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

TRUST BOARD
30 July 2015

TITLE	**Quality Report**
EXECUTIVE SUMMARY	The Quality Report is presented for June 2015. Please refer to the Executive Summary on page 3.
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.
ALIGN TO TRUST RISK REGISTER	Refer to Risk Scrutiny Committee submissions.
LINK TO STRATEGIC OBJECTIVE	**SO1**: Best outcomes. **SO2**: Excellent experience.
STAKEHOLDER / PATIENT IMPACT AND VIEWS / STAFF VIEWS	Patients' views are included via the reporting mechanisms for quality. The clinical quality metrics indicate where poor care and poor experience are occurring. Where appropriate staff views are included.
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 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Compliance with these regulations is a legal requirement and failure to do so could affect the Trust's Care Quality Commission registration and Monitor licence.
The Trust Board is asked to:	Review the paper and discuss the contents seeking additional assurance as necessary.
Submitted by:	Dr David Fluck, Medical Director and Mrs Heather Caudle, Chief Nurse
Date:	24 July 2015
Decision:	For Assurance

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1 Executive Summary

Scorecard
The scorecard on page 3 is defined on pages 18-19. Areas outside limits are shown below.

In-hospital Deaths
There has been no significant change regarding In-hospital deaths which at 88 is marginally above limit of 86 but just below May of 91.

Mortality Reviews
The proportion of mortality reviews completed in June is 59% which largely reflects performance in the Acute Medicine and Emergency Services Division which has yet to achieve a sustainable process to meet this measure.

Pressure Ulcers Per 1000 Bed Days
Pressure ulcers per 1000 bed days decreased from 2.79 in May to 1.32 in June reflecting sustained input from both the Tissue Viability Team and wards with no stage 3 or 4 ulcers.

Emergency Readmissions Within 30 Days
30 day emergency readmissions of 12.8% decreased from 13.9% in May but performance remains above target of 12.2%. The Medical Director is progressing a shift to a divisionally led approach in order to promote a sustained impact on emergency readmissions and divisional plans have been sought for Q2.

Stroke
Admission to stroke unit within 4 hours is 56.3% based on discharge month which is below the 90% required. Applying admission month as opposed to discharge month performance rises to 76% indicating that the ring fencing of beds along with active inreach is having a favourable impact.

Medication Errors
An error rate of 3.19% is up from 2.48% last month. A culture promoting reporting errors along with multiple initiatives to tackle the safety of clinical practice is being used to address this.

Report of the Independent Cancer Taskforce: England's 5 Year Strategy
On 19 July the Report of the Independent Cancer Taskforce was published which outlines England's strategy to achieve world class cancer outcomes over the next 5 years, aligned to the Five Year Forward View. The headlines are that cancer services are projected to grow at around 9% per annum and nationally cancer services is an area with opportunity to be an early exemplar area under the FYFV. The strategy outlines 6 priority areas to be focussed on between 2015 and 2020 which are public health and prevention, earlier diagnosis, patient experience on a par with effectiveness and safety, patient support, and investment.

A summary of the report is provided in Appendix 7 and this includes demonstrating how our current Quality Account and Business Plan priorities are aligned with this new national strategy.

2 Performance Monitoring

2.1 Quality and Safety Balanced Scorecard[1]

Table 1: Quality Performance Dashboard

Measures outside limits have been summarised in Section 1 on page 3.

1. Best outcomes

	Measure	Outturn 14/15	Monthly Target 15/16	Annual Target 15/16	Jun 15 Actual	6-month trend	YTD 15/16
1-01	In-hospital SHMI	58	<72	<72	64		60
1-02	RAMI	60	<70	<70	56		60
1-03	In-hospital deaths	1111	86	<1033	88		204
1-04	Proportion of mortality reviews	38%	>90%	>90%	59%		40%
1-05	Number of cardiac arrests not in critical care areas	72	-	-	7		17
1-06	MRSA (Hospital only)	1	0	0	0		0
1-07	C.Diff (Hospital only)	18	1.4	17	0		4
1-08	Falls (Per 1000 Beddays)	3.29	3.00	3.00	2.63		2.94
1-09	Pressure Ulcers (Per 1000 Beddays)	2.03	1.19	1.19	1.32		2.10
1-10	Readmissions within 30 days - emergency only	12.6%	12.2%	12.2%	12.8%		12.9%
1-11	Stroke Patients (% admitted to stroke unit within 4 hours)	52.8%	90.0%	90%	56.3%		49.6%
NEW	Medication errors - rate per 1000 bed days	2.04%	2.01%	2.01%	3.19		2.91
NEW	Sepsis audits undertaken (PLACEHOLDER ONLY - TO BE ADDED IN Q3)						

3. Excellent experience

	Measure	Outturn 14/15	Monthly Target 15/16	Annual Target 15/16	Jun 15 Actual	6-month trend	YTD 15/16
CHANGED	Serious Incidents Requiring Investigation (SIRI) Reports Overdue to CCG				39		39
NEW	Serious Incidents Requiring Investigation (SIRI) Reports Submitted to CCG				8		8
3-07	Friends & Family Satisfaction Score - InPatients (incld Daycases)	93.3%	95%	95%	96.8%		96.5%
3-08	Friends & Family Satisfaction Score - A&E (incld Paeds)	83.6%	87%	87%	88.6%		86.2%
3-09	Friends & Family Satisfaction Score - Maternity (Composite Score)	95.8%	TBC	TBC	98.7%		96.3%
3-09a	Friends & Family Satisfaction Score - Outpatients	NEW	TBC	TBC	94.7%		93.4%
3-10	Follow-up complaints	85	7	81	2		9
3-11	Dementia screening (Composite Score)	96.6%	>90%	>90%	97.5%		96.8%

Rating table

Delivering or exceeding target		Improvement month on month
Underachieving target		In line with or just below last month
Failing target		Below target

[1] Indicators are defined in Appendix 1.

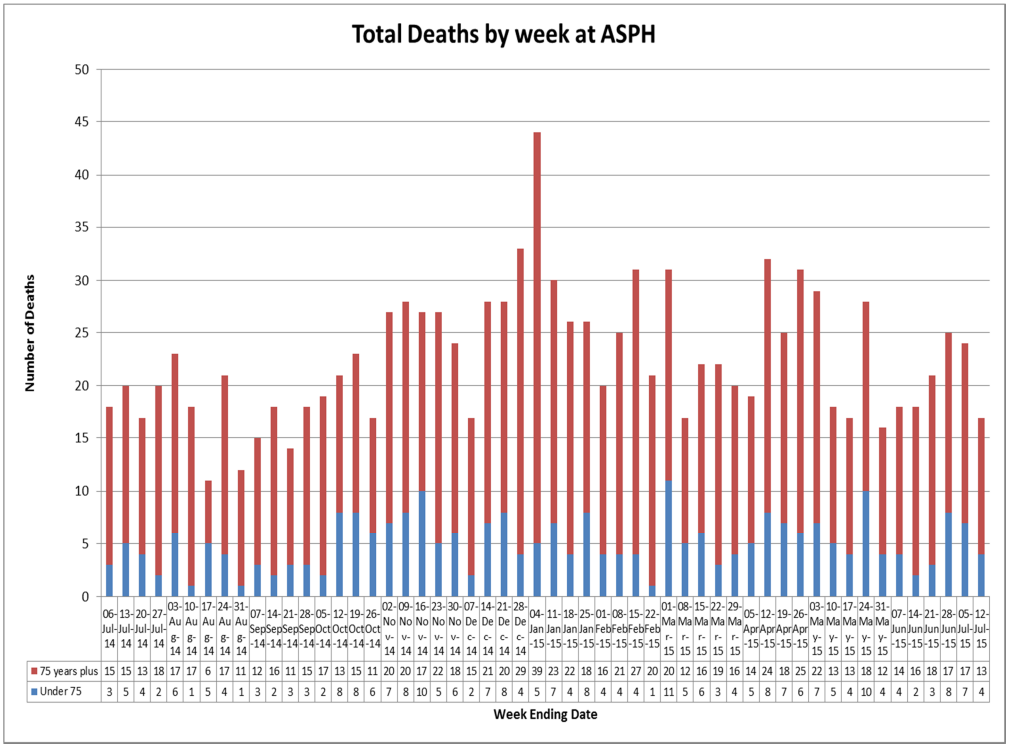
Scorecard Measures

In-hospital Summary Hospital Level Mortality Indicator (SHMI)[2]
In hospital SHMI of 64 for June is below both the monthly target of 72 and 67 in May.

Risk Adjusted Mortality Index (RAMI)
RAMI of 56 is below the limit of 70 and 71 in May. The mortality indices are reflecting the expected improvement associated with seasonal variation.

In-hospital Deaths
There has been no significant change with In-hospital deaths which at 88 is marginally above limit of 86 but just below May of 91.

Table 2: Total Deaths by Week at ASPH 2014/15



	06-Jul-14	13-Jul-14	20-Jul-14	27-Jul-14	03-Aug-14	10-Aug-14	17-Aug-14	24-Aug-14	31-Aug-14	07-Sep-14	14-Sep-14	21-Sep-14	28-Sep-14	05-Oct-14	12-Oct-14	19-Oct-14	26-Oct-14	02-Nov-14	09-Nov-14	16-Nov-14	23-Nov-14	30-Nov-14	07-Dec-14	14-Dec-14	21-Dec-14	28-Dec-14	04-Jan-15	11-Jan-15	18-Jan-15	25-Jan-15	01-Feb-15	08-Feb-15	15-Feb-15	22-Feb-15	01-Mar-15	08-Mar-15	15-Mar-15	22-Mar-15	29-Mar-15	05-Apr-15	12-Apr-15	19-Apr-15	26-Apr-15	03-May-15	10-May-15	17-May-15	24-May-15	31-May-15	07-Jun-15	14-Jun-15	21-Jun-15	28-Jun-15	05-Jul-15	12-Jul-15
75 years plus	15	15	13	18	17	17	6	17	11	12	16	11	15	17	13	15	11	20	20	17	22	18	15	21	20	29	39	23	22	18	16	21	27	20	20	12	16	19	16	14	24	18	25	22	13	13	18	12	14	16	18	17	17	13
Under 75	3	5	4	2	6	1	5	4	1	3	2	3	3	2	8	8	6	7	8	10	5	6	2	7	8	4	5	7	4	8	4	4	4	1	11	5	6	3	4	5	8	7	6	7	5	4	10	4	4	2	3	8	7	4

[2] Both the SHMI and the RAMI are reported on data 1 month in arrears.

