Quality Report for the Trust Board Meeting – May 2012
Patient Experience

1.0 Introduction

The following report aims to inform the Trust Board of current trends and activities associated with patient experience. This includes presenting data and summaries from:-

- Patient Services Team,
- PALS (Patient Advice and Liaison Service) team
- Trust Volunteers
- National Inpatient/Outpatient 'patient experience' surveys,
- Patient Experience Action Team report
- The Friends and Family Test
- Patient Experience and Nursing Indicator metrics
- Privacy and Dignity surveys.
- Comfort rounds
- High Risk Scrutiny Group
- Patient Engagement and Involvement Panel

2.0 Patient Services Team

The Patient Services team consists of staff handling complaints, comments, concerns and compliments, as well as providing bereavement services and overseas visitors assessments.

In 2011/12 there was an increase of 3.5% in the number of complaints received and accepted for investigation compared with the previous year. During the first three Quarters of 2011/12 the number of complaints responded to and closed each month, fell behind the number of new complaints received, which developed a backlog.

In Quarter 4, following a number of staffing changes and developments in process, there was a 42% increase in closure rate achieved, compared with the same period in 2010/11. As a result of this progress, there has been a significant decrease in the overall active caseload of complaints under investigation and in the number of cases overdue for a response.

The Patient Services team has continued to place greater expectations on Clinical Centres to better investigate and respond to complaints received about their services. This will continue to develop during 2012/13 and training will be arranged to support and progress this. The newly adopted case management structure will also support more efficient communication between PST team and clinical centre leads.

There is now a greater emphasis placed on the analysis of the active caseload in the complaints team and the oldest 30 cases awaiting a first response are now subject to regular exception reporting. The patient services team are further developing their processes and staffing arrangements to maintain and build on the progress made and to improve the timeliness and quality of responses issued. They are also planning to develop the way in which Clinical Centres are engaged in complaint handling activities.

In 2011/12, there were 47 referrals to the second stage of the complaints process; however, no cases were accepted for investigation by the Ombudsman. About a third of these cases were returned for further or ongoing local resolution and the rest were for no further action. One investigation from 2010 was concluded by the Ombudsman in 2011.

The Patient Services team handle not only complaints but also comments and suggestions, concerns and compliments. All feedback is disseminated to the relevant staff for their information and action as required and is acknowledged by either the Patient Services team or the Chief Executive. In 2011/12, the Patient Advice and Liaison Service (PALS) handled 1,962 concerns and also acknowledged over 3000 compliments.

The issues being raised and reported by patients and their relatives bear similarities across these different patient experience functions and activities, this information is used to triangulate and identify hot spots which require further investigation and scrutiny.

Serious complaints are also raised on a weekly basis at the High Risk Scrutiny to subject to the triangulation process this meeting employs to identify hot spots.

The main themes identified in complaints and PALS concerns in 2011/12, were in respect of:

- Care, monitoring, review delays
- Outpatient Appointment problems
- Communication issues involving patients and carers

The main areas complained about were:

- Outpatients
- The Accident and Emergency Departments
- Car Parking

3.0 PALS Report

PALS (Patient Advice and Liaison Service) receive contacts from patients, relatives and the public about how the Trust's services are provided. Contacts can include enquiries, concerns, or requests for information or help. Where applicable, PALS will signpost people to alternative services where they can get the help they seek.

The breakdown by area is as follows:

PALS October 2011 to December 2011: Total 479

The three main themes are:-
Appointments 97 contacts
Communication (including staff attitude and information) 222 contacts
Care monitoring review delays 31 contacts

