	614	tba	tba
NPS* see key below				57%	57%	▲										56%	51%	▼	77%	65%	▲				**64.0%**	**61%**	65%	65%
Intimations of claims	1	2	▲	2	6	▶	0	0	▶	0	0	▶	1	4	▲	2	13	▲	2	5	▲	3	12	▲	11	41	tba	tba
Reported claims	0	2	▶	0	1	▼	0	0	▶	0	0	▶	0	2	▶	0	1	▼	0	2	▶	0	5	▼	0	17	tba	tba
NHS Choices +ve rec rate Ashford																										100%		n/a
NHS Choices +ve rec rate St Peter's Hospital																										92%		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 & Emerg Servs	Medical Wards x 12	Trust Inpatient NPS score
WH & Paedaitrics	Maternity & Paed Inp	Trust Inpatient NPS score
Surgery	Surgical Wards x 5	Trust Inpatient NPS score
Trauma & Orthopaedics	Orthopaedic Wards x 3	Trust Inpatient NPS score
Spec Med & Spec Surgery	Outpatient - rolling dept survey	Trust Outpatient NPS score
Diagnostics & Therapeutics	Outpatient Areas	Trust Outpatient NPS score
Null	Insufficient or no data provided	