Mortality Reviews
The table below shows the percentage of mortality reviews completed by Division[3], effective at the date of each month's scorecard cut-off date for Board reporting.

Percent of reviews completed by Division	April (%)	May (%)	June (%)
Acute Medicine and Emergency Services (AMES)	60	24	51
Diagnostics, Therapies, Trauma and Orthopaedics (DTTO)	0	66	50
Women's Health and Paediatrics (WHPAED)	100	100	100
Theatres, Anaesthetics, Surgery and Critical Care (TASCC)	100	100	100
Trust	**58**	**40**	**59**

The DTTO Division's deaths are low in number therefore the case not completed owing to an associated incident investigation resulted in diminished overall performance at 50%. Going forward the Division intends reviews to be completed on the wards whenever possible in order to improve timeliness. The lower compliance in the AMES Division was contributed to by the fact that the June Divisional Quality Governance meeting did not take place.

Number of Cardiac Arrests in Non-Critical Care Areas
In the most recent review of arrests only one event was not in the optimal location reflecting lack of bed capacity. In 66% of cases DNACPR[4] documentation was not in place when this would have been appropriate. The Treatment Escalation Plan process is being implemented by the Resuscitation Service so that on admission a patient's needs are assessed regarding care levels of which resuscitation status is a part.

MRSA[5]
There have been no hospital acquired MRSA cases this year.

C Difficile
There were no C.difficile cases this month.

Falls per 1000 Bed Days
Falls per 1000 bed days has decreased from 3.11 in May to 2.63 in June which is below target of 3.0. Total falls has similarly decreased from 49 to 38. Falls were reported in a deep dive review in May and improvement actions are continuing.

Pressure Ulcers Per 1000 Bed days
Pressure ulcers per 1000 bed days has decreased from 2.79 in May to 1.32 this month which is a significant achievement despite this being narrowly above the monthly target of 1.19. There were no stage 3 or 4 pressure ulcers and 14 stage 2 pressure ulcers, 4 of which were on Swan Ward. The target reduction of 20% in stage 2 ulcers equates to fewer than 22 per month and this was achieved in June. The Tissue Viability Service is providing targeted pop-up training in applicable areas and ward managers are implementing local actions. In Critical Care areas the SSKIN bundle[6] is now implemented in the electronic record and intermittent pneumatic compression device education has been provided to Swan Ward.

Emergency Readmissions Within 30 Days
The June 30 day emergency readmission rate of 12.8% exceeds target of 12.2%. The Medical Director has decided that following a 2 year multidisciplinary programme approach to readmissions there is a need to shift to a divisionally led approach in order to achieve a sustained impact on emergency readmissions in 2015/16. Divisional Directors are to notify their divisional plans to the Medical Director in Q2.

[3] Mortality reviews are reported 1 month in arrears, so June data pertains to review of May deaths.
[4] DNACPR: Do not attempt cardio-pulmonary resuscitation
[5] MRSA: Methicillin-resistant Staphylococcus Aureus
[6] SSKIN is a five step model for pressure ulcer prevention

Stroke
Admission to the stroke unit within 4 hours is 56.3% which is below the 90% required. Of note, the target is calculated based upon discharge data. Based upon June admissions data there has been an improvement to 76% which is in line with action plan expectations. Performance is monitored daily and is supported by both the ring fencing of beds and active inreach for patients in both the Emergency Department and Medical Assessment Unit.

Medication Errors per 1000 Bed Days
This month the medication error rate is 3.19 which is an increase from 2.01 in May. Benchmarked data indicates that overall medication errors are under reported in the Trust at 7% compared to the NRLS sector average of 11%. The categorisation as either prescribing or administration errors is under review. The aim is to promote the culture of reporting medication errors whilst simultaneously working to improve clinical practice through Pharmacy led training and the Manchester Patient Safety Framework. The Medication Safety Thermometer is being piloted in July and this will further promote safety improvement.

Serious Incidents Requiring Investigation (SIRI)
This month 8 SIRI reports were submitted to the Clinical Commissioning Group (CCG) for clearance which is in line with 7 in May. There were 39 SIRIs past their closure due date at the end of June which is a slight increase on 36 in May. There is a plan to submit all SIRIs to the CCG over the next few months in order to achieve submission of the remaining overdue SIRIs by the week commencing 7 September 2015.

Friends and Family Test (FFT) Satisfaction Score
In future the Maternity Department will be reporting at Touchpoint 2 (Labour Ward) only following a change in national guidance. This is due to a sector limitation regarding reporting patient numbers for other Touchpoints. Inpatients, Accident and Emergency, and Outpatients have all reported favourable satisfaction scores.

Follow-up Complaints
There were 2 follow-up complaints in June compared to 5 in May and this is a rate of 4.5% which is within the target range of less than 10%.

Dementia Screening
The dementia screening composite score of 97.5% exceeds target of 90%. A new process is being implemented so dementia screening will be medically led as part of intial clerking-in of patients with transmission to General Practitioners via the Realtime system.

Safety Alerts
No new safety alerts were received in June.

Safety Thermometer
The Classic NHS Safety Thermometer[7] is on track this month with all measures below the national average. The data incorporates the reclassification of May VTE prophylaxis data.

The Medication Safety Thermometer is to be piloted in July which is slippage against the Q1 target. The aim is to have this fully rolled out by December and this is progressing.

Nationally Maternity Safety Thermometer went into live phase from November 2014. The Trust submitted sample data from March 2015 including Q1 2015/16 sample data. From August onward full data is scheduled to be submitted for Postnatal ward, Labour Ward and Abbey Birth Centre. Community data will be on a sample basis owing to the data volume. Benchmarking nationally will be analysed when the dataset is larger.

[7] Refer to the explanation in Section 4.2, NHS Safety Thermometer (Charts 1 to 4)

Patient Experience
In June the new Datix Web complaints system is still being embedded and this has impacted upon the ability to provide complainants with responses to their concerns in accordance with the new timescales. We have made further system and process improvements and this is expected to improve response timescales over the next quarter.

Best Care Audits
10 wards/areas were audited in June, with no level 0 wards and 7 wards achieved level 2. There was 1 level 3 ward and 2 level 1 wards and half of the wards increased accreditation levels from previous months.

3 Clinical Effectiveness

3.1 NICE Guidance

The Trust registered in May as a stakeholder for consultation and review of the following guidance:

- Abdominal aortic aneurysm
- Attention deficit hyperactivity disorder (update)
- Urinary tract infection in children: Diagnosis, treatment and long-term management
- Failure to thrive
- Diagnostic services

As a stakeholder the Trust will be included on the list of registered stakeholders for the guidelines; the list will be posted on the NICE website during and after the development of the guidelines. Our contact details will be sent to the National Collaborating Centres to enable them to contact us at specified points during the process.

3.2 Q1 Update on Quality Priorities 2015/16

The Quality Priorities were approved by the Trust Board in 2014/15 and published in the Quality Account in May 2015. The dashboard in Appendix 5 summarises the progress against priorities during Q1.

The results will be presented to stakeholders in detail at the Quality Account Stakeholder Workshop on 12 August.

Exception reporting of red/amber items is below.

The Medication Safety Thermometer was not rolled out in Q1 when due. The pilot implementation has slipped marginally to July 2015 and it is intended to achieve full rollout by a revised timescale of December 2015. An internal Standard Operating Procedure is under development along with a mechanism for data collection.

The Trust aims to undertake root cause analysis (RCA) of 100% of identified cases of hospital associated thrombus (HAT). All RCAs for Q1 HAT cases are completed or in progress. However, some cases have exceeded the customary 2 month completion period that the Trust continues to aim for therefore this measure is amber rated.

The Trust undertook to audit the documentation of the prescription of chemical thromboprohylaxis for VTE with the aim of achieving 85%. Performance has declined from 81% in April, 77% in May to 75% in June. A deep dive to include validation of audit returns will be undertaken as priority to establish causes and guide improvement.

Quarterly audits of duty of candour is amber rated as this is yet to be commenced.

98% of eligible inpatients are to be screened for diabetes. The percentage of patients tested within 24 hours has remained just under the target of 98% in Q1 which is a significant improvement on 95% in Q4 2014/15. To guide improvement the Diabetes Specialist Nurses are visiting under performing wards to assess whether the score reflects actual practice or audit process.

30 day readmissions is amber rated and this is explained in Section 2.1, Performance Monitoring.

The Orthopaedic Supported Discharge expansion was required to have a business case by Q2. Whether the model is to be expanded beyond the Orthopaedics area is to be further explored in Q2.

The review of discharge assessment pertaining to return to care homes was to be reviewed by Q2. An update on this area is being progressed currently.

4 Safety

4.1 Safety Alerts

Risk of inadvertent injection with skin preparation solution of 26 May 2015
Divisional Quality Teams are working to provide the information to clear this alert as priority.

Acute Kidney Injury alert of 9 June 2014
Surrey Pathology Services is live testing the new algorithm with a view to providing monthly data to the Renal Registry from July in order to fulfil the requirements of the alert.

4.2 NHS Safety Thermometer (Charts 1 - 4)

The Classic NHS Safety Thermometer programme aims to achieve significant reductions in 4 types of avoidable harm: pressure ulcers, falls, Catheter Associated Urinary Tract Infection (CAUTI) and Venous Thromboembolism (VTE). Data is collected on inpatients on 1 day per month.[8] [9] Safety Thermometer performance for these harms is shown on Charts 1 to 4 on pages 13-14.