Appointments	
MEDICINE	25
SURGICAL	37
OPHTHALMOLOGY AND BOOKING	17
WOMEN AND CHILDREN	3
HEAD AND NECK	6
MUSCULOSKELATAL	7
DIAGNOSTICS	2
Communication	
MEDICINE	64
SURGICAL	52
OPHTHALMOLOGY AND BOOKING	10
WOMEN AND CHILDRENS	21
HEAD AND NECK	4
MUSCULOSKELATAL	14
DIAGNOSTICS	11
EMERGENCY & CRITICAL CARE	14
ESTATES	4
OTHER	12
THERAPIES	1
FINANCE	2
CORPORATE SERVICES	2
TRANSPORT	1
ONCOLOGY	10
Care, monitoring, review delays	
MEDICINE	9
SURGICAL	12
OPHTHALMOLOGY AND BOOKING	1
WOMEN AND CHILDRENS	2
HEAD AND NECK	2
MUSCULOSKELATAL	3
EMERGENCY & CRITICAL CARE	1
ONCOLOGY	1

PALS January 2012 to March 2012: Total 521
The three main themes are:

- Appointments 113 contacts
- Communication (including staff attitude and information) 212 contacts
- Care monitoring review delays 35 contacts

Appointments	
MEDICINE	20
SURGICAL	31
PATHOLOGY	2
OPHTHALMOLOGY AND BOOKING	26
WOMEN AND CHILDREN	8
HEAD AND NECK	7
THERAPIES	3
MUSCULOSKELATAL	13
ONCOLOGY	2
DIAGNOSTICS	1
Communication	
MEDICINE	49
SURGICAL	52
HEAD AND NECK	7
THERAPIES	3
MUSCULOSKELATAL	15
ONCOLOGY	6
DIAGNOSTICS	7
EMERGENCY & CRITICAL CARE	11
OTHER	28
ESTATES	4
FINANCE	3
WOMEN AND CHILDREN	12
OPHTHALMOLOGY	7
CORPORATE SERVICES	5
TRANSPORT	1
PATHOLOGY	2
Care, monitoring, review delays	
MEDICINE	12
SURGICAL	8
HEAD AND NECK	1
THERAPIES	1
MUSCULOSKELATAL	4
ONCOLOGY	5
DIAGNOSTICS	3
EMERGENCY & CRITICAL CARE	1

The trends for PALS contacts continue to include issues with communication and service delays, particularly in outpatient services. The same themes are demonstrated in Complaint data, as per the earlier data presented in this report.

The themes identified within the PALS and complaints data are also reflected within the National Outpatient Survey results for 2011 , a draft action plan to address these and others issues has been presented to the Clinical Centre for action. Progress with the action plan will be monitored through the clinical centre governance structure, reporting progress quarterly to Q&S and PEIP.

A copy of the action is attached as Appendix 1.

4.0 Ward to Board Quality Assurance Tool (Patient Surveys)

The Ward to Board Quality Assurance Tool has been included in previous Quality and Safety Committee reports. In September 2011, peer review audit collection commenced on 4 wards, with senior nurses (Matron grade and above) 'adopting' wards. It has been agreed that the same senior nurses will undertake both the comfort round and ward to board audits on their adopted wards. The tool is now employed across all the wards but not OPD, this is due to implemented within these areas later this year

The objective is to give the opportunity for relationships to be developed between the senior nurse and the ward teams and for dedicated structured support to be provided to the team to improve their performance and drive up standards in care delivery using a non-threatening and nurturing approach.

The Ward to Board Quality Assurance Tool includes fundamental care audits, which consist of 9 nursing metrics and a real time patient experience survey which includes 12 questions ranging from cleanliness of the ward to discharge planning.

The Ward Managers and Matrons are tasked with producing action plans to address the areas of concern identified in the survey, the action plans are to produced quarterly and presented and monitored at Clinical Centre Governance meetings and NMF .

The trust is developing a standardised quality board which will be displayed in each ward department area, the ward or departments Ward to Board metrics will be displayed along other data such a number of falls, pressure ulcers and complaints. This information will provide a visual indication of the standard of care that patients, family and staff can expect to be delivered on that ward.