New harms of 1.30% this month is well below national average of 2.22%. 1 new CAUTI occurred in June but performance is below national limits. Although there were 2 hospital acquired falls with harm in June the rate was below the national average of 0.66%.

5 Patient Experience

Divisional Patient Experience metrics are shown in the Patient Experience Dashboard in Appendix 2.

In June 119 patients or families contacted PALS, a notable reduction compared to the previous quarter's average of 138. Concerns relating to the outpatient experience and communication were the highest areas of concern with 38 and 35 contacts respectively. Encouraginly 35 contacts pertaining to communication issues marks a notable drop from April and May where there were 53 and 49 concerns raised respectively. It is too early to indicate whether this drop is due to a natural variation or sustained improvement in communicating with patients. Improvement work continues to focus on the outpatient

[8] Approximately 500 patients
[9] The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care see: http://www.hscic.gov.uk/thermometer) http://www.ic.nhs.uk/services/nhs-safety-thermometer

journey with an Outpatient User Group commencing in September. Treatment and care concerns remain consistent with 13 concerns raised in June.

5.1 Formal Complaints

29 new formal complaints in June is below expected levels when compared with previous years. This is the 4th consecutive month where there has been a decline and whilst a seasonal decline is expected in summer the total numbers of new complaints are tracking below previous years. With the continuing decline in PALS concerns and complaints this could be indicative of an evolving culture on the frontline where staff are encouraged and empowered to resolve issues and concerns straight away. Whilst numbers of complaints relating to treatment and care remained consistent to previous months complaints relating to communication showed a significant drop to just 3. There was a spike in formal complaints pertaining to the outpatient journey with 10 complaints. No complaints in June pertained specifically to discharge concerns.

The previous month's spike in follow-up complaints has recovered with 2 complaints in June received as follow-ups or 4.5%.

5.1.1 Complaint Performance Against Timescale

The Patient Experience Dashboard in Appendix 2 shows divisional performance against timescale.

None of the divisions achieved the target introduced from April 2015 for responding to complainants within new timescales linked to the grade of complaint. The reason for this is largely because many of these complaints were received into the Trust in April and early May which is before 21 May, the date at which the complaints system was modified to accommodate differing complaint response dates by grade. Going forward performance is anticipated to improve significantly once the effects of the new system are fully embedded.

Complaints received before 1 April 2015 are reported against the previous measure of timescale agreed with complainant. In June there was a relatively low volume of such complaints thus the missed cases had a significant effect on performance rate. From July onwards there are 15 complaints still open which were received before April 2015. There are various reasons for the complaints being oustanding including serious incident investigations and complex multi-agency complaints. Excepting the 5 serious incidents, the10 remaining cases are scheduled to be resolved by the end of August.

5.1.2 Parliamentary and Health Service Ombudsman (PHSO) Cases

The status of active investigations is outlined in Appendix 3.

5.2 Patient Feedback

5.2.1 Friends and Family Test (FFT)[10]

Inpatients recommending the service remains stable and above the national average at 96.8%. The response rate has dipped slightly in June, however this is due to a minority of areas and all have provided assurance for refocussing efforts for obtaining feedback in July.

The Accident and Emergency Department recommended score has improved for the third consecutive month in May at 88.6% and is now exceeding the national average target of 87%. The response rate remains stable at 26.6%.

[10] The FFT asks the following standardised question: "How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?

The Maternity Department is now reporting at Touchpoint 2 (Labour ward) only, following a change in national guidance resulting from a sector issue with reporting patient numbers for the other Touchpoints. The Maternity Department is communicating this change to the team and will focus collection on this Touchpoint of the patient journey moving forwards. The responses are low for Touchpoint 2 in June at 8.7%, however the focus had previously been on Touchpoint 3, the inpatient experience, and this will now shift to Touchpoint 2. Therefore this figure is expected to improve and stabilise from July onwards.

The Outpatient Department's percentage recommended score[11] is stable at 94.7%. The first month for national submission was April 2015, however, latest data from NHS England is not showing Outpatient scores and therefore we are currently unable to benchmark.

5.3 Wow Awards

There were 15 WOW award nominations for Acute Medicine and Emergency Services, 11 for Diagnostics and Therapies, Trauma and Orthopaedics, 8 for Women's Health and Paediatrics and 7 for Theatres, Anaesthetics, Surgery and Critical Care. Human Resources had 4 proposals and Finance and Information received 3 nominations. Estates and Facilities had 2 nominees and Quality, Research, Medical, Nursing and Midwifery had 1.

5. 4 Best Care Audits

The Best Care Audit is an on going accreditation scheme used to assess wards against 14 quality and safety indicators. The frequency of Best Care Audits is aligned with performance. Wards may be reassessed every 2, 3, 4 or 6 months dependent upon achievement of accreditation levels of 0, 1, 2 or 3 respectively.

In June 10 wards were audited. The accreditation levels are shown below with detailed results in Appendix 6.

Swift and Theatres Ashford dropped to level 1 from levels 2 and 3 respectively. Swift had nursing documentation red rated decreasing from 86% to 64%. The specific areas of documentation that were not being met related to evidence of care planning, entries being dated and signed and evidence of patient/carer signature on care plans. The Ward Sister has raised these concerns with ward staff and spot checks of documentation have been implemented.

Theatres Ashford achieved red ratings for safeguarding and leadership. Patient observations, environment and infection control dipped from green to amber. The Theatre Sister has addressed safeguarding and the complaints procedure with staff at the department's daily debriefs.

Following the meeting with the Best Care Surveillance team, criteria for the leadership section will be reviewed as they are different to the criteria used by the rest of the wards and departments.

7 wards gained accreditation level 2: Birch, Medical Short Stay Unit, St Peter's Outpatients, Falcon, Heron, Theatres St Peters and Dickens.

Emergency Department achieved level 3 with 12 out of 14 indicators rated green.

[11] Outpatients is not yet nationally reported so there is no nationally set target. National average data is not available currently.

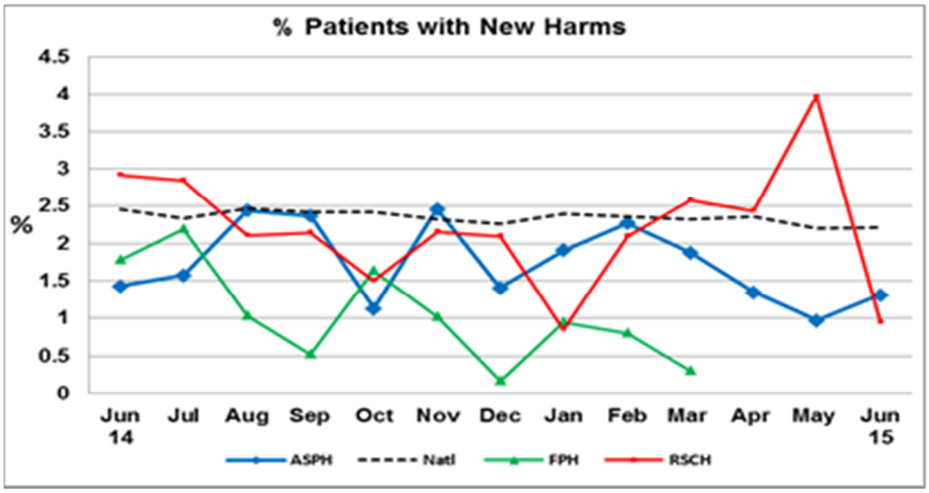
Table 3 Best Care Accreditation Levels June 2015

		Jan	Feb	Mar	Apr	May	Jun	Re-audit
Medicine & Emergency Services	Aspen	2				2		Sep
	CCU & Birch			1			2	Oct
	Cedar	2				2		Sep
	Holly		3					Aug
	May	3						Jul
	MAU			2				Jul
	MSSU		2				2	Oct
	Maple		3					Aug
	Fielding		3					Aug
	WWW/Chaucer			1				Jun
	Swift		2				1	Sep
	ED		2				3	Dec
	OPD ASH		3					Aug
	OPD SPH		2				2	Oct
Theatres Anaesthetics Surgery & Critical Care	Kingfisher	2				1		Aug
	Falcon			1			2	Oct
	SDU				3			Oct
	Heron			1			2	Oct
	SAU	1			1			Jul
	ITU		3					Aug
	HDU				3			Oct
	DSU ASH	3						Jul
	Theatres ASH						1	Sep
	Theatres SPH						2	Oct
T & O	Dickens			1			2	Oct
	SWAN	2				0		Jul
Women's Health & Paediatrics	Oak	2				3		Nov
	Ash			0		2		Sep
	NICU	2				1		Aug
	Paeds ED	3						Jul
	Labour Ward				2			Aug
	Joan Booker	2				3		Nov

6 Charts

Safety Thermometer Charts

Chart 1 Percentage of Patients with New Harms



Note: May data has been restated to reflected the updated VTE submission.

Charts 1 to 4 do not contain FPH data since April and the Health and Social Care Information Centre (HSCIC) has confirmed previously that the data has not been available.