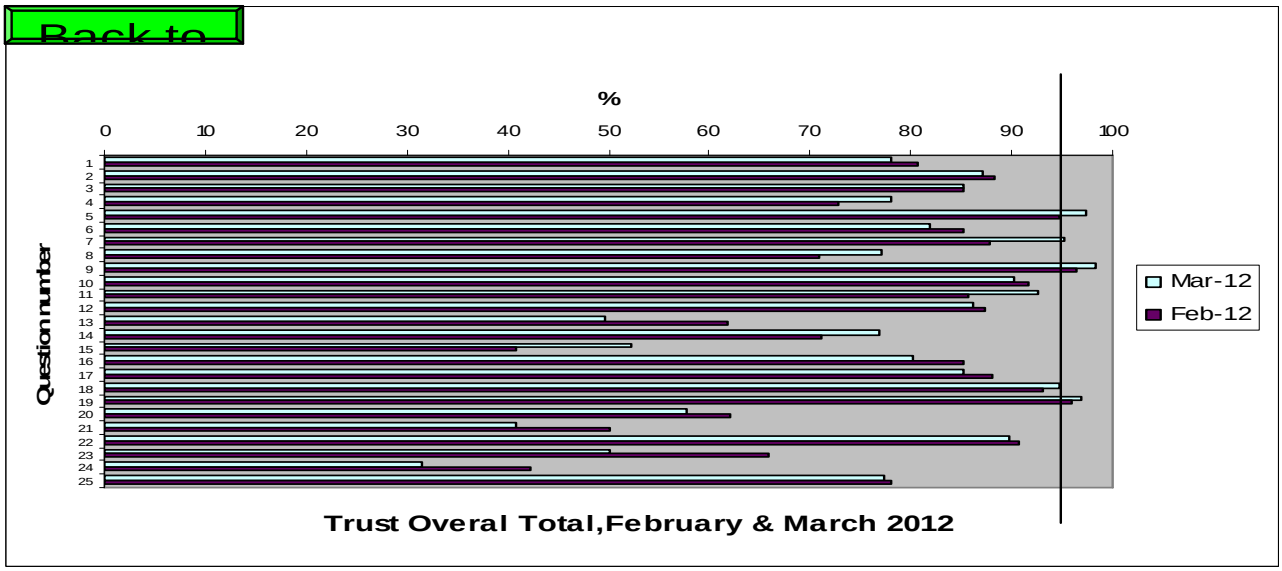
Patient Experience Metrics – September 2011 - April 2012

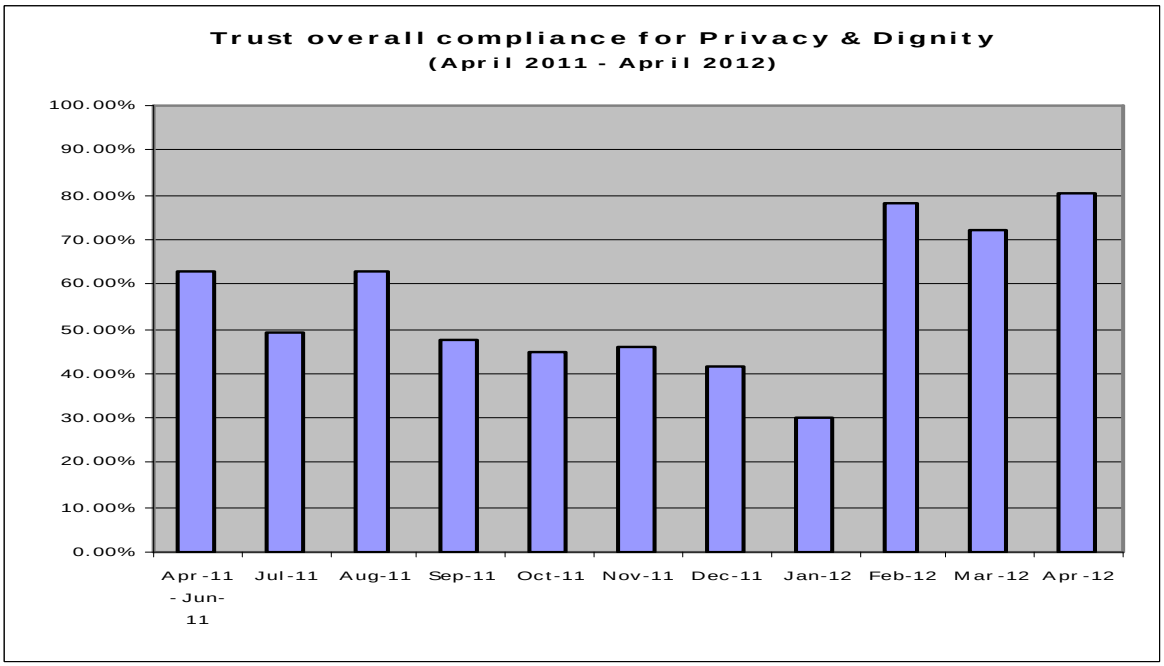
	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012
How clean is this ward (including toilets)?	95%	94%	91%	92%	97%	95%	94%	95%
As far as you know do the staff wash or clean their hands between touching patients?	91%	92%	92%	91%	95%	93%	94%	95%
Do you feel informed about potential medication side effects?	72%	58%	65%	71%	60%	67%	62%	46%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	91%	87%	82%	85%	86%	92%	85%	88%
Do you feel that you have been treated with respect and dignity while you are on this ward?	97%	96%	96%	90%	95%	97%	95%	91%
Do you feel involved in decisions about your treatment and care?	68%	77%	82%	80%	83%	82%	86%	80%
Have hospital staff been available to talk about any worries or concerns you have?	84%	86%	90%	81%	90%	89%	84%	82%
Do you get enough help from staff to eat your meals?	83%	86%	92%	83%	90%	90%	90%	92%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100%	99%	100%	97%	99%	98%	98%	100%
Do you think hospital staff do everything they can to help control your pain?	96%	88%	90%	82%	90%	91%	89%	89%
When you use the call buzzer is it answered?	77%	81%	90%	82%	83%	85%	80%	88%
Have staff talked to you about your discharge from hospital?	32%	50%	61%	52%	55%	55%	62%	64%
Total	**82%**	**83%**	**86%**	**82%**	**85%**	**86%**	**85%**	**83%**

Privacy and Dignity Survey

A system has been put in place to ensure that 6 dignity and privacy patient surveys are completed for allocated wards on a monthly basis. Surveys are completed by Clinical Nurse Specialists and are returned to the Clinical Governance Department for scanning and analysis upon completion. The compliance rate in completion has fallen with a number of wards failing to submit their surveys. The wide variation in response needs to be addressed in order to enable meaningful and reliable conclusions to be made from the data.

The survey is divided into 9 areas; Autonomy, Communication, Eating and Drinking, Pain and Discomfort, Personal Hygiene, Safety, Privacy and Dignity, Social Inclusion and Environment. The results for Trust overall compliance for the year 2011 – 2012 are attached below. The trust needs to see considerable improvement if the 95% overall score is to be achieved in 2012 - 13.





There are some similarities in the results from the Privacy and Dignity Surveys and the Ward to Board Patient Experience Survey.

Again, results suggest that we have issues in the Trust in relation to the timely response of answering call bells, discussing medication and preparing patients for discharge including .

Results have been shared with individual Lead Nurses and Matrons for the areas audited, action plans will be developed and monitored within individual Clinical Centres and progress reported at NMF.

Clinical Centres and Matrons have also been tasked with improving the compliance in completion of the audit there is consistent problem at PRH which will require immediate attention. Discussion has taken place with both Matrons and the Audit Department to see if it is feasible to incorporate the Privacy and Dignity questionnaire into the current Patient experience metric survey. This would be efficient in terms of time and effort and will enhance compliance in completing the audit

The proposal is to review the current Privacy and Dignity Survey against the surveys included within the Ward to Board Tool and include the Dignity survey into the electronic Ward to Board Tool and collect the information on a quarterly basis. It is envisaged that this will simplify the process, the Senior Nurses who have already 'adopted' wards will complete as part of their monthly data collection on a quarterly basis. However, most importantly any outstanding actions/issues will be included in the ward action plan and monitored against the Ward to Board Performance Assurance Framework and progress reported to NMF.