Chart 2 Incidence of new Catheter Associated Urinary Tract Infection (CAUTI)

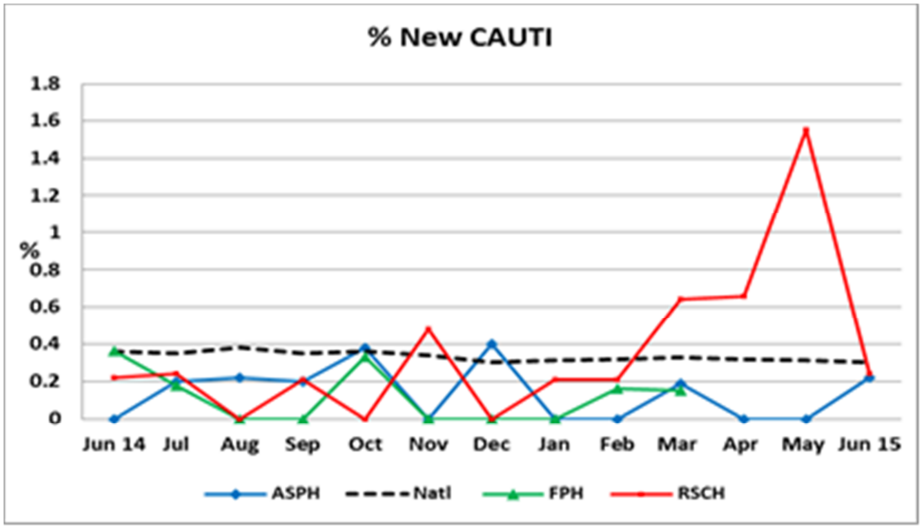


Chart 3 Incidence of New Pressure Ulcers

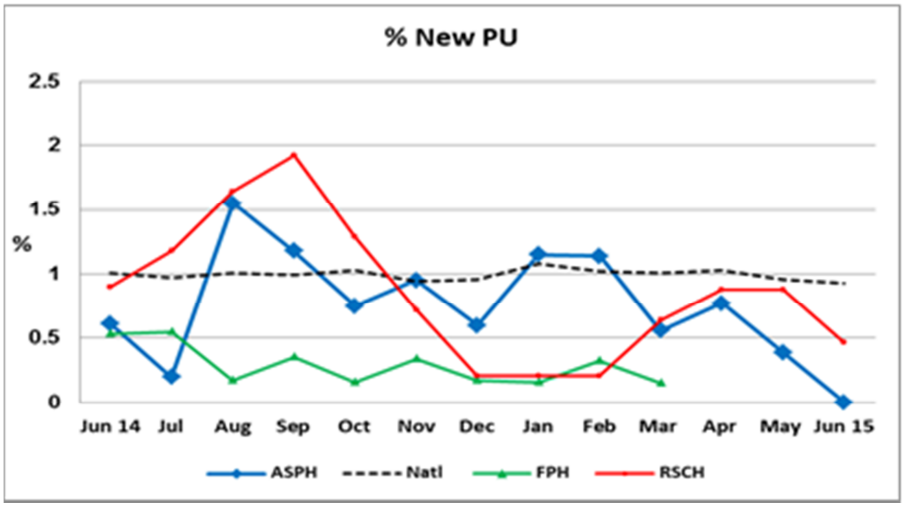
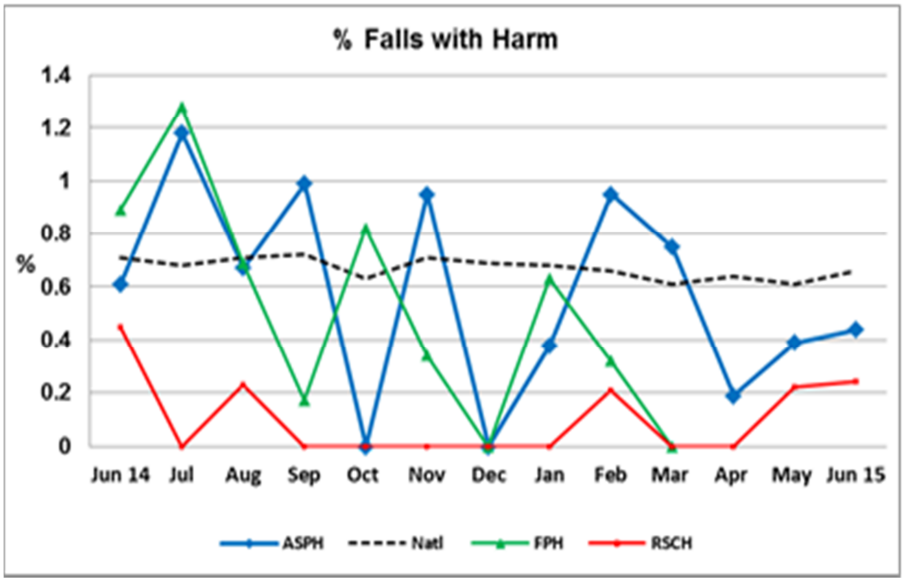
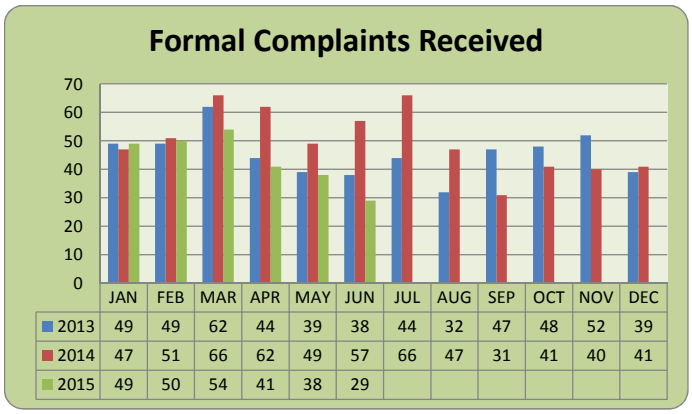


Chart 4 Percentage of Falls With Harm



Patient Experience Charts

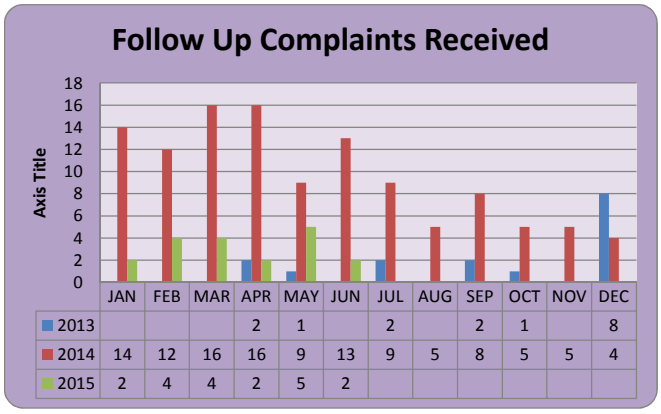
Chart 5a: Complaints Received by Month



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2013	49	49	62	44	39	38	44	32	47	48	52	39
2014	47	51	66	62	49	57	66	47	31	41	40	41
2015	49	50	54	41	38	29						

Complaint numbers are showing a reduction to date in 2015 and whilst in line with the expected seasonal trend numbers are falling below that of previous years.

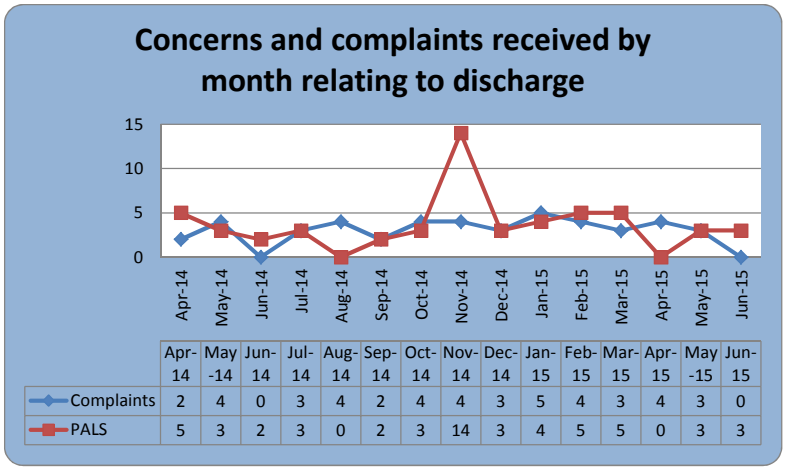
Chart 5b: Follow-up Complaints Received



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2013				2	1		2		2	1		8
2014	14	12	16	16	9	13	9	5	8	5	5	4
2015	2	4	4	2	5	2						

Follow-up complaints remain an important measure in quality of complaint response and these reduced to 2 in June providing assurance that the quality process around complaints remains robust.

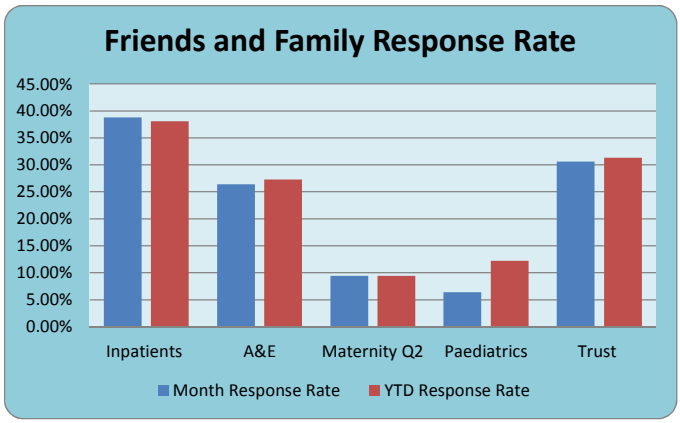
Chart 6: Concerns and Complaints about Discharge



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Complaints	2	4	0	3	4	2	4	4	3	5	4	3	4	3	0
PALS	5	3	2	3	0	2	3	14	3	4	5	5	0	3	3

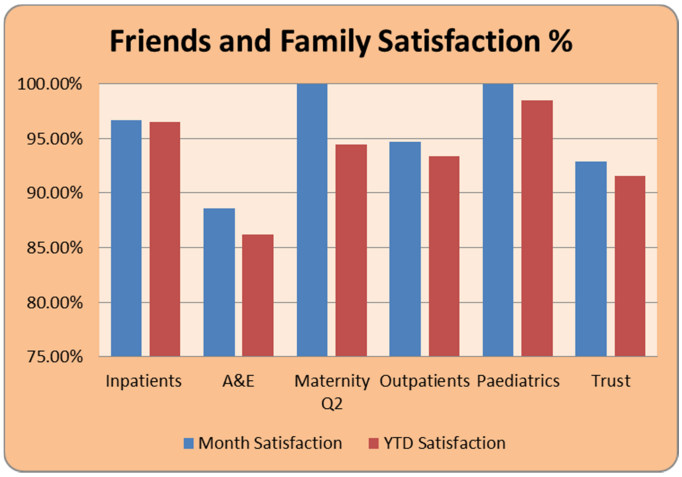
Complaints and concerns pertaining to discharge show a reduction in June. Discharge complaints are often complex in nature and work is being undertaken by the Head of Patient Experience to support the discharge teams in improving the journey of patients and families.