A number of initiatives are taking place in 2012 which aim to drive improvements:

- Clinical centres have been asked to identify Dignity Champions who will have a package of training delivered by Prof. McSherry during May 2012 , these Dignity Champions will then provide cascade training in their clinical areas to drive forward the delivery of patient centred dignified care
- A comprehensive review of nursing documentation including the discharge checklist
- National Inpatient Action plan will address concerns relating to medication information and discharge after care
- A uniform visual indicator of quality will be developed for the lobby areas of all wards which will at a glance give a patient , carer or staff a clear indication as the safety of care likely to be delivered by that ward
- This will incorporate a Safety Cross
- Patient Experience Metrics
- Cleanliness monitoring scores
- Comments

Comfort Rounds

Since the last report to board was presented the comfort round has been reviewed , in its latest iteration it has been amended to incorporate key elements of the comfort round including hydration and assessment of pain, as well as the SKINN care bundle and the Dementia Care plan . This new version will be trialled during June 2012 and rolled out subsequently.

Monthly Average % non-compliance, by question

	Month							
Question	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	**YTD Average**
1	100%	44%	35%	17%	22%	8%	7%	**33%**
2	25%	8%	10%	5%	1%	5%	3%	**8%**
3	100%	41%	5%	18%	14%	25%	17%	**31%**
4	80%	8%	0%	4%	13%	9%	3%	**17%**
5	100%	37%	15%	18%	15%	26%	17%	**33%**
6	60%	42%	0%	20%	13%	30%	10%	**25%**
7	100%	38%	0%	12%	14%	24%	20%	**30%**
8	85%	27%	5%	14%	11%	13%	7%	**23%**
9	100%	42%	0%	14%	16%	24%	23%	**31%**
10	55%	3%	10%	3%	6%	16%	0%	**13%**
11	3%	0%	10%	8%	9%	6%	3%	**6%**
12	100%	17%	0%	16%	14%	23%	20%	**27%**
13	8%	12%	0%	13%	6%	9%	3%	**7%**

Number	Question text
1	Are the demographics completed in black ink or a patient identification label attached?
2	Is the date documented?
3	PAIN - is there an initialled entry in each timed column?
4	PAIN - if any evidence of pain is recorded has this been actioned?
5	POSITION - is there an initialled entry in each timed column?
6	POSITION - if patient is restricted to bed rest is their position noted?
7	TOILET - is there an initialled entry in each timed column?
8	TOILET - for patients restricted to bed is there evidence of action as appropriate?
9	DRINK - is there an initialled entry in each timed column?
10	DRINK - if any concerns documented in regards to fluid intake is there evidence of action as appropriate?
11	DRINK - Is the patient's drink within reach?
12	ANYTHING ELSE - is there an initialled entry in each timed column?
13	CAN THE PATIENT REACH THE CALL BELL?

High Risk Scrutiny Group

The High Risk Scrutiny Group continues to meet weekly to triangulate serious incidents, complaints and safeguarding concerns. During April the meeting received presentations form the Named Nurse for Safeguarding Vulnerable adults updating the meeting on action plans from previous incidents, the group will receive similar presentations at the fourth meeting of every month from any clinical centres which has a closed Serious Incidents (SI), action plan and lessons learned to present.

National Inpatient and Outpatient Surveys 2011

National Inpatient Survey 2011

The results of the 2011 National Inpatient survey were published in April 2012. An initial review of the ratings we have achieved show that we are about the same as other hospitals in England. We have shown significant improvement in two areas both relating to how quickly we move patients into a bed on a ward.

		CQC Inpatient Survey 2011		CQC Inpatient Survey 2010
		Published April 2012		Published April 2011
		502 patients who were inpatients in June, July or August 2011		444 patients who were inpatients in June, July or August 2010
	Score	Comparison with other Trusts in England	Score	Comparison with other Trusts in England
The Emergency/ A&E Department	8/10		7.6/10	
Waiting lists and planned admissions	6.3/10		6.4/10	
Waiting to get a bed on a ward	8.3/10		7.7/10	
The hospital and ward	8/10		8.1/10	
Doctors	8.3/10		8.4/10	
Nurses	8.4/10		8.4/10	
Care and treatment	7.3/10		7.2/10	
Operations and procedures	8.2/10		8.3/10	
Leaving a hospital	6.5/10		6.7/10	
Overall views and experiences	5.6/10		6.4/10	

National Outpatient Survey 2011

There are four major area were we need to demonstrate improvement, relating to the patient bedside environment, the quality of the food, information we give to our patients about their medication and who to contact if a patients condition deteriorates after discharge. Whilst these areas had improved or declined since our last survey in 2010, the overall score was still “about the same “as other hospitals.

The key areas for development are:

- Ensuring patients are given the opportunity to discuss their discharge with a member of clinical staff
- Ensure patients are given information about their medication and potential side effects
- Ensure that the patients are given information about what to do and who to contact if their condition deteriorates after discharge

- Improve the quality of the patient experience in relation to the food offered at mealtimes

The National CQC Outpatient survey conducted for 2011 was reported February 2012.
The trust overall performance in relation the eight domains questioned was about the same as other trusts in England, and the overall performance had also improved from the 2009 score. 8.8/10 compared with 8.5 in the 2009 survey.

Overall the trust performance has remained largely constant but certain domains surrounding patient information, patient choice and involvement in care have shown a significant downward shift since the last survey.

Key themes surrounding the engagement of the patient in the outpatient process have emerged:

- Patient information
- Information about waiting times in OPD
- Involvement in care choice/treatment
- Explanations given to patient about tests and treatments

In considering an improvement plan it is proposed that the next step will be to disseminate results across the organisation and to draw up a Corporate and Clinical Centre action plans to address the areas of concern highlighted in this briefing.

	CQC Outpatient Survey 2011	
	Published February 2012	
	500 patients who attended an outpatient appointment in April and May 2011	
	Score	**Comparison with other Trusts in England**
Before the appointment	7.2/10	
Waiting in hospital	4.8/10	
Hospital environment and facilities	8.7/10	
Tests and treatment	7.9/10	
Seeing a doctor	8.5/10	
Seeing another professional	8.6/10	
Overall about the appointment	8.1/10	
Leaving the outpatients department	6.3/10	
Overall impression	8.8/10	

Patient Experience Action Team (PEAT)
In our 2012 annual PEAT inspection the trust has been rated as excellent in the patient environment, patient food and providing privacy and dignity. In a recent innovation members of the trust Patient Engagement and Involvement panel have been involved in conducting a periodic mini version of the PEAT inspection.

Site Name	Environment Score	Food Score	Privacy & Dignity Score
ROYAL SHREWSBURY HOSPITAL	5 Excellent	5 Excellent	5 Excellent
PRINCESS ROYAL HOSPITAL	5 Excellent	5 Excellent	5 Excellent

Patient Engagement and Involvement Panel
The patient Experience and Involvement Board supports the Trusts principals of "Putting the patient first" by inviting patients and patient representatives to come together as a group and support and equally challenge the Trust around the delivery of care so that care provision continually improves and the patients experience of their care is as positive as it can be.