Chart 7: **Friends and Family Test (FFT) Response Rate**



There is no response rate calculated for Outpatients in line with national guidance. Maternity Touchpoint 2 is now the only nationally reported Touchpoint and there will be additional focus on gathering feedback in this area from July.

Chart 8: Friends and Family Test Satisfaction Percent



Friends and family satisfaction scores in the Trust are a reliable measure indicating satisfaction levels of our patients. The Trust is consistently above the national average in most areas, and has seen a continued improvement in the Accident and Emergency Department in recent months which is reflected in performance which exceeds the national average for June, a considerable achievement for the team.

7 APPENDICES

APPENDIX 1 Quality and Safety Balanced Scorecard Indicator Definitions 2015/16

1-01 The SHMI (Summary Hospital-Level Mortality Indicator) 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. A 3 year dataset is used to create the risk adjusted models. A 1 year dataset is used to score the indicator. The 1 year dataset used for scoring is a full 12 months up to, and including, the most recently available data. The 3 years used for creating the dataset is a full 36 months up to, and including, the most recently available data. The data source is CHKS. The monthly figure shown is a rolling 6 month position, reported one month in arrears and the YTD figure shown is a rolling 12 month position, reported one month in arrears.

1-02 The RAMI is the Risk Adjusted Mortality Index from CHKS. RAMI (Risk Adjusted Mortality Index) uses a method developed by CHKS to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data. The model calculates the expected probability of death for each patient based on the experience of the norm for patients with similar characteristics (age, sex, diagnoses, procedures, clinical grouping, and admission type) at similar hospitals (teaching status). After assigning the predicted probability of death for each patient, the patient-level data is aggregated. The data source is CHKS. The monthly figure and YTD are reported 1 month in arrears.

1-03 In-Hospital deaths as per the former CQUIN definition, with exclusions for age <18, maternity. The total number of in-hospital deaths (CQUIN definition, excludes age<18, maternity and ICD10 codes that relate to trauma - V01, X*, W*, Y*, O*).

1-04 Proportion of deaths for which mortality reviews are completed. Number of mortality reviews (numerator) divided by total number of deaths (denominator). Unlike 1-03, the denominator has no exclusions, i.e. all deaths are counted. This measure is reported 1 month in arrears to account for the time lag to carry out and record the mortality review.

1-05 Number of cardiac arrests which occurred other than in critical care areas, i.e. not in MAU, CCU, SDU, SAU, Endoscopy, Cardiac Catheter Laboratory, A&E, ICU, Theatres, MHDU, Paediatrics A&E.

1-06 Number of Hospital acquired MRSA cases.

1-07 Number of Hospital acquired C. difficile cases.

1-08 The total number of falls per 1000 bed days.

1-09 The total number of hospital acquired pressure ulcers per 1000 bed days.

1-10 Readmissions within 30 days of first admission where the first admission was an emergency.

1-11 Percentage of stroke patients admitted to a stroke unit within 4 hours.

1-12 Medication errors relating to administration and prescribing per 1000 bed days.

1-13 A measure for sepsis audits undertaken will be formulated in Q3.

3-03A The total number of Serious Incident Requiring Investigation (SIRI) reports submitted to the Clinical Commissioning Group (CCG) this month.

3-03B The total number of SIRI reports overdue for submission to the CCG.

3-07 Friends and Family Test Satisfaction: Percentage recommended score for Inpatients (Test asks following standardised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?"). Includes Daycase and Paediatric activity.

3-08 Friends and Family Test Satisfaction: Percentage recommended score for A&E (Test asks following standardised question: "how likely are you to recommend our A&E Department to friends and family if they needed similar care or treatment?"). Includes Paediatric activity.

3-09 Friends and Family Test Satisfaction: Percentage recommended score for Maternity (Composite Score). Maternity Composite Score calculated from the questions asked at 4 touch points - antenatal care, birth, labour ward and postnatal care.
3-09a Friends and Family Test Satisfaction: Percentage recommended score for Outpatients (Test asks following standardised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?"). Includes Paediatric activity.
3-10 The number of follow-up complaints received.
3-11 Dementia screening (Composite Score based on the national return, combining the two questions).

Note: Indicators 1-01 to 1-13 are from the Trust's Best Outcomes dashboard and Indicators 3-03 and 3-07 to 3-11 are from the Excellent Experience dashboard. Only indicators applicable to the Quality Report are included.

2. Target (T*) - where possible a national (N) or local (L) target has been used; where not available, we have used a percentage improvement on the 2014/15 year end total.

3. Outturn 2014/15 – the overall results for 2014/15.

4. YTD (Year-to-date) 2015/16 – the sum of the indicator from the beginning of the financial year (April).

5. Monthly Target 15/16 – the target for each month.

6. Annual Target 15/16 – the target for the 12 month period ending March 2016.

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

8. Performance - Monthly Trend Indicator - The arrows represent 1 of 3 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.

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APPENDIX 2 Patient Experience Dashboards – June 2015

Jun-15	AMES	YTD		TASCC	YTD		TODT	YTD		WH & Paeds	YTD		Fac &IS	YTD		HR & Other	YTD		Monthly Total	YTD	YTD target	Annual target
COMPLAINTS AND PALS DATA																						
Complaints Rec'd	16	50	▼	6	27	▼	2	16	▼	5	12	▲	0	1		0	2		29	108		
Discharge related complaints	0	6	▼	0	0		0	1		0	0								0	7		
Follow ups received	0	3		0	1		1	4		1	1								2	9		
PALS Concerns	49	156	▼	30	93	▲	25	92	▼	12	28	▲	1	13	▼	2	7	▼	119	391		
COMPLAINT TIMESCALE PERFORMANCE																						
% Response timescales met (pre April 15)	75.0%	90.9%		0.0%	94.0%		100.0%	100.0%		33.0%	63.0%		N/A	N/A		100.0%	100.0%		77.0%	89.0%	95.00%	>95%
Response to timescale Grade 1&2 in 25 days)	70%	76%		80%	92%		67%	71%		50%	33%		0%	0%		N/A	100%		67.0%	77.0%	95%	95%
Response to timescale Grade 3&4 in 35 days)	83%	89%		20%	50%		75%	75%		50%	67%		N/A	N/A		N/A	N/A		59.0%	71.0%	95%	95%
CLAIMS DATA																						
Intimations of claims	3	7	▲	5	8	▲	1	5		0	6	▼	0	0		0	0		9	21		
Reported claims	2	2	▲	3	3	▲	2	4	▲	0	1	▼	0	0		0	0		7	8		

FRIENDS AND FAMILY TEST PERFORMANCE						
Jun-15	FFT Returns	YTD	FFT Rec Score	YTD	Annual Target Returns	Annual Target Rec Score
Inpatients inc Daycase	28.7%	34.9%	96.8%	96.5%	30.0%	95.0%
Maternity Touchpoint 2	8.7%	10.6%	100%	94.5%	30.0%	97.0%
Maternity Composite Scores	15.2%	10.9%	98.7%	96.3%	TBC	TBC
Paediatrics	6.4%	12.2%	100.0%	98.5%	30.0%	95.0%
A&E	26.6%	27.1%	88.6%	86.2%	20.0%	87.0%
Outpatients	N/A	N/A	94.7%	93.4%	N/A	TBC - no national data
Trust	N/A	N/A	92.80%	91.50%	N/A	N/A

Decrease compared to previous month	▼
Increase compared to previous month	▲
Equal to or above target	
Within 5% of target	
+ 5% below target	
Not applicable	

APPENDIX 3 Patient Experience Schedules – June 2015

5.1.1 Complaint Response Time

Mean response time to complaint							
Month	AMES	WHPAED	TODT	TASCC	Facilities	Info/Fin/HR	Trust
April	23	22	21	26	22	18	23
May	27	21	16	31	21	-	25
June	24	29	20	40	29	-	28
July	25	26	19	50	16	61	33
August	22	21	19	41	19	-	26
September	33	35	36	32	14	28	33
October	32	26	34	49	-	-	39
November	38	40	37	37	-	-	36
December	34	44	38	39	15	-	38
January	41	31	29	32	-	31	35
February	30	34	38	30	26	-	32
March	34	35	32	29	24	-	32
April	28	31	39	27	-	-	28
May	31	32	37	23	-	28	32
June	36	44	40	30	31	-	39

The above table includes serious incident investigation responses which were initiated via the complaints system. Whilst this can cause a skew to overall mean response times it highlights the impact on timescale and the Trust goal is to identify serious incidents internally wherever possible.

One complaint was closed in June which was owing to a concurrent serious incident investigation. The TODT and WHPAED Divisions are focussing on managing timescales more robustly going forward through close monitoring by members of the Triumvirate.

Complaint Response Time by Grade of Complaint (post April 2015)

Mean response time by grade			
MONTH	Grade 1&2	Grade 3&4	COMBINED
April	24	37	28
May	31	32	32
June	26	30	28

Complaint Response Time Against Target Days (post April 2015)

Percent response within timeframe for grade (complaints received after 01 April 2015)		
MONTH	Grade 1&2 within 25 working days	Grade 3&4 within 25 working days
April	N/A	N/A
May	86%	100%
June	67%	53%

Grades 1 – 2: Of the complaints that breached the timescale, 100% of these were received before such a time that the system and process was set up in order to robustly manage this target. As such, these were all on a timeframe of 35 days. This was corrected for all complaints received after the 21 May 2015.

Grades 3 – 4: Of the complaints that breached the timeframe, 100% were received before teams were aware of the new targets in place and the new system was not set up to robustly manage the timeframes. Of the breached complaints the longest resolution took 57 days resulting from a multi-organisation complaint. The average time it took for the remaining breached complaints to be closed was 40 days. However it is reassuring that the average timescale for Grade 3 and 4 complaints has reduced down to 30 days indicating that the process is improving. The Trust is currently transitioning to the new target standard and the divisions are working towards ensuring they can meet these targets wherever possible. Gradual improvement is expected over the coming months. All complainants are fully informed if the original timescale set is not achievable.

5.1.2 Parliamentary and Health Service Ombudsman (PHSO) Cases

The table below shows the status of complaints currently active with the Ombudsman.

Division	Complaint Ref	Progress
AMES	JAN-2014 #1	Request for information fulfilled.
AMES	JAN-2014 #2	Information provided for investigation. Complaint not upheld.
AMES	MAR-2014#1	Still under consideration for local resolution.
AMES	APR-2014#3	Under consideration. Documents sent in May 2014.
AMES	APR-2014#4	Under consideration for possible local resolution, awaiting final response letter locally.
AMES/HR	APR-2014#5	Complainant has notified Trust of referral to PHSO – no contact from PHSO yet.
TASCC	APR-2014#6	Verbal contact from Ombudsman only, no documents requested yet. Still at local resolution stage.
DTTO&TASCC	MAY-2014 #1	Still with local resolution.
WHPAED	MAY-2014 #2	Draft report issued September. Trust to response by 13th October. PHSO plan not to uphold complaint.
WHPAED	JUN-2014 #1	Documentation provided June 2014.
AMES	AUG-2014#1	Request for information fulfilled. Currently under consideration.
AMES	AUG-2014#2	Not upheld. Awaiting full report.
TASCC	AUG-2014#3	Partially Upheld
AMES	OCT-2014 #1	Request for information fulfilled. Currently under consideration.
AMES	DEC-2014 #1	Request for information fulfilled. Currently under consideration.
AMES	JAN-2015 #1	Confirmation of investigation received 12.01.2015. Currently under consideration.
AMES	MAR-2015#1	Request for information received, due to submit by 13.04.2015.
AMES	JUN-2015#1	Request for information received, due to submit by 06.07.2015

5.1.3 Independent Investigations

The Trust is required to report to Commissioners on independent investigations into complaints. Active investigations are outlined below.

Division	Complaint Ref	Progress
AMES	REV#5	Independent Expert appointed to undertake an investigation - awaiting report

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Appendix 4 Quality Account Dashboard Priority Measure Definitions

Patient safety priority 1 - Improving harm-free care
Medication and Maternity Safety Thermometers are to be implemented by the end of Q1. Maintain Safety Thermometer performance better than (i.e., demonstrating a lower rate than) the national average.
Set and agree with clinical divisions trajectories for falls and hospital acquired pressure ulcers reductions by the end of Q1.
Risk assess 97% of adult inpatients for VTE on admission.
Perform root cause analysis of 100% of identified cases of hospital associated thrombosis.
Audit the documentation of the prescription of appropriate chemical thromboprophylaxis with the aim of achieving 85%.
Achieve VTE Exemplar Centre Status by 31 March 2016.
Patient safety priority 2 - Embedding and measuring the safety culture to strengthen transparency
Duty of candour training via induction from April 2015 with wider training programme to other staff groups fully rolled out by the end of Q2.
Audit duty of candour requirements quarterly with exception reporting to the Integrated Governance and Assurance Committee (IGAC).
Manchester Patient Safety Framework (MaPSaf) specialty rollout will be achieved by the end of Q2 with feedback via Team Brief. Action plans for each area including a heatmap will be in place by the end of Q3. Improvement work will progress in Q4. Quarterly updates to Trust Board.
The Board will be updated on progress through the quarterly reports to Trust Board. Action plans for each area including a heatmap will be in place by the end of Q3. Implementation of improvement work will progress in Q4.
Patient safety priority 3 - Preventing death and promoting successful recovery of patients with sepsis

Sepsis measure will be formulated once the CQUIN programme is finalised in conjunction with our Commissioners. Performance overseen by IGAC.

Clinical effectiveness priority 4 – Work to improve diagnosis and treatment for patients with diabetes

The population of eligible admitted patients to be screened for diabetes will continue to be audited on a spot day each month, with target performance to remain at 98% as per 2014/15.

Implement quarterly audits of the documentation of the prescription of insulin from Q2 with an action plan to be rolled out by Q3.

Undertake a review by the end of Q3 to identify an opportunity to work with external stakeholders to improve pathway working for patients with diabetes. The review will include setting a trajectory for implementation.

Clinical effectiveness priority 5 - Readmissions

The Readmissions Project led by the Medical Director to continue: review the pilot of contacting patients following discharge by the end of Q2. If analysis of the data demonstrates that the pilot resulted in benefits (of which one was reduction in readmissions) an action plan for expanding the post discharge contact of patients will be implemented by the end of Q2. Target 30 day emergency readmissions will be no greater than 12.2% by Q4.

Contribute to the feedback process of the locality hub pilot project in Woking and continue dialogue with external partners as to a trajectory for potential system wide expansion.

Clinical effectiveness priority 6 – National Audits, NICE Guidance and Technology Appraisals

NICE Technology Appraisals are to be implemented within the mandatory 3 month deadline (target: 100%).

Implementation of relevant NICE Clinical Guidelines – monthly status report on progress including gap analysis with reasons for non-compliance.

Monthly status report to be prepared identifying the introduction of new NICE Interventional Procedures to the Trust with clinical audit to provide evidence of safe practice.

Patient experience priority 7 – Improved experience of vulnerable groups; dementia and carers, mental health and cancer patients

The review of Mental Health Act policies and procedures by Q2 will demonstrate good practice within the sector.

Implement a process to ensure all applicable staff have had Mental Health Act training specific to their role by Q4.

Identify applicable front-line staff to attend and complete Surrey Public Health's 2015/16 suicide prevention training programme by the end of Q4.

A further quality account priority measure for dementia will be considered once the CQUIN programme is finalised with our Commissioners.

The Trust will improve the engagement with and feedback from carers of people with dementia via the carer survey and establishment of a memory café within the trust by end of Q2.

At least 50% of people with a dementia diagnosis who have significant memory impairment have a targeted document (either This Is Me[12] or REACH[13]) to improve staff awareness of their history and preferences by the end of Q3.

A review of an aspect of dementia friendliness of the physical environment in clinical areas will be undertaken by the end of Q2 and an adaptation or modification of the environment will be impact assessed for potential wider rollout.

The Trust will demonstrate an improved dementia training programme for staff by the end of Q4 2015/16 by:

- Implementing a mandatory level 1 update for all staff
- Developing and delivering level 2 training to staff who frequently work with people who may have dementia
- Exploring the need for level 3 training for specialist staff and Executive Directors.

Priority 8 – Obtain patient feedback on outpatient experience in conjunction with the Trustwide outpatient service improvement project

We will implement a system for communicating waiting time in Outpatients to patients attending clinics by end of Q3 2015/16.

[12] The This is Me tool is a booklet which people with dementia can use to inform staff about their needs, interests, likes and dislikes. Refer to the This is Me section of alzheimers.org.uk

[13] REACH is a special response plan for patients with dementia and is often undertaken in the community setting.

The Head of Patient Involvement and Experience will implement a process for obtaining feedback from patients and other service users regarding their experience of the new communication process by end of Q4 2015/16.

Priority 9 – Improve inpatient experience including discharge

We will prepare a business case for expanding the Orthopaedic Supported Discharge methodology to other divisions in order to implement this service more widely. The business case is to be developed by the end of Q2 2015/16.

We will implement a review of ward moves of patients during their inpatient stay including identification of a baseline, reasons for ward moves and an action plan for minimising moves. A trajectory for improvement against the baseline is to be set by Q3 2015/16.

By Q2 2015/16 we will implement a review of the process for discharge assessment of patients returning to care homes.

We will maintain follow-up complaints to fewer than 10% of complaints received, on average, across the year. Where the limit is exceeded we will perform root cause analysis and implement action plans to improve performance.

The Trust will continue design and implementation of end of life care outreach partnership working with hospices and other community organisations.