Members are provided with comprehensive training programme and sign a concordat to guide their conduct on the clinical areas

The PEIP panel undertake a programme of work which is determined through the review of the patient experience surveys, reports and inspections and determine the priorities for improvement

PEIP Work programme

Real time patient feedback (ward / depts / OPD)	Protected meal-time audits
Observations of care	Equality Duty Systems (EDS) Panel membership
Collecting Patient Stories	Reviewing external reports
Facilitating Patient Diaries	Reviewing internal reports
Ward Reviews following concerns	Involvement with progressing inpatient survey
Planned reviews on wards / departments	Involvement with progressing outpatient survey
PEAT Inspections	Active involvement for themed workshops for Quality Improvement (Strategy Quality Accounts)

Observations of Care
Members of the Patient Engagement and Involvement Panel (PEIP) have recently undertaken Observations of care on wards and departments in the trust. An observation is conducted for an hour and a half and the observations noted. Immediate feedback is given to the team being observed and a summary sent to the Matron for the area visited, any action needed to be acted upon immediately are completed and an action plan is formulated if required . The PEIP members feed back on the observations during the PEIP meeting. Themes that have emerged are:

- Use of Personal Protective Equipment
- Standard of work of the ward domestic staff.

Volunteer role in enhancing the patient experience
Responsibility for the recruitment and retention of volunteers and the development of volunteers across the Trust lies with the Foundation Trust Co-ordinator who is a member of the Compliance and Risk Management team.

All volunteer roles are created with the aim of enhancing and improving the patient experience whilst supporting the work of our staff teams. Current roles are many and varied and include general ward helpers, administration and clerical support roles, chaplaincy helpers, fundraisers and clinic volunteers.

Several new roles have recently been introduced and it is hoped that these roles will have a positive impact on the experience of the patients in our hospitals. One such role is that of Be-friender, individual volunteers are allocated a specific ward and, with the assistance of ward staff, will identify patients who may not have visitors or access to social support from family members or friends. The Be-friender will then introduce him or herself to the patient and explain their role. They will then ask the patient if they would like to spend some time chatting. Feedback received from both volunteers and ward staff has been very positive and a considerable number of volunteers currently completing the recruitment process have applied specifically for this role.

A further new volunteer role recently introduced is that of Patient Survey Volunteer. The volunteers will become involved in a variety of surveys and will be trained in various methods to capture information. Patient Survey Volunteers have recently been involved in the Net Promoter questionnaire and it is anticipated that they will soon be active in our Out Patient Departments, assisting with the 10 Point Dignity Challenge.

The Trust has exceptional support from a very high number of volunteers currently numbering over 500 in total.

Friends and Family Test – Net Promoter Question
NHS Midlands and East's (SHA) Board has endorsed the implementation of a headline metric, "Net Promoter" question and methodology, for monitoring real time patient experience data across the NHS in our region.

In 2010 the new coalition government announced in the White Paper their intention to strengthen efforts to tackle both the problem of relatively poor clinical outcomes and that of insufficient focus on patient experience and patient engagement.

The slogan, 'no decision about me, without me' was coined in the context of shared decision making and a particular emphasis was placed upon using information and choice to empower patients. The current NHS Reforms argue that patients should be in control of their care and involved in the decisions made, which means the NHS must be more open and accountable and must properly involve individuals throughout the patient journey. A modernised service will publish more information about the quality of its care so that patients can hold the NHS to account and clinicians can see where they need to improve.

The lessons from the Francis Review into the Mid Staffordshire NHS Foundation Trust underlined the vital link between patient and public engagement and quality and the risks when the two are not linked.

From the 1st April 2012 all acute hospitals must ensure that a minimum 10% of their weekly footfall (discharged patients) of patients is asked the "Net Promoter" question and the results reported to staff, boards, commissioners and the SHA. The SHA will publish the results on NHS Local and in their Board reports. Commissioners are expected to set a contractual trajectory to improve their acute provider "Net Promoter" scores by 10 points over the next year using month 1 of financial year 2012-13 as the baseline for improvement. This programme is a CQUIN for 2012/13

Moreover this Net Promoter question will in time roll out across all services provided within the Trust.

Commissioners are asked to ensure that the standardised "Net Promoter" question and methodology is asked in all existing patient surveys from 1st April 2012, i.e.