Appendix 5 Q1 Quality Account Priorities Dashboard

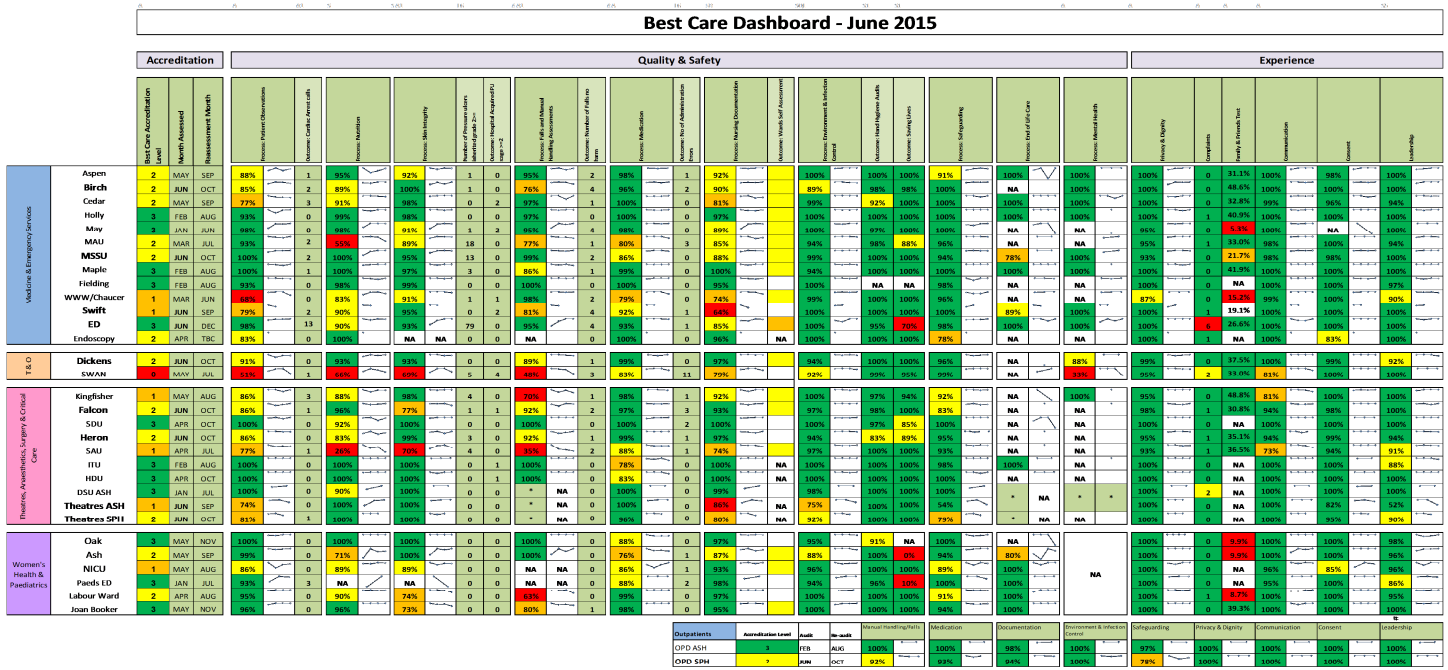
Q1 Quality Priority Dashboard 2015-16

REF	Quality Account Measure	Q1	Quarter 1 Narrative
	Safety - Improving harm free care		
1.1	Medication safety thermometer implemented by end of Q1		Nationally Medication Safety Thermometer commenced in October 2013. ASPH pilot will commence July 2015, to achieve full rollout by December 2015, an extension against the initial timescale. An internal Standard Operating Procedure is under development, along with a mechanism for data collection.
1.2	Maternity safety thermometer implemented by end of Q1		Nationally Maternity Safety Thermometer went into live phase from November 2014. The Trust submitted sample data from March 2015, including Q1 2015/16 sample data. From August onward full data is scheduled to be submitted for Postnatal ward, Labour Ward and Abbey Birth Centre. Community data will be on a sample basis owing to the data volume. Benchmarking nationally will be analysed when the dataset is larger.
1.3	Falls trajectories agreed with divisions by end of Q1		Achieved with accompanying action plan.
1.4	Pressure ulcer trajectories agreed with divisions by end of Q1		Achieved with accompanying action plan.
1.5	Maintain Safety Thermometer performance better than national average		Classic safety thermometer achieved this for new harms, CAUTI, pressure ulcers and falls.
1.6	Risk assessed 97% of adult inpatients for VTE on admission		Over 97% of adult inpatients have been VTE Risk assessed on admission for Q1 with April 97.6%, May 97.8% and June 98.9%.
1.7	Root cause analysis of 100% of identified cases of hospital associated thrombus (HAT)		All RCAs for Q1 HAT cases are completed or in progress. However, some cases have exceeded the customary 2 month completion period that the Trust continues to aim for.
1.8	Audited documentation of the prescription of appropriate chemical thromboprophylaxis with the aim of achieving 85%		Performance has declined from 81% in April, 77% in May to 75% in June. A deep dive to include validation of audit returns will be undertaken to establish causes and guide improvement.
1.9	Achieve VTE Exemplar Centre Status by 31 March 2016		The Trust has achieved 3 of the 6 required indicators so far, with work ongoing to meet VTE Prevention England's award criteria.
	Partially achieved at Q1		
	Safety - Embedding and measuring safety culture		
2.1	Duty of candour programme included in Trustwide induction by April 2015		Achieved.
2.2	Disseminate duty of candour training programme to other staff groups by Q2		Duty of candour workshops commenced and compulsory online training is due for complete rollout by Q2.
2.3	Quarterly audits of duty of candour with exeception reporting to IGAC		The framework and plan for quarterly audits requires formulation.
2.4	Complete Manchester Patient Safety Framework rollout by end of Q2, feedback via Team Brief		MaPSaF rollout is progressing well in both Medicine and Surgery.
2.5	Divisional actions plans for MaPSaF, including heatmaps, in place by end of Q3		To progress in Q2.
2.6	Progress implementation of MaPSaf improvement work in Q4		To progress in Q2.
	Partially achieved at Q1		
	Safety - Preventing death and promoting recovery (sepsis)		
3.1	Sepsis measure to be formulated based on CQUIN		To be formulated in Q2.
	Not due at Q1		

Clinical Effectiveness - Diagnosis and treatment of diabetes		
4.1 Screen 98% eligible inpatients for diabetes (spot audit)		The percentage of patients tested within 24 hours has remained just under the target of 98% in Q1 which is a significant improvement on 95% in Q4 2014/15. To guide improvement the Diabetes Specialist Nurses are visiting under performing wards to assess whether the score reflects actual practice or audit process.
4.2 Insulin prescribing documentation audits undertaken quarterly from Q2		To progress in Q2.
4.3 Action plan to improve insulin prescribing to be rolled out by Q3		To progress in Q2 following audit implementation.
4.4 Diabetes pathway working with external stakeholders - review and implementation trajectory by Q3		Plan to be scoped in Q2.
Not due at Q1		
Clinical effectiveness - Readmissions		
5.1 Readmissions project led by the Medical Director is to continue		The Medical Director has decided that following a 2 year multidisciplinary programme approach to readmissions there is a need to shift to a divisionally led approach in order to achieve a sustained impact on emergency readmissions in 2015/16. Divisional Directors are to notify their divisional plans to the Medical Director in Q2.
5.2 Target 30 day emergency readmissions will be no greater than 12.2% by Q4		See above combined readmissions commentary.
5.3 Review post discharge contacting patients pilot and consider expansion by end Q2		The Medical Director is exploring whether junior doctor post discharge contact of patients can progress, as this showed early promise and was well received by patients in the 2014/15 Q4 pilot.
5.4 Input to Woking hub pilot feedback, continue external dialogue re. expansion		To progress.
Partially achieved at Q1		
Clinical effectiveness - Learning from audits and NICE guidance		
6.1 100% implementation of NICE Technology Appraisals within 3 month deadline		None published for April or May, work is underway for meeting the September deadline for implementing the Technology Appraisals received in June. All drug related appraisals are implemented via Pharmacy in order to meet the deadline.
6.2 NICE Guideline status report and gap analysis		Twelve guidelines are being reviewed to identify any gaps and implementation required.
6.3 NICE Procedures - status report and audit to evidence safe practice		April and May (none published). June guidance being reviewed. 2 new procedures being planned.
Achieved at Q1		

	Patient Experience - Experience of vulnerable groups		
7.1	Mental Health Act (MHA) policies and procedures review by Q2		To progress in Q2.
7.2	MHA training specific to role by Q4		In progress.
7.3	Complete Surrey Public Health suicide prevention training by end Q4		To progress when the external training material is available.
7.4	Dementia quality priority to be formulated once CQUIN finalised		To progress in Q2.
7.5	Improve feedback via carers survey, establish memory café by Q2		This is progressing and the Memory Café has been set up.
7.6	50% applicable dementia patients to have This is Me/REACH documents by end Q3		To progress in Q2.
7.7	Dementia friendly environment review by Q2, followed by impact assessment		To progress in Q2.
7.8a	Mandatory level 1 dementia training update (all staff) by Q4		Dementia mandatory training is under review.
7.8b	Level 2 training delivered to all staff frequently working with dementia (Q4)		Review of training by level is in progress.
7.8c	Level 3 training for specialist staff and Executive Directors to be explored by Q4		Review of training by level is in progress.
	Not due at Q1		
	Patient Experience - feedback of outpatient experience		
8.1	System for communication Outpatient Clinic wait time implemented by end Q3		In place in SPH via Clarity system, updates to patients every ten minutes. Roll out iminent in Ashford.
8.2	Implement service user feedback process about new wait time system (Q4)		To be implemented following roll out of communication system.
	Partially achieved at Q1		
	Patient Experience - inpatient experience		
9.1	Orthopaedic Supported Discharge methodology expansion business case by Q2		There are plans to increase the capacity to support orthopaedics relating to the Orthopaedic Supported Discharge model; exploration of whether the model will be expanded to other divisions will occur in Q2.
9.2	Ward moves review with trajectory and improvement plan by Q3		A cross-divisional approach is to be explored in Q2.
9.3	Discharge assessment re. return to care homes to be reviewed by Q2		This action will be reviewed as priority in Q2 in association with the Discharge Team.
9.4	Follow-up complaints < 10% of complaints received, on average. RCA and action plan if exceeded.		Q1 follow-up complaints were 6.5%. This provides assurance that the quality of complaint response has improved and complainants are largely satisfied with the responses they are receiving from the Trust. All follow-ups received in Q1 have been discussed at the weekly complaints panel and further learning and imporvement has been taken from this.
9.5	Continue end of life care outreach partnership working		There is a quarterly plan for partnership working covering Palliative Medicine Consultant appointment, attending North West Surrey End of Life Steering Group and the North West Surrey Palliative Care Forum. We are collaborating with hospices and community providers to support advance care planning.
	Partially achieved at Q1		