"How likely is it that you would recommend this service to friends and family?"

- Extremely Likely?
- Likely?
- Neither likely nor unlikely?
- Unlikely?
- Not at all?
- Don't Know?"

The answers will be mapped to the following scoring system.

- Score Question scale
- Promoters Extremely likely
- Passive Likely
- Detractors Neither Likely
- nor Unlikely
- Unlikely
- Not at all
- Don't Know

The Net Promoter will be determined by the percentage of detractors subtracted from the percentage of promoters to obtain a net promoter score. Weekly figures should be submitted to commissioners and NHS Midlands and East on a monthly basis.

We propose to ask the standardised "Net Promoter" question and methodology to all patients within the Trust. Initially this will be within the acute inpatient services from 1st April 2012 and a roll out programme over a 12 month period to include, A&E, Out Patients, and Day Case services.

The Trust has two key actions to ensure compliance:

1. To develop systems and processes to capture the Net Promoter replies and report
2. Resources required include facilitating, collating, analysing, reporting and monitoring action required to improve patient experience.

Proposed Roll out plan

- April – May introduce the Net Promoter Question (NPQ) across all acute inpatient areas excluding OPD, AED, and Day patient areas. Any member of staff can ask the question of the patient. A paper scannable form will be used to ask the question of all patients discharged, the forms will be collated on the ward placed in ward audit box and collected on a Friday by Audit team and scanned into database. We collect data weekly but report monthly to SHA. April data will set our benchmark. Month one data fed back to clinical centres for action plans to be produced
- We had approx 5500 discharges in March 2012 so we need to question 138 patients a week arcos site
- May – June Introduce Volunteers to ward areas to ask the NPQ using real time patient devices (PDA). Review data collected and determine if alternative methods of asking the NPQ are required
- June-July roll out NPQ into AED, OPD and Day Case areas using Volunteers and PDA's. Clinical centres action plans to be reviewed.

April 2012 Benchmark month data

Friends and Family Submission Proforma

ITEMS in YELLOW: please select from drop down
ITEMS in BLUE: please type value
ITEMS in GRAY: will auto populate

1.0 Submission descriptors

1.1 PCT cluster name (select from list)	West Mercia PCT Cluster
1.2 Time period – month (select from list)	APR
1.3 Provider name (select from list)	Shrewsbury and Telford Hospital NHS Trust
1.4 Provider procode (populates automatically, please review)	RXW
1.5 NPS tool (please detail the data collection route)	

2.0 Submission confirmations

2.1 Confirmation of survey timeliness (survey within 48 hours of discharge)	YES
2.2 Confirmation of internal reporting (monthly reporting to board at organisational, speciality and ward level, including plans for improvement)	YES
2.3 Confirmation of weekly reporting (if you are submitting combined monthly data please insert all figures under week 1)	YES

3.0 Organisational NPS Response

	Week 1	Week 2	Week 3	Week 4	Week 5
START DATE	01/04/2012	08/04/2012	15/04/2012	22/04/2012	N/A
END DATE	07/04/2012	14/04/2012	21/04/2012	28/04/2012	N/A
3.1 Total number of inpatients in period (number of defined DISCHARGES within calendar month)	1248	1083	1215	1212	

3.2 Total number of responses in period (number of NPS responses from cohort in 3.1)	248	217	201	235	
3.3 Number of promoters	155	156	148	159	
3.4 Number of passives	73	51	43	63	
3.5 Number of detractors	20	10	10	13	

4.0 Net Promoter Score

	Week 1	Week 2	Week 3	Week 4	Week 5
4.1 Organisation NPS - weekly (automatically populates from data entered above)	54.43548387	67.28110599	68.65671642	62.12765957	#DIV/0!
4.2 Organisation Monthly (automatically populates from data entered above)	63.12524146				

Recommendations
The Board is requested to **DISCUSS** the contents of the report.

Graeme Mitchell
Associate Director of Patient Quality and Experience
The Shrewsbury and Telford Hospital