APPENDIX 6



Best Care Dashboard - June 2015

		Accreditation			Quality & Safety																						Experience					
		Best Care Accreditation Level	Month Assessed	Reassessment Month	Process: Patient Observations	Outcome: Cardiac Arrest calls	Process: Nutrition	Process: Skin Integrity	Number of Pressure ulcers (ulcers that upgrade 2+)	Outcome: Hospital Acquired PU stage 2+3	Process: Falls and Manual Handling Assessments	Outcome: Number of Falls no harm	Process: Medication	Outcome: No of Administration Errors	Process: Nursing Documentation	Outcome: Wounds Self Assessment	Process: Environment & Infection Control	Outcome: Hand Hygiene Audits	Outcome: Saving Lives	Process: Safeguarding	Process: End of Life Care	Process: Mental Health	Privacy & Dignity	Complaints	Family & Friends Test	Communication	Consent	Leadership
Medicine & Emergency Services	Aspen	2	MAY	SEP	88%	1	95%	92%	1	0	95%	2	98%	1	92%		100%	100%	100%	91%	100%		100%	0	31.1%	100%	98%	100%
	Birch	2	JUN	OCT	85%	2	89%	100%	1	0	76%	4	96%	2	90%		89%	98%	98%	100%	NA		100%	0	48.6%	100%	100%	100%
	Cedar	2	MAY	SEP	77%	3	91%	98%	0	2	97%	1	100%	0	81%		99%	92%	100%	100%	100%		100%	0	32.8%	99%	96%	94%
	Holly	3	FEB	AUG	93%	0	99%	98%	0	0	97%	0	100%	0	97%		100%	100%	100%	100%	100%		100%	1	40.9%	100%	100%	100%
	May	3	JAN	JUN	98%	0	98%	91%	1	2	96%	4	98%	0	89%		100%	97%	100%	100%	NA		NA	0	5.3%	100%	NA	100%
	MAU	2	MAR	JUL	93%	2	55%	89%	18	0	77%	1	80%	3	85%		94%	98%	88%	96%	NA		NA	1	33.0%	98%	100%	94%
	MSSU	2	JUN	OCT	100%	2	100%	95%	13	0	99%	2	86%	0	88%		99%	100%	100%	94%	78%		100%	0	21.7%	98%	98%	100%
	Maple	3	FEB	AUG	100%	1	100%	97%	3	0	86%	1	99%	0	100%		94%	100%	100%	100%	100%		100%	0	41.9%	100%	100%	100%
	Fielding	3	FEB	AUG	93%	0	98%	99%	0	0	100%	0	100%	0	95%		100%	NA	NA	98%	NA		NA	0	NA	100%	100%	97%
	WWW/Chaucer	1	MAR	JUN	68%	0	83%	91%	1	1	98%	2	79%	0	74%		99%	100%	100%	96%	NA		NA	0	15.2%	99%	100%	90%
	Swift	1	JUN	SEP	79%	2	90%	95%	0	2	81%	4	92%	1	64%		100%	100%	100%	100%	89%		100%	1	19.1%	100%	100%	100%
	ED	3	JUN	DEC	98%	13	90%	93%	79	0	95%	4	93%	1	85%		100%	95%	70%	98%	100%		100%	6	26.6%	100%	100%	100%
	Endoscopy	2	APR	TBC	83%	0	100%	NA	NA	0	0	NA		0	100%	NA	100%	100%	100%	78%	NA		NA	1	NA	100%	83%	100%
T & O	**Dickens**	2	JUN	OCT	91%	0	93%	93%	0	0	89%	1	99%	0	97%		94%	100%	100%	96%	NA	88%	99%	0	37.5%	100%	99%	92%
	SWAN	0	MAY	JUL	54%	1	66%	60%	5	4	68%	3	83%	11	79%		92%	99%	95%	99%	NA	33%	95%	2	33.0%	81%	100%	100%
Theatres, Anaesthetics, Surgery & Critical Care	Kingfisher	1	MAY	AUG	86%	3	88%	98%	4	0	70%	1	98%	1	92%		100%	97%	94%	92%	NA	100%	95%	0	48.8%	81%	100%	100%
	Falcon	2	JUN	OCT	86%	1	96%	77%	1	1	92%	2	97%	3	93%		97%	98%	100%	83%	NA	NA	98%	1	30.8%	94%	98%	100%
	SDU	3	APR	OCT	100%	0	92%	100%	0	0	100%	0	100%	2	100%		100%	97%	85%	100%	NA	NA	100%	0	NA	100%	100%	100%
	Heron	2	JUN	OCT	86%	0	83%	99%	3	0	92%	1	99%	1	97%		94%	83%	89%	95%	NA	NA	95%	1	35.1%	94%	99%	94%
	SAU	1	APR	JUL	77%	1	26%	70%	4	0	35%	2	88%	1	74%		97%	100%	100%	93%	NA	NA	93%	1	36.5%	73%	94%	91%
	ITU	3	FEB	AUG	100%	0	100%	100%	0	1	100%	0	78%	0	100%	NA	100%	100%	100%	98%	100%	NA	100%	0	NA	100%	100%	88%
	HDU	3	APR	OCT	100%	0	100%	100%	0	1	100%	0	83%	0	100%	NA	100%	100%	100%	100%	NA	NA	100%	0	NA	100%	100%	100%
	DSU ASH	3	JAN	JUL	100%	0	90%	100%	0	0	*	NA	0	100%	0	99%	98%	100%	100%	100%	*	NA	*	2	NA	100%	100%	100%
	Theatres ASH	1	JUN	SEP	74%	0	100%	100%	0	0	*	NA	0	100%	0	86%	NA	75%	100%	100%	54%	*	NA	0	NA	100%	82%	52%
	Theatres SPH	2	JUN	OCT	81%	1	100%	100%	0	0	-	NA	0	96%	0	80%	NA	92%	100%	100%	73%	-	NA	NA		100%	95%	90%
Women's Health & Paediatrics	Oak	3	MAY	NOV	100%	0	100%	100%	0	0	100%	0	88%	0	87%		95%	91%	NA	100%	NA		100%	0	5.9%	100%	100%	98%
	Ash	2	MAY	SEP	98%	0	71%	100%	0	0	100%	0	76%	1	87%		88%	100%	0%	94%	80%		100%	0	9.9%	100%	100%	96%
	NICU	1	MAY	AUG	86%	0	89%	89%	0	0	NA	NA	0	86%	1	93%	96%	100%	100%	89%	100%	NA	100%	0	NA	96%	85%	96%
	Paeds ED	3	JAN	JUL	93%	3	NA	NA	0	0	NA	NA	0	88%	2	98%	94%	96%	10%	100%	100%		100%	0	NA	95%	100%	86%
	Labour Ward	2	APR	AUG	95%	0	90%	74%	0	0	63%	0	99%	0	97%		100%	100%	100%	91%	100%		100%	1	8.7%	100%	100%	95%
	Joan Booker	3	MAY	NOV	96%	0	96%	73%	0	0	80%	1	98%	0	95%		100%	100%	100%	94%	100%		100%	0	39.3%	100%	100%	100%

Outpatients	Accreditation Level	Audit	Re-audit	Manual Handling/Falls	Medication	Documentation	Environment & Infection Control	Safeguarding	Privacy & Dignity	Communication	Consent	Leadership
OPD ASH	3	FEB	AUG	100%	100%	98%	100%	97%	100%	100%	100%	100%
OPD SPH	?	JUN	OCT	92%	93%	94%	100%	78%	100%	100%	100%	100%



PLEASE NOTE THAT THIS DASHBOARD HAS BEEN PARTIALLY UPDATED. ONLY WARDS DUE FOR REASSESSMENT HAVE A NEW ACCREDITION AND SCORE. THIS IS HIGHLIGHTED IN BOLD

The Spartline incorporates the reassessment audits since April 2013

Outcome:	KEY:	Description:
MRSA		Numbers of Hospital acquired MRSA
C. Diff	NA = Not Applicable	Number of Hospital acquired C. Diff
Hospital Acquired PU	NS = Non Submission	Number of hospital acquired pressure ulcers
Number of Falls	WM = Ward Not Open	Number of falls
Number of Falls resulting in injury	* = Indicator Not Established	Number of falls resulting in injury
Appropriate referrals to Dietician		Percentage of patients who were appropriately referred to a dietician
No of Incidents of poor documentation		TBC
No of Administration Errors		Number of errors in drug administration

APPENDIX 7 Report of the Independent Cancer Taskforce: England's 5 Year Strategy

On 19 July the Report of the Independent Cancer Taskforce was published which outlines England's strategy to achieve world class cancer outcomes over the next 5 years, aligned to the Five Year Forward View. The headlines are that cancer services are projected to grow at around 9% per annum and nationally cancer services is an area with opportunity to be an early exemplar area under the FYFV. The strategy outlines 6 priority areas to be focussed on between 2015 and 2020:

1. Public health and prevention with emphasis on smoking and obesity.
2. Earlier diagnosis with impact on diagnostic capacity and new testing models.
3. Patient experience is to be on a par with clinical effectiveness and safety. There is focus on patient access to their medical results online, the annual Cancer Patient Experience Survey and patient experience metrics.
4. Patient support via a follow-up pathway and a recovery package along with end of life care in accordance with the NICE Quality Standard.
5. Investment in capital equipment, workforce and medication.
6. A population based commissioning framework with Cancer Alliances for service redesign.

The national strategy provides the Trust with some really challenging areas for our services, but it is encouraging that already both our Quality Priorities and Business Plan Priorities for the current year are already in alignment with this vision.

In our Business Plan within Best Outcomes we have committed to partnership working regarding end of life care. We have a quarterly plan for implementing the new end of life care service with the hospice/community involving an integrated staff training and development programme which in Q2 is to focus on service integration. In quarters 3 and 4 a link nurse development programme is to support mentoring and buddying. Further initiatives include the Preferred Place of Care – Rapid Discharge Tool to be piloted in Q2 with a view to implementing this in Q4.

In Great Experience within the Business Plan we have committed to improved experience for cancer patients via pathway integration. There is a quarterly plan for implementing cancer pathway integration encompassing stakeholder liaison, Accident and Emergency Department audit of cancer admissions in Q2, review of further external support in Q3 and education delivery to General Practitioners in Q4.

Whilst clearly the national strategy provides the Trust with a significant challenge in how going forward we meet the stretch goals set, it is a positive start that our current priorities are already aligned with both the FYFV[14] and this priority national initiative.

[14] FYFV: NHS Five Year Forward View, NHS England: October 2014

Bibliography:

Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020, Executive Summary. A Report of the Independent Cancer Taskforce.

Link to Executive Summary:http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_executive_summary.pdf

Full report: http